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Professional identity transitions, violations and reconciliations among new nurses in low- and middle-income countries

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ABSTRACT

We examine how new nurses construct their professional identity in Low- and Middle-Income Countries (LMICs) when they enter clinical practice and encounter practical norms violating procedural standards. We conducted interviews and focus group discussions with 47 Kenyan nurses. We describe new nurses experiencing 'shock' entering nursing practice (working and learning alone while responsible for many patients and doing 'dirty work'), which contrasted with their idealized image and expectations of nursing and prior training. We explain this transition using theory about identity and identity work, which we argue elucidates nurses' experiences in LMICs. We suggest that nurses' transition into clinical practice violated pre-existing expectations for their professional identities, which then triggered identity work of 'toughening up', 'maturing through experience', and 'learning practical norms'. Through this identity work, and finally experiencing satisfaction from caring for and nursing patients back to health, some nurses were able to restore their valued professional identity.

Our findings highlight the need for professional educators and healthcare policymakers in LMICs to reconsider the way new healthcare workers are prepared for and socialized into professional practice, acknowledging that nursing practice is often very different to training. We argue for developing formative spaces in which health professionals can safely discuss practical norms deviating from procedural standards. Drawing on such conversations, practical norms benefitting the quality and safety in resource constrained contexts might then be incorporated into care standards and ways found to address practical norms harming of patient care.

1. Introduction

The idealized identity of the 'good nurse' often fails to reflect economic circumstances affecting much nursing work (Fealy, 2004). Becoming a new nurse, transitioning from training into work where practices contrast with expectations, therefore often involves a 'shock' (Duchscher, 2009). This shocking transition may be extreme in Low- and Middle-Income Countries (LMICs), where nurses (and other health professionals) commonly lack the resources they need, are overworked, and feel undervalued and demotivated (Willis-Shattuck et al., 2008; Chandler et al., 2009; Hadley et al., 2007; Walker & Gilson, 2004, McKnight et al., 2020). However, while nurses comprise the largest part of the healthcare workforce (Bangdiwala et al., 2010; WHO, 2016), we know little about nurses' formative experiences in health care systems in LMICs, or their impact on nurses' careers and clinical practices in the longer term.

Amalberti et al. (2006) discuss time and resource pressure on health systems generally pushing professionals to the boundaries of tolerating violations of procedural standards to cope, although such violation are rarely reported and difficult for outsiders to see. High disease burdens and resource shortages mean that nurses in LMICs often struggle to meet professional standards, usually transposed from different (high income) settings (Ritchie et al., 2016), so violations of procedural standards may

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be particularly prevalent in resource constrained health systems in LMICs. Some violations may enhance patient safety, enabling professionals to cope and provide some patient care in pressurized and resource-limited contexts, while others procedural violations are dangerous and harm patient care.

More generally in LMICs, 'practical norms' (De Sardan, 2015) are often at odds with professional and official norms learned during training. Practical norms are tacit and informal norms diverging from official or social norms, but which implicitly regulate many public servants' practices in Africa and other LMICs in circumstances where laws and guidelines cannot be effectively enforced. 'Adaptive' or 'palliative' practical norms may be deemed necessary to maintain public services in resource constrained contexts unable to meet official norms but elsewhere 'transgressive' practical norms perpetuate corruption and malpractice (De Sardan, 2015).

New nurses commonly adopt the practical norms of senior colleagues, while experiencing procedural violations and transgressive practical norms when starting practicing in health systems in LMICs. This may lead nurses to question their new professional identities and expectations, leading to loss of confidence, demotivation and burnout. However, through 'identity work' (Pratt et al., 2006), other health professional have reconciled their desired professional identity and motivation after similar transitions and identity violations (Pratt et al., 2006. Accordingly, we ask the following research question: *How do nurses experience and deal with the transition from training into practice in LMICs and how does this process affect their professional identities and practices?* The purpose of this paper is therefore to analyse the way new nurses in Kenya construct their professional identities as they encounter and are encultured into nursing practices in new nursing roles.

We discuss theory relating to professional and nursing identity, then outline our qualitative research methods. Next, we describe Kenyan nurses' motivations for professional training and the 'shock' they experienced moving from training into nursing practice, working and learning alone, and doing 'dirty work'. We then explain their identity work, involving 'toughening up' 'maturing through experience' and 'learning practical norms'. Finally, through caring for and nursing patients back to health, some nurses fulfilled their professional calling, secured their position in the health care system, and became role models and mentors to newer cadres of nurses. We conclude by highlighting our contribution to the understanding of healthcare professional and practices in LMICs and discuss their implications for policy, quality and safety in healthcare.

2. Professional identity and nursing

We draw upon theory about identity and identity work to elucidate the experiences of new nurses beginning working in health systems in LMICs. Rather than contributing to the already crowded literature on identity in organizations, we use identity theories to explain new professionals' experiences in health care settings in LMICs. In doing so, we highlight implications for professional training and improving Human Resources for Health (HRH) and in how quality and safety might be improved in health systems in LMICs.

The concept of '*identity* refers to the meanings that individuals attach reflexively to themselves, and developed and sustained through processes of social interaction as they seek to address the question 'who am I?'' (Brown, 2015, p. 23). Identity may incorporate a *personal identity* (an individual sense of self), a collective *social identity* (membership of a group, e.g. a nationality or profession) and a *role identity* (e.g., being a nurse). Identity is also constructed in relation to wider circumstances, narratives, discourses, the organizations people work in, and so may change as people move between contexts or as contexts change (Brown, 2015). Transitions and tension often require agentic *identity work*, which 'refers to people being engaged in forming, repairing, maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness' (Sveningsson & Alvesson, 2003, p. 1165). *Professional* identities reflect and shape how professionals (e.g. nurses or doctors) think of themselves individually and collectively (as a member of their profession) and, in turn, enact social roles. Aligning a desired identity with the work people do is a fundamental motivator for healthcare professionals but may require challenging identity work in health care (Croft et al., 2015; Ibarra, 1999; McGivern et al., 2015; Pratt et al., 2006).

For nurses, development of professional identity begins during nursing education. However, moving from being a student to a practicing nurse can be shocking and stressful, as novice nurses struggle to cope with work demands, expectations, theory-practice dissonance, unfamiliar complex workplaces (Duchscher, 2009; Marañón & Pera, 2015) and responsibility for patients (Deppoliti, 2008). Supportive collegial relationships, supervision and mentorship are often crucial during transition from training into practice (Ten Hoeve et al., 2018). Frustration with work, role ambiguity, value conflicts and failure to meet expectations have been associated with new nurses feeling disillusioned, burned-out and wanting to leave their profession (Ke & Stocker, 2019).

Nurses can construct positive professional identities in difficult circumstances. For example, South African nurses in Walker and Gilson's (2004) study described themselves as 'bitter but satisfied' serving the public under difficult conditions. Female nurses dealing with socially 'difficult' and 'distasteful' issues in the UK were found to 'celebrate their status as women carrying out 'dirty work' as ennobling, something that only 'real' women could possibly do' (Bolton, 2005, p. 182).

Conversely, Jewkes et al. (1998) describe South African nurses slapping, shouting at and neglecting patients they judged as inferior or subordinating nurses' authority, which the authors explain as these nurses attempting to secure insecure middle-class professional identity and superior status over patients. Likewise, Hadley et al. (2007) describe female Bangladeshi nurses avoiding caring for male patients, because physical contact with men was associated with commercial sex work and so deemed inappropriate for women, instead busying themselves with 'respectable' administrative work to protect their social status.

Established nurses' and nursing norms influence new nurses' identities and practices in ways that may both be beneficial and harmful to patient care. Yet, despite much interest in the way professionals develop their identity, we know little about nurses' transition from training into nursing practice in LMICs settings or how it affects the way they construct their professional identity. Addressing this oversight, we analyse Kenyan nurses' identity work while transitioning from training into nursing practice.

In particular, we draw upon Sveningson and Alvesson (2003), Pratt et al. (2006), who describe identity 'violations' junior doctors experienced during training involving menial work and administration in the USA, which led them to question their professional expectations and identities. However, through 'identity reconciliation work' these junior doctors were able to reconstruct a prized professional identity validated by peers and mentors. We also discuss identity work in relation to practical norms, building on the work of Nzinga, Mcgivern, and English (2019), who explain doctors' identity work involving navigating between competing professional, official and practical norms in the LMIC context.

3. Methods and research context

3.1. Nurses' training in Kenya

In Kenya, nurses are initially trained in three levels; *certificate* (enrolled nurses) involving training for two years; *diploma* (registered nurses) involving training for three years; and *degree* (Bachelor of Science in Nursing, BSN) involving four years' training plus an additional 1-year internship before licensing. Later, nursing training is also offered in various specializations at higher diploma and postgraduate level. Nursing training is offered in both government medical training colleges and universities, as well as faith-based and private sector training colleges. The Nursing Council of Kenya is responsible for developing training guidelines, clinical log book (in addition to other assessment tools), and

guiding in the curriculum development and approving curricula for use in the nursing training institutions.

All Kenyan nursing schools are accredited by the Nursing Council of Kenya (NCK) with minimum standard requirements for both training and practical areas set out by the NCK, with most training centres consequently relatively well resourced in terms of infrastructure and staffing. After the initial accreditation, the NCK conducts quality assurance visits from time to time and re-accredit every 5 years to ensure that the training institutions maintain training standards. Trainee nurses must pass a final licensing examination administered by the NCK to be registered and licensed to work in Kenya.

Nursing training in Kenya encompasses learning theory in class, skills lab experience, and skills-building placements within clinical areas in hospitals and in units responsible for public health and community health, which are meant to provide practical experience and develop training nurses' practical skills.

Diploma nursing students begin their placements in their first year, going for a one-month work placement after every three months of classroom-based training during their first and second year. In their third year, diploma trained nursing students undertake placements at primary healthcare facilities and in community placement, each lasting 3 months.

Bachelor of nursing students also begin their placements in their first year, going for a one-month placement after every three months of classroom-based training, with the remaining two semesters being classroom based. However, this varies from one nursing school to another, with some nursing schools offering morning classes and afternoon placements. Bachelor of Nursing students then undergo an additional compulsory one-year internship at the end of their training in approved internship training centres, during this internship period they have a provisional license to practice. During internship, nurse interns have full responsibility for patient care under the supervision of experienced nurses who serve the role of mentors.

Students on placements practice under the supervision of a qualified nurse, who provide feedback through student logbooks on their skill level in addition to the formal assessments, both contributing to the overall grading. NCK accreditation guidelines require that for adequate mentorship in clinical placements the qualified nurses to nursing student ratios in various units should be: Medical/Surgical units 1:6, maternity 1:2, ICU 1:1, Renal unit 1:1, and Theatre 1:2. However, as we describe in our findings section, due to high numbers of students enrolled in nursing schools, placements are sometimes shortened, limiting students' practical work experience and development of practical skills. Furthermore, due to the high numbers, supervision may be compromised or lacking, with some nursing students avoiding menial nursing activities unnoticed during their placements. Similarly, students rarely receive sufficient mentorship due to shortages of senior staff and tutors (Appiagyei et al., 2014). Consequently, nursing students in Kenyan receive varying levels of practical experience and skills required for independent nursing work depending on their training institution.

3.2. Study setting and study participants

We conducted our study in two referral hospitals in different counties in Kenya. The hospitals vary in size and bed capacity, face diverse challenges in terms of financial and human resources and serve different urban/peri-urban and rural areas with a range of disease burdens. Moreover, we purposively selected one hospital in each county to ensure wider generalizability of findings as the counties vary in how they have organized their healthcare systems. County A has independently implemented measures to achieving Universal Health Coverage (UHC) without assistance of the national government. County B is a county nominated to be a UHC pilot site supported by the Kenyan government.

We interviewed 47 nurses, 38 during individual in-depth interviews and 9 during three focus groups with purposively selected frontline nurses and nurse interns, frontline nurse managers, mid-level nurse managers and senior nurse managers in the hospitals in County A and B. To understand how nurses perceive their identities across different stages in their careers, we deliberately sampled new nurses moving from training into clinical practice for the first time, as well as senior nurses. Additionally, we conducted seven purposively selected interviews with national nurse leaders representing nursing policy and technical actors in Kenya (See Table 1 for more details). Data collection and analysis were undertaken iteratively, and the preliminary analysis also informed the sampling process; the emergent themes in our preliminary analysis therefore was used to inform our sampling process as outlined in the next section on 'Data analysis'.

In interviews, we asked frontline nurses and frontline nurse managers questions around their professional identities and identity work (see interview questions in Appendix x). For the senior nurses, questions centred around leadership and involvement in policy and decision making. Written informed consent was obtained from all the participants. Ethical approval for this study was obtained from the Kenya Medical Research Institute Ethical Review Committee. Data collection was conducted from September 2019 to September 2020.

3.3. Data analysis

We inductively coded and iteratively analysed the data from audio recorded interviews (which were transcribed verbatim and imported into NVIVO 12 Qualitative Software) (Corbin & Strauss, 1990; Gioia et al., 2013). Preliminary data analysis began with two authors (DM and JN) developing interview summaries identifying emerging themes from the outset of data collection and nascent 'in vivo' and theoretical codes emerging from the data. By comparing the emerging codes, we were able to develop our initial themes and categories (such as passion and appeal for nursing work). This informed subsequent data collection and revision of our interview questions/protocol where subsequent data collection pursued emerging themes from our data, and participants who were considered best to inform emerging themes were sampled. Data collection and analysis was therefore done iteratively, making comparisons between new data and the themes and categories from coded data (Corbin & Strauss, 1990; Gioia et al., 2013).

The second level of coding (Corbin & Strauss, 1990; Gioia et al., 2013) involved developing higher level more theoretical themes and categories, grouping similar codes into themes and categories by looking at the relationships between themes to develop higher level concepts in a process of selective coding to explain the emergent phenomenon. We then connected the selected codes to relevant literature on professional identity in nursing (e.g., Professional calling, identity violations and identity reconciliation work) to identify core concepts that explain the development of nurses' identities in the context of Kenyan health care. We show how we connected our data to codes and theoretical concepts in Appendix 1.

Table 1
Study participants.

Location	Role	Total (n = 47)	Female (n = 38)	Male (n = 9)
County A	Frontline nurses *(Of whom 3 participated in focus group & 3 in individual interviews)*	6	5	1
	Frontline nurse managers	5	5	0
	Mid-level nurse managers	3	2	1
	Senior nurse managers	3	1	2
County B	Frontline nurses & nurse interns *(Of whom 6 participated in focus group & 4 in individual interviews)*	10	9	1
	Frontline nurse managers	7	6	1
	Mid-level nurse managers	2	2	0
	Senior nurse managers	4	3	1
National level	Senior nurse managers	7	5	2

4. Results

4.1. Joining the profession

4.1.1. Intrinsic professional motivations: professional 'calling'

Some nurses were inspired by positive interactions with nurses during childhood and the associated image of the smartly dressed, caring and empathic nurse:

> When I was young, I used to visit hospitals… like nurses… I really desired to be a nurse when I grow up… I admired the way they… attended to patients. [Frontline Nurse Manager, County A_005]

To some, nursing was described as 'a calling', with most mentioning that they were attracted to nursing because of its altruistic quality as 'a service to humanity' and 'helping the needy', spending time with patients, listening to their problems and trying to find solutions to them. For some, this 'calling' transcended into professional passion, validated by nursing patients back to health and experiencing 'contentment' from that:

> "It was a calling for me, I felt I should be a nurse, taking care of the patients because… I could see how patients have been taken care of… interacting with the staff in that [nearby health] facility… That is how I became a nurse…. when you render the service… you feel… you've helped that person, and you feel contented." [Senior nurse manager, County A_007]

4.1.2. Pragmatic professional motivations: nursing as a second-choice career or 'job in demand'

For others, nursing was a second career choice, sometimes an alternative to medicine for those who did not get the grades for medical school:

> "Nursing… was somehow sort of failure, because I wanted to be a medical officer… from childhood and then… KCSE [Kenyan Certificate in Secondary Education] I got B plain [Mean grade across subjects] and I couldn't manage to attend the medical class so… my parents, they had to push me, I landed in nursing." [Focus group discussion, County A_004].

Some nurses embarked upon a nursing career because they believe it would enable them pursue interests in sciences:

> "My career was to be an air hostess, but… I realized… I'm doing so well in sciences… [not] things which are needed in air hostess, like language… There was no one to tell me, 'Nursing is like this' … I just saw myself, like, I'm doing well in sciences, so I can do well in nursing, which is more of science". [Frontline nurse, County A_013]

For other nurses, nursing training was more pragmatically motivated by the prospect of getting a job *'in demand'*, which offered easy and attractive career opportunities in Kenya and abroad. As one nurse noted, "*it's easy to land a job… nursing is always in demand everywhere you go, that's what I like about nursing." Frontline Nurse, County A_013*.

Another nurse commented: *"I never dreamt [or]… wanted to be a nurse but one of my relatives [said nursing] … is like being a 'hot cake' when you go abroad, so that is how I was wooed into nursing." [Frontline nurse focus group, County A_004*].

In sum, we see alternative motivations for a nursing career; pursuing a professional 'calling' and desire to help patients, a second-choice career for those good at science, an alternative to medicine, a career pushed by relatives, or a pragmatic decision to train for a '*job in demand'*, providing relatively easy career opportunities.

4.2. Nurses' experiences transitioning into nursing practice

Most Kenyan nurses we interviewed described their shock upon moving into nursing practice, in poorly resourced hospital with full responsibility for patient care. Below we describe the shock of 'working and learning alone' with demanding workloads and responsibility for patients, and doing 'dirty work', which violated their expectations of nursing and pre-existing professional identities.

While placements during nurse training are meant to expose students to the realities of nursing practice, nurses we interviewed noted that, due to over-enrolment of students and insufficient numbers of lecturers at nursing schools, clinical placements were often shortened and mentorship was lacking, providing new nurses with insufficient practical experience and understanding before starting work:

> 'A student is supposed to be here [training] for eight weeks… We had a class that stayed here for only three weeks… This person does not know anything.'
>
> [Frontline nurse focus group, County B_011]

> 'Some of these [nursing] colleges they don't have even qualified lecturers… They have reduced the number of years for the training… and now want to reduce the… placement weeks in the clinical area, and you know nursing is more or less practical… we get… half-baked nurse. That is why I am saying the terms of training … of supervision, they have failed. [Frontline nurse manager, County B_005].

A nurse manager noted new nurses lacking practical skills and also highlighted the attitude of a few students who came to nursing with a mentality of wanting to skip nursing practice and move straight into managerial roles:

> "I don't [know] what is being taught in the [nursing] school but we are finding… weakness in the skills that they are supposed to be doing…. [New nurses] needs a lot of supervision and mentorship… The BSN [degree nurses]… come with another mentality… you tell them about patient care... they are not taking it very positively. It's like for them, they are supposed to be… a nurse manager who will be sitting in the office and solving issues in the office… You see the kind of attitude that they have? So even if you taught them a skill, they are not going to grasp it because they know they are not going to use it." [Nurse manager, County B_016]

4.2.1. Working and learning alone

A first transition shock nurses described was being left alone to look after many patients, without collective professional support, and being forced to engage in practices that contrasted what they had learned during training:

> "That experience, in the first few days, wasn't good because while we were in college, we would work under instructions… [In] my first posting… I was shocked. I was left alone with 27 patients and to conduct every procedure, including administering the drugs the tutors had told us we should not administer alone." [Frontline Nurse Manager, County A_006]

Nurses reported having to 'learn the hard way' when left alone in charge of wards and being criticized for asking colleagues questions:

> "[Senior nurse colleagues] used to say, 'now you are qualified, why keep on asking as if you are a student? Some would ignore you; others would tell you, 'You will be left alone in the shift, you will learn the hard way'." [Frontline nurse, County B_014]

Participants also described having to win the trust of the senior nurses despite lacking experience and confidence in their own competence and fearing approaching experienced nurses as this would often be perceived as a sign of incompetence.

> "Being alone in the field, or being with experienced people, they want you to do this and do that, but you can't. You cannot tell them, 'I am not good at this'. You must be competent … yet you know very well

that you are not competent... it was very difficult." [Frontline nurse, County A_013]

New nurses were criticized for making mistakes and reminded by senior colleagues they were no longer students 'in that blue cyanose dress' (a dress worn by nursing students) and expected to assume the responsibilities of a fully trained nurse, while experienced nurses took advantage by assigning them extra duties:

"*You have done a mistake… somebody… tells you, "You are not in that blue cyanose dress, now you should be doing this" … You are oppressed. You are new, and instead of being assigned duties like everyone else, you are placed on duty every single day… taking advantage of you." [Frontline nurse, County A_013]*

To reconcile discrepancies between the theory they learned in class and practice, newcomers adopted experienced nurses' practical norms, violating official guidelines to cope in resource constrained contexts:

"Colleagues, they told me this is how things are done here, I started doing the same and I got used, but it was quite a challenge… Like for example… chloroquine injection, we had been instructed in college not to administer the drug alone… you are forced to go and ask a neighbour [in the next ward] … She tells you, 'Let me help you, but next time you will do it on your own." [Frontline Nurse Manager, County A_006]

For some new nurses, frustrations, challenges, and workload involved in nursing practice led to fatigue, burnout, self-doubt, and loss of 'passion' for nursing and patient care:

"I had a passion for nursing, it is only that the frustrations… make you feel like you would want to quit… you work for so many hours, you are overstretched, your whole energy is drained." [Frontline nurses focus group, County B_011]

For others, coping with this new reality of nursing work and the magnitude of work that was expected of them as qualified nurses necessitated them adopting coping mechanisms, including learning how to ration care and prioritizing care for the very sick patients and focusing on nursing sensitive indicators.

"After I joined, I noticed that there was a lot of work to be done! There was a lot of things nurses needed to do… then a capacity of 60 [patients], documentation became a challenge, you only now had to prioritize the care for the patients, so I learned how to prioritize the care." [Frontline nurse manager, County A_002]

Thus, new nurses' shock transitioning from training into nursing practice, working, and learning alone while responsible for many patients, practicing in ways contradicting nursing training, was experienced as a professional and ethical identity violation, which undermined motivation for nursing.

4.2.2. 'Dirty work'

New nurses were also shocked to learn that nursing involved tasks deemed as 'dirty work', as one noted:

"These dirty, dirty… patients… who has diarrhoea… you will clean from head to toe… we did not know that they are in nursing," [Frontline Nurse Manager, County B_09]

Dirty work violated nurse's image, social status in their communities, and personal identity:

"You are seen as somebody whose job is to carry patients' dirt, your work is taking care of wounds… looked down upon because of that… when somebody sees you taking a bed pan to a patient, you will be called names such as somebody whose job is to carry patients' excrements." [Frontline nurse manager, County A_002]

A senior nurse described a new generation of 'paper nurses' who have a negative attitude towards some of the nursing roles and often avoided dealing with dirty work and lacked 'passion for patients':

"[New nurses] don't want to perform those dirty works… a patient who is dirty and they pass. They don't have that passion for patients… They are paper nurse; they just want to perform light, clean tasks. They don't want to clean up patients' excrements." [Frontline nurse manager, County B_007]

For some nurses, lived experiences of nursing practice led to a realization they were in the wrong profession and were not motivated for work they perceived as 'inferior' to their self-identity:

"Nursing is a calling… [But] because of the shortage of the careers or jobs… [people are] joining the profession without even knowing what it entails… only to… realize they are in the wrong profession… Post someone to a facility, when they get there, he feels it's inferior to do some of the services… They have that mentality… when they see a patient… it's a bother." [Senior nurse manager, County A_007]

New nurses' shock of the dirty work involved in nursing therefore violated some nurses' personal professional identity in ways linked to their social status.

4.3. Identity reconciliation work

As interview extracts above hinted, through their experiences of nursing practice, nurses began to use localized practical norms to reconcile their professional identity with the realities of nursing practice. They did this in ways that were a necessary part of their professional identity construction but also at times detrimental to patient care, as we describe below.

4.3.1. Adopting practical norms: 'Toughening up' and 'maturing through experience'

Nurses described how "*the environment, the nature of work just toughens you up."* [Frontline nurses focus group, County A_004] and they *'have to'* adopt ways of practically coping with unexpected challenges at work, as described in the following account:

"I was still so small, so young… working in a male ward. Those men start toying with you… want to flirt with you… harass you... So, you have to be aggressive… [so patients] know I am the boss… you have to be harsh." [Frontline Nurse, County A_013]

Nurses described how they learned norms of patient care by picking up traits from senior nurses, then changing to behave more like themselves:

"You find the more experienced nurse who is very harsh on patient, you see? You also learn that 'Oh, so this is how things are done', so you also find yourself doing the same …. Some of them [nurses] were kind, polite, so you feel that the trait you had picked [from experienced nurses] is… too harsh, so let me tone down… become polite to the patients like the other nurses. You also start being kind to [patients]… Other nurses… I picked some of their traits, I would be mean, and won't be myself." [Frontline Nurse, County A_013]

However, sometimes 'toughening up' also involved adopting 'transgressive practical norms' (De Sardan, 2015) and procedural violations that were harmful to patients. For instance, some interviewees described work environments where patients were seen as a 'bother' and beneath nurses' social level:

"When I entered the profession, I started going to the clinical area, I started interacting with them [nurses] more, I really didn't like [it]… I trained in [name of public hospital mentioned], it was really bad. The language used on patients was bad… like patients were a bother…

The nurses felt like they were above the patient… that patients were wasting their time." [Frontline nurse manager, County A_011]

Reflecting Jewkes et al.'s (1998) study, nurses described sometimes abusing patients, for example justifying slapping 'uncooperative' mothers giving birth as necessary to maintain authority over them and prevent baby deaths:

"This patient comes out of this hospital… saying nurses are bad but in other ways you have to react… Uncooperative mothers, for example, if she closes the legs when the baby is coming, what do you do? You slap the mother because… the baby's head is outside, so this baby is getting chocked, at the end of it you are coming out with a dead baby, so… you have to pinch… slap… or you shout at them… so that they know the seriousness about this matter." [Focus group discussion_ Frontline nurse, County A_004]

Nurses also described how they had 'matured up through experience' and learned to understand and deal with rude patients:

"I have matured up through experience… now I know if… the patient is rude… [In the past when a] patient was agitating… I'd talk… out of the anger. I have come to realize… maybe that person is doing that because he is stressed by the disease." [Frontline Nurse Manager, County B_001]

Another nurse described how she 'changed her mind' about caring for patients suffering from distasteful conditions, developing sense of service and empathy:

"We were being punished if you were brought to ward eight… full with stinking and smelling wounds… We had to change our mind and say this is not a punishment ward… we are here because God chose us to give these services… This is part of the nursing… That patient... is not [here] by choice… So, you put yourself into their shoes, 'If it was me, would I want someone to do this?' So that is what kept me nursing." [Frontline Nurse Manager, County B_09]

Thus, nurses' identity reconciliation work involved 'toughening up' in their new working environment, adopting practical nursing norms and learning to deal with difficult circumstances sometimes in ways violating procedures. They then described 'maturing up through experience' and later treating patients kindly and politely to reflect a sense of service expected of a nurse.

4.3.2. Reclaiming professional identity: fulfilling a professional calling through caring for patients

Eventually, new nurses realized they had become fully fledged nurses when senior colleagues recognized them as such by assigning them important responsibilities, such as allocating duties and mentoring students:

"I used to be given tasks by my previous In-Charges [senior nurses], like duty allocations, student mentorship... I made it and they saw I was a capable person" [Frontline Nurse Manager, County A_002]

More significantly, despite the challenges during the transition from training into practice, many nurses were finally about to reclaim and derive satisfaction from their valued professional identity through caring for and nursing patients to recovery:

"This is the profession I needed… the right place to be… despite all the challenges… you just feel like you are doing the best you could ever do in your life… to take care of these people… that pushes me to love the job." [Frontline nurse manager, County A_002]

"Nursing is a… good profession, I just feel we are good because that sick patient depends on you… It is satisfying especially when that sick baby comes in the ward, you do the right thing… that child goes home" [Frontline Nurse, County B_014]

Coping with difficult situations, work pressure, high expectations, learning from mistakes and earning the trust of colleagues and patients, enabled nurses to reclaim their professional identity:

"You take responsibility for… everything you do, so if you make a mistake you take responsibility for that… When you finish the day without mistakes, messed [up] because of the pressure, but you have learnt, it is a step and then when you get used to the system things become very simple." [Frontline Nurse_ County B_003]

Proximity to and caring for patients also then enabled nurses to claim to best understand and represent patient interests, and thus reclaim their inter-professional status in relation to doctors within the wider health care system:

"The nurses want now to claim their position in healthcare… as much as some of the other cadres look down upon them… the healthcare system, it depends largely on what they [nurses] do, because they are the ones with the patients most of the time, they understand the patients better than any other person." [Senior nurse manager, County B_015]

Finally, nurses described how they became role models and sources of knowledge for new generations of nurses, enabling them to restore their collective professional identity:

"*[New nurses] keep on asking me, so it has even made me go back to books to equip myself with more knowledge, so that I can be a source of knowledge to them, because they always look upon you and they feel that you should be knowing". [Frontline Nurse Manager, County A_011]*

In sum, by overcoming the challenges of transitioning into nursing practice, through identity reconciliation work, caring for and nursing patients back to health, nurses were able to reclaim their professional identity and authority within their wider health system.

5. Discussion

Research (Macintosh, 2003; Duchscher, 2009) has long highlighted the shock nurses in high income countries experience moving into new roles, yet little research has examined this transition in LMIC healthcare contexts involving extreme resource limitations. We examine such experiences among new nurses in the LMIC context of Kenya.

Some nurses we interviewed described being motivated by a professional 'calling' and idealized image of nursing providing 'service to humanity', often following inspiring encounters with nurses during childhood. However, for others, nursing was a second choice career (for example, for those unable to get into medical school) or simply a 'job in demand' in which they could easily earn a living (cf Price, 2009).

Regardless of initial motivations, transitioning from training into nursing practice was a shock for most nurses, as it violated their previous idealized image and expectation of nursing and patient care. First, nursing involved 'working and learning alone', 'learning the hard way', dealing with heavy workloads, responsibility for patients and having to treat patients in ways violating training (e.g., administering drugs single-handedly), with little support from experienced colleagues. This violated new nurses' expectations of a being part of a collegial and ethical profession providing high quality patient care.

Second, nurses described being shocked having to deal with 'dirty' patients and medical conditions, work they described meant that the public looked down upon them. Drawing on Jewkes et al. (1998) and Hadley et al. (2007), we suggest this 'dirty work' violated some new nurses' expectations of a middle-class professional status and identity, which led them to question their nursing career and undermined their motivation to provide high quality patient care.

Such transition shocks suggest that nursing schools are failing to adequately prepare trainee nurses for nursing work, placing too much emphasis on abstract theory and too little on placements that bridge the

theory-practice gap (Shoghi et al., 2019). This, in part, is due to the large student cohorts and low number of tutors able to provide the guidance and mentoring student nurses need (Appiagyei et al., 2014). Furthermore, having to take responsibilities and decisions affecting patients' health and lives in chaotic working environments, was more stressful than nurses expected. This consequently resulted in some nurses having to depersonalize patients and patient care to cope with working in such resource-constrained contexts, as have been described in other studies of nursing work (Menzies, 1959, McKnight et al., 2020).

However, as we noted earlier, identity violations can trigger identity reconciliation work (Pratt et al., 2006). Similarly, through *toughening up*, learning and adopting localized *practical norms* violating procedural standards to cope with the demands of practice, nurses in our study reconstructed their professional selves. Novice nurses were quickly encultured into experienced nurses' routines and practices, including rationing care, prioritizing technical care, justifying bad behaviours and procedural violations, and using authority over patients, reflecting practices also noted in other studies of nursing work (Mackintosh, 2006; McKnight et al., 2020; Nzinga, Mcknight, et al., 2019).

Nurses then described how 'maturing up through experience' they gradually found their more authentic professional selves, adopting or rejecting more experienced nurses' practices, behaviours and practical norms. For some, this often resulted in the provision of sub-optimal patient care, while other nurses were able to restore their valued professional identity and reclaimed this position in the health system through caring for patients and experiencing satisfaction as patients recovered. The development of a mature nursing identity was finally recognized and validated by senior colleagues, as for junior doctors (Pratt et al., 2006), when seniors assigned nurses responsibility for mentoring other new nurses, thus passing down knowledge to a new cadre of new nurses.

We make several contributions. First, we extend analysis of identity newcomer transition shocks for nurses (Macintosh, 2003; Duchscher, 2009) into the empirical context of LMICs, using theory about professional identity work (Pratt et al., 2006), practical norms (De Sardan, 2015; Nzinga, Mcgivern, & English, 2019) and normalized procedural violations (Amalberti et al., 2006; Banja, 2010) to explain this transition. Empirically, we explain shocks (particularly 'working and learning alone' and doing 'dirty work') that new nurses in a LMIC health care context experience transitioning from training into practice, which violate their expectations of their professional identities. We also show the consequent identity work ('toughening up', 'maturing through experience', and 'learning practical norms') nurses use to restore their professional self. As we noted earlier, rather than contributing to the crowded identity and identity work literature, we argue that using identity theories in this way can highlight nurses' experience in ways bringing out implications for the HRH training, patient safety and quality improvement in LMICs.

Novice nurses' early experiences in the workplace play a huge role in helping them cope with work demands (Ten Hoeve et al., 2018) but these experiences are often negative, characterized by lack of supportive mentorship and mistrust as reported above. Such difficult relationships between new nurses and their supervisors contribute to a 'stifled' identity, as novices' self-confidence and competence are undermined (Ke & Stocker, 2019). To cope with harsh realities, nurses are forced to innovate coping mechanisms (Nzinga, Mcknight, et al., 2019, McKnight et al., 2020). We highlight the importance of professional 'calling' in helping health professionals' transition into clinical practice. We show how, through using practical norms to care for patients to recovery, and validating a mature identity with senior colleagues, health professionals in LMICs can reclaim a valued professional identity. This appears important for the motivation and retention in health professions and subsequently role modelling.

5.1. Implications for policy, quality and safety in health care in LMICs

Idealistic images of nursing profession among students can result in disillusionment and negatively impact how new health professionals settle into, interpret, and enact their roles (Mooney, 2007; Ten Hoeve et al., 2018; Mackintosh, 2006). In our study, we similarly found that preconceived and idealized expectations of nursing work playing a big role in new nurses' transition shock. Therefore, providing a more realistic image of nursing practice and providing more practical experience during training would help to mitigate this shock during transition into practice.

Our study therefore highlights the need for nursing education to better prepare students for nursing work, perhaps through more extensive placements and practical experiences. While such placements and experiences may be the norm in high income countries, they seem to be squeezed out during nurses training in LMICs, over-enrolment and increasingly busy nurse trainers, resulting in the problematic transition shocks we describe. New nurses need to be made aware of and prepared for potential transitional shocks and identity violations they may experience when first encountering nursing practice.

New nurses then need to be supported to rework their professional practices and identities during this period. Novice nurses might be provided dedicated mentoring, supervision and professional groups that they can draw upon for support and advice. The lack of preceptors to orient and support new nurses into practice can contribute to difficulties transitioning into work, with research linking this to intentions to leave the profession (Flinkman & Salanterä, 2015; Ulupinar & Aydogan, 2021). Policymakers and nurse managers therefore need to cultivate more supportive workplace culture where new nurses can discuss work performance with preceptors and feel comfortable asking questions and foster positive socialization to help new nurses develop competency and confidence (Azimian et al., 2014; Innes & Calleja, 2018). However, given the resource constraints within LMICs, this aspiration may be challenging.

We described new nurses learning to cope with their demanding work through 'toughening up' and 'learning the hard way' but, in doing so, they adopted senior colleagues' practices that deviated from official guidelines as a tolerated practical norm. In our study, some violations were seen to be justified, for example as means for pushing new nurses to learn and improve or to control patients to avert negative outcomes. This raises important questions relating to patient safety as the distinction between practical norms enabling the delivery of health care in severely resource constrained circumstances and those simply perpetuating low quality and dangerous practices, is often unclear. Similar findings are reported in other LMIC settings, a study in India describe birth work as 'dirty work' and mistreatment of women during labour being normalized and therefore informing workplace norms such that these violations become acceptable (Mayra et al., 2021).

Amalberti et al. (2006) posit that the consequence of this is that it predisposes professionals to operate at the boundary of the deviance, which poses a significant risk to the way new professionals are socialized into practice. This normalization of deviance may be problematic where deviations and violations become accustomed to or condoned to the extent that they are not questioned, but instead become rationalized. This problem may be compounded by the lack of transparency in LMIC health systems (McGivern et al., 2017; Cleary et al., 2013), meaning that procedural violations are allowed to continue by virtue of their invisibility.

Given the extreme human, material and financial resources limitations in most LMICs, care guidelines need to be contextualized to reflect local realities (English et al., 2020). Internationally recommended guidelines transposed into these settings may be unachievable and may therefore contribute to stress, resistance to change and demotivation of healthcare workers. Therefore guidelines need to be better adapted to reflect LMIC settings in practice, taking into account the perspectives of the local experts andstakeholders (Maaløe et al., 2021; Olayemi et al., 2017).

Echoing Banja (2010), we therefore call for 'formative spaces' (Mcgivern & Fischer, 2012) within healthcare systems in LMICs, in which professionals can openly speak, in 'psychological safety' (Edmondson, 1999), about practical norms, procedural violations and challenge

violations that are both necessary or dangerous/harmful to patients. This has important implications for both patient safety and professional identity formation, as a means of preventing the normalization of deviance in future generations of health professionals. If nurses and other health professionals are able to safely and openly discuss adaptive and transgressive practical norms and procedural violations affecting their work, both nurses and policy makers may become more aware of both harmful and adaptive practical norms. Adaptive practical norms might then be incorporated into professional standards to better reflect practices on the ground and become easier to comply with, while nurses will hopefully become more reflective of the harms caused by transgressive practical norms.

Creating such space, supervision, and mentoring is challenging in resource constrained LMICs. However positive examples of formative spaces, supervision and mentoring exist, like 'Balint Groups' (Kjeldmand & Holmström, 2008), 'Schwartz Rounds' (Lown & Manning, 2010) and Quality Improvement networks (McGivern et al., 2017; English et al., 2016, 2017; English et al., 2016), which help health professionals cope with work challenges, learn, avoid burnout, and might serve as guiding models for future policy-development.

5.2. Limitations, boundary conditions and future research

We suggest that Kenyan nursing may be an extreme case revealing transition shocks and identity work relevant to health professionals in other LMICs and beyond. However, our study was conducted in one country (Kenya) and profession (nursing) hence further research in other countries and professions is needed to test whether our findings can be generalised.

Moreover, the number of nurses we interviewed who were undertaking their internships at that time was limited. We interviewed other nurses about their experiences of becoming new nurses several years after they had done so. We believe their accounts of internships and independent practice are valid. However, we acknowledge that these nurses may have suffered from recall and survival bias, involving recalling past events in a way neglecting, overlooking, justifying or reinterpreting past failures to construct a more socially acceptable account of their behaviours. Future research therefore is needed to further critically explore the changing 'live' experiences of new nurses as they are going through internships to further validate our findings.

Finally, our study also highlights the need for more research examining the practical norms health professionals draw upon and normalized procedural violations in health systems in LMICs. Making such practical norms and normalized procedural violations more visible, and then informing ways to challenge and prevent those that are harmful from reoccurring, could have a highly positive impact on the quality of patient care provided in practice in LMICs.

6. Conclusion

We examine how new nurses in LMICs construct their professional identities when starting clinical practice involving unexpected practical norms deviating from training and official procedures. Novice nurses trained to pursue a 'calling' to service and patient care or because nursing was a 'job in demand'. However, nurses described their 'shock' when they were forced to work and learn alone while responsible for many patient and doing the 'dirty work'. This violated their expectations of an idealized professional identity and previous training. However, this violation triggered identity reconciliation work, involving 'toughening up', 'maturing through experience', and learning practical norms. Finally, some nurses experienced satisfaction from caring for and nursing patients back to health and restored their valued professional identity. Our findings highlight the need for professional educators and health policymakers to better prepare new professionals for the challenges of clinical practice, providing more extensive placements involving more practical experience of nursing and better supervision. We also suggest that policymakers provide formative spaces, supervisory and mentoring to help nurses through their transition into nursing work and to develop positive professional identities essential to the motivation and retention of nurses in LMICs.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmqr.2021.100024.

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