



**Constructing Professional Identity in Operating
Department Practitioners: Shaping Engagement with
Feedback and Professional Community Formation**

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Declaration of Originality

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Dedication

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Abstract

Professional identity within healthcare professions is socially constructed through participation, recognition, and negotiated membership within professional communities. For professions situated within complex interprofessional hierarchies, identity formation involves ongoing evaluation of legitimacy, belonging, and professional consequence. This study explores how registered and student Operating Department Practitioners (ODPs) perceive and construct their professional identity within contemporary perioperative practice in Scotland, and examines whether and how these identity constructions influence engagement with feedback provision to Higher Education Institutions (HEIs) contributing to the development of a professional community.

The study draws on Social Identity Theory (SIT) alongside the Recognition, Respect, and Reward (3R) framework to examine how professional identity is interpreted and enacted within clinical and educational contexts. An exploratory qualitative design was adopted. Semi-structured, one-to-one online interviews were conducted with student and registered ODPs across Scotland. Thematic analysis was used to explore patterns of meaning across participants' accounts and to interpret how professional identity was experienced within practice.

Findings demonstrate that professional identity among ODPs is shaped through ongoing negotiation of recognition, respect, value, and access to opportunity within clinical and educational contexts. Recognition emerged as central, with limited visibility within institutional systems experienced as symbolic marginalisation rather than administrative oversight. Respect was constructed through everyday interprofessional interactions that signalled legitimacy and belonging, though such recognition was described as unevenly distributed, particularly for students and newly qualified practitioners. Value was associated with acknowledged competence and meaningful contribution to team practice, and its relative absence within student accounts highlighted the fragility of early professional identity formation. Structural conditions including role ambiguity, interprofessional hierarchy, and restricted career progression further shaped how participants understood the boundaries and future trajectory of their profession.

Engagement with feedback provision to HEIs was mediated by these identity constructions. Where recognition, respect, and value were experienced as secure, feedback was framed as an expression of professional responsibility and collective stewardship. Where identity was perceived as fragile or contested, participation became tentative or strategically limited. Feedback engagement therefore functioned as an enactment of professional positioning rather than simply an academic task.

The thesis advances a Recognition, Respect, and Value (RRV) framework as a theoretically informed refinement of the 3R model, offering a contextually grounded account of professional identity formation within publicly funded healthcare systems. By integrating insights from SIT with the RRV framework and situating professional identity within interprofessional hierarchy and institutional design, this study contributes to professional identity literature and demonstrates how identity dynamics shape engagement with higher education processes. The findings hold implications for HEIs as identity environments, for interprofessional practice, and for policy initiatives aimed at strengthening emerging professional communities.

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Abbreviations

3R:	Recognition, Respect Reward
A:	Alumni (registered) participant
BSc:	Bachelor of Science
CODP	College of Operating Department Practitioners
CoP:	Communities of Practice
DipHE:	Diploma of Higher Education
GA:	Graduate Apprenticeship
GMC:	General Medicine Council
HCPC:	Health and Care Professions Council
HCSW:	Healthcare Support Worker
HE:	Higher Education
HEI:	Higher Education Institution
IPE:	Interprofessional Education
MDT:	Multidisciplinary Team
MEQ:	Module Experience Questionnaire
NHS:	National Health Service
NMC:	Nursing and Midwifery Council
ODP:	Operating Department Practitioner
QAA:	Quality Assurance Agency for Higher Education
REL:	Regional Education Lead
RRV:	Recognition, Respect, Value
S:	Student participant
SFC:	Scottish Funding Council
SIT:	Social Identity Theory
TA:	Thematic Analysis

Chapter 1: Introduction

1.1. Introduction

This thesis explores how student and registered Operating Department Practitioners (ODPs) construct and negotiate their professional identity within both the perioperative environment and higher education (HE), specifically within the participating institutional context. Although professional identity is widely discussed within health professions education, it is increasingly understood as dynamic and socially situated rather than secured through qualification alone (Cornett et al., 2023). Within perioperative practice, ODPs continue to navigate questions of professional visibility, recognition, and interprofessional positioning, with the profession remaining comparatively unfamiliar within both public and professional domains (Taylor et al., 2019). Simultaneously, Higher Education Institutions (HEIs) promote student voice through formal feedback mechanisms, yet engagement with these processes remains variable and is often framed as an issue of motivation or responsiveness (Carless & Boud, 2018). What remains under-examined is how professional identity shapes whether feedback participation is experienced as legitimate, meaningful, and capable of shaping collective practice.

This chapter introduces the study and establishes the professional, HE, and personal contexts in which it is situated. Furthermore, this chapter outlines my personal and professional background, presents the historical development and contemporary role of the ODP profession, reviews the evolution of ODP education, situates the student within contemporary HE, and explains the rationale for the research. In doing so, it establishes the central problem underpinning the study: the limited theoretical understanding of how professional identity is constructed within smaller, specialist healthcare professions whose recognition, visibility, and legitimacy remain negotiated within hierarchical clinical and educational environments, and how this shapes engagement with feedback as a form of professional and educational participation. The chapter concludes by setting out the research aim and the structure of the thesis.

The following section reflexively situates the study in relation to my personal and professional background before examining the broader professional and educational context of operating department practice.

1.2. Personal and Professional Background

To contextualise this research, I must acknowledge the personal and professional experiences that have shaped my interest in the ODP profession. In qualitative inquiry, researchers are not separate from the worlds they explore, rather, interpretations are informed by their histories, values, and social positioning. Cognisant that professional identities are developed through lived experience and participation within professional contexts (Cornett et al., 2023; Rath, 2024), by outlining my journey into operating department practice and HE, I aim to provide transparency regarding the perspectives that inform this research.

My exposure to healthcare began early through caring responsibilities for my grandparents, who lived with multiple chronic conditions including Parkinson's disease, chronic obstructive pulmonary disease, and a long-standing tracheostomy. These experiences shaped my developing understanding of care, vulnerability, and responsibility. During my fourth year of high school, work experience in a General Practice setting provided my first insight into healthcare as organised professional practice.

As the first in my family to attend university, I commenced a Bachelor of Science (BSc) in Operating Department Practice at Glasgow Caledonian University (GCU) in September 2014. My entry into the profession was shaped less by strategic planning and more by chance. While attending an open day with the intention of exploring adult nursing, I unintentionally entered an ODP session. This experience introduced me to a professional group I had not previously encountered, whose role I found immediately engaging and of interest.

Throughout my undergraduate programme, mentors played a significant role in shaping my developing professional identity. Professional socialisation literature

suggests that identity formation occurs through observation, participation, and relational validation within practice communities (Trede et al., 2012). My experience reflected this pattern. Through feedback, dialogue, and repeated engagement, I began to see myself not only as a learner but as a legitimate participant within perioperative practice. Identity was therefore not achieved at the point of enrolment or registration, but negotiated through interaction across clinical and educational settings.

Following graduation in July 2017, I began practising as a registered ODP while undertaking a Master of Science (MSc) in Health and Social Care at GCU. This transition involved navigating new responsibilities and expectations, alongside shifts in how I was positioned within the perioperative team. Literature highlights the importance of recognition and inclusion in consolidating early-career professional identity (Cruess et al., 2016), a pattern reflected in my experience. Mentoring students and newly qualified staff during this period further shaped my sense of contribution within the professional collective.

Completion of a qualitative exploratory study during my MSc (Porteous et al., 2025) marked a turning point in my professional trajectory. Engagement in research deepened my interest in how knowledge is constructed and disseminated within professional contexts, and in the role of relationships in shaping professional experience. This led me to pursue a Doctor of Education (EdD) at the University of Strathclyde, focusing on leadership within educational contexts. Simultaneously, I commenced a lecturing role within the ODP programme at a Scottish university, requiring the negotiation of multiple identities, including practitioner, academic, and doctoral researcher. These overlapping roles further shaped my understanding of how identity is influenced by institutional positioning, recognition, and participation within professional groups.

This account is not intended as an autobiography, but as an acknowledgement that my interpretations of professional identity among ODPs are informed by lived participation within the profession and HE. By making these influences explicit, I seek to enhance transparency and reflexive integrity within the study, as explored further in Chapter 3.

Having established the experiences that shaped this research, the following section turns to the wider professional context, outlining the historical development of operating department practice to situate contemporary questions of identity, legitimacy, and professional positioning.

1.3. Operating Department Practice: A Historical Overview

As noted, the ODP profession remains comparatively unfamiliar within public and professional domains (Taylor et al., 2019). Understanding contemporary professional identity among ODPs therefore requires attention to the historical processes through which the role has been constructed, contested, and legitimised. Professions do not emerge fully formed, rather, they develop through evolving patterns of work, regulation, and collective organisation. This section provides a focused historical overview of operating department practice, drawing primarily upon documentation from the College of Operating Department Practitioners (CODP, 2021), while acknowledging that professional histories are often shaped and preserved by the communities to which they belong (Timmons & Tanner, 2004).

The origins of the role can be traced to the early nineteenth century, prior to the development of anaesthesia, when individuals known as “handlers” physically restrained patients during surgical procedures. As surgical practice advanced, these informal roles evolved into positions such as “surgeymen,” responsible for preparing instruments, and later “box boys,” who transported equipment. These roles were task-oriented and lacked standardised training or formal recognition, reflecting broader shifts in surgical practice and the increasing differentiation of labour within healthcare. What began as functional assistance gradually developed into more specialised technical support within the operating theatre.

Formal training structures emerged in the mid-twentieth century. In 1951, the Operating Theatre Technician Diploma was introduced at selected hospitals, marking an attempt to standardise preparation for the role. Trainees were registered under the Board of Registration of Medical Auxiliaries and completed written and oral examinations. This period represented a move toward occupational consolidation,

signalling a transition from informal task allocation to structured professional preparation. The renaming of the role to Operating Department Assistant in 1970 reflected ongoing negotiation of occupational boundaries and status within perioperative teams.

The establishment of the British Association of Operating Department Assistants (BAODA) in 1977 marked a significant moment in collective organisation. Professional associations play a central role in articulating group identity and advocating for recognition within healthcare hierarchies. However, professional consolidation is rarely linear. The introduction of NVQ and SVQ Level 3 standards in the early 1990s generated internal tensions regarding educational pathways and professional standards. Debates at the 1992 BAODA conference revealed divisions concerning qualification routes and perceived legitimacy, illustrating how professional identity is negotiated not only through external regulation but also through internal disagreement.

In 1998, BAODA rebranded as the Association of Operating Department Practitioners, formally adopting “Operating Department Practitioner” as the professional title. The introduction of a voluntary register and Code of Conduct in the same year strengthened the profession’s regulatory aspirations. Shortly thereafter, a 2000 NHS Executive directive recommending employment of those listed on the voluntary register provided important institutional endorsement of the profession’s developing status. These developments reflect a shift from occupational grouping toward a recognised professional community with clearer boundaries and shared standards.

Statutory recognition followed in 2004 through the Health Professions (Operating Department Practitioners and Miscellaneous Amendments) Order. Registration with the Health Professions Council (HPC, 2004a), later renamed the Health and Care Professions Council (HCPC, 2012), legally protected the professional title. Legal protection extends beyond regulating entry to practice, it signals institutional validation of expertise and collective legitimacy. The establishment of the College of Operating Department Practitioners (CODP) in 2007 further consolidated professional representation, education standards, and collective advocacy.

Across three centuries, the ODP role has evolved from informal assistant within surgical settings to a statutorily regulated profession with defined educational standards and a protected title. This trajectory illustrates how professional identity has been shaped through sustained efforts toward recognition, regulation, and collective organisation. Contemporary experiences of visibility, legitimacy, and engagement are therefore situated within a profession that has repeatedly negotiated its boundaries and status. Understanding this evolution provides an essential foundation for examining how professional identity is constructed and enacted by ODPs today.

1.4. Role of the ODP in Contemporary Healthcare

To contextualise this study, it is necessary to outline the contemporary role of the ODP within perioperative care. Regulatory standards identify anaesthesia, surgery, and recovery as core areas of ODP practice (HCPC, 2023a). However, these domains should not be understood only as technical divisions of work. They are also professional contexts in which ODPs collaborate with different members of the multidisciplinary team (MDT), exercise clinical judgement, and encounter differing expectations of expertise, autonomy, and contribution. This section therefore establishes the practice context within which questions of professional identity, recognition, and role visibility become relevant.

Within anaesthetic practice, the ODP works as a specialist member of the anaesthesia team across elective and emergency contexts, meeting both regulatory requirements (HCPC, 2023a) and the standards for inclusion in the anaesthesia team set by the Association of Anaesthetists of Great Britain and Ireland (AAGBI, 2018). This role involves preparation of anaesthetic equipment, pharmacological agents, airway devices, respiratory equipment, and monitoring systems, alongside support for airway management, procedural readiness, intravenous therapy, fluid and blood replacement, and physiological monitoring (Budharapu et al., 2015; Cullen et al., 2024; Knudsen, 2016; Siddiqui & Kim, 2023; Vassou, 2021). While anaesthetic agents are administered by the anaesthetist, the ODP's contribution is central to anticipation, vigilance, and rapid response within high-acuity clinical environments.

ODPs may also practise as scrub or circulating practitioners during the intraoperative phase. As scrub practitioners, they maintain the sterile field and ensure instruments, materials, and equipment are prepared, organised, and accounted for throughout surgery (Stables et al., 2018). This requires technical precision and anticipatory awareness of procedural progression (Keeley, 2022). As circulating practitioners, ODPs support surgical procedures from outside the sterile field by managing equipment, co-ordinating resources, and connecting sterile and non-sterile activity safely (Lowes et al., 2020). Together, these roles position the ODP as a contributor to surgical safety, continuity, and theatre efficiency, while also demonstrating the breadth of knowledge required across anatomy, physiology, instrumentation, infection prevention, and procedural flow.

In recovery, or the Postanaesthetic Care Unit (PACU), ODPs provide direct postoperative care and continuous assessment as patients emerge from anaesthesia and surgery (Preston & Gregory, 2015). This involves monitoring airway patency, respiratory and cardiovascular stability, level of consciousness, pain, thermoregulation, and signs of bleeding or deterioration (Royal College of Anaesthetists (RCoA), 2019). Recovery practice is guided by structured protocols and interdisciplinary communication, with competencies outlined by the AAGBI (2013) and reflected in HCPC (2023a) standards. It also requires ODPs to interpret physiological change, administer pain relief where appropriate, respond to deterioration, and escalate concerns when necessary (Abbott & Booth, 2014; Davidson & Litchfield, 2018). Recovery therefore extends the ODP role beyond procedural support, positioning the practitioner as central to postoperative surveillance, patient safety, and continuity of care.

Across anaesthetics, scrub and circulating, and recovery, the ODP role is enacted through distinct yet interconnected domains of expertise. These areas demonstrate the breadth of ODP practice and the extent to which the profession is embedded across the perioperative pathway. However, contemporary healthcare is not static. Evolving service demands, increasing surgical activity, workforce pressures, and regulatory developments continue to reshape professional boundaries and scope of

practice. As a result, ODP expertise is increasingly being considered beyond the traditional confines of the operating theatre.

Mixed-methods research by Lowes et al. (2020) identified ODPs working in out-of-theatre settings across five NHS Trusts in England, including Intensive Care Units, High Dependency Units, Accident and Emergency departments, resuscitation teams, and other acute care environments. These developments suggest that core ODP competencies, including airway management, physiological monitoring, situational awareness, and emergency response, are transferable to wider high-acuity settings. More recently, NHS England (2023) acknowledged ODPs' growing contribution to workforce development, critical care capacity, surgical recovery and system resilience. ODPs are also becoming more visible within education, leadership, and research roles, contributing to curriculum development, mentorship, and research inquiry (Lowes, 2019).

This role expansion represents both opportunity and complexity. It may strengthen recognition of ODP expertise and create new routes for professional contribution, but it may also require ongoing negotiation of professional boundaries, role clarity, and interprofessional positioning. As ODPs move into spaces traditionally associated with other professional groups, their contribution may be interpreted differently depending on local context, organisational culture, and existing professional hierarchies. This is significant for the present study because professional identity is shaped not only by what ODPs are educated and regulated to do, but also by how their contribution is recognised, understood, and valued within contemporary healthcare environments.

This breadth of responsibility draws attention to the educational structures through which ODPs are prepared for practice. The following section therefore outlines the development of ODP education in Scotland, with particular attention to the programme context within which participants in this study were educated.

1.5. ODP Education Overview

The structure and delivery of ODP education in Scotland has evolved considerably over recent decades, reflecting broader regulatory, workforce, and professional

developments. Historically, ODP education moved from the City and Guilds 752 qualification and SVQ routes to the Diploma of Higher Education (DipHE), later progressing to BSc level before reverting to DipHE status in 2019. More recently, the qualification has returned to a BSc award since 2024. These shifts illustrate how professional education is shaped not only by pedagogical considerations, but also by regulatory expectations, financial realities, and workforce need, as to be discussed.

Until 2012, the programme retained an apprenticeship-style model, after which GCU advanced the qualification to BSc level through condensed blocks of full-time university study interspersed with full-time clinical placement. However, due to financial constraints, the final cohort commenced at GCU in 2017 (HCPC, 2025). In response to growing workforce pressures within perioperative services, the participating university subsequently secured a contract with NHS Education for Scotland (NES) to deliver the programme under a trainee initiative. Under this arrangement, students were employed within NHS Scotland pan-Scotland, while completing the academic component entirely online through distance learning at university (TURAS, 2023).

This trainee model also introduced regional variation. NHS Scotland was divided into North, West, and East and South groupings, within which differing contractual approaches were adopted. Health boards in the North, East and South regions implemented trainee contracts under Annex 21, remunerating students at 70% of a Band 5 salary (NHS Staff Council, 2021). By contrast, health boards in the West initially offered no financial remuneration, although tuition fees were covered nationally. These disparities contributed to increased attrition in the West region, highlighting how structural conditions can shape educational experience and progression.

The later adoption of Annex 21 contracts across the West of Scotland, including private providers in 2021, marked a significant shift in workforce strategy. By the September 2022 intake, all health boards had aligned their employment models, contributing to rapid programme expansion and increased student numbers. Such developments demonstrate how educational structures are embedded within wider

organisational and economic contexts, shaping not only access to training but also learners' sense of belonging and security within the profession.

At the time of data collection in 2023, the programme under investigation was a two-year DipHE ODP qualification delivered by a Scottish university. This programme was structured as a full-time distance-learning course across three academic terms per year, with a 60% practice and 40% theory distribution. It was approved by the HCPC, and successful completion enabled graduates to apply for registration as ODPs (HCPC, 2019). Clinical placement oversight was co-ordinated by Regional Education Leads (RELs) employed by NHS Scotland, who functioned as line managers and co-ordinators. This model required close collaboration between the university and practice partners to support student progression and professional development.

Since data collection, the educational landscape has changed significantly. Following the HCPC's (2021) decision that new registrants from 2024 onward must hold a BSc qualification as the minimum threshold for entry to the register, the programme was redeveloped as a three-year Graduate Apprenticeship (GA) BSc. In alignment with the Scottish Apprenticeship Advisory Board and Skills Development Scotland (SDS) framework, the revised model operates on an 80% work-based learning and 20% theory structure (SDS, 2024). Apprentices remain employed throughout and undertake one designated study day per week for academic engagement, representing a return to an apprenticeship-style model within a degree framework.

That said, all participants in this research were educated under the DipHE framework in operation at the time of data collection in 2023. Although the programme has since transitioned to a GA BSc model, the first cohort will not graduate until 2027, and will require a period of post-qualification practice before becoming fully embedded within clinical environments and professional communities. The findings of this study are therefore situated within the DipHE configuration and offer insight into professional identity formation during a period of structural transition within ODP education. The rationale for this sampling boundary is outlined in Chapter 3, while its implications for future longitudinal research are considered in Chapter 7.

Within the profession, the move to a mandatory BSc threshold has also been interpreted as a step towards parity with nursing colleagues, who enter perioperative roles following three-year degree programmes (HCPC, 2021; Royal College of Nursing (RCN), 2025). In Scotland, theatre nurses may enter perioperative environments without a formal postgraduate qualification, relying instead on local training structures. In contrast, ODPs qualify through a specialist, perioperatively focused programme from the point of entry. The elevation of the threshold qualification may therefore contribute to perceptions of educational equivalence and professional legitimacy within shared roles. Therefore, educational reform in this context is not solely a matter of curriculum redesign, but also one of recognition, status, and positioning within MDTs.

Having outlined the development of ODP education and the programme context within which this study was conducted, it is also necessary to situate the research within the broader contemporary HE context. This is important because the study examines not only professional identity formation within ODP education, but also how students and alumni engage with feedback provision to HEIs as a form of educational participation.

1.6. Contemporary Higher Education, Student Voice, and Professional Formation

Within the broader context of contemporary HE, this study is concerned not only with professional identity formation in ODP education, but also with engagement in feedback provision to HEIs. The participating university therefore forms part of the context in which professional identity, educational participation, and student voice are shaped.

Within contemporary HE, student feedback has become embedded within systems of quality assurance, enhancement, and institutional accountability (Klemencic, 2018). Formal mechanisms such as module evaluations, student representative structures, programme committees, and student-staff liaison processes are intended to provide students with opportunities to comment on their educational experience

and inform curriculum development. These mechanisms position students not only as recipients of education, but as contributors to the ongoing development and evaluation of their programmes (Mercer-Mapstone & Bovill, 2020).

This is particularly significant within professional healthcare education, where students are simultaneously learners within an academic institution and emerging members of a professional community. In this context, engagement with curriculum, assessment, placement learning, and feedback processes may contribute to how students understand professional expectations, responsibilities, and forms of participation. This aligns with wider HE research which suggests that professional identity formation acts as a bridge between university learning and future professional practice (Tomlinson & Jackson, 2021). HEIs therefore do more than deliver academic content or administer assessment. They also provide educational environments in which professional belonging, voice, and participation may be developed.

For ODP education, this wider HE context matters because the profession continues to negotiate recognition, role clarity, and visibility within perioperative and wider healthcare environments. Feedback provision may therefore be understood not only as a mechanism for evaluating educational provision, but as one way through which students and graduates participate in shaping the educational and professional community. This is important because student engagement is shaped by the interaction between institutional conditions, student agency, belonging, and the perceived meaningfulness of participation (Kahu & Nelson, 2018). Similarly, feedback engagement requires students to understand the purpose of feedback, recognise their active role within the process, and perceive feedback as something that can inform learning or change (Carless & Boud, 2018; Winstone et al., 2017a). This study is therefore situated at the intersection of contemporary HE, professional healthcare education, and ODP professional identity formation.

Having established this broader HE context, the following section turns to the more specific research context and rationale, including the professional, educational, and experiential factors that led to the development of this study.

1.7. Research Context and Rationale

As my academic career developed, my responsibilities expanded from lecturer to module co-ordinator across both the ODP and Adult Nursing programmes. This progression required engagement not only with curriculum delivery, but also with processes of evaluation, quality assurance, and student representation. In this context, my role extended beyond teaching and increasingly involved considering how students understood their place within the educational community, how they interpreted the significance of their contribution, and whether they experienced themselves as having a meaningful voice within programme development.

At the same time, my position as an early-career lecturer appeared to shape the kinds of conversations students were willing to have with me. Students often approached me to reflect on their experiences in practice, and these discussions frequently centred on how they were positioned within clinical environments as ODP students. Recurrent issues included being asked why they had chosen ODP rather than nursing, being excluded from learning opportunities beyond the theatre environment because they were not nursing students, and competing with nursing students for access to perioperative learning experiences where some mentors appeared to favour one group over another. Although these conversations arose informally, the consistency of such accounts drew my attention to the possibility that professional identity was being shaped not only through formal teaching and placement exposure, but also through repeated experiences of comparison, limitation, and differential recognition.

These observations prompted me to think more critically about the kinds of messages students were receiving about professional value, legitimacy, and belonging during training. What struck me was not simply that such experiences occurred, but that they seemed to communicate something broader about where ODP students were perceived to fit within the clinical environment. The issue was therefore not reducible to isolated incidents or individual dissatisfaction. Rather, these accounts suggested that questions of recognition and status were embedded within everyday interactions and could plausibly influence how students came to understand themselves in relation to their chosen profession.

Alongside these informal conversations, my responsibilities as a module co-ordinator introduced me to more formal mechanisms of student voice, particularly the Module Experience Questionnaire (MEQ), which was designed to capture student feedback through Likert-scale ratings and open-text responses. Although the instrument provided a structured opportunity for students to comment on their educational experience, response rates were consistently low, frequently below ten percent. Discussions with colleagues suggested that this was not unique to one module, but reflected a wider pattern across programmes. While low response rates in HE are not uncommon and have often been linked to survey fatigue and competing student demands (Nulty, 2008), I began to question whether procedural explanations alone were sufficient to account for this disengagement.

This concern was reinforced by my responsibility for completing the Module Review Form, through which reflections on module delivery and proposed changes are documented in response to student feedback and scrutinised by the School Assessment Board. Within this process, student feedback has formal consequence. It contributes to decisions about module enhancement, curriculum development, and the broader quality assurance infrastructure of the university. Yet this raised a further question for me: did ODP students fully recognise that consequence, and did they perceive their feedback as a legitimate and worthwhile means of influencing the educational environment? The issue, in other words, was not simply whether opportunities for feedback existed, but whether students experienced themselves as entitled to contribute and likely to be heard.

These considerations were further informed by revisiting reflective journals I had maintained since commencing ODP training in 2014. These entries documented my experiences across different stages of my own journey, first as a student, then as a practitioner, and later as an educator. On revisiting them, I became aware that many of my reflections centred on moments of affirmation, exclusion, or uncertainty about where I fitted within clinical and professional spaces. What was particularly striking was the extent to which these experiences mirrored those being described by students nearly a decade later, suggesting a degree of continuity in how ODP identity is positioned and negotiated within practice. Two themes appeared

particularly often within experiences I had recorded as negative: the need to justify choosing to become an ODP rather than a nurse, and a recurring sense of conditional belonging within clinical teams.

One phrase appeared repeatedly in those journals: “you’re just an ODP”. The phrase had been underlined in the original notes, suggesting the strength of its impact at the time. What was significant about such statements was not only their wording, but the assumptions they conveyed. They did not necessarily reflect overt hostility, but rather a more subtle positioning of the ODP role within professional hierarchies. I was reminded, for example, of a placement experience in which I asked to observe a nurse specialising in pain to broaden my understanding of pain assessment and management. The request was declined on the basis that, because I was not a nurse, the learning experience was not considered relevant to my role. This was striking given that postoperative pain management is integral to perioperative care, with the majority of surgical patients experiencing pain to some degree (Vasilopoulos et al., 2021), and that understanding pain physiology and analgesic pathways remains important to safe and responsive practice even where prescribing authority is absent (Sonneborn & Miller, 2021). Experiences such as this highlighted how professional boundaries may be interpreted and enacted in ways that shape not only access to learning, but also developing understandings of professional place and legitimacy.

The second recurrent theme within my reflections related to belonging within clinical environments. Placement areas often appeared organised around established professional groupings, whether by discipline, role, or specialty, and as a student moving through different settings, I was required repeatedly to negotiate where I fitted and how I was recognised. Research on clinical learning environments has emphasised the importance of inclusion, mentorship, and relational validation in shaping professional development (Liljedahl et al., 2016). Consequently, my own experiences, together with the accounts students later shared with me, suggested that where these conditions were inconsistent, feelings of marginality could intensify rather than resolve over time.

Through subsequent conversations with colleagues, peers, and students, it became increasingly apparent that these experiences were neither entirely isolated nor universally shared. Some ODPs described strong interprofessional cohesion and supportive learning environments, while others recounted experiences of undervaluation, exclusion, or reduced access to opportunity. Earlier sociological work has suggested that ODPs have at times been positioned as occupying an inferior status relative to nursing colleagues (Timmons & Tanner, 2004), and it seemed possible that such positioning continued to shape how ODP students and practitioners interpreted their membership within clinical and educational communities.

Taken together, these experiences led me to a broader set of questions. If professional identity is shaped through recognition, inclusion, and perceived legitimacy within clinical communities, might these same dynamics also influence engagement within educational communities? More specifically, I began to ask whether experiences of professional positioning, belonging, and value shaped how ODPs understood feedback provision to HEIs: whether they saw it as meaningful participation, as something peripheral, or as a process in which their contribution was unlikely to carry weight. It was through this intersection of professional identity, student voice, and educational participation that the present study emerged.

Having established the professional, educational, and experiential contexts from which this research emerged, the following section clarifies the focus, aim, and direction of the study.

1.8. This Research

The preceding sections have outlined the historical evolution of the ODP profession, contemporary scope of practice, shifting educational landscape, and experiential influences that informed this study. Across these domains, recurring themes of recognition, belonging, legitimacy, and voice became increasingly visible. These themes were not abstract concepts introduced retrospectively, but patterns observed through lived participation in clinical and educational communities and reinforced through engagement with existing literature.

As the research design developed, the title, aims, and research questions underwent refinement to ensure conceptual coherence with the study's social constructivist orientation. The focus moved beyond describing experiences of feedback engagement toward examining how professional identity is constructed and how that construction may shape participation within educational processes. The study therefore situates feedback provision not as a procedural activity, but as a socially situated practice through which professional membership may be enacted, negotiated, or withheld.

Within this framing, the following overarching aim and research questions were established.

1.8.1. Research Aim and Questions

This study aims to examine how professional identity is constructed among student and registered Operating Department Practitioners (ODPs), and to explore how this identity shapes engagement with feedback provision as a contribution to professional community development. The study is situated within the context of a smaller, specialist healthcare profession whose recognition, visibility, and legitimacy continue to be negotiated within hierarchical perioperative and wider healthcare environments. In this way, operating department practice provides a focused case through which to examine how professional identity is formed within a profession whose contribution is essential to patient care, yet whose visibility and status remain unevenly recognised within wider healthcare and educational contexts.

To address this aim, the study is guided by the following research questions:

1. What are student and registered ODPs' perceptions of their professional identity?
2. How does professional identity shape engagement with feedback provision to HEIs as a contribution to professional community development?

Having established the aim and research questions, the following section therefore explains the use of a first-person narrative and its alignment with the social constructivist foundations of this thesis.

1.9. The Use of “I”

At the outset of writing this thesis, I initially adopted a third-person narrative, consistent with conventions often associated with formal academic writing. However, this approach created an unintended distancing effect, positioning me as a researcher separate from the work itself. Within qualitative inquiry, particularly that informed by constructivist traditions, knowledge is understood as emerging through interaction rather than detachment. The use of first-person voice in academic writing has therefore been widely debated. Webb (1992) argues that first-person writing is not only acceptable but appropriate in qualitative research, while Fulbrook (2003) suggests that third-person constructions can introduce unnecessary distance between the researcher and the research.

In this study, a third-person narrative was inconsistent with how the research developed. The questions explored did not arise abstractly, but through lived experience within clinical and educational contexts. My positionality has informed the framing of the research questions, the methodological choices made, and the interpretation of the findings. To remove that positioning linguistically would risk presenting the work as more detached than it is. These influences are examined further in Chapter 3, where critical reflexivity is explored in detail.

The decision to write in the first-person is therefore not a stylistic preference, but a deliberate alignment with the social constructivist foundations of the study. A thesis concerned with professional identity, belonging, and voice necessitates acknowledgement of the researcher's participation within those social contexts. Therefore, writing in the first-person ensures coherence between paradigm, method, and narrative stance.

Having established the rationale for writing in the first-person, the following section outlines the structure of the thesis, demonstrating how the chapters collectively develop the study's central argument.

1.10. Structure of the Thesis

This thesis is structured into seven chapters, each contributing to the central argument that, within a smaller, specialised healthcare profession, professional identity among ODPs is constructed through relational participation within clinical and educational communities, and that engagement with feedback provision reflects how that identity is interpreted and enacted.

Chapter 2 critically reviews literature on professional identity construction, interprofessional positioning, student engagement and feedback processes. It introduces Social Identity Theory (SIT) and the Recognition, Respect and Reward (3R) framework as the study's principal conceptual foundations. In doing so, it identifies a conceptual gap in understanding the relationship between professional identity and feedback engagement among ODPs. The chapter also establishes the basis for later refining the 3R framework into Recognition, Respect and Value (RRV).

Chapter 3 outlines the social constructivist paradigm and exploratory qualitative design underpinning this research. Drawing on Stebbins' (2001) framework, it justifies the methodological choices and explains how sampling, recruitment, data collection and analysis captured the relational and interpretive dimensions of professional identity. Ethical considerations are addressed not only procedurally, but as integral to research within professional communities where belonging and voice are central.

Chapters 4 and 5 present the findings of the data analysis, focusing on professional identity construction and engagement with feedback provision respectively. Together, these chapters trace how participants describe experiences of recognition, respect, and value within clinical and educational contexts, and how these experiences shape their engagement with institutional feedback processes.

Chapter 6 develops the analytical discussion, drawing on SIT and the RRV framework to argue that feedback engagement is not solely an educational behaviour, but an expression of professional identity within collective contexts. Convergences and divergences with existing literature are explored, alongside implications for professional identity construction.

Finally, Chapter 7 synthesises the study's key contributions and considers their implications for HE, clinical practice and policy. It also examines the research strengths and limitations, identifies areas for future research, including longitudinal work on professional identity development across the transition to the GA BSc model, and concludes with a reflection on my professional doctorate journey.

Chapter 2: Literature Review

2.1. Introduction

This chapter critically examines the literature on how professional identity is constructed and negotiated within healthcare and higher education (HE). It integrates literature on professional identity construction, interprofessional hierarchy, feedback provision, and professional communities, treating these not as discrete areas but as interconnected processes shaped by institutional structures, professional boundaries, and relational experiences of legitimacy, recognition, and participation.

The Operating Department Practitioner (ODP) profession provides a particularly useful context for this discussion. As a comparatively recent profession within the United Kingdom (UK), ODP has evolved through changes in regulation, educational preparation, and scope of practice, all unfolding within perioperative systems shaped by established professional hierarchies. This positioning invites consideration of how emerging professions negotiate identity, recognition, and collective voice within environments where legitimacy is unevenly distributed.

This chapter begins by examining sociological understandings of the term *profession*, establishing that professional categories are historically and institutionally constructed rather than fixed. It then explores professional identity as the experience of professional membership, before considering how this is shaped within healthcare education and practice. Particular attention is given to the positioning of ODPs in relation to nursing and medicine, and to the interprofessional hierarchies through which legitimacy and authority are interpreted within perioperative settings.

Within this context, Social Identity Theory (SIT) is introduced as the first theoretical lens, enabling analysis of how group membership, comparison, and perceived standing shape professional identity within hierarchically organised environments. The second framework, the Recognition, Respect, and Reward (3R) framework, is

then introduced as an equally pertinent lens for examining the relational conditions through which such standing is experienced in practice.

The chapter also examines feedback provision within HE as a participatory practice shaped by voice, legitimacy, and institutional recognition, alongside professional communities as sites where belonging, participation, and collective identity are formed across clinical and educational contexts.

Taken together, the chapter argues that professional identity, feedback engagement, and professional community formation are mutually informing processes. This framing provides the conceptual foundation for examining how identity is constructed, enacted, and negotiated within an emerging healthcare profession. The following section outlines the exploratory orientation guiding the selection and organisation of literature within the chapter.

2.2. Exploratory Research and the Literature Review

The structure of this literature review is shaped by the exploratory orientation of this study. Exploratory research is particularly appropriate where conceptual intersections remain underdeveloped and existing literature does not fully account for the relational dynamics under investigation (Stebbins, 2001). In examining the intersection between professional identity construction, feedback engagement, and professional community formation within ODP practice, this study engages a field in which research remains fragmented across disciplines rather than coherently integrated. An exploratory approach therefore enables selective depth and conceptual synthesis rather than exhaustive cataloguing. While the methodology is examined in detail in Chapter 3, its implications for the structure and orientation of the literature review require consideration at this stage.

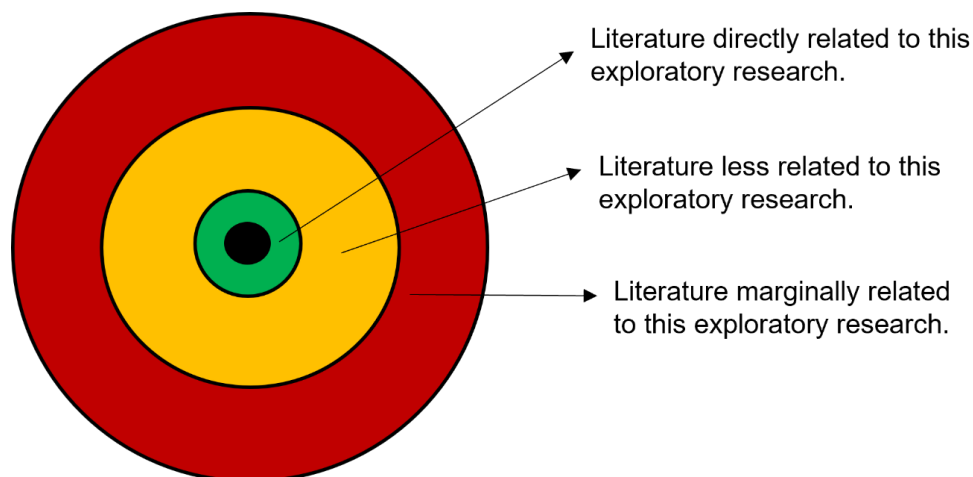
Consistent with Stebbins' (2001) guidance, the review draws on literature that illuminates how professional membership, legitimacy, and participation are socially constructed within institutional contexts. Rather than treating literature as a repository of knowledge, it is approached as an evolving conversation through which meanings of profession, identity, and voice are negotiated. This reflects this study's

position that professional identity and engagement are not fixed traits but situated and relational processes.

To support this synthesis, the review adopts a concentric organisation in which literature is engaged according to its analytical proximity to this study's core concerns (see Figure 2.1). Literature directly addressing **professional identity construction**, **feedback engagement**, and **professional community** development forms the central focus, while **sociology of professions** literature provides foundational theoretical anchorage for understanding how professional categories, legitimacy, and boundaries are constructed. Adjacent work on **interprofessional dynamics** provides broader theoretical anchorage. Where **ODP**-specific research is limited, comparative insights from **nursing** and **medicine** are drawn upon to illuminate how identity, legitimacy, and participation are constructed within more established professional systems. Through this structured engagement, this chapter develops a coherent conceptual foundation for examining how **professional identity**, **feedback participation**, and **community formation** intersect within an emerging profession.

Figure 2.1.

Conceptual Concentric Structure of the Literature Review



Having outlined the exploratory framework guiding the organisation of the literature, attention now turns to the conceptual foundations underpinning this study. Before professional identity and participatory practices can be meaningfully examined, it is

necessary to consider how a *profession* is defined, constructed, and sustained within healthcare systems.

2.3. Construction of the Term “Profession”

Before examining professional identity, it is necessary to clarify what is meant by the term *profession*. The designation of an occupation as a profession is neither neutral nor universally agreed, but shaped by historical claims to expertise, institutional regulation, and social recognition. Within healthcare, professional status carries implications for authority, autonomy, and legitimacy, directly influencing how professional identities are constructed and experienced. Clarifying how professions are defined and contested therefore provides an essential foundation for understanding the structural conditions within which ODP identity formation and participatory practices are situated.

Traditional sociological understandings of professions have been strongly influenced by functionalist perspectives, which view professions as stable, cohesive, and morally integrated social structures. Grounded in the work of Parsons (1939) and Goode (1957), this approach conceptualises professions as unified bodies characterised by shared values, collective identity, and normative consensus. Professions are understood to fulfil essential societal functions through the provision of expert services guided by ethical codes and underpinned by altruistic motives. Socialisation into a profession is therefore framed as a largely uniform process through which individuals adopt established norms, roles, and responsibilities. Functionalist accounts tend to privilege professional autonomy, internal cohesion, and public trust as the foundations of professional legitimacy. However, later sociology of professions literature has challenged the assumption that professional status rests primarily on shared values or service orientation, instead emphasising how professions secure, defend, and maintain control over particular forms of knowledge and work (Abbott, 1988; Freidson, 2001; Saks, 2012).

Abbott's (1988) account of the system of professions is particularly useful because it shifts attention from professions as isolated occupational groups to professions as interdependent actors competing for jurisdiction within a wider division of expert

labour. From this perspective, professional status is not simply an internal characteristic of an occupation, but is produced through claims over particular problems, tasks, and bodies of knowledge. Jurisdiction may be secured through legal regulation, workplace organisation, public recognition, or professional discourse, but remains open to challenge from adjacent occupational groups. This is significant within healthcare, where professional boundaries are frequently negotiated through overlapping scopes of practice, interprofessional collaboration, and changing service demands. Abbott's perspective therefore helps explain why professional identity cannot be separated from questions of role boundary, authority, and recognised expertise.

Bucher and Strauss (1961) offer a complementary but distinct account through their "process-model" of professions. Rather than treating professions as internally consistent, they argue that professions are heterogeneous, dynamic, and in constant flux. Central to this model is the concept of "segments", subgroups organised around differing values, practices, and priorities, which seek to establish legitimacy and influence institutional structures. The profession is therefore understood as a contested terrain in which multiple identities and interests coexist. Professional identity, legitimacy, and authority emerge through ongoing negotiation and interaction rather than through uniform socialisation.

This divergence between functionalist and process-based perspectives is both theoretical and epistemological. Functionalism reflects structuralist and positivist assumptions, presenting professions as stable entities and downplaying internal conflict. In contrast, Bucher and Strauss (1961), influenced by symbolic interactionism, conceptualise professions as socially constructed fields of negotiation. This resonates with Abbott's (1988) emphasis on jurisdictional contestation, as both perspectives reject the idea that professions are fixed or naturally bounded categories. Professional identity is therefore not simply inherited through occupational membership, but continually produced through discourse, institutional dynamics, and collective action. This perspective also foregrounds the role of power in shaping professional boundaries and public representation and claims to legitimacy.

The process-model further highlights how particular segments may come to dominate professional institutions and narratives. What appears as unity, including professional associations, ethical codes, and certification standards, may instead reflect the outcomes of internal power struggles. Bucher and Strauss (1961) describe this as “spurious unity,” where cohesion is presented despite underlying disagreement. This invites critical examination of whose interests are represented within professional narratives, and how exclusion or marginalisation may be produced within occupational fields, particularly during periods of change or redefinition.

Saks’ work further strengthens this critical understanding by locating professionalisation within neo-Weberian ideas of social closure. Saks (2012) argues that professions are most usefully understood not through trait-based lists of characteristics, but through the ways occupational groups use knowledge, expertise, and regulation to establish boundaries and secure social and economic advantage. In later work, Saks (2015) applies this perspective to medicine in Britain, the United States, and Russia, demonstrating how professional power is shaped through relationship between professions, the state, and the market. This is particularly relevant to healthcare because professional status is not determined by expertise alone, but by how expertise is legally recognised, institutionally organised, and socially authorised.

Freidson (2001) also contributes to this discussion by conceptualising professionalism as a distinct logic for organising expert work, different from both market and bureaucratic control. His account is useful because it highlights the relationship between specialised knowledge, occupational autonomy, and professional control. However, when read alongside Abbott and Saks, professional autonomy can be understood not as a settled attribute, but as something constructed and defended through jurisdictional claims, regulatory recognition, and institutional authority.

Applied to contemporary and evolving professions, these perspectives offer a nuanced account of professionalisation. This is particularly relevant to the ODP profession, which is characterised by shifting boundaries, internal diversification, and

ongoing negotiation of status and identity. The functionalist emphasis on stability and consensus struggles to account for such conditions, whereas process-based models provide a framework for examining how professional identities are constructed and negotiated over time. For ODPs, questions of professional status are therefore not simply matters of title or regulation, but relate to how the profession claims and sustains jurisdiction over perioperative expertise, how its contribution is recognised by adjacent professional groups, and how legitimacy is secured within wider healthcare structures. These perspectives position professions as dynamic and contested rather than fixed categories.

Having examined how professions are constituted and positioned, attention now turns to how individuals understand and enact membership within these categories. If professional status is constructed at a structural level, professional identity represents its lived and interpreted experience within practice and education.

2.4. Professional Identity

Professional identity provides a lens for examining how authority, legitimacy, recognition, and participation are experienced within healthcare. In perioperative settings, these dynamics are particularly important because practitioners work within hierarchically organised environments where professional roles intersect and recognition is unevenly distributed.

Although regulatory frameworks (General Medical Council (GMC), 2024; Health and Care Professions Council (HCPC), 2023a; Nursing and Midwifery Council (NMC, 2018) formalise professional accountability and competence, professional standing is not secured through regulation alone. Rather, it is continually negotiated through workplace interaction, interprofessional positioning, and the extent to which a profession is publicly and institutionally recognised. This is especially relevant to ODPs, whose role remains comparatively less visible within wider healthcare discourse (Taylor et al., 2019).

This section therefore examines how professional identity is conceptualised, constructed, and negotiated within healthcare professions. It first considers

professional identity as a lived experience of professional membership, before exploring how identity is shaped through training, interprofessional hierarchy, and the positioning of ODPs in relation to nursing and medicine. It then introduces SIT and the 3R framework as key lenses for analysing how legitimacy, belonging, and professional standing are experienced.

2.4.1. What is Professional Identity?

Although widely invoked across health professions education and organisational research, professional identity remains conceptually unsettled. The term profession derives from the Latin *professare*, meaning to declare publicly, historically signalling affirmation of specialised knowledge and shared values (Fitzgerald, 2020).

Contemporary literature, however, suggests that professional identity cannot be reduced to occupational title, regulatory status, or behavioural compliance. Trede et al. (2012) conceptualise identity as an interpretive process rather than a static designation, while Monrouxe (2010) emphasises that it involves coming to experience oneself as belonging within a professional collective. Identity therefore extends beyond formal qualification to how individuals understand and position themselves in relation to their professional group.

Within health professions education, professional identity formation is increasingly regarded as central to training. Sarraf-Yazdi et al. (2021) identify it as a defining concern within undergraduate medical education, with similar patterns observed across health professions (Cornett et al., 2023). Despite this, conceptual ambiguity persists. Forouzadeh et al. (2018) note that professional identity is often conflated with professionalism, obscuring the distinction between externally observable standards and internally interpreted belonging. While professionalism refers to conduct aligned with regulatory codes, identity concerns how individuals come to see themselves as legitimate participants within those frameworks (Bebeau & Monson, 2011), a distinction that is particularly significant where behavioural compliance does not equate to experienced legitimacy.

Organisational research extends this understanding by conceptualising professional identity as identity work undertaken within structured environments. Brown (2017)

defines identity work as the ongoing activity through which individuals construct and sustain narratives of who they are at work, while Caza et al. (2018) argue that identity emerges through engagement with organisational norms and power relations. This is important because it shifts professional identity away from being understood as a stable possession and towards an ongoing interpretive accomplishment shaped by context. It also shifts attention from developmental stage models toward the relational conditions in which identity is negotiated. Empirical studies illustrate this process: Ibarra (1999) shows how professionals experiment with provisional selves, and Pratt et al. (2006) demonstrate how medical residents refine identity through reflection shaped by workplace feedback. Professional identity formation is therefore an ongoing process of interpreting expectations, recognition, and institutional positioning.

Competence remains a key element within many accounts of professional identity. Van Oeffelt et al. (2017) emphasise expertise and commitment to development, while Zarshenas et al. (2014) and Binyamin (2018) highlight the role of perceived capability in shaping professional self-understanding. That said, equating identity solely with competence risks reducing it to technical proficiency. Cruess et al. (2014) argue that professional education involves transformation in self-concept, not simply knowledge acquisition, with identity formation requiring internalisation of collective values and their integration into one's sense of self (Cruess et al., 2016). Professional identity therefore encompasses how individuals interpret their legitimacy within a recognised community, rather than simply whether they meet regulatory standards.

More recent research foregrounds belonging as a critical dimension of identity formation. Lin et al. (2024) demonstrate that identity develops unevenly and is shaped by relational experiences in clinical environments, while Luong et al. (2025) and Mayer et al. (2025) show how marginalised identities require ongoing negotiation within established professional cultures. These findings reinforce that identity is shaped by how individuals interpret their standing within hierarchies, educational systems, and professional cultures.

Taken together, this literature positions professional identity as an ongoing, socially situated process through which individuals interpret themselves as legitimate members of a professional collective. Contemporary work further conceptualises identity formation as dynamic and shaped through participation, institutional context, and social interaction (Pach et al., 2025; Varpio et al., 2025). It is constructed through engagement with expectations, negotiation of boundaries, and alignment with collective norms, and is continually enacted within environments that distribute recognition, authority, and belonging unevenly. Establishing this conceptual foundation enables subsequent analysis of how professional identity is constructed during training and shaped through participation in practice.

2.4.2. Professional Identity Construction

If professional identity is understood as an interpretive and relational process, its construction must be examined within the social environments in which individuals learn to participate. Early sociological research provides enduring insight into this process. In *Boys in White*, Becker et al. (1961) demonstrated that medical students learned not only clinical knowledge but also implicit rules governing behaviour, ambition, and deference. Success was defined through alignment with institutional expectations, with those who mastered these norms recognised as insiders and those who did not at risk of marginalisation.

Subsequent research has reinforced the significance of this hidden curriculum. Brown et al. (2020) argue that identity is shaped as much by informal interaction as by formal teaching, while Scholtens et al. (2023) and Larrotta et al. (2025) demonstrate how hierarchies and power relations are reproduced through subtle practices that normalise particular forms of conduct. These findings extend Becker et al.'s (1961) work by showing that professional socialisation continues to operate through informal channels within contemporary healthcare education. Identity is therefore constructed through interpretation of institutional cues, responses to authority, and negotiation of status within practice environments, rather than transmitted through formal curricula alone.

This emphasis on situated experience also resonates with Dewey's (1938) understanding of education as grounded in experience and interaction. Dewey did not equate experience itself with learning. Rather, he argued that the educative value of experience depends on how individuals engage with and make meaning from their environment. This is important for professional identity construction because clinical placement does not simply expose learners to practice, it provides structured and unstructured experiences through which they interpret what kinds of participation are available, whose knowledge is recognised, and how professional belonging is communicated. From this perspective, what students are enabled to do in practice is central not only to what they learn, but to how they come to understand their role, contribution, and place within the professional community. This is supported by recent work linking professional identity formation to legitimate peripheral participation within clinical communities of practice (Orsmond et al., 2022).

Situated learning theory further clarifies how participation contributes to identity formation. Lave and Wenger (1991) conceptualise learning as legitimate peripheral participation within Communities of Practice (CoP), where movement from observation toward fuller engagement depends on recognition by established members. Participation becomes identity-forming only when it is understood as meaningful within the community. Empirical work supports this position: Orsmond et al. (2022) show how medical students' identities are shaped by permitted engagement, while Stoffels et al. (2022) demonstrate that boundary crossing between communities influences how learners interpret their place within the professional landscape. Progression from peripheral to central participation is therefore contingent upon opportunity, recognition, and access to valued tasks, all of which are structured by institutional hierarchies. The concept of CoP is explored in greater depth in Section 2.6, where its relevance to this study is examined more fully.

Crucially, these dynamics are not confined to medicine. Research across nursing and allied health professions demonstrates that identity formation unfolds unevenly across training. Lin et al. (2024) show that inclusion strengthens identity, while exclusion or diminished responsibility weakens it. Zarshenas et al. (2014) similarly emphasise the role of relational validation, and Lima et al. (2020) highlight how identity is shaped through personal experience, pedagogical relationships, and

broader socio-cultural context. In allied health education, Snell et al. (2020) note that tensions between formal curricula and observed practice require learners to reconcile the values presented in education with those enacted in practice. As in Becker et al. (1961), identity formation therefore involves navigating institutional contradictions rather than simply internalising stated standards.

Organisational and structural conditions further shape these processes. Currie et al. (2009) argue that NHS modernisation has reconfigured professional boundaries and expectations, while Noordegraaf (2016) describes contemporary professionalism as shaped by managerial accountability and performance regimes. Within such environments, identity is constructed not only through interpersonal interaction but through engagement with systems of regulation, audit, and performance measurement. Learners encounter these structures early, interpreting what forms of contribution are valued and which remain peripheral.

Professional identity construction must therefore be understood as socially situated within structured institutional environments. It develops through participation in communities where access to meaningful roles is mediated by hierarchy, recognition, and often tacit professional norms. This is particularly significant for more recent professions, such as ODP, where identity construction remains visibly contingent upon recognition within existing healthcare hierarchies. The discussion therefore now turns to the professional identity of ODPs.

2.4.3. Professional Identity of ODPs

While the operational scope of ODP practice has been outlined in Chapter 1, the professional identity of ODPs must be understood in relation to the profession's comparatively recent consolidation and its positioning within established perioperative hierarchies. Unlike medicine and nursing, whose authority was institutionalised over the nineteenth and early twentieth centuries, the ODP role emerged through a more fragmented trajectory of technical training, apprenticeship models, and later regulatory consolidation, as outlined in Chapter 1. This developmental pathway has implications for how professional identity is constructed and recognised within contemporary healthcare systems.

Beyond these historical developments, gender represents an additional dimension shaping the organisation and perception of healthcare professions. Nursing has long been characterised as a feminised profession, associated with expectations of care and emotional labour (NMC, 2014; Theodosius, 2008), while surgical environments have traditionally been organised around masculinised forms of authority and technical expertise. The ODP profession occupies a more ambiguous position within this landscape. With a comparatively balanced gender distribution (HCPC, 2023b), it is shaped less by a single dominant gender narrative and more by its structural positioning within perioperative hierarchies. Gender therefore informs, but does not solely determine, how ODP professional identity is interpreted and negotiated.

Taken together, these historical and gendered dynamics can be further understood through sociological analyses of professional development. As discussed in Section 2.3, Bucher and Strauss (1961) conceptualise professions as dynamic and segmented formations rather than stable entities, a perspective that helps to interpret the development of the ODP profession. Movement toward statutory regulation under the HCPC (2023a; 2024) formalised standards of proficiency and accountability, aligning ODP with other registered healthcare professions. However, as Trede et al. (2012) note, formal recognition in this form does not in itself consolidate collective identity. Professional legitimacy must be enacted and affirmed within everyday clinical interaction. For ODPs, professional identity cannot be understood as secured by regulation alone, but must instead be examined in relation to how the profession is recognised and positioned within practice.

This process has unfolded alongside broader NHS workforce reform. Currie et al. (2009) argue that modernisation initiatives have reconfigured professional boundaries, while Buchan (2004) highlights the redistribution of responsibility through workforce strategy. Within this context, ODP role development has been shaped not only by professional advancement but by institutional demands for flexibility and service efficiency. The National ODP Workforce Programme (Lowes, 2019) situates the profession within workforce expansion strategies, while Marshall and Farrington (2024) document continued role extension into areas such as critical care. These developments reflect Noordegraaf's (2016) account of professionalism

as reconfigured under managerial and policy-driven conditions, indicating that identity formation occurs within systems shaped by organisational as well as regulatory change. The implications of policy and infrastructural conditions for the positioning of the ODP profession are considered in greater depth in the following section.

Alongside these organisational dynamics, educational reform has also contributed to identity consolidation. The transition to degree-level entry and integration within HE aligns ODP with wider developments across health professions (Cardoso et al., 2014; Cruess et al., 2014). However, academic positioning does not automatically translate into structural parity within clinical settings. Molleman and Rink (2015) demonstrate that strong professional identification does not necessarily alter hierarchical positioning where historical distinctions persist. For ODPs, whose educational pathways have shifted between apprenticeship and university-based models before re-emerging within degree apprenticeships, identity consolidation has unfolded alongside ongoing debates concerning equivalence and professional status. These transitions require practitioners to interpret how their expertise is understood within perioperative teams already structured by established professional narratives.

The positioning of ODPs within perioperative care intensifies this dynamic. Although the role intersects closely with nursing practice, it does not benefit from the same degree of public visibility or historical consolidation (Taylor et al., 2019). This differential visibility has implications for how professional identity is interpreted within shared clinical spaces. Where nursing draws upon a longer history of societal recognition, ODP identity is negotiated within environments already shaped by established professional hierarchies (Essex et al., 2023). Claims to expertise and autonomy are therefore interpreted relationally, requiring ongoing articulation of professional distinctiveness within multidisciplinary teams (MDTs).

Professional identity in this context is constructed through regulatory consolidation, organisational restructuring, and interprofessional comparison. For ODPs, the transition from technical occupation to regulated profession has redefined how knowledge, authority, and professional standing are articulated. Yet this occurs within

healthcare systems shaped by workforce redesign, service pressures, and longstanding hierarchies. ODP identity formation therefore involves aligning with formal standards while negotiating recognition within structures that do not automatically confer equivalent visibility or influence. The discussion therefore now turns to the policy and infrastructural conditions through which ODP visibility and recognition are shaped within contemporary Scottish healthcare.

2.4.3.1. Policy, Infrastructure and the Structural Positioning of ODPs

These negotiations are shaped not only by regulation, education, and interprofessional interaction, but also by wider policy and infrastructural conditions. For ODPs, this broader structural context helps explain the distinction between longstanding regulatory legitimacy and the more uneven visibility of the profession within workforce planning, service reform, and national policy discourse. Where the preceding section established that ODP identity is formed under conditions of uneven recognition, this section extends that argument by showing how such unevenness is also reproduced at policy and system level.

Policy and infrastructure have influenced the development of ODP practice, but have not consistently translated into explicit professional recognition or clearly defined career pathways. In England, greater attention has been given to the education, deployment, and evolving scope of the ODP workforce (Lowes et al., 2020; Marshall & Farrington, 2024; NHS England, 2023). In Scotland, by contrast, policy has focused more broadly on service recovery, planned care reform, and workforce sustainability rather than on the ODP profession specifically (Scottish Government, 2022a). This distinction suggests that ODPs may be integral to system delivery while remaining less visible within profession-specific policy discourse. For example, the NHS Recovery Plan 2021–2026 prioritised increasing elective activity and expanding capacity through National Treatment Centres (Scottish Government, 2021), with subsequent reporting emphasising reliance on service redesign, staffing, and infrastructure rather than estate expansion alone (Scottish Government, 2024).

The significance of this context is reinforced by sustained pressure on elective care. Shah et al. (2025) demonstrate substantial increases in waiting lists between 2013

and 2023, while Audit Scotland (2024) identifies ongoing challenges relating to demand, workforce shortages, and limited progress in backlog reduction. These findings suggest that recovery is structural rather than temporary. Policy ambitions to increase surgical throughput therefore do not automatically equate to workforce capacity. For professions such as ODPs, this is significant because service dependence does not necessarily translate into enhanced visibility, development, or institutional support. Infrastructure expansion may signal growth, yet the contribution of specialist perioperative roles remains constrained where staffing, investment, and reform are insufficiently aligned.

This context highlights how professional recognition operates differently across levels of the system. At a regulatory level, ODPs have been formally recognised for many years through Standards of Proficiency (HCPC, 2014, 2023a; HPC, 2004a, 2008) and broader Standards of Conduct, Performance and Ethics (HCPC, 2012, 2024; HPC, 2003, 2004b, 2008). These frameworks consistently position ODPs as autonomous practitioners responsible for safe, ethical, and collaborative care, with increasing emphasis on leadership, equality, and quality assurance over time. However, while such standards demonstrate regulatory legitimacy, they do not guarantee equivalent visibility within national workforce planning or service reform.

In Scotland, workforce and allied health policies emphasise system-wide development, planning, and sustainability (NHS Education Scotland, 2022; Scottish Government, 2022a, 2022b), yet tend to subsume ODPs within broader workforce categories rather than foreground the profession directly. This reinforces a distinction between formal recognition and policy visibility. For this thesis, this distinction is critical. It suggests that professional identity is shaped not only through interpersonal recognition within clinical teams, but also through whether specialist roles are explicitly acknowledged, supported, and strategically incorporated within wider reform agendas. The structural positioning of ODPs within policy and infrastructure therefore forms part of the conditions through which professional legitimacy and visibility are experienced.

Taken together, these policy and infrastructural conditions reinforce that ODP identity is formed within a system that relies upon the profession while not always explicitly

foregrounding it. This is significant analytically as it illustrates that questions of legitimacy and visibility are not confined to interpersonal or workplace interaction, but are also embedded within the wider structures through which professions are recognised, prioritised, and developed.

This context provides an important backdrop for professional comparison. Whereas ODP identity has developed within conditions of more recent consolidation and less explicit policy visibility, medicine and nursing have a longer and more publicly established trajectory of professionalisation. The discussion therefore now turns to the professional identity of nurses.

2.4.4. Professional Identity in Established Healthcare Professions: Nursing and Medicine

Nursing and medicine provide important comparative contexts for understanding ODP professional identity because both occupy more historically established and publicly visible positions within healthcare. Although their trajectories of professionalisation differ, both demonstrate that professional identity is shaped through education, regulation, institutional authority, socialisation, and everyday interaction.

Nursing has followed a longer and more visible trajectory of professionalisation than operating department practice, although its identity remains negotiated within healthcare hierarchies. Historically positioned in proximity to medicine, nursing developed within gendered and classed systems that associated the profession with care, compassion, and moral responsibility (Pimentel et al., 2011). While these attributes have contributed to public trust, they have also constrained claims to authority. Integration into HE and regulatory oversight through the NMC (2018) have strengthened educational standards and professional accountability, while contemporary nursing identity has increasingly been reconstructed around patient safety, leadership, evidence-informed practice, and advanced professional responsibility (Heldal et al., 2019; Lewis, 2022; Reynolds et al., 2024). Nevertheless, nursing identity remains shaped by medical dominance, organisational change, interprofessional hierarchy, inclusion, marginalisation, and the coexistence of

professional and interprofessional identities within MDTs (Essex et al., 2023; Fosah & Llahana, 2025; Lin et al., 2024; Marold et al., 2025; Tong et al., 2020).

Medicine provides a contrasting example because its authority has been consolidated through control of specialised knowledge, regulatory structures, and jurisdiction over diagnosis and treatment (Freidson, 2001). This authority has become embedded within healthcare systems, meaning medical leadership may be treated as inherent rather than historically produced (Lewis, 2022). However, medical identity is also internally differentiated. Bucher and Strauss (1961) emphasise that professions are segmented, and distinctions between consultants, registrars, and resident doctors reflect differences in autonomy, responsibility, and authority. Medical identity is further reproduced through educational culture, workplace feedback, provisional identity work, and the hidden curriculum, through which students internalise norms of responsibility, hierarchy, and authority (Becker et al., 1961; Brown et al., 2020; Ibarra, 1999; Pratt et al., 2006). Although workforce reform has required renegotiation of professional boundaries, medicine continues to occupy a central organising role in many clinical settings (Currie et al., 2009).

The comparison between nursing and medicine is important because ODPs work alongside both professions within perioperative environments. Nursing demonstrates that even visible professions continue to negotiate legitimacy within hierarchical systems, while medicine illustrates how historical consolidation and jurisdictional authority can make legitimacy appear less contested. For ODPs, whose professional development is more recent and whose public visibility remains less secure, these professions provide important points of contrast. In perioperative practice, the authority of medicine and the visibility of nursing may influence how ODP contribution is recognised, compared, or misrecognised. This comparative positioning provides the foundation for examining how interprofessional hierarchies shape the construction and negotiation of professional identity.

2.4.5. Interprofessional Hierarchies and the Construction of Professional Identity

Hierarchy within perioperative environments is not incidental but structurally embedded within healthcare systems shaped by history, regulation, and organisational design (Pattni et al., 2019). Although often described in terms of formal rank, its influence extends beyond positional ordering to shape how authority is interpreted, how expertise is acknowledged, and how legitimacy is distributed across professional groups (Lewis, 2022). Professional identity formation therefore unfolds within systems that structure recognition unevenly rather than within neutral collaborative spaces (O'Donovan et al., 2021). This uneven distribution can generate what McNeil et al. (2013) describe as 'professional identity threat', where individuals experience their role as devalued or marginalised within interprofessional contexts.

Research examining operating theatre dynamics consistently demonstrates the persistence of hierarchical differentiation in everyday interaction. Lingard (2002) shows how communication patterns reflect status distinctions, influencing whose contributions are prioritised, while Pakkanen et al. (2022) highlight how power imbalances shape collaboration and decision-making. Ewashen et al. (2013) further complicate idealised accounts of teamwork by suggesting that collaboration may be more rhetorical than realised when professional decisions are contested. However, such tensions are not reducible to interpersonal conflict. Engel and Prentice (2013) and Avgerinos et al. (2020) demonstrate that disagreements frequently align with established professional boundaries, indicating that institutional authority shapes how expertise is interpreted. In these contexts, legitimacy is conferred relationally rather than solely through competence, and professional roles are continually negotiated within conditions of uncertainty (Payne & Farrell, 2015; Sabone et al., 2020).

Hierarchical organisation also influences voice and participation. Edmondson and Lei (2014) argue that psychological safety is closely tied to perceived standing within a team, while O'Donovan et al. (2021) show that experiences of voice and silence are shaped by professional position as much as individual confidence. Where roles are historically consolidated, authority may be assumed, where professional standing is

less established, contribution may require more explicit justification. Professional identity is therefore constructed through repeated encounters with systems that signal whose knowledge carries weight and whose requires validation (Khalili & Price, 2022).

Importantly, hierarchy functions as a relational structure rather than a static ladder. Molleman and Rink (2015) note that strong professional identification can reinforce boundary maintenance, particularly where scope overlaps occur, while Etherington et al. (2021) show that functional diversity can enhance performance when supported by effective team processes. These findings indicate that hierarchy simultaneously differentiates and connects professional groups. Interprofessional learning environments may either reinforce or disrupt these dynamics, depending on how participants are positioned within practice (Squires et al., 2025).

Understanding hierarchy as a structuring condition of professional interaction allows analysis to move beyond simplified accounts of dominance and subordination. Authority within perioperative settings is embedded within institutional arrangements that confer legitimacy unevenly, yet is enacted through everyday relational practice. This section therefore establishes hierarchy as an active social condition of professional identity formation, rather than a background characteristic of healthcare organisation. To illustrate how this uneven distribution of authority and legitimacy operates in practice, it is necessary to consider how hierarchical positioning is negotiated between specific professional groupings. The longstanding relationship between doctors and nurses provides one such illustration.

2.4.5.1. Doctors and Nurses

Medical and nursing practice are frequently described as collaborative, particularly within high-risk environments such as the operating theatre where co-ordinated action is essential for patient safety (Almghairbi et al., 2019). However, research consistently demonstrates that such collaboration unfolds within historically consolidated hierarchies rather than structurally equal arrangements. In perioperative contexts, nurses report their expertise as undervalued in interactions with doctors, particularly where clinical decision-making authority remains

concentrated within medical roles (Attri et al., 2015). Furthermore, Blomberg et al. (2019) similarly show that perceived status imbalance shapes how professional contributions are interpreted and acknowledged. At its most pronounced, such asymmetries may manifest as antagonistic interactions across hierarchical levels, described by Xu et al. (2023) as vertical hostility, suggesting that tensions within collaborative practice reflect structural organisation rather than individual disposition. Collaboration, therefore, does not dissolve hierarchy but operates through it.

These dynamics extend beyond interpersonal interaction to reflect structural patterns of professional dominance. Sociological analyses argue that medicine consolidated authority through control of specialised knowledge, regulatory closure, and jurisdiction over standards of practice (Abbott, 1988; Dierick-van Daele et al., 2009; Freidson, 2001). Although healthcare systems have become increasingly managerial, this historical consolidation continues to shape interprofessional positioning. Currie et al. (2009) note that workforce reform has reconfigured organisational structures without fully displacing medicine's structural advantage. Nursing identity therefore develops in relation to an established centre of authority, meaning that professional self-understanding is shaped through comparison rather than in isolation. From a social identity perspective, such asymmetry is significant, as group standing is interpreted relationally rather than solely through internal cohesion (Ashforth & Mael, 1989).

Contemporary workforce debates illustrate how these boundaries remain actively negotiated. Oliver (2023), responding to proposals within NHS England's long-term workforce plan, expressed concern that expansion of advanced practice roles risked diluting medical distinctiveness. While framed in terms of standards and patient safety, such responses can also be interpreted as efforts to protect professional boundaries. When institutional reform appears to redistribute authority, established groups may experience this as a shift in comparative standing, highlighting that professional identity is not only constructed but defended.

Taken together, doctor-nurse disparities must be understood as embedded within institutional histories and power arrangements rather than as isolated interpersonal tensions. Within this chapter, the doctor-nurse relationship is important because it

illustrates a more vertically organised hierarchy in which one profession occupies a more established position of authority and the other negotiates identity in relation to it. This example demonstrates how interprofessional comparison is built into professional life, and prepares the ground for considering a different, more horizontally organised form of boundary negotiation between nurses and ODPs. It is to this form of boundary negotiation, particularly between nurse and ODP roles, that the discussion now turns.

2.4.5.2. Nurses and ODPs

Where doctor-nurse disparities reflect vertical hierarchy, tensions between nursing and ODP roles are more productively understood as horizontal boundary negotiation within the shared space of perioperative practice. Both professions contribute directly to surgical care and may undertake overlapping responsibilities across anaesthetics, scrub and circulating, and recovery (Corbett, 2017). Proximity, however, does not dissolve distinction and may instead intensify questions of role clarity, expertise, and professional standing. This relationship is particularly significant because it highlights how hierarchy does not operate only through clear rank difference, but also through boundary negotiation between professions whose scope, visibility, and standing partially intersect (Taylor et al., 2019).

When emerging occupations enter established clinical domains, uncertainty around boundaries often follows. The emergence of the ODP role within perioperative environments historically associated with specialist nursing practice was therefore not solely a redistribution of tasks, but a reconfiguration of recognised expertise. This is illustrated in practice by Timmons and Tanner (2004), who report that some perioperative nurses altered their name badges to avoid being mistaken for ODPs. This can be interpreted as symbolic boundary maintenance, through which professional identity is made visible and distinction actively asserted. Such tensions were also reflected in clinical role allocation. Williams et al. (2005) observed that nurses were increasingly associated with scrub and recovery roles, while ODPs were more closely linked with anaesthetic practice. Although these patterns may reflect differences in training pathways, repeated association with particular domains

shapes how expertise is interpreted within teams. Over time, task allocation becomes symbolically loaded, influencing perceptions of autonomy and authority.

These interprofessional tensions were also made publicly visible within professional discourse during this period. Shields and Watson (2007, p. 71) described ODPs as being “trained to hand instruments to the surgeon, but have none of the knowledge of well educated, specialist perioperative nurses.” The contrast between “trained” and “well educated” constructs a hierarchy of knowledge, privileging academic legitimacy over technical expertise. Responses from ODPs were direct. Evans (2007, p. 209) referred to the comments as “disparaging remarks,” while Clarke (2007, p. 209) argued that the authors were “clearly ignorant of the role of an ODP.” Defending scope and education therefore functioned as legitimacy work through which collective standing was asserted.

While these exchanges were historically situated, empirical research suggests that these dynamics persist. Coe and Gould (2008) reported that more than half of perioperative staff identified disagreement between theatre nurses and ODPs, while Taylor et al. (2019) found that ODPs were more likely to seek interprofessional learning with nurses than nurses were with ODPs. This asymmetry indicates that collaboration does not automatically translate into reciprocal recognition and may instead reproduce existing hierarchies within shared practice.

Structural context further shapes these negotiations. Nursing has benefited from a comparatively stable educational trajectory and sustained public visibility, reinforcing its professional consolidation (Heldal et al., 2019). By contrast, ODP education has shifted between apprenticeship and university-based models before re-entering apprenticeship structures within a degree framework, as discussed in Chapter 1 (Section 1.5). While these transitions reflect workforce reform rather than diminished expertise, variability in educational pathways may influence perceptions of parity within interprofessional comparison. Professional identity formation for ODPs therefore occurs within a landscape where equivalence must often be articulated rather than presumed.

The UK-specific nature of the ODP title introduces an additional layer to this positioning. Nursing is internationally recognised as a professional category with established mobility and shared regulatory language (Kingma, 2006). In contrast, the ODP title remains largely confined to the UK (Taylor et al., 2019). In other countries such as Dubai and New Zealand, practitioners may be re-classified under alternative titles, often limited to anaesthetic practice. Where recognition is geographically bounded, legitimacy may rely more heavily on local institutional recognition. Identity is therefore shaped not only through interaction within theatre teams but also through the broader visibility of the profession within healthcare systems.

Taken together, the literature has demonstrated that interprofessional hierarchy operates through more than formal rank. It is enacted through comparative standing, boundary defence, differential voice, and uneven recognition across professional groups. This is significant as professional identity is shaped not only by internal commitment or competence, but by how membership of a professional group is interpreted in relation to others within structured settings. To examine these comparative and relational processes more directly, it is now necessary to articulate the theoretical framework through which this study interprets them: Social Identity Theory.

2.4.6. Theoretical Framework: Social Identity Theory

The preceding sections have demonstrated that professional identity within perioperative practice is constructed through interaction, comparison and negotiation across professional boundaries. Understanding these processes requires a framework capable of explaining how group membership informs self-understanding and behaviour within structured environments. SIT offers such a perspective. Originally developed by Henri Tajfel and John Turner (1979) and later extended by Turner et al. (1987), the theory proposes that individuals derive part of their sense of self from membership in social groups. From this standpoint, professional identity represents a form of social identity emerging through comparison with relevant occupational groups.

SIT is particularly appropriate in this study because the professional identity of ODPs is not formed in isolation, but in relation to more historically established occupational groups: nursing and medicine. More specifically, this study is concerned not only with how individuals come to understand themselves as professionals, but with how perceived group standing, intergroup comparison, and boundary negotiation shape legitimacy, participation, and voice. In this respect, SIT offers a strong explanatory fit, as it highlights the comparative and relational nature of identity within interprofessional environments (Haslam et al., 2009).

A central premise of SIT is that identity is not fixed but enacted through processes of categorisation and comparison (Turner et al., 1987). This is particularly relevant in healthcare environments where professional groups work in close proximity and where boundaries remain visible and symbolically significant. Adams et al. (2006) argue that complex professional identities evolve through interprofessional interaction rather than in isolation. SIT therefore helps explain not simply that professional identity is socially shaped, but why comparison with other groups becomes especially significant in contexts where authority, recognition, and role boundaries are unevenly distributed.

Application of SIT within organisational research further clarifies these dynamics. Ashforth and Mael (1989) extend the theory to workplace settings, suggesting that identification occurs when individuals define themselves in terms of collective membership. Haslam et al. (2009) demonstrate that group identification influences wellbeing and resilience, indicating that identity is consequential rather than descriptive. Within professional settings, identification may shape motivation, engagement and boundary maintenance. This is illustrated by Molleman and Rink (2015), who found that strong professional identification among medical specialists reinforced occupational distinction, suggesting that identity both reflects and reproduces professional boundaries.

Within health professions education, SIT has become increasingly relevant. Monrouxe (2010) argues that identity must be understood as socially constructed through participation in professional communities, while Burford (2012) highlights how group processes during training can reinforce hierarchy. Quantitative research

demonstrates that professional and interprofessional identities fluctuate during training, shaped by placement context and exposure to other occupational groups (Oosterbaan-Lodder et al., 2025; Van den Broek et al., 2021). These studies reinforce the value of SIT for this thesis because they show that professional identity is not merely acquired during training, but continually shaped through changing relations with relevant others.

Several key concepts within SIT further illuminate these processes. One central concept within SIT is salience, referring to the extent to which a particular identity becomes prominent within a given context (Randel, 2002). Although individuals hold multiple identities simultaneously, certain environments heighten the relevance of one identity over others (Randel & Jaussi, 2003). In professionally diverse teams, visible differences in training, authority or scope may intensify awareness of professional affiliation. Mitchell and Boyle (2015) suggest that diversity can accentuate group distinctions, rendering occupational categories more pronounced. In perioperative practice, moments of comparison or disagreement may therefore heighten professional identity, shaping how inclusion or exclusion is experienced.

Social comparison processes further illuminate how professional groups interpret status. Stets and Burke (2000) argue that individuals seek to maintain positive distinctiveness for their group. In educational contexts, Rose et al. (2025) demonstrate that feedback is interpreted not only as information but as a signal of position within a professional collective. Recognition and perceived legitimacy therefore influence how professional identity is enacted.

SIT also accommodates layered forms of identification. Hogg and Abrams (2001), and Hogg and Terry (2002) describe nested identities through which individuals identify simultaneously with broader and more localised groupings. An ODP may identify as a healthcare professional, as an ODP specifically, and as a member of a particular team. Willetts and Clarke (2014) note that identities embedded in daily practice often feel more immediate, while broader professional identities carry symbolic weight. These layers are context-dependent, with shifts in setting influencing which identity becomes most salient and how authority, belonging and boundary negotiation are interpreted.

Cross-cutting identities introduce further complexity. Ashforth and Mael (1989) observe that individuals may belong to groups that traverse professional categories, such as specialist committees or informal networks. Haslam (2012) emphasises that the influence of any identity depends upon contextual relevance. In perioperative environments, identification with a theatre team may mitigate professional tension in some circumstances, while in others occupational distinctions become more pronounced.

The implications of SIT extend to collective functioning. Ashforth et al. (2011) argue that strong identification increases alignment with shared goals. In healthcare settings where patient safety relies on co-ordinated action, identification may influence communication and willingness to contribute. Edmondson and Lei (2014) suggest that psychological safety is shaped by shared norms and perceptions of belonging, reinforcing the relationship between identity and participation.

At its core, SIT offers a framework for understanding how professional identity is constructed through belonging, comparison and recognition within structured environments. Goldie (2012) observes that healthcare professions frequently define themselves relationally, reflecting Tajfel and Turner's (1979) emphasis on intergroup differentiation. As Haslam (2003, 2020) argues, influence and leadership are grounded in shared identity, demonstrating that professional positioning is inseparable from collective identification.

Within this study, SIT provides a lens for interpreting how ODPs construct and negotiate identity within perioperative systems characterised by both vertical hierarchy and horizontal boundary negotiation. More specifically, it enables analysis of how ODP identity is shaped through comparison with adjacent professional groups, how professional voice may be influenced by perceived group standing, and how participation may reflect not only individual confidence but the social meaning attached to group membership.

If SIT explains how professional identity is shaped through group membership, comparison, and perceived standing, it is also necessary to consider how such

standing is encountered in everyday professional life. Group position is not experienced abstractly, but through whether contribution is acknowledged, expertise is respected, and participation is treated as worthwhile. The following section therefore examines the Recognition, Respect, and Reward (3R) framework as a complementary lens for understanding the relational conditions through which professional legitimacy and identity are experienced in organisational and interprofessional contexts.

2.4.7. Recognition, Respect, and Reward (3R) Framework

The 3R framework provides a useful lens for examining how professionals interpret their standing within organisational environments. Dellve et al. (2007) drew attention to the role of recognition and respect in shaping workplace experience, while Aalders (2023) highlighted how reward and acknowledgement influence perceptions of professional value. The framework is valuable not simply because it identifies three dimensions of work, but because it explains how professional contribution becomes meaningful within institutional life. In healthcare settings shaped by interdependence, hierarchy and differentiation, it helps illuminate how contribution, credibility and significance are interpreted rather than assumed.

It is important to acknowledge that recognition has also been theorised extensively within social justice literature, particularly through Fraser's framework of recognition, redistribution, and representation (Fraser, 1995, 2000, 2005). Fraser's work is concerned with the conditions under which individuals and groups can participate as peers in social life, with misrecognition understood not only as a matter of identity or esteem, but as a form of status subordination. In this respect, Fraser's theory has relevance to this study, particularly where ODPs describe questions of visibility, legitimacy, and voice within hierarchical clinical and educational contexts. However, I do not adopt Fraser's framework as the primary analytical lens because the focus of this thesis is not principally on social justice claims, distributive arrangements, or political representation at a societal level. Rather, my empirical concern is with how professional standing is interpreted through everyday clinical and educational interaction, and how these interpretations shape professional identity and feedback engagement. The 3R framework adopted therefore offered a closer analytical and

organic fit with the coding process because participants' accounts clustered around experiences of being recognised, respected, and treated as worthwhile contributors within practice and HE.

Used alongside SIT, the 3R framework helps move the analysis from comparative group positioning to the relational conditions through which that positioning is experienced in practice. While SIT explains why group membership and perceived standing matter, the 3R framework helps identify how such standing is signalled in everyday interaction and institutional response. Recognition, respect, and reward are therefore relevant not as abstract workplace preferences, but as mechanisms through which legitimacy becomes experientially visible.

Although recognition, respect, and reward can be distinguished conceptually, they are closely interrelated in practice. Recognition concerns acknowledgement of professional contribution, respect refers to the legitimacy afforded to expertise and judgement, and reward relates to the returns associated with professional effort, whether formal or symbolic. Aalders (2023) presents reward and recognition as organisational signals shaping how contribution is understood, while Mowbray et al. (2024) show that both tangible and intangible rewards influence whether individuals feel able to speak. These dimensions are therefore relational experiences interpreted through interaction with colleagues, institutions and wider professional structures. Reissner and Armitage-Chan (2024) similarly argue that professional meaning is constructed through ongoing identity work. Professionals make sense of whether their work matters through the responses they receive from others and from the systems in which they practise.

Recognition is particularly significant within interdependent and occupationally differentiated environments. Where multiple professions work in close proximity, the visibility of expertise influences how roles are understood in practice. Wackerhausen (2009) argues that professions maintain a public face through which authority and credibility are communicated. Recognition is therefore not only about being noticed, but about whether contribution is understood as consequential within collective practice. Consistent acknowledgement supports interpretation of oneself as a

legitimate participant, while its absence may generate uncertainty regarding role positioning.

Respect represents a related yet distinct dimension. Whereas recognition concerns acknowledgement, respect refers to the legitimacy attributed to knowledge and judgement. In perioperative settings, Lingard (2002) demonstrates that communication reflects assumptions about authority, shaping whose knowledge is prioritised. Mawuena and Wilkinson (2024) show that power, expertise and hierarchy influence voice in patient safety contexts, while Pakkanen et al. (2022) identify implicit hierarchies within interprofessional interaction. Respect therefore operates through the distribution of authority within everyday practice. Where knowledge is treated as legitimate, participation becomes more secure, where it is marginalised, professional standing may be experienced as provisional.

Reward introduces a further dimension through which professional standing is interpreted. While reward may include financial or career progression in some professions, within publicly funded systems such as the NHS, these are often structured through national frameworks (Roderick & Pollock, 2022). Reward may therefore be experienced more through symbolic indicators of professional standing, including opportunities to influence practice, acknowledgement of expertise and participation in decision-making. Aalders (2023) conceptualises reward as part of a broader system of organisational acknowledgement, while Mowbray et al. (2024) demonstrate that intangible rewards influence voice by shaping perceptions of safety and responsiveness. Reward is thus not simply what is given, but how institutional responses signal the significance of professional contribution.

Understanding the 3R framework in these terms aligns with wider literature on professional identity. Monrouxe (2010) emphasises that identity is constructed through participation in contexts where legitimacy is interpreted rather than assumed, while Fitzgerald (2020) highlights the role of identification with a professional collective. From a SIT perspective, Ashforth and Mael (1989) argue that self-understanding is shaped through group membership and perceived group standing. Additionally, Haslam et al. (2009) demonstrate that identification influences motivation, wellbeing and engagement, while Reissner and Armitage-Chan (2024)

emphasise the ongoing nature of identity work. Experiences of recognition, respect, and reward therefore contribute to how individuals interpret the value of their professional group. Positive experiences may strengthen identification, while uncertainty may generate ambiguity regarding professional position. This aligns with Molleman and Rink (2015), who found that perceptions of being valued were associated with stronger professional identification.

The relevance of the 3R framework is particularly apparent in perioperative environments, where professions operate within shared spaces but occupy different positions within institutional hierarchies. As discussed earlier, ODPs practise within systems shaped by the historically consolidated authority of medicine and the established identity of nursing. Currie et al. (2009) note that workforce reform has altered professional boundaries without removing hierarchical differentiation. Recognition, respect, and reward are therefore unlikely to be experienced evenly across professional groups. Instead, they are interpreted within systems in which authority, visibility and influence remain socially organised. Therefore, the 3R framework provides a means of examining how ODP practitioners may understand their legitimacy within both the MDT and the profession itself.

The framework also extends beyond clinical practice. Engagement in feedback provision within HE depends partly on whether students perceive their contribution to carry consequence within institutional systems. Kahu and Nelson (2018) argue that engagement is shaped by how students experience the educational interface, including whether their voice is treated as meaningful. Although educational feedback differs from workplace voice, the underlying principle is comparable. Where institutional processes appear responsive, participation is more likely to be experienced as worthwhile, where they appear symbolic, engagement may be weakened (Kahu & Nelson, 2018). For students in emerging professions, this may shape not only participation but also perceptions of professional voice, an issue examined in greater depth in the following section.

Taken together, SIT and the 3R framework suggest that professional identity is shaped both by intergroup comparison and by the relational signals through which comparative standing is interpreted in practice. In this thesis, the framework is later

refined from Recognition, Respect, and Reward to Recognition, Respect, and Value (RRV), reflecting the argument that in the context of publicly funded healthcare and HE, perceived value more accurately captures participants' experiences than reward alone. Even at this stage, however, the framework is useful in showing that legitimacy is not simply possessed, but encountered through whether contribution is acknowledged, respected, and treated as worthwhile. Feedback represents one such context. Rather than functioning solely as informational exchange, it may operate as a relational mechanism through which voice, legitimacy and professional standing are interpreted and enacted. The following section therefore examines feedback provision as a site in which professional identity is both expressed and shaped.

2.5. Feedback Provision

Having examined how professional identity is constructed within institutional and interprofessional contexts, attention now turns to feedback provision as a site of participation within HE. This section considers how feedback provision is conceptualised within contemporary higher and healthcare education research and policy before examining the structural and relational factors that shape engagement. In doing so, it maintains the chapter's central argument that feedback provision is not only an educational process, but an identity-relevant practice shaped by legitimacy, recognition, and voice.

2.5.1. Defining Feedback Provision

Within higher and clinical education, feedback is often understood as information provided to students to support development (Boud & Molloy, 2013). However, this study is concerned with feedback provision in the opposite direction: feedback provided by students to educators and institutions. Contemporary research challenges the view of feedback as simple information transmission. De Kleijn (2023) argues that feedback is better understood from a social constructivist perspective as a sense-making process shaped through interaction and interpretation. If feedback is relational rather than transmissive, then student feedback cannot be reduced to data collection, but must be understood as a socially situated evaluative practice. Tai et al. (2018) reinforce this position, suggesting that meaningful engagement with feedback

requires evaluative judgement, enabling students to contribute to academic dialogue rather than passively receive information.

Lane and Meth (2021) emphasise that feedback processes are inherently reciprocal, requiring students to contribute evaluative perspectives on teaching and curriculum. In the UK, this reciprocity has become increasingly formalised within accountability and enhancement systems. This is reflected in the UK Quality Code for Higher Education, which positions providers as responsible for securing academic standards and assuring and enhancing the quality of learning experiences. Importantly, the 2024 Quality Code also emphasises student engagement within enhancement activity, including the expectation that improvements identified through student engagement are implemented where appropriate and communicated to students and staff (Quality Assurance Agency for Higher Education (QAA), 2024a). However, these enhancement-oriented expectations also sit within a wider accountability context. Wiley (2019) notes that HE operates under intensified scrutiny regarding teaching quality, with instruments such as the National Student Survey (NSS) carrying reputational consequences. While such mechanisms are framed as supporting student performance and satisfaction (Lomos et al., 2011), they also position student feedback within broader regulatory and competitive frameworks. Feedback provision is therefore not simply an interpersonal exchange, but an institutional practice shaped by wider expectations about responsiveness, accountability, and enhancement.

At institutional level, students are routinely invited to complete module evaluations and programme-level reviews to inform curricular development (Ellery, 2006). These processes reflect a wider emphasis on student involvement in educational enhancement. In Scotland, this aligns with the Tertiary Quality Enhancement Framework, which guides quality arrangements for colleges and universities across the tertiary sector (Scottish Funding Council, 2024, 2025). The Tertiary Quality Enhancement Review provides a mechanism through which institutions are expected to evidence academic standards, the quality of the student experience, and enhancement across tertiary provision (QAA, 2024b). This reinforces the positioning of student voice as part of institutional quality and enhancement activity.

Student voice refers to the articulation of learners' perspectives on curriculum, assessment, and learning environments (Darwin, 2016). Brooman et al. (2015) identify growing institutional commitment to student engagement, while Campbell et al. (2007) argue that the credibility of student voice depends on visible responsiveness. Engaging student voice can challenge established assumptions about teaching and learning (Cook-Sather, 2006), and is increasingly recognised as a source of experiential insight for pedagogical refinement (Schluer et al., 2024). Within healthcare education, Sargeant et al. (2013) highlight its particular importance given its connection to professional preparation and safe practice.

This institutional framing is particularly significant within healthcare education, where student feedback is not only a mechanism for educational enhancement but also part of wider quality assurance processes. Healthcare programmes must demonstrate that curricula meet regulatory expectations, including those set by the HCPC (2020), alongside broader educational standards (Sreedharan et al., 2022). Birch et al. (2019) outline formal mechanisms such as audits, external examination, and structured review through which quality is monitored. Within these processes, students are positioned as stakeholders. However, Sreedharan et al. (2022) note that student contributions are not always afforded equivalent authority to academic or professional expertise, creating a structural tension between inclusion and influence. Despite this, Dai et al. (2021) argue that meaningful curricular improvement rarely occurs without substantive engagement with student feedback. This tension is important for this study because it suggests that opportunities to provide feedback do not necessarily equate to equal influence within educational systems.

Critical perspectives further complicate this picture. Seale (2010) suggests that quality assurance may privilege procedural compliance over transformation, while Mockler and Groundwater-Smith (2015) argue that evidence-based reform can obscure underlying power dynamics. Nevertheless, student feedback remains a central component of curriculum development, historically (Moore & Kuol, 2005) and in contemporary research (Ahmad, 2018; Ajjawi & Regehr, 2019; Debroy et al., 2019; Jenq et al., 2024).

Within health professions education, the implications of student feedback extend beyond institutional metrics. As ODP students participate in frontline care, the quality of their education has direct consequences for clinical practice. Fluit et al. (2010) argue that high-quality patient care depends on high-quality education, while Cavalerio and de Carvalho Filho (2023) caution that failure to respond meaningfully to learner feedback risks weakening educational standards. Student feedback provision therefore forms part of a broader system linking educational quality, professional preparation, and patient safety.

For the purposes of this research, feedback provision is defined as the processes through which students offer evaluative accounts of their educational experiences to educators and HEIs. Such provision is understood not merely as institutional evaluation, but as a participatory practice through which students express judgement, position themselves in relation to educational authority, and potentially contribute to the shaping of professional preparation. That said, while such processes are embedded within quality systems, their presence does not ensure meaningful engagement. Opportunities to provide feedback exist, yet participation is shaped by structural, relational, and practical factors. The following section therefore examines the barriers that may influence engagement with feedback provision.

2.5.2. Barriers to Feedback Provision

There are a variety of challenges associated with collecting student feedback which require critical exploration. A frequently cited issue is feedback fatigue. Winstone et al. (2017b) describe this as a sense of disillusionment that develops when repeated requests for evaluation yield little visible impact. Fass-Holmes (2022) similarly notes that high survey frequency, particularly when unaccompanied by observable change, can diminish both the quality and sincerity of responses. Within systems where students are routinely asked to complete evaluations, engagement may shift from reflective participation to procedural compliance. Fatigue therefore reflects not simply survey volume, but a judgement about whether contribution is meaningful and consequential.

Relational dynamics further complicate students' willingness to provide candid feedback. Offering evaluative critique to educators occurs within hierarchical environments characterised by power asymmetry. Ramani et al. (2017a) found that cultures of politeness often temper honest critique, as students seek to avoid appearing confrontational. Although anonymity is frequently proposed as a mitigating strategy (Boud & Molloy, 2013), it does not fully address the broader relational context in which feedback is situated. Research on psychological safety indicates that individuals are more likely to voice concerns when interpersonal risk is perceived to be low (Edmondson & Lei, 2014). Within healthcare settings, O'Donovan et al. (2021) demonstrate that voice and silence are shaped by perceptions of status and trust. This indicates that policy commitments to student engagement and enhancement do not remove the relational conditions that shape whether students feel able to contribute. Feedback provision is therefore influenced not only by the availability of mechanisms, but by whether students perceive participation to be safe and legitimate.

Students' capacity to articulate evaluative insight also influences the quality of feedback. Carless and Winstone (2023) conceptualise feedback literacy as the skills required to generate and communicate evaluative judgement effectively. While institutional focus has often centred on educators' ability to deliver feedback, less attention has been given to preparing students to produce it. Boerboom et al. (2015) report that student comments are frequently perceived as insufficiently specific, limiting their usefulness. Peterson et al. (2020) and Schmidt et al. (2021) similarly argue that students require structured support to develop the ability to provide meaningful, constructive feedback. Limitations in feedback quality should therefore be understood not as individual deficit, but as a consequence of how participatory roles are institutionally supported.

The design of feedback mechanisms further shapes both expression and interpretation. Many institutional instruments rely on scaled rating items (Fluit et al., 2010), yet narrative feedback is often considered more informative than numerical scores (Burford et al., 2010; Van der Vleuten et al., 2010). Open-ended responses allow contextual detail to emerge (Overeem et al., 2010; Van Es et al., 2012), while specificity enhances usability for development (Brutus, 2010; Ferguson et al., 2014).

Instrument design is therefore not neutral. It structures the type of contribution that can be made and influences how that contribution is subsequently valued.

Temporal factors also influence engagement. Feedback collected at isolated points may fail to capture cumulative experience. Hattie and Timperley (2007) highlight that feedback processes are often tied to discrete events rather than longitudinal patterns. Additionally, O'Connor and McCurtin (2021) identify workload pressures and proximity to assessment deadlines as constraints on participation. When feedback requests coincide with periods of high academic demand, students may prioritise performance over reflection. Engagement may therefore be shaped by situational conditions as well as intention.

Barriers to feedback provision also extend beyond students to include educator responsiveness. Jenq et al. (2024) emphasise that effective teaching development requires active engagement with evaluative data. However, evidence suggests that feedback does not consistently result in change (Atwater et al., 2002; Seifert et al., 2003; Smither et al., 2005). Without supportive dialogue, feedback may evoke defensiveness (Overeem et al., 2009; Sargeant et al., 2008). Vaughan (2020) argues that sustainable evaluation cultures depend on reciprocal engagement between students and educators. Where institutional responses are absent or unclear, students may interpret their participation as symbolic rather than influential, reinforcing disengagement. In this sense, barriers to feedback provision are not located solely within students, but within the wider relational and institutional conditions that shape whether contribution appears worthwhile.

Collectively, these barriers indicate that feedback provision is shaped by perceptions of impact, relational safety, evaluative capacity, institutional design, and responsiveness. Participation does not arise simply because mechanisms exist. It is constructed within a social environment in which voice may be enabled, constrained, or rendered inconsequential through everyday practice.

While these barriers illuminate structural and relational constraints, they do not fully explain engagement. Decisions to participate are also shaped by how students understand their position within educational and professional communities.

Feedback provision may therefore reflect not only practical limitation, but also perceptions of legitimacy, belonging, and standing. Exploring this dimension requires attention to the relationship between professional identity formation and engagement with feedback provision.

2.5.3. Linking Professional Identity to Feedback Provision

While the preceding discussion has examined structural and relational barriers that shape feedback provision, engagement is also mediated by how students understand themselves as emerging professionals. Research by Watling et al. (2014, p. 718) and Telio et al. (2016, p. 938) indicates that learners may hesitate to engage in feedback exchanges when they perceive that educators do not fully recognise who they are, often expressed as a sense that “they don’t know me.” Such findings suggest that feedback provision is not simply the transmission of evaluative information, but a relational practice shaped by recognition. Where students feel unseen or insufficiently understood, participation may be experienced as exposing vulnerability rather than offering informed contribution (Castanelli et al., 2022).

This relational sensitivity aligns with broader understandings of professional identity as socially constructed through interaction and recognition (Monrouxe, 2010). Sun et al. (2016) further demonstrate that professional identity is closely connected to personal self-concept, indicating that evaluative encounters are rarely detached from processes of self-understanding. Engagement in feedback provision may therefore reflect how secure students feel in their developing professional role and whether that role is acknowledged within the educational environment. From a social identity perspective, individuals interpret situations in relation to group membership and perceived standing (Ashforth & Mael, 1989). Where students do not experience themselves as recognised members of the professional or academic community, participation in feedback may appear incongruent with their perceived position. This is supported by SIT, which suggests that individuals draw on both personal and collective identity cues when deciding whether to act within institutional contexts (Davis et al., 2019).

Professional identity is also associated with perceptions of professional responsibility. Van Oeffelt et al. (2017) argue that identity underpins practitioners' ability to enact professional standards, while Ramani et al. (2017b) highlight that developing awareness of feedback processes forms part of professional growth. Within ODP education, where communication and accountability are embedded within regulatory expectations (HCPC, 2024), contributing evaluative insight aligns with professional conduct. Providing feedback may therefore represent participation in professional dialogue rather than simply commentary on teaching.

HE literature further positions healthcare students as adult learners responsible for their own development (Varvara et al., 2021), with evaluative judgement increasingly recognised as part of that responsibility (Carless & Boud, 2018). However, responsibility does not automatically result in participation. Engagement depends on whether students believe their voice will be heard and taken seriously. Research on psychological safety indicates that individuals are more likely to speak when contribution is unlikely to result in dismissal or negative consequence (O'Donovan et al., 2021). Students may therefore recognise the importance of feedback for professional competence while still questioning the legitimacy and influence of their contribution within structured hierarchies.

Recent work further reinforces the connection between identity and feedback engagement. Rose et al. (2025) argue that students interpret feedback practices through educational identities, suggesting that participation reflects how learners position themselves within institutional communities. Feedback provision may therefore function as an enactment of belonging. When students perceive themselves as legitimate contributors to professional discourse, engagement aligns with identity. Conversely, where identity feels provisional or marginal, participation may be restrained. This aligns with CoP literature, where participation is shaped by whether individuals perceive themselves as recognised members of a shared professional community (Davis, 2006).

Within ODP education, professional skills and knowledge develop through both formal and informal feedback processes across clinical and academic contexts. O'Connor and McCurtin (2021) observe that such processes support not only

individual learning but collective professional development. Feedback provision therefore extends beyond personal progression, contributing to the shaping of standards and practices within the professional community. Engagement may signal a developing sense of responsibility and belonging, whereas limited participation may reflect uncertainty regarding recognition, legitimacy, or influence.

Taken together, these perspectives indicate that feedback provision cannot be understood solely as a procedural mechanism or response to structural barriers. Rather, it is embedded within the ongoing construction of professional identity and shaped by perceptions of legitimacy, recognition, and group standing. Therefore, decisions to engage may reflect how secure students feel in their emerging role and whether they perceive their contribution as credible and consequential within both HE and the profession. Feedback provision can therefore be understood as an identity-relevant act through which students position themselves in relation to educators, institutions, and their future professional community.

Understanding feedback as an enactment of professional identity invites consideration of the broader collective contexts that shape belonging and legitimacy. Identity is negotiated within CoP and MDTs, where recognition and influence are continually interpreted. It is therefore necessary to examine how professional communities function within perioperative and educational settings.

2.6. Professional Communities

Building on the preceding discussions of professional identity, hierarchy, and feedback engagement, attention now turns to the professional communities within which these processes unfold. Research in health professions education positions professional identity as developing within shared professional contexts rather than through individual progression alone (Trede et al., 2012; Cornett et al., 2023). Professional communities provide the contexts in which belonging, recognition, participation, and voice are sustained, reinforced, or destabilised.

This section examines how professional communities are conceptualised, how they are formed within perioperative and educational settings, and how they intersect with

professional identity development. In doing so, it maintains the chapter's central argument that participation is shaped not only by individual willingness, but by whether membership, recognition, and contribution are socially and institutionally validated.

2.6.1. What Is a Professional Community?

The concept of a professional community appears frequently within education and healthcare literature, yet its meaning remains unsettled. Lowes et al. (2020) note the absence of a universally agreed definition, reflecting that professional life is organised through multiple and sometimes competing forms of collective association. This lack of agreement indicates that professional communities cannot be reduced to simple groupings of individuals who work together. Rather, they are shaped by shared practice, institutional structures, and negotiated boundaries that determine who is recognised as a legitimate participant.

Early educational research positioned professional communities as collaborative spaces oriented toward shared learning and development. Little (1982) examined teacher collegiality as a driver of improvement, while McLaughlin and Talbert (1993) explored how professional communities supported reform within schools. Lieberman (2000) extended this thinking by emphasising networks of professional exchange. While these accounts foreground collaboration and collective purpose, they tend to present community as inherently constructive, potentially obscuring the structured conditions and power relations that shape participation.

The framework of Communities of Practice (CoP) offers a more nuanced conceptualisation. Lave and Wenger (1991) describe a CoP as a social structure in which learning occurs through participation in shared practice. Central to this is legitimate peripheral participation, through which newcomers move toward fuller membership. Legitimacy is not automatic but conferred through recognition by established members and shaped by group norms. Participation therefore functions as both a learning process and a mechanism through which belonging is negotiated. Wenger (1998) further emphasises that shared enterprise, mutual engagement, and a developing repertoire of practice sustain such communities over time.

More recent work extends this perspective by demonstrating how CoP function as mechanisms for change within health professions education. Jenkins et al. (2024), through a realist synthesis, show that CoP facilitate transformation through context-dependent mechanisms such as legitimacy, relational trust, and opportunities for meaningful participation. This reinforces that engagement within professional communities is contingent upon recognition as a credible contributor rather than assumed through membership alone. Similar findings in healthcare settings highlight the role of CoP in facilitating knowledge exchange, professional learning, and identity development through sustained interaction (Ranmuthugala et al., 2011; Seibert, 2015).

While CoP provides a valuable lens, it must be considered alongside sociological accounts of professions as stratified and internally segmented. As discussed in Section 2.3, Bucher and Strauss (1961) conceptualise professions as comprising segments with differing interests and orientations, suggesting that apparent unity may mask internal differentiation. Professional communities are therefore not cohesive wholes but structured formations shaped by hierarchy and institutional positioning. Subsequent analyses reinforce this perspective. Noordegraaf (2016) demonstrates that professional practice in public services is embedded within managerial systems that reshape authority and accountability, while Currie et al. (2009) show that workforce reform within the NHS reconfigures professional boundaries without eliminating status distinctions. Communities thus operate within organisational arrangements that influence whose knowledge is prioritised and whose participation is marginal.

From a social identity perspective, community membership is consequential because group affiliation shapes self-understanding and behaviour. Ashforth and Mael (1989) demonstrate that identification within organisational groups influences participation and boundary maintenance. Belonging to a professional community therefore carries symbolic weight, reinforcing in-group distinctions and shaping perceptions of legitimacy. Therefore, community is not simply a setting in which identity forms, it is one of the mechanisms through which identity is enacted and recognised.

Taken together, the literature suggests that professional communities should not be understood solely as collaborative networks. Instead, they are relational and institutional formations in which participation, legitimacy, and authority are continually negotiated. Within perioperative and educational contexts, these dynamics are shaped by hierarchy, regulation, and evolving workforce structures. Understanding professional communities in this way shifts attention toward how such communities are formed, sustained, and structured within practice. The following section examines the processes through which professional communities emerge and the factors that influence their composition within perioperative and educational settings.

2.6.2. Formation and Composition of Professional Communities

Having outlined the conceptual framing of professional communities, attention now turns to their formation and composition in practice. Professional communities do not emerge spontaneously but develop through structured patterns of participation that begin during training and continue within practice environments (Berry, 2011; Orsmond et al., 2022). From a CoP perspective, formation occurs through engagement in shared activity rather than formal designation alone. Lave and Wenger (1991) describe this as legitimate peripheral participation, whereby newcomers move toward fuller membership as competence and recognition are established. Participation therefore depends not only on developing technical capability, but on being acknowledged as a legitimate contributor. In this sense, participation functions both as a mechanism for learning and as a process through which professional identity is constructed and affirmed.

In healthcare education, interprofessional education (IPE) represents one formal mechanism through which such participation is initiated. Taylor et al. (2019) describe IPE as an intentional strategy to foster collaboration and reduce stereotyping between professional groups. However, opportunities for interprofessional engagement are not uniformly distributed. Within perioperative contexts, ODP students may encounter fewer integrated learning experiences than other healthcare trainees (Taylor et al., 2019), potentially limiting early exposure to broader professional networks and shaping how community membership is experienced.

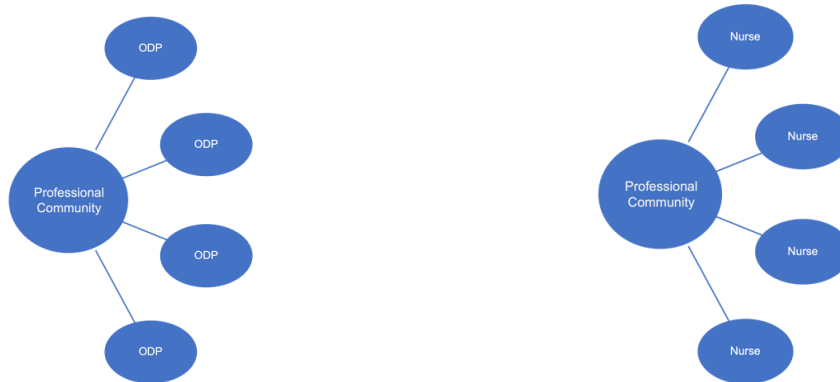
Community formation continues within clinical practice, where participation is structured by established role expectations and hierarchical positioning. Lingard's (2004, 2006) analyses of perioperative communication demonstrate how authority, expertise, and status influence whose contributions are prioritised. Movement toward fuller participation is therefore mediated by institutional norms and power relations rather than determined solely by competence. Entry into the community is shaped not only by training, but by the relational dynamics of the workplace.

These patterns of participation reflect the segmented composition of professional communities. As discussed in Section 2.3, professions are internally segmented rather than unified (Bucher & Strauss, 1961), with differing interests, priorities, and status claims. Within perioperative settings, segmentation may be visible across surgical, anaesthetic, and recovery domains, as well as between registered professionals and support workers. Although these groups collaborate within the MDT, their positioning within organisational hierarchies shapes patterns of influence and recognition. Currie et al. (2009) further demonstrate that workforce reform within the NHS reshapes professional boundaries without eliminating stratification, indicating that community composition is continually reconfigured through institutional change.

Within the perioperative environment, professional communities operate at multiple, overlapping levels. At the broadest level, the perioperative department functions as a collective formation. Within this, sub-communities emerge across stages of care, including preoperative, intraoperative, and postoperative practice. Further differentiation occurs through speciality-based groupings, such as orthopaedic or general surgery teams. At a more immediate level, individual theatre teams constitute situated communities organised around specific surgical lists, where participation is structured through interdependence and role allocation (see Figure 2.2).

Figure 2.2.*Singular Theatre Team Professional Community*

Beyond individual theatre teams, broader communities operate across anaesthetic, surgical, and recovery domains, alongside profession-specific groupings such as ODP-only or nursing-only communities. These exist in parallel with multidisciplinary formations, reflecting segmentation within collective practice (see Figure 2.3). While shared goals such as patient safety and quality care are often presented as unifying features (Noar et al., 2023; Wenger, 1998), they do not eliminate structural differentiation. Professional communities may therefore foster cohesion while simultaneously reinforcing boundary distinctions through everyday interaction.

Figure 2.3.*ODP Specific and Nursing Specific Professional Communities*

That said, professional communities are not confined to clinical environments. Educational cohorts create parallel formations that shape early professional socialisation. For ODP students engaged in online distance-learning, virtual environments introduce distinct patterns of interaction and visibility that influence how belonging is experienced. Mayne et al. (2015) demonstrate that CoP can be cultivated across educational contexts, supporting connection, shared identity, and progression into professional roles. Although focused on nursing, this work illustrates that educational environments function as active sites of community formation rather than merely preparatory spaces.

Taken together, these processes highlight that professional communities are structured through participation, hierarchy, and institutional positioning. Their operation depends not only on shared purpose, but on the everyday practices through which roles and boundaries are negotiated and maintained. This layered composition provides the context within which professional identity and belonging are interpreted.

Within the scope of this research, analytical attention is directed toward two overarching formations:

1. The MDT perioperative professional community, and

2. The ODP professional community, encompassing both registrants and students.

These communities represent the primary contexts within which participation, recognition, and identity negotiation are examined.

2.6.2.1. MDT Perioperative Professional Community

The MDT constitutes one of the most visible and influential professional communities within the perioperative environment. Although the terms MDT and interprofessional team are often used interchangeably, they represent more than functional collaboration (Wackerhausen, 2009). Within perioperative practice, the MDT provides a critical context in which participation, authority, and legitimacy are negotiated rather than assumed.

Extensive research emphasises the importance of teamwork for patient safety, communication, and co-ordinated care delivery (Das et al., 2024; Green et al., 2017; Weller & Boyd, 2014). Effective collaboration has been associated with improved surgical outcomes and reduced adverse events (Raveendran et al., 2023). However, the persistence of incidents linked to communication breakdowns suggests that teamwork cannot be understood solely as a technical skill set (Wu & Parks, 2023). Interprofessional interaction instead occurs within structured social environments where professional identities, power relations, and role expectations shape whose contributions are heard and whose authority is prioritised (Marrone, 2018).

From a SIT perspective, group membership provides a source of belonging and self-definition, while also generating intergroup comparison and status differentiation (Ashforth & Mael, 1989). Burford (2012) demonstrates how professional categories become socially meaningful during training, shaping expectations before qualification. Within perioperative MDTs, categorisation into professional groups such as surgery, anaesthesia, nursing, and ODP practice structures interaction through implicit assumptions about expertise and authority.

Empirical research supports this interpretation. Marrone (2018) highlights how differences in education, language, and professional socialisation can disrupt collaboration when distinct professional groups intersect. A meta-synthesis by Pakkanen et al. (2022) identifies power imbalances as central barriers to cohesive teamwork, particularly where professional groups hold divergent perspectives on patient management. Additionally, Grace et al. (2017) similarly show that task sharing becomes more challenging where professional status is perceived as unequal. Interprofessional difficulty is therefore not simply a matter of communication technique but is rooted in structural differentiation between occupational groups.

Hierarchical positioning within perioperative environments reflects broader institutional arrangements. Organisational status is often associated with qualifications, clinical responsibility, and remuneration (Rosario et al., 2023). Consultants and senior medical staff typically occupy positions of elevated authority, while nurses and ODPs operate within more constrained decision-making spaces. These distinctions are reinforced through everyday practices of delegation, leadership, and voice distribution. Lingard's (2004, 2006) analyses of perioperative communication demonstrate how authority is enacted in moment-to-moment interaction, shaping who speaks, who defers, and whose assessments influence clinical direction. Furthermore, O'Donovan et al. (2021) further argue that psychological safety and willingness to speak up are closely tied to perceived status. Silence, in this context, may reflect structural positioning rather than lack of insight.

Simultaneously, MDTs are characterised by functional diversity. Janss et al. (2012) describe how interdependent expertise enables teams to draw on varied knowledge to achieve shared objectives. Etherington et al. (2021) note that diversity can enhance decision-making through broader information exchange, while also generating tension where professional boundaries are contested. Furthermore, Johnson et al. (2018) suggest that team processes such as conflict management and shared reflection can mitigate these tensions, although such processes operate within, rather than outside of, established hierarchies. As Noordegraaf (2016) observes, contemporary professional work increasingly requires negotiation across blurred boundaries while retaining embedded stratification. The MDT therefore represents a site in which co-operation and competition coexist.

Efforts to strengthen MDT functioning often emphasise shared goals, particularly patient safety and quality care (Mitchell et al., 2012). However, shared purpose alone does not eliminate status distinctions. Wackerhausen (2009) argues that belonging within professional communities is conferred through shared practice rather than abstract alignment with values. Additionally, Dahl and Clancy (2015) demonstrate that shared workplace experience can foster a sense of common identity, yet these experiences are interpreted through existing professional narratives. Coe and Gould (2008, p. 616) illustrate this tension by showing how nurses articulated a distinct “special contribution” in contrast to ODPs, reinforcing boundary differentiation even within collaborative contexts, as discussed in Section 2.4.5.2.

Taken together, the MDT perioperative professional community cannot be understood simply as a functional arrangement of complementary roles. It is a structured social formation in which participation is shaped by hierarchy, professional categorisation, and institutional reform. While interdependence is essential for safe surgical practice, recognition, authority, and influence remain unevenly distributed. Within such arrangements, profession-specific communities acquire particular significance as sites where identity is consolidated and collective legitimacy negotiated. Attention therefore turns to the ODP professional community as a distinct formation operating both within and alongside the MDT.

2.6.2.2. ODP Professional Community

While the MDT structures interprofessional interaction, profession-specific communities provide a distinct space in which members consolidate shared standards, interpret collective positioning, and sustain professional coherence. For ODPs, whose role continues to evolve within established perioperative hierarchies, this community carries particular significance in maintaining visibility and legitimacy within the wider NHS landscape.

In the perioperative environment, the ODP professional community is enacted primarily through shared clinical practice. It is sustained through informal mentorship, collaborative decision-making, engagement in continuing professional development,

and adherence to regulatory standards (Woods et al., 2016). These interactions reinforce shared repertoires of practice while clarifying role expectations. As service pressures and workforce reform reshape perioperative roles, practitioners must collectively interpret scope and responsibility. Within this context, the ODP community provides a space in which distinct contribution is articulated and reaffirmed alongside adjacent professions.

This consolidation is not only procedural but relational. Identification with a defined occupational group can enhance psychological security, particularly where intergroup comparison is salient. Ashforth and Mael (1989) suggest that organisational identification strengthens alignment and commitment, while Haslam et al. (2009) demonstrate that group belonging supports wellbeing within hierarchical environments. In stratified perioperative settings, the profession-specific community may therefore provide a comparatively stable context in which contribution is recognised, and professional standards are collectively affirmed.

Alongside these workplace dimensions, digitally mediated interaction extends the ODP professional community, particularly for students within this study. Given that pre-registration ODP education is substantially delivered through online and distance-learning models, a virtual CoP develops during training. Hara and Hew (2007) emphasise that knowledge sharing within CoP is sustained through dialogue and reciprocal exchange. Within virtual environments, this exchange occurs through asynchronous discussion, shared reflection on placement experiences, and collaborative problem-solving. Evidence from healthcare contexts suggests that digitally enabled communities can mitigate professional isolation and support development when engagement is structured and purposeful (Rolls et al., 2016, 2020; Shaw et al., 2022).

For students undertaking geographically dispersed placements, such interaction may provide continuity and early consolidation of professional identity. Oosterbaan-Lodder et al. (2025) indicate that identity formation is strengthened when learners experience inclusion and meaningful participation within peer communities. However, engagement within online environments is shaped by access to technology, confidence in contribution, and perceptions of psychological safety (Sivamalai et al.,

2011). The virtual ODP community may therefore function as a comparatively protected space in which emerging practitioners rehearse professional identity and seek affirmation without the immediate pressures of hierarchical clinical interaction.

Taken together, understanding the ODP professional community in this way highlights its layered character. In-person practice provides a foundation through shared standards and relational reinforcement, while virtual interaction extends these connections across educational and geographical boundaries. Across both contexts, participation depends upon mutual recognition and the perception that contribution carries professional consequence. The ODP professional community therefore operates not only as a mechanism of knowledge exchange but as a structured environment in which belonging, legitimacy, and professional coherence are actively interpreted and reaffirmed. It is within these participatory contexts that professional identity is both consolidated and contested, prompting closer examination of how community membership and identity formation intersect.

2.6.3. Exploring the Intersection of Professional Identity and Professional Communities

The preceding sections have established that professional communities are structured environments in which participation, hierarchy, and shared standards shape everyday practice. The relationship between professional identity and community membership therefore warrants closer examination. Professional identity does not develop independently of social context, but is continually formed and reformed through engagement with the groups to which individuals belong.

Fitzgerald (2020) argues that professional identity is inseparable from social identity because entry into a profession involves identification with a collective. This aligns with SIT, which proposes that individuals derive part of their self-concept from group membership and the comparative standing of those groups (Ashforth & Mael, 1989). Within healthcare environments characterised by clear occupational boundaries, professional identity is therefore shaped not only by role performance, but by perceived legitimacy, recognition, and positioning in relation to other professional groups.

Empirical research in health professions education supports this relational perspective. Lewis et al. (2025) observe that professional identity formation is closely tied to participation in professional communities, particularly where learners are able to interpret expectations through meaningful interaction. Furthermore, Sternszus et al. (2024) suggest that identity consolidation is strengthened when community membership fosters belonging and shared purpose. That said, belonging is not uniformly distributed. As Goldie (2012) notes, integration into professional communities is mediated by local cultures and implicit norms, meaning that acceptance is negotiated rather than assumed. Similarly, Zarshenas et al. (2014) demonstrates that professional socialisation involves gradual alignment with collective expectations through situated interaction.

From a structural perspective, participation in the MDT may expose ODPs to unequal distributions of authority, while engagement within the ODP professional community may provide opportunities to reinforce distinct contribution and shared standards. Identity formation is therefore shaped through both interprofessional comparison and intraprofessional consolidation. From a SIT perspective, where group boundaries are salient, individuals may strengthen identification with their in-group to maintain positive distinctiveness (Haslam et al., 2009).

Therefore, professional identity and professional communities are shaped through reciprocal processes. Community participation provides the relational conditions through which individuals interpret what it means to belong, while identity work shapes how members engage with and sustain those communities (Levett-Jones et al., 2007). As Hara and Hew (2007) argue, active participation within CoP reinforces shared meaning and collective understanding. However, such reinforcement depends upon recognition and perceived value. Where participation is constrained or marginalised, identity may be destabilised rather than strengthened.

Exploring this intersection demonstrates that professional communities are not simply settings in which identity develops, but active conditions through which legitimacy, belonging, and contribution are interpreted. For this thesis, this matters because participation in feedback provision and engagement in professional life are

not enacted in isolation, but within communities that shape whether individuals experience themselves as recognised members whose voice carries consequence. Professional identity is therefore not an internalised attribute secured through qualification, but an ongoing social accomplishment enacted within structured communities.

Taken together, these dynamics demonstrate that professional identity, feedback engagement, and professional community formation are closely interconnected. Participation alone does not determine whether identity is affirmed or destabilised, rather, it is shaped by the quality of interaction, the distribution of recognition, and the perceived value of contribution. Professional communities therefore provide more than a backdrop to identity formation. They constitute the social settings in which legitimacy is interpreted, participation is enabled or constrained, and professional voice acquires or loses consequence. In this sense, community formation is not separate from professional identity or feedback engagement, but one of the conditions through which both are shaped.

2.7. Chapter Conclusion

This chapter has shown that professional identity within perioperative practice is not fixed or individually held, but socially constructed through participation in institutional and interprofessional contexts. Across the literature, identity is contingent upon recognition, negotiated through hierarchy, and sustained through engagement in professional communities rather than secured through qualification or regulatory status alone.

Additionally, it has further demonstrated that professional status and legitimacy are historically and institutionally constructed. The process model of professions illustrates how professional identities develop within contested and segmented fields, a perspective especially relevant to ODPs as a comparatively recent profession positioned within established perioperative hierarchies.

Across contexts, identity construction emerges through participation, exposure to implicit norms, and experiences of inclusion and exclusion. For ODPs, these

processes are intensified by uneven visibility and by professional environments where authority and legitimacy have historically been shaped by other occupational groups. Interprofessional analysis has highlighted vertical and horizontal boundary negotiations as central to how legitimacy, voice, and participation are experienced.

Furthermore, the chapter has argued that feedback provision in HE is not purely procedural, but a participatory practice shaped by relational and structural conditions, including perceptions of impact, psychological safety, and evaluative capability. Feedback is therefore better understood as an identity-relevant practice through which individuals interpret their legitimacy and voice within institutional systems.

Attention to professional communities further demonstrates that identity is constructed within collective environments shaped by hierarchy, participation, and institutional positioning. Read alongside SIT and the 3R framework, these perspectives illuminate how professional legitimacy is experienced through relational signals of acknowledgement, credibility, and contribution.

Taken together, this chapter establishes the conceptual foundation for this thesis by demonstrating that professional identity, feedback engagement, and professional community formation are interconnected processes shaped through social interaction, institutional structure, and intergroup comparison. While identity formation has been widely explored in medicine and nursing, and feedback engagement has received increasing attention within HE, limited research has examined how these processes intersect within emerging professions such as ODPs. In particular, there remains insufficient understanding of how professional identity shapes engagement with feedback provision as a participatory practice contributing to professional community development.

The following chapter outlines the methodological approach adopted to explore how student and registered ODPs construct and negotiate professional identity, and how these constructions shape engagement with feedback processes within HE.

Chapter 3: Methodology

3.1. Introduction

This chapter outlines the study's methodological framework, detailing the philosophical positioning, research design, and methods used to explore professional identity and engagement with feedback provision among Operating Department Practitioners (ODPs). In line with the principle that research design should be guided by clearly articulated aims and questions (Thomas, 2017), the methodological approach is directly informed by this study's overarching aim, as outlined in Chapter 1. This study aims to examine how professional identity is constructed among student and registered ODPs, and to explore how this identity shapes engagement with feedback provision as a contribution to professional community development. The study is situated within the context of a smaller, specialist healthcare profession whose recognition, visibility, and legitimacy continue to be negotiated within hierarchical perioperative and wider healthcare environments.

To address this aim, the study is guided by the following research questions:

1. What are student and registered ODPs' perceptions of their professional identity?
2. How does professional identity shape engagement with feedback provision to HEIs as a contribution to professional community development?

These questions require a methodological approach capable of exploring how professional identity, belonging, and participation are interpreted within social, educational, and clinical contexts. Rather than seeking to measure professional identity as a fixed attribute, this study examines how identity is constructed through experience, interaction, and meaning-making. The main contribution of this chapter is therefore to establish the philosophical, methodological, and procedural foundations through which professional identity and feedback engagement were investigated.

The chapter begins by outlining the philosophical assumptions underpinning the study, including its relativist ontology and social constructivist epistemology. It then explains the rationale for adopting an exploratory qualitative design, before detailing the sampling strategy, recruitment procedures, data generation methods, and approach to thematic analysis. Ethical considerations, rigour and trustworthiness, and researcher positionality are also addressed. Collectively, the chapter demonstrates the coherence between the study's aims, research questions, philosophical positioning, design, and methods, providing a transparent foundation for the findings and analysis presented in Chapters 4 and 5.

3.2. Research Paradigm

Establishing a clear philosophical foundation is essential for methodological coherence in qualitative research, as ontological and epistemological assumptions shape research design, data generation, and interpretation. Addressing this study's aim therefore required consideration of how reality is understood and how knowledge about professional identity, meaning-making, and professional community is constructed.

Rather than selecting a paradigm in isolation, I engaged with methodological literature including Crotty (1998), Braun and Clarke (2013), and Cohen et al. (2018) to articulate a stance consistent with the study's interpretive orientation.

Ontology concerns the nature of reality (Oliver, 2010). I adopted a relativist ontological position, understanding reality as multiple, subjective, and socially constructed through experience and social interaction. Braun and Clarke (2013) argue that meaning is generated through interpretation rather than direct observation of an objective world. Within perioperative and educational contexts, ODPs' professional identities and understandings of feedback are shaped through interactions within clinical teams, organisational structures, and educational contexts. A relativist ontology therefore provides an appropriate basis for examining how these experiences are interpreted and negotiated.

This position aligns with my broader commitment to social constructivist thinking, which resonated with my experiences as both a student and practising ODP. Social constructivist perspectives suggest that understanding develops through interaction with others and engagement with institutional and cultural structures (Polit & Beck, 2017). Such assumptions reflect the central concerns of this research, particularly the view that professional identity is not fixed but continually negotiated through participation within professional communities.

Epistemology concerns the nature and construction of knowledge. I adopted a social constructivist epistemology, understanding knowledge as generated through interpretation, interaction, and shared meaning-making rather than as fixed or universally observable (Crotty, 1998). This perspective aligns with this study's focus on how ODPs interpret their professional roles and experiences of feedback engagement. As Baxter Magolda (2004) and Cohen et al. (2018) suggest, knowledge is actively developed through reflection, social relationships, and institutional context.

Accordingly, I adopted a social constructivist epistemological stance in which participants' accounts are treated as meaningful interpretations of their professional experiences rather than objective representations of reality. I was therefore not positioned as a detached observer, but as an active interpreter engaged in the co-construction of meaning through the research process.

These ontological and epistemological commitments are brought together through a social constructivist paradigm. Paradigms provide the overarching framework through which inquiry is organised, incorporating assumptions about reality, knowledge, and appropriate methodological approaches (Denzin & Lincoln, 2018). A social constructivist paradigm was appropriate for this study because it supports exploration of how professional identity and feedback engagement are interpreted within professional and educational contexts, rather than treating them as stable or objective phenomena. As Chapter 2 demonstrated, professional identity is formed through participation, comparison, and recognition within professional communities and interprofessional systems. A social constructivist paradigm therefore provides a coherent framework for examining these processes as socially situated and interpretively constructed.

With these philosophical foundations established, attention now turns to the qualitative research design through which these commitments were applied.

3.3. Qualitative Design

The design of this study is informed by the exploratory nature of its aim and its alignment with the social constructivist paradigm outlined in the previous section. It is situated within a small, specialist healthcare profession where professional identity, recognition, and feedback engagement remain under-examined. As discussed in Chapter 2, limited empirical research currently exists examining the relationship between professional identity and engagement with feedback provision among ODPs. Investigating how practitioners interpret and construct these experiences therefore requires an approach capable of exploring meaning, perception, and interpretation within professional contexts. For this reason, I adopted a qualitative methodology.

In developing the research design, I considered several qualitative methodologies, including action research, ethnography, phenomenology, and grounded theory (Cain, 2011; Cohen et al., 2018; Ellis, 2022; Glaser & Strauss, 1999; Holloway & Galvin, 2015; Polit & Beck, 2022). However, these were deemed less appropriate because this study did not seek to implement change, immerse me within a cultural setting, identify a singular essence of experience, or generate a wholly new formal theory. In particular, I did not consider grounded theory the best fit because this study did not begin from a theory-free position. Existing conceptual work, including the 3R framework discussed in Chapter 2, provided a useful starting point for understanding identity-related experience.

Given these considerations, I selected an exploratory design to support investigation of this relatively under-examined phenomenon. Exploratory research is particularly appropriate when a topic remains conceptually underdeveloped or insufficiently understood within existing literature. Stebbins (2001) describes exploratory inquiry as a methodological approach suited to investigating phenomena that are not yet clearly defined or widely studied. Rather than beginning with fixed hypotheses or

predetermined variables, exploratory research enables openness to discovery and responsiveness to insights emerging from participants' accounts. Additionally, Swedberg (2020) suggests that exploratory inquiry often represents the starting point of robust investigation, enabling deeper understanding of complex social phenomena.

Consequently, an exploratory qualitative design guided by Stebbins (2001) was selected as the most appropriate methodological approach. This framework was chosen for its capacity to support flexible, open-ended inquiry while maintaining sufficient methodological structure to ensure rigour and trustworthiness, as will be discussed in Section 3.9.

Having established the research design, the following sections outline the methods used to implement this design, including the sampling strategy, recruitment procedures, data generation methods, and analytical processes employed within this study.

3.4. Sampling

Sampling is a critical methodological decision in any research study, as it determines who is included in the inquiry. Flick (2023) notes that qualitative researchers must consider whether the aim is to achieve breadth or depth within the sample. In qualitative inquiry, where the objective is to explore meaning and lived experience within specific contexts, depth is typically prioritised. In alignment with this principle, I adopted a non-probability sampling approach, targeting ODPs whose experiences were directly relevant to the research questions (Cohen et al., 2018).

Purposive sampling formed the primary strategy for participant selection. This approach enables researchers to intentionally recruit individuals whose knowledge or experiences are closely aligned with the phenomenon under investigation. Newby (2014) highlights that purposive sampling allows the researcher to identify participants capable of providing rich and meaningful insights. For this study, purposive sampling was essential, as participants were required to meet defined inclusion criteria relating to their professional status as either student or registered

ODPs (see Table 3.1). While purposive sampling introduces the potential for researcher bias in participant selection (Moule, 2015), transparency in recruitment procedures and clearly defined eligibility criteria helped to mitigate this risk (see Section 3.5).

To support recruitment, I complemented purposive sampling with elements of convenience and snowball sampling. Convenience sampling involves recruiting individuals who are accessible and willing to participate (Trotter, 2012). Although sometimes criticised for potential bias, it remains a pragmatic strategy within practice-based research contexts where the researcher has established professional networks (Newby, 2014). In this study, my existing professional connections within perioperative education and clinical practice facilitated access to both student and registered ODPs across Scotland.

Additionally, through the use of snowball sampling, I was able to extend recruitment through professional networks. This technique involves participants recommending other individuals who may be eligible to participate in the study (Newby, 2014). Snowball sampling can be particularly useful in professional communities where potential participants are dispersed across different organisations or geographical regions, as was the case in this study, where participants were recruited across Scotland. However, Cunningham (2013) cautions that reliance on participant referrals may introduce bias if recommendations are based on personal relationships rather than research relevance. To address this risk, all suggested participants were required to meet the established inclusion criteria (see Table 3.1) prior to being invited to participate.

In addition to these approaches, I incorporated stratification to ensure representation across key participant groups. In qualitative research, stratified sampling involves identifying relevant subgroups within the population to support comparative analysis (Hunt & Lathlean, 2015). In this study, two primary cohorts were identified: student ODPs and registered ODPs (alumni). Consideration was also given to regional variation across Scotland, including the North, West, and East and South regions, to allow for potential contextual differences in experience.

The question of sample size in qualitative research differs fundamentally from quantitative traditions. Rather than aiming for statistical representativeness, qualitative sampling prioritises depth and the generation of meaningful data. Polgar and Thomas (2020) emphasise that larger samples do not necessarily produce better insights, particularly when data collection methods such as interviews require detailed analysis. Hunt and Lathlean (2015) similarly argue that qualitative research seeks to develop understanding of particular phenomena rather than to generalise findings to wider populations. Consequently, the sample size in this study was guided by the aim of generating sufficient depth and diversity of data to address the research questions.

In line with this approach, I initially aimed to recruit approximately twenty participants, comprising ten registered ODP alumni and ten current student ODPs, to support comparison across cohorts. While this target was largely achieved, the final sample comprised eighteen participants, including eight alumni and ten students. As discussed further in Section 3.5, alumni recruitment proved more limited than anticipated. Nevertheless, the final sample provided sufficient depth and diversity of data to support meaningful analysis of the research questions.

Taken together, the combined use of purposive, convenience, and snowball sampling provided a flexible yet focused approach to recruitment, enabling me to access participants with relevant professional experience while maintaining alignment with the research aims. This strategy supported the development of a data-rich sample capable of generating meaningful insights.

Having established the sampling techniques utilised, the following section outlines the inclusion and exclusion criteria applied in this study.

3.4.1. Inclusion and Exclusion Criteria

As Parahoo (2014) emphasises, establishing clear inclusion and exclusion criteria prior to recruitment is essential to ensure that participants are appropriate to the aims of the study. Such criteria are determined in relation to the research questions, the scope of the inquiry, and practical considerations associated with participant

access (Flick, 2023). Clearly defined criteria support transparency in participant selection and help ensure that those recruited are well positioned to contribute meaningful insights to the research.

In this study, I developed eligibility criteria to ensure that participants had relevant experience of the professional and educational contexts under investigation. These criteria focused on two groups: registered ODPs (alumni) and current student ODPs, reflecting the DipHE programme in operation at the time of data collection in 2023, prior to the introduction of the Graduate Apprenticeship (GA) BSc model. GA participants were not included, as the first intake commenced in September 2024, and the programme will not produce graduates until November 2027.

Restricting the sample to DipHE students and alumni enabled comparison between cohorts who had experienced the same programme, supporting analysis of professional identity construction and engagement with feedback within a shared curricular and institutional context. The GA route did not offer the same comparability, as it represents a different educational model.

Limiting participation to students and alumni from a single institution inevitably introduced certain limitations, as restricting the sample in this way excluded perspectives from ODPs trained elsewhere. However, including participants from other institutions would have limited my ability to examine professional identity development in relation to engagement with feedback provision within a specific educational context. I therefore considered this delimitation necessary to maintain coherence between the research questions, the institutional setting, and the participant sample.

The inclusion and exclusion criteria applied in this study are summarised in Table 3.1.

Table 3.1.*Inclusion and Exclusion Criteria*

Inclusion Criteria		
Category	Details	Justification
Registered ODP	HCPC-registered ODP who graduated from a DipHE ODP programme at the participating institution	Including alumni from the DipHE ODP programme enables comparison across participants who have completed the same educational pathway, supporting reflection on the transition from student to practitioner and engagement with feedback processes within a shared educational context.
Student ODP	Individuals currently enrolled on the DipHE ODP programme at the participating institution.	Enables comparison of professional identity construction and feedback engagement between students and qualified practitioners within a shared educational context.
Exclusion Criteria		
Category	Details	Justification
Other registered healthcare professionals	Individuals who are not registered as an ODP or who trained outside the participating institution.	Excluded as they do not share the same educational and institutional context required for meaningful comparison of professional identity and feedback engagement.
Other student healthcare professionals	Students not enrolled on the DipHE ODP programme at the participating institution.	Excluded as they do not share the same educational context required for meaningful comparison of professional identity and feedback engagement.
Graduate Apprenticeship (GA) ODPs	Individuals enrolled on, or who or graduated from, the GA BSc ODP programme.	Excluded due to the recent introduction of the programme and absence of graduates at the time of data collection, limiting comparability with DipHE cohorts.

Having established the sampling strategy and participant eligibility, the following section outlines participant access and recruitment procedures.

3.5. Recruitment and Access to Participants

In qualitative research, accessing the field is a critical stage of the research process, as it determines the researcher's ability to engage meaningfully with participants and generate data relevant to the research questions (Flick, 2023). As Moule (2015) notes, qualitative methods such as interviews often require participants to engage reflexively with the researcher, which introduces additional ethical considerations when establishing access and recruiting participants.

Initial access to potential participants was facilitated through engagement with relevant gatekeepers. Gatekeepers are individuals responsible for regulating access to participants and safeguarding their interests within the research process (Moule, 2015). In this study, academic gatekeepers included the DipHE ODP Programme Leader and the Head of Division (HoD) for Adult Nursing, Community and Health within the School of Health and Life Sciences at the institution. Practice-based gatekeepers included Regional Education Leads (RELs) and Lead Nurses within perioperative departments across several NHS boards where potential participants were employed. Initial contact with gatekeepers was made through a formal letter requesting permission to access the participant population (see Appendix 1).

Given the pan-Scotland scope of this study, gaining access within the NHS required the establishment of professional relationships, which involved engaging with relevant gatekeepers through meetings conducted via Microsoft Teams. Assurance was sought regarding the ethical integrity of the research, particularly in relation to my dual role as both an academic and a registered ODP. Further discussion of these factors is provided in Sections 3.8 and 3.10.

As outlined in Section 3.4, recruitment was undertaken across two participant cohorts within the same overall study: registered ODP alumni and current student ODPs. Although recruitment took place within the same timeframe, I approached

each cohort separately to reflect their different positions within the professional journey and to support comparison across the dataset.

Once access had been granted by NHS gatekeepers, recruitment of registered ODP participants was facilitated through RELs within participating NHS boards. RELs initially circulated information about the study within their professional networks through an email advertisement (Appendix 2) and sought permission from eligible practitioners for their NHS email addresses to be shared with me. Only where individuals provided explicit consent for their contact details to be disclosed were these details forwarded. I then contacted potential participants directly via their NHS email address, providing the participant information sheet (Appendix 3) and consent form (Appendix 4).

Individuals who expressed interest in taking part were invited to contact me to arrange a mutually convenient date and time for interview. To minimise the risk of perceived pressure to participate, follow-up contact was limited. Where no response was received to the initial invitation, I sent a single reminder email. No further contact was made if a response was not received after this second communication.

Recruitment of student participants required particular sensitivity due to my role as an educator within the programme. Concerns were raised by the HoD regarding the potential for a perceived power imbalance if I were to recruit students directly. To mitigate this risk, a neutral academic staff member, not involved as either gatekeeper or researcher, distributed the recruitment materials to eligible students through programme communication channels using an Aula (virtual learning environment) advertisement (see Appendix 5). This approach ensured that students were able to consider participation without perceived pressure from a member of teaching staff. Students who were interested in taking part were invited to contact me directly. This was an important ethical safeguard, as recruitment of university students by those involved in their education can raise concerns regarding undue influence, perceived obligation, and difficulty distinguishing voluntary participation from academic expectation (Leentjens & Levenson, 2013).

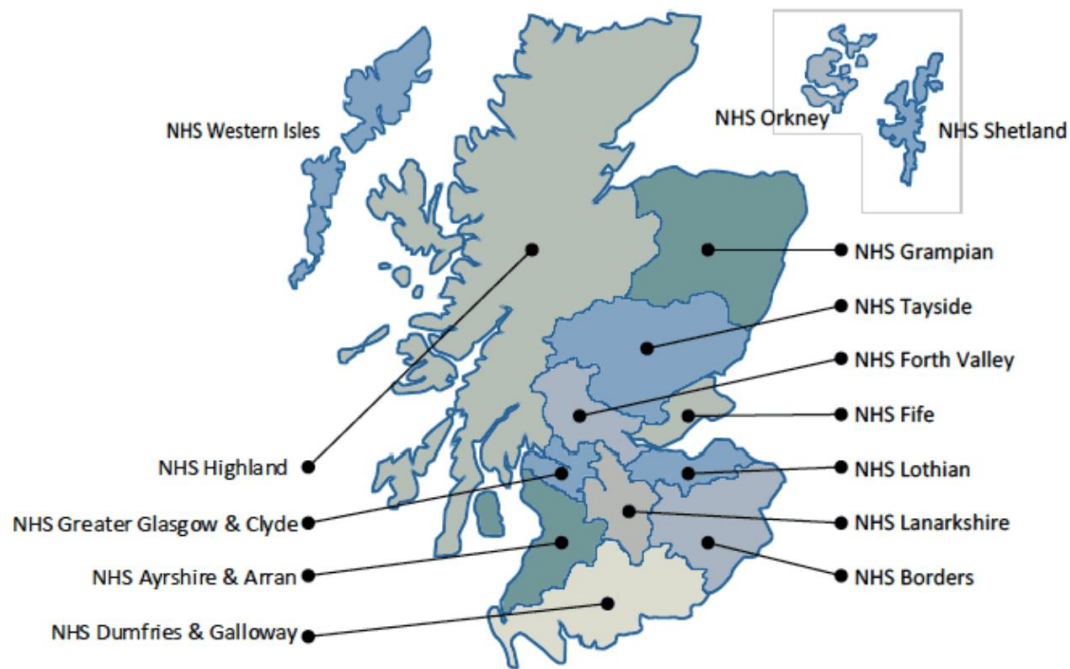
Given the national scope of this research, I sought to recruit participants from different regions of Scotland, including the North, West, and East and South. While achieving an equal distribution across all regions was not feasible, engaging with multiple regions was intended to capture a broader range of professional experiences and contextual perspectives within the ODP profession. This supported the development of a more comprehensive understanding of professional identity construction and feedback engagement across varied clinical settings.

Recruitment of registered ODP alumni participants proved more limited than anticipated, with no alumni participants identified from the East and South region. Prior to commencing recruitment, an informal discussion with the REL for this area indicated that this may present a challenge due to regional factors, including workforce pressures and high levels of sickness absence resulting in reduced staffing capacity. In addition, broader factors such as variable engagement with professional networks and the voluntary nature of participation in the research may also have contributed. Collectively, these conditions may have limited the available pool of alumni participants and their willingness to engage with the study. Despite this, the final sample provided sufficient representation across both cohorts to support the aims of the research.

Taken together, the recruitment strategy was designed to balance practical access to participants with careful attention to ethical considerations and my professional positionality. By working collaboratively with gatekeepers and implementing procedures to minimise potential influence, I sought to ensure transparency, voluntariness, and fairness in participant engagement. The following section outlines the characteristics of the participant sample generated through this process.

3.5.1. Participant Characteristics

Following the recruitment procedures outlined in the previous section, a total of eighteen participants took part in the study, comprising eight registered ODP alumni and ten student ODPs, with no post-interview withdrawals. Furthermore, to illustrate the geographical context of the study, Figure 3.1 presents the NHS health boards across Scotland.

Figure 3.1.*NHS Scotland Estate (Scottish Government, 2012)*

Participants were recruited from regions broadly categorised as North, East and South, and West (see Table 3.2). These groupings reflect the distribution of clinical placement sites and employment locations within the ODP workforce across Scotland. This classification, however, does not account for participants' clinical experience in private hospitals. In this study, I used regional categorisation to refer to participants' educational, placement, or employment location within Scotland, rather than to nationality, ethnicity, or country of birth. Although I collected demographic information relating to nationality, I decided not to report this in detail because only a very small number of participants were born outside Scotland. Given the relatively small ODP community and the small sample used in this study, reporting these details could increase the risk of deductive disclosure.

Table 3.2.*Regional Grouping of NHS Health Boards in Scotland*

Region	Health Board
North	NHS Grampian
	NHS Highland
	NHS Orkney
	NHS Tayside
	NHS Western Isles
East & South	NHS Lothian
	NHS Fife
	NHS Dumfries & Galloway
	NHS Borders
West	NHS Ayrshire & Arran
	NHS Greater Glasgow & Clyde
	NHS Golden Jubilee
	NHS Lanarkshire
	NHS Forth Valley

Participant demographic characteristics are presented in Tables 3.3 and 3.4. These tables provide an overview of participant gender, regional location, and, for alumni ODPs, primary intraoperative practice area. Similar to nationality, participant age is not reported to protect anonymity, as the relatively small and identifiable nature of the ODP community within the study context could increase the risk of identification. Alumni participants are identified using the prefix “A”, while student participants are identified using the prefix “S”.

Table 3.3.*Demographic Characteristics of Alumni Participants*

Alumni Participant No.	Gender	Region	Intraoperative Area
A1	Female	West	Anaesthetics
A2	Male	North	Dual (Anaesthetics & Scrub)
A3	Male	North	Scrub
A4	Female	North	Scrub
A5	Female	West	Scrub
A6	Female	North	Dual (Anaesthetics & Scrub)
A7	Female	West	Scrub
A8	Female	West	Anaesthetics

Table 3.4.*Demographic Characteristics of Student Participants*

Student Participant No.	Gender	Region
S1	Female	West
S2	Female	West
S3	Male	West
S4	Female	North
S5	Female	East & South
S6	Female	West
S7	Female	East & South
S8	Male	North

Having outlined the characteristics of the participant sample, the following section describes the methods used to generate the data.

3.6. Data Generation

To address the research questions, I used one-to-one semi-structured interviews conducted online via Microsoft Teams. This approach aligned with the exploratory qualitative design adopted in this study and supported the generation of rich, detailed accounts from student and registered ODPs across Scotland.

Interviews were appropriate because they enabled participants to articulate their experiences, interpretations, and perspectives in their own terms (Ellis, 2022). This was important when exploring professional identity, as individuals may draw upon multiple and overlapping forms of identification when narrating their experiences. The conversational nature of interviewing provided space for reflection, negotiation, and context-specific meaning-making, allowing me to explore how participants understood professional identity and feedback engagement within their clinical and educational contexts (Braun & Clarke, 2013; Meisenbach & Kramer, 2014).

I considered focus groups but deemed them unsuitable for this study. Co-ordinating suitable meeting times for participants with clinical schedules, academic commitments, and personal responsibilities would have been difficult. More

importantly, discussing professional identity and experiences of feedback provision in a group setting may have inhibited open discussion, particularly where participants worked within overlapping professional networks. There was also a risk that more dominant participants could influence the discussion, potentially limiting the diversity of perspectives captured (Green, 2019; Parahoo, 2014). Individual interviews were therefore more appropriate because they provided a confidential setting for participants to discuss potentially sensitive experiences of professional identity, belonging, and feedback engagement.

Interviews were conducted solely between the participant and me, with no non-participants present. This supported confidentiality and enabled in-depth exploration of participants' experiences while maintaining flexibility in scheduling across multiple regions of Scotland. The pan-Scotland nature of the DipHE ODP programme and this research made online interviewing the most practical and accessible approach. Conducting interviews via Microsoft Teams enabled participation across geographical regions without requiring travel. Participants were also familiar with the platform through its routine use in teaching and meetings, which supported ease of engagement. The platform's integrated recording function enabled secure capture of interview data.

Online interviews presented limitations, including potential connectivity issues and reduced access to non-verbal cues where cameras were disabled (Braun & Clarke, 2013). To mitigate this, I encouraged camera use where possible while remaining flexible where technical difficulties arose.

Semi-structured interviews were selected because they enabled a balance between consistency and flexibility. The interview schedule ensured that key areas relevant to the research questions were explored across participants, while open-ended questions allowed individuals to elaborate on their own experiences of professional identity and engagement with feedback provision. This was important for an exploratory study because it allowed unanticipated meanings and connections to emerge while maintaining sufficient focus across the dataset. Following Castillo-Montoya's (2016) guidance, I developed an interview schedule to guide the conversations and support inquiry-based dialogue (see Appendix 6).

As outlined, eighteen interviews were conducted, comprising eight registered ODPs (alumni) and ten student ODPs. Interviews lasted between 37 and 94 minutes (mean = 63 minutes) and were audio- and video-recorded with participants' informed consent. In addition to the recordings, I made brief field notes during and immediately after interviews to capture contextual details, early impressions, and points for later analytic reflection. Prior to the interview, participants were informed that there were no right or wrong answers, that participation was voluntary, and that they could withdraw their consent up to 1st January 2024. This date was specified because data analysis was scheduled to commence from this point, after which it would no longer be possible to remove participants' data without compromising the integrity of the developing analysis. Interviews were transcribed verbatim, and participants were offered the opportunity to review their transcripts and recordings to support transparency and accuracy (Birt et al., 2016).

Having established the data generation process, the following section outlines the analytical approach I used to interpret the data generated through these interviews.

3.7. Data Analysis

Following the generation of the interview data, I undertook a rigorous and methodologically coherent process of analysis to address the research questions guiding this study. Analysing qualitative data involves more than organising textual material, it requires sustained engagement with participants' accounts to interpret patterns of meaning within the dataset. Within qualitative research, the analytical process therefore involves reflexivity, transparency, and attentiveness to the contextual meanings embedded within participants' experiences (Nowell et al., 2017).

To interpret the qualitative data generated through the interviews, I selected Braun and Clarke's (2022) Thematic Analysis (TA) as the primary analytical framework (see Figure 3.2). Thematic analysis is widely recognised for its flexibility, accessibility, and capacity to generate rich and nuanced interpretations of qualitative data. Importantly, TA can be applied within a range of epistemological positions, making it particularly

suitable for research grounded in a social constructivist paradigm, where the aim is to explore patterns of meaning constructed through participants' experiences (Braun & Clarke, 2006; King, 2004). Within this study, TA enabled me to identify and interpret shared patterns across participants' accounts of professional identity and engagement with feedback provision within perioperative and educational contexts. The analysis was theoretically informed by the study's social constructivist orientation and by the conceptual lenses of Social Identity Theory and the 3R framework. These perspectives informed my interpretation of participants' accounts without determining themes in advance.

My previous experience of using TA during my master's dissertation also informed the selection of this approach. That earlier experience provided familiarity with the analytical principles underpinning TA while emphasising the importance of systematic and reflexive engagement with qualitative data. In the present study, I adopted Braun and Clarke's (2022) six-phase framework to ensure that the analytical process was conducted in a structured and transparent manner.

Figure 3.2.

Braun and Clarke's (2022) Six-Phase Thematic Analysis Process



Despite its widespread use, TA is not without critique. As an interpretive analytical approach, TA involves active engagement by the researcher, meaning that the development and interpretation of themes are shaped by the researcher's analytical perspective (Nowell et al., 2017). Its methodological flexibility has also been criticised for creating the potential for inconsistency if researchers do not clearly articulate how analysis was undertaken (Kiger & Varpio, 2020). Braun and Clarke (2006) further note that TA can be time intensive, requiring careful and sustained engagement with the dataset to ensure that themes meaningfully capture patterns across participants' accounts. These considerations reinforced the importance of applying TA in a systematic and transparent manner. In response to these

considerations, I applied Braun and Clarke's (2022) six-phase framework in a structured and reflexive way.

The analytical process began with familiarisation with the dataset through repeated reading of the interview transcripts. This stage involved immersing myself in the data to develop an understanding of the content, tone, and contextual nuances present within participants' accounts. Braun and Clarke (2013) describe this stage as cognitively demanding but essential for deep engagement with qualitative data. During this process, I recorded initial reflections and observations through analytic notes, supporting reflexive engagement with emerging ideas within the dataset.

Following familiarisation, the next phase involved generating initial codes that captured meaningful features of the data relevant to the research questions. I began by analysing two transcripts manually to support close engagement with the text. These early coding decisions were discussed with both members of the supervisory team, enabling refinement of the coding approach before analysis of the full dataset. Once the initial coding framework had been developed, I uploaded all transcripts into NVivo to facilitate systematic coding across the dataset. The use of NVivo provided an efficient means of storing, organising, and retrieving coded data across the dataset. Prior to commencing analysis, I undertook training in the use of NVivo to ensure that the software was applied appropriately. Importantly, the software functioned as a tool to assist with data management rather than as an analytical mechanism in itself. The interpretive work of analysis remained my responsibility.

The subsequent stage involved examining relationships between codes to identify broader patterns of shared meaning across participants' accounts. I grouped conceptually related codes together and developed them into candidate themes. This stage required movement between individual coded extracts and the dataset as a whole to ensure that emerging themes accurately reflected the meanings present within participants' accounts. Through this iterative process, the analysis moved beyond descriptive coding towards interpretive engagement with the data.

Candidate themes were then reviewed and refined through repeated comparison with the dataset. This process ensured that themes remained grounded in the data

while maintaining coherence across the analysis. The final phase involved defining and naming themes in a way that clearly captured the patterns of meaning identified across participants' experiences. These themes subsequently informed the structure of the findings presented in Chapters 4 and 5.

Having outlined the analytical procedures used to interpret the dataset, it is now necessary to consider the ethical principles that informed the design and conduct of the research. The following section therefore outlines the ethical considerations underpinning this study.

3.8. Ethical Considerations

Ethical integrity is central to research, particularly when studies involve participants drawn from identifiable professional or educational communities. As Cohen et al. (2018) emphasise, ethical research practice requires careful attention to voluntary participation, informed consent, confidentiality, and the protection of participants' wellbeing. These considerations were particularly important in this study due to the involvement of student and registered ODPs within a relatively small professional community.

I adhered to established ethical guidance for educational research, including the principles outlined by the British Educational Research Association (BERA, 2024) and the University of Strathclyde's Code of Practice (2021). Ethical approval was obtained from the University of Strathclyde Ethics Committee prior to the commencement of data generation (Appendix 7). I also completed a research risk assessment in accordance with the University of Strathclyde's procedures (Appendix 8). Additionally, as the study involved current students and alumni from the institution, I consulted the relevant School of Health and Life Sciences ethics committee. This confirmed that a separate institutional application was not required to avoid duplication of the ethical review process, and confirmation of this is provided in Appendix 9.

I also considered whether NHS research governance approval was necessary, as all participants were employed within the NHS. Completion of the decision tool provided

by the Medical Research Council and NHS Health Research Authority (2022) confirmed that formal NHS ethical approval was not required because the research focused on participants' professional experiences rather than clinical practice or patient data. A copy of the completed checklist is provided in Appendix 10.

While formal NHS ethical approval was not required, careful attention to ethical practice at the point of participant involvement remained essential. Participation in this study was entirely voluntary. Prior to providing written informed consent, participants received information outlining the purpose of the research and their rights. I gave particular attention to maintaining confidentiality and anonymity, recognising the relatively small size of the ODP professional community in Scotland. Identifying information was removed during transcription and anonymised identifiers were used throughout the dataset. Interview recordings and transcripts were stored securely in accordance with institutional data protection policies and the requirements of the Data Protection Act (2018).

Given my professional role within perioperative education, I also considered the potential for power dynamics to influence participation. Such dynamics may affect individuals' willingness to participate or shape the nature of the information they choose to share (Ferguson et al., 2004). This issue was especially pertinent in relation to the recruitment of student participants. Leentjens and Levenson (2013) highlight that university students may constitute an ethically sensitive participant group where recruitment is undertaken by those involved in their teaching or assessment, as perceived coercion or concerns regarding academic consequences may compromise voluntariness. Although participation may be formally optional, students may nevertheless feel pressure to participate because of existing educational relationships or assumptions about staff expectations. Miller and Kreiner (2008) similarly note that perceptions of coercion may arise even in the absence of explicit pressure when recruitment occurs within institutional relationships characterised by authority or dependency.

In recognition of this, I implemented specific safeguards to protect student autonomy and minimise any perception of coercion. These strategies are discussed earlier in relation to recruitment procedures (Section 3.5), while a fuller consideration of my

positionality and reflexive engagement with the research process is presented later in Section 3.10. Together, these measures helped ensure that this study was conducted in a manner that safeguarded participants' rights, autonomy, and confidentiality.

While ethical approval and participant protections form a fundamental component of responsible research practice, qualitative inquiry also requires careful attention to methodological rigour. The following section therefore outlines the strategies I implemented to enhance the trustworthiness and quality of the study.

3.9. Rigour and Trustworthiness

To support methodological rigour, I drew on Lincoln and Guba's (1985) criteria for evaluating the trustworthiness of qualitative inquiry. Rigour refers to the extent to which research is conducted in a systematic, transparent, and methodologically coherent manner (Ellis, 2022). It is commonly reflected in the quality of the study design, the care taken during data generation, and the robustness of analytical procedures (Grove et al., 2014). Establishing rigour is particularly important in qualitative research, where findings are interpretive and therefore require clear evidence that conclusions are grounded in participants' accounts.

Within qualitative research, trustworthiness is frequently used as an indicator of methodological quality (Baillie, 2015; Tracy, 2010). Although debate exists regarding how qualitative rigour should be evaluated (Forero et al., 2018), I drew on the framework proposed by Lincoln and Guba (1985), which identifies four key criteria: credibility, dependability, transferability, and confirmability (Connelly, 2016; Cope, 2014; Thomas & Magilvy, 2011). Each of these criteria is outlined below in relation to how rigour was established within this study.

Credibility refers to the degree of confidence in the findings (Polit & Beck, 2017). In this study, I supported credibility through sustained engagement with the dataset and iterative analysis of the interview transcripts. Familiarisation involved repeated reading of transcripts and the development of analytic notes during coding. Early coding decisions were also discussed with members of the supervisory team,

allowing refinement of the coding approach prior to analysis of the full dataset. Participants were additionally offered the opportunity to review their interview transcripts, supporting transparency and accuracy in the representation of their accounts.

Dependability concerns the transparency and consistency of the research process (Thomas & Magilvy, 2011). To enhance dependability, I documented methodological decisions throughout this study and described them in detail within this chapter. Clear explanations were provided regarding sampling procedures, participant recruitment, interview methods, and the application of TA. Furthermore, the use of NVivo supported systematic organisation of the dataset while maintaining an accessible record of coding decisions and thematic development.

Transferability refers to the extent to which findings may be relevant to other contexts (Cope, 2014). Rather than aiming for statistical generalisation, qualitative research seeks to provide sufficiently rich contextual description to enable readers to judge the relevance of findings to other settings (Lincoln & Guba, 1985). In this study, I supported transferability through detailed descriptions of the research context, participant characteristics, and the professional environment within which this study was conducted. By outlining the educational and clinical context of ODP practice relevant to this study, I aimed to enable readers to assess the potential relevance of the findings to comparable professional settings.

Confirmability addresses the extent to which findings are grounded in participants' accounts rather than unduly shaped by researcher bias (Cope, 2014). In this study, I supported confirmability through reflexive awareness of my position as both practitioner and educator. I maintained reflexive notes throughout the research process to document analytical decisions and emerging interpretations. Alongside the opportunity for participants to review their transcripts, this reflexive process helped ensure that interpretations remained closely connected to participants' accounts while maintaining transparency in the analytical process.

In addition to these criteria, transparent reporting of the research process was informed by the Standards for Reporting Qualitative Research (SRQR) (O'Brien et

al., 2014), which I used to support clarity of reporting throughout this study (see Appendix 11).

Together, these strategies were implemented to strengthen the credibility, dependability, transferability, confirmability, and transparency of reporting within the study. By maintaining a transparent analytical process and providing detailed methodological explanation, I sought to demonstrate that the findings presented in the following chapters are grounded in a rigorous and trustworthy qualitative inquiry.

While these strategies supported the trustworthiness of this study, qualitative research also requires acknowledgement of the researcher's role in both shaping the research process and the interpretation of the data. The following section therefore considers my positionality and its implications for the conduct and interpretation of this study.

3.10. Researcher Positionality

Debates surrounding researcher positionality within qualitative inquiry are long established and remain central to discussions of research transparency and interpretation (Mendez, 2023). Positionality refers to the ways in which a researcher's background, experiences, and social position shape the research process and the interpretation of findings. As Berger (2015) notes, the position of the researcher can influence several aspects of a study, including access to participants, the nature of the researcher-participant relationship, and the interpretive lens through which participants' accounts are understood.

In this study, my position as a registered ODP and an academic educator within perioperative education inevitably shaped my engagement with this research. Having previously undertaken the ODP student journey before entering professional practice, I shared experiential understanding with many of the participants involved in this study. This professional familiarity supported meaningful engagement with the clinical and educational contexts discussed during the interviews and may have encouraged openness in participants' accounts, as individuals may feel more

comfortable sharing experiences with a researcher who understands the professional environment in which they work (Berger, 2015).

At the same time, my role as an educator within the professional community required careful consideration of the researcher-participant relationship. All participants were current or former students, meaning that differences in professional role and authority had the potential to influence how individuals perceived their participation. Power dynamics between researchers and participants may shape how comfortable individuals feel in discussing their experiences (Ferguson et al., 2004). Strategies implemented to address these considerations were discussed earlier in relation to recruitment procedures (Section 3.5).

Beyond considerations of access and relationships, my positionality also shaped the interpretive perspective brought to the analysis. My familiarity with perioperative practice and professional education informed how participants' accounts were understood and situated within the broader professional context. While this supported contextual depth in interpretation, it also required ongoing awareness of how prior knowledge and assumptions may influence analytic decisions.

Reflexivity therefore formed an important component of the research process. Reflexivity refers to the practice of critically examining how the researcher's experiences, assumptions, and perspectives may influence the research process and the interpretation of findings (Attia & Edge, 2017; Berger, 2015). Within qualitative research, reflexive engagement allows researchers to acknowledge their role in the construction of meaning while maintaining transparency in the analytical process (Kariippanon et al., 2020).

Throughout this study, I maintained a reflexive journal to document methodological decisions, emerging interpretations, and my engagement with the dataset. Drawing upon reflective practices developed through both clinical and academic experience, this approach supported ongoing awareness of how my professional knowledge informed engagement with the data, while also promoting transparency in the analytical process (Dodgson, 2019).

By acknowledging my position within the research context and maintaining reflexive awareness throughout the study, I sought to promote transparency and thoughtful interpretation of participants' accounts. This reflexive engagement formed an important part of the research process and supported a more critically aware analysis of the data.

3.11. Chapter Conclusion

This chapter has established a methodologically coherent framework to address the aims of this study. This study is grounded in a social constructivist paradigm, underpinned by a relativist ontology and social constructivist epistemology. Additionally, an exploratory qualitative design, guided by Stebbins (2001), provided an appropriate methodological foundation for investigating this underexplored intersection. Furthermore, the combined use of purposive, convenience, and snowball sampling enabled access to participants with relevant professional experience while maintaining alignment with the study's focus on depth, context, and meaning. Moreover, semi-structured interviews conducted via Microsoft Teams facilitated the generation of rich, contextually grounded accounts, and TA supported a systematic yet interpretive examination of patterns across the dataset.

Consideration of ethical practice, trustworthiness, and researcher positionality further strengthened the rigour and transparency of this study. In particular, the integration of reflexive engagement throughout the research process ensured that interpretation remained grounded in participants' accounts while acknowledging the influence of the researcher's professional position. Collectively, these methodological decisions establish a robust and philosophically aligned foundation for addressing the research questions, enabling a nuanced analysis of how professional identity is constructed, experienced, and related to engagement with feedback provision. This framework underpins the findings presented in Chapters 4 and 5 and supports the broader contribution of the thesis to understanding professional identity, participation, and community formation within the ODP profession.

Chapter 4: Constructing Professional Identity Among Operating Department Practitioners

4.1. Introduction

In this chapter, I present the findings from qualitative interviews with student (S) and alumni (A) Operating Department Practitioners (ODPs), examining how participants construct and negotiate professional identity within clinical and educational contexts. The analysis demonstrates that professional identity is best understood not as a stable attribute, but as continually shaped through interpersonal interaction, workplace culture, and the structural conditions of both environments.

The main contribution of this chapter to the thesis is to establish the empirical basis for understanding ODP professional identity as socially constructed through recognition, respect, and value. Drawing on the Recognition, Respect, and Reward (3R) framework outlined in Chapter 2, the chapter first examines how these dimensions appeared within the dataset. Although the framework proposes reward as a key component, participants rarely described their experiences in these terms. Instead, their narratives centred on value, particularly the extent to which their contribution was acknowledged, relied upon, and meaningfully integrated within the multidisciplinary team (MDT). This data-driven shift from reward to value provides an important empirical refinement of the framework, as participants' accounts emphasised professional worth, contribution, trust, and legitimacy rather than material or transactional forms of reward. Recognition, respect, and value therefore provide a more empirically grounded lens through which participants articulated the foundations of their professional identity.

Participants' accounts are explored through direct quotation to preserve the detail and nuance of how professional identity was experienced in practice. These quotes provide insight into how professional identity is constructed, experienced, and negotiated in everyday practice, offering depth and nuance beyond abstract descriptions of professional roles. At the same time, the analysis recognises the

interpretive nature of qualitative research, balancing participants' accounts with a critical examination of the structural conditions that shape them.

This chapter first outlines the themes identified through thematic analysis, using both student and alumni quotations to illustrate how professional identity was constructed and experienced across the dataset. It then examines the challenges participants associated with constructing and sustaining professional identity, including professional visibility, role specificity, interprofessional disparities, and career progression constraints. In doing so, the chapter establishes the empirical foundation for Chapter 5, where these identity dynamics are examined in relation to engagement with feedback provision and professional community formation.

4.2. Identification of Themes

In accordance with Braun and Clarke's (2022) TA, I gave considerable attention to theme development and refinement during analysis (see Chapter 3). I explored several iterations before identifying a set of themes that coherently represented patterns across participants' accounts.

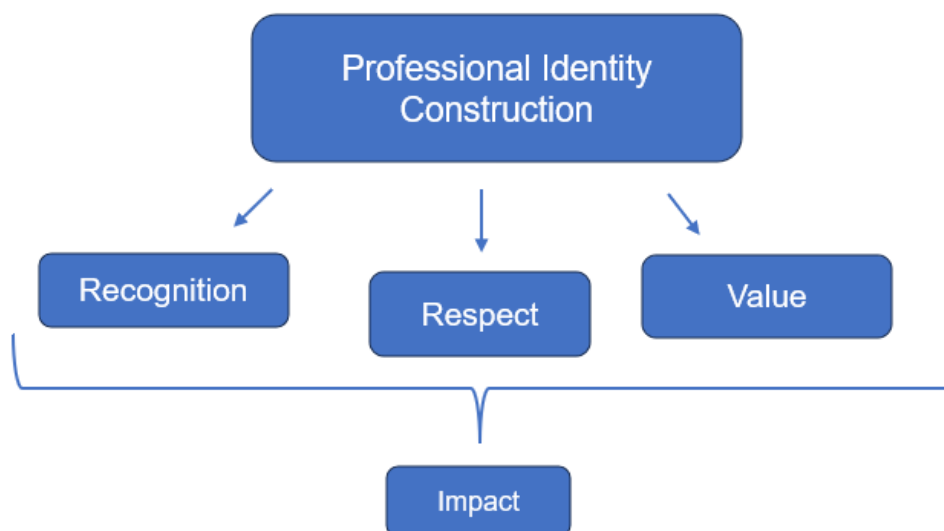
During analysis, participants' narratives consistently reflected experiences relating to recognition, respect, and the extent to which their professional contribution was valued within the perioperative team. These themes align closely with the Recognition, Respect, and Reward (3R) framework introduced in Chapter 2 (Section 2.4.7), which proposes that professional identity is shaped through experiences of acknowledgement, professional regard, and reward associated with one's contribution (Aalders, 2023; Dellve et al., 2007).

However, participants rarely described their experiences in terms of reward. Instead, their accounts centred on whether they felt valued within clinical teams, particularly through acknowledgement of their expertise, reliance on their role, and whether their contribution was meaningfully integrated within multidisciplinary practice. As a result, I adopt a modified framework of Recognition, Respect, and Value (RRV), which more accurately reflects the emphasis emerging from the dataset. Importantly, I position this adaptation as a better fit for the present data, suggesting that assumptions

embedded within existing frameworks may underplay the significance of professional worth, collective reliance, and legitimacy in contexts such as perioperative practice, where reward was not described in any meaningful or sustained way. Figure 4.1 therefore illustrates the adapted analytical framework used to organise the findings presented in this chapter.

Figure 4.1.

Recognition, Respect, and Value (RRV) as Dimensions of ODP Professional Identity Construction



The sections that follow examine each dimension in turn, exploring how recognition, respect, and value are experienced, negotiated, and interpreted by both student and registered (alumni) ODPs within the perioperative environment. While this chapter focuses on presenting the empirical findings, the broader theoretical implications of the RRV framework are explored further in Chapter 6.

4.2.1. Theme One: Recognition

Recognition emerged as a foundational component of professional identity across both alumni and student participants. Many described the ODP role as relatively invisible within the wider healthcare environment, and this perceived lack of visibility

influenced how participants understood their place within clinical teams. Alumni participants frequently articulated a tension between specialist identity and limited public awareness. This sense of exclusivity was captured by A2 (North, April 2023), who described ODPs as a “*niche little group*”, while A3 (North, May 2023) referred to the profession as a “*secret society*”. These descriptions conveyed both pride in belonging to a specialised profession and an awareness that the role was not widely understood beyond theatre environments. The experience of professional invisibility was further illustrated by A6 (North, June 2023), who explained that “*it sometimes feels like we’re hidden away. People don’t really know we exist unless they work in theatres*”. Rather than representing a simple contradiction, this co-existence of pride and invisibility suggests that participants experienced ODP identity as both distinctive and marginal: distinctive because of its specialist expertise, yet marginal because that expertise was not widely recognised beyond the perioperative setting.

Experiences of misunderstanding or role confusion were commonly described across the dataset. Several participants reflected on situations in which colleagues within the hospital environment were unsure about the responsibilities associated with the ODP role. This was demonstrated by A2 (North, April 2023), who explained that colleagues “*still don’t really know what an ODP is*”, even within the hospital itself. A similar observation was made by A3 (North, May 2023), who noted that “*everyone knows what a nurse is... but no one knows what an ODP is*”. These accounts suggest that recognition was often shaped through everyday interactions within clinical environments, rather than simply through public awareness of the profession. The issue, then, was not only visibility in the abstract, but whether ODPs entered clinical interactions from a position of assumed legitimacy or from one that required ongoing explanation.

That said, not all participants interpreted these experiences in the same way. Some reflected more critically on the assumption that professional roles are always clearly understood. This perspective was illustrated by S9 (North, May 2023), who suggested that confusion surrounding professional roles was not unique to ODPs, noting that “*people mix up nurses’ roles too. I’m sure not everyone knows the difference between a staff nurse or an advanced nurse practitioner*”. This observation indicates that some participants viewed recognition challenges as part of

a broader complexity within healthcare rather than a problem specific to the ODP profession. Nevertheless, many participants described situations in which they were mistaken for nurses or healthcare support workers, or were asked to explain their presence in clinical areas. These experiences contributed to a recurring sense that the ODP role was not always immediately recognised within hospital settings. Even where role ambiguity was seen as a wider feature of healthcare, participants' accounts suggest that its effects were intensified for ODPs because their profession occupied a less secure position within institutional and public awareness.

While recognition challenges were widely discussed, participants also described clinical environments where the profession was more clearly understood. In such contexts, recognition appeared to support a stronger sense of belonging within the team. This was illustrated by S8 (North, May 2023), who explained that *"in my placement, the staff really knew what an ODP was, and they treated us like part of the team, so being recognised makes my professional identity"*. Experiences such as this suggest that recognition was strongly influenced by local workplace cultures and the degree to which teams were familiar with the ODP role. Where understanding of the profession was established, participants described feeling more integrated within the MDT. Conversely, where knowledge of the role was limited, recognition appeared more conditional and less secure, as explored further in Section 4.3.1.

Students frequently described recognition as particularly significant during the early stages of their professional development. For many, emerging professional confidence was closely connected to whether colleagues outside of theatres understood the purpose and contribution of their role. This relationship between recognition and developing identity was clearly articulated by S5 (East & South, May 2023), who explained that *"people outwith theatres... having an understanding of your role and recognising your role is what develops my professional identity"*. When recognition was absent, some students described feeling peripheral within the clinical environment. This experience was reflected in the account of S2 (West, April 2023), who noted that *"sometimes you feel invisible because nobody really knows what your job is yet"*. Such descriptions indicate that recognition often served as a signal that their developing professional identity was legitimate within the workplace.

For these students, recognition functioned as an early marker that their emerging role was intelligible to others and therefore more easily inhabited by themselves.

At the same time, participants demonstrated different levels of reliance on external recognition when forming a sense of professional self. While many emphasised its importance, others described a more internally grounded sense of identity. This perspective was illustrated by S10 (East & South, June 2023), who reflected that *“it doesn’t bother me too much if people don’t know the role. I know why I’m there and what I’m learning”*. This variation highlights that recognition was significant for many participants, but its influence was not uniform across the dataset. This suggests external acknowledgement mattered widely, but interacted differently with participants’ own confidence, self-understanding, and sense of vocational purpose.

Participants also emphasised that recognition was only one component within a broader understanding of professional identity. For some, identity was described as encompassing a combination of professional knowledge, personal values, and behavioural presentation. This broader perspective was articulated by S3 (West, April 2023), who explained that identity involved *“recognising my knowledge of the job, your personal values and ethics, your skill set, and how you actually present yourself”*.

In addition, recognition appeared to vary across different clinical environments. The visibility of ODP expertise was sometimes described as stronger in certain areas of theatre practice than others. This contrast was illustrated by A4 (North, May 2023), who explained that *“in anaesthetics they know exactly what we do, they see us, but in other areas they just assume you’re extra hands”*. Students working in larger theatre departments described similar experiences of blending into the wider workforce. For example, S6 (West, May 2023) reflected that *“in big theatres you sometimes just blend in... nobody really pays attention to the students”*. These accounts indicate that recognition was shaped not only by knowledge of the profession but also by local team structures and how responsibilities were distributed within theatre environments. Recognition, in this sense, depended not only on whether ODPs were known, but on whether their contribution remained visible as specialist practice rather than being absorbed into generalised support work.

Pride in the profession was closely intertwined with recognition across many participants' accounts. Several described a strong sense of pride associated with their training and professional role. This was expressed by S2 (West, April 2023), who stated that *"I've got a lot of pride in saying that I'm training to be an ODP"*. However, this pride appeared closely connected to the extent to which participants felt their work was acknowledged. For some, a lack of recognition could gradually erode this sense of professional pride. This dynamic was described by A1 (West, April 2023), who reflected that *"my pride comes from knowing we make a difference... but it's hard to hold onto that when there's no recognition from higher up. Without support or visibility, people just switch off"*.

A similar experience was expressed by A5 (West, May 2023), who explained that *"you can be proud of what you do, but it wears you down if nobody seems to notice"*. These reflections suggest that pride in the role was sustained through relational and organisational affirmation rather than existing independently of it. Analytically, this is important as it demonstrates that pride and invisibility were not mutually exclusive. Participants could hold a strong sense of professional pride while simultaneously experiencing that pride as vulnerable to repeated omission, misrecognition, or institutional silence.

Recognition was therefore experienced not only through broader awareness of the profession but also through everyday interpersonal interactions within clinical teams. Feeling acknowledged within these interactions appeared to play an important role in shaping participants' sense of belonging. This was illustrated by S4 (North, April 2023), who explained that *"it's not just about people knowing what we do. It's about feeling like we belong there and are valued as part of the team"*. Conversely, a lack of acknowledgement could create uncertainty about one's professional standing. A3 (North, May 2023) reflected that *"you can be the most skilled person in the room, but if people don't listen to you or take you seriously, it makes you question your place"*.

Positive moments of recognition were also described, particularly when participants felt their professional contribution was acknowledged by colleagues. For example, A7 (West, October 2023) described how being invited to contribute to clinical

decisions reinforced their sense of belonging, explaining that “*when they ask for your opinion, it shows they know what you bring, that makes you feel part of it*”.

Taken together, participants’ accounts illustrate recognition as a central foundation of professional identity. Experiences of visibility, acknowledgement, and inclusion influenced how participants interpreted their place within the perioperative environment. However, these experiences were not consistent. Recognition fluctuated across clinical settings, interpersonal relationships, and stages of professional development. I therefore interpret recognition not as a simple presence or absence, but as a socially mediated condition through which ODP identity became more or less visible, credible, and secure within practice. These dynamics lead into the next theme, respect, which further explores how interpersonal treatment influenced participants’ sense of belonging and professional legitimacy.

4.2.2. Theme Two: Respect

Respect was consistently described by participants as an important element in shaping how they understood their place within perioperative teams. Across both student and alumni accounts, respectful interactions influenced how confident, included, and professionally legitimate individuals felt within their clinical environments. Participants frequently linked respectful treatment from colleagues with a stronger sense of belonging and professional identity. While the importance of respect was widely acknowledged, the ways in which it was experienced varied depending on workplace culture, interpersonal relationships, and participants’ stage of professional development.

For some participants, respect appeared to develop gradually as familiarity with the role increased. Alumni frequently reflected on how their experiences changed as they moved from student status to qualified practitioner. This shift was illustrated by A1 (West, April 2023), who reflected that “*compared to being a student, I can also clearly recognise that they respect me more now as a fully qualified ODP*”.

Experiences such as this suggest that respect was often interpreted as something that emerged through experience and professional visibility within the team.

At the same time, respect was not described solely as an individual achievement. Participants also emphasised the importance of mutual professional regard within ODP teams themselves. This relational aspect was highlighted by A7 (West, October 2023), who described how *“respect for me and respect from others to their ODP colleagues... developed my professional identity”*. In this sense, respect was constructed not only through individual progression but also through the ways colleagues acknowledged and supported one another within their professional community. Respect therefore appeared to operate both vertically and horizontally: through recognition from others in established positions and through reciprocal regard within the profession itself.

That said, participants' experiences of respect were not uniformly positive. Some described situations where their contributions were overlooked or dismissed, which shaped how they interpreted their professional standing. This was particularly evident in the account of A5 (West, May 2023), who expressed a strong sense of frustration, stating that *“there is no respect for me, for ODPs, and it's a disgrace. I respect others, because I'm a professional. But the others don't respect me, so I'll never fit in”*. Experiences such as this illustrate how the absence of respect could contribute to feelings of exclusion from the wider team.

A similar dynamic was described by A4 (North, May 2023), who explained that *“sometimes you speak up and it's like you're not even there. That knocks your confidence”*. These accounts indicate that respect was not experienced consistently across workplaces and that dismissive interactions could undermine participants' confidence and sense of professional legitimacy. In these moments, respect operated as more than courtesy. Its absence communicated something about participants' relative standing and about whether their contribution was treated as worthy of serious consideration.

Students also described respect as a significant influence on their developing professional identity. Early clinical experiences often shaped how students interpreted their emerging role within the theatre environment. Respectful engagement from colleagues was frequently described as an indicator that they were becoming accepted members of the team. This relationship between respect and

identity development was expressed by S7 (East & South, May 2023), who reflected that *“having that sort of respect from the people you are working with has been a big part in building it”*. Similarly, S10 (East & South, June 2023) emphasised the importance of being listened to during clinical interactions, noting *“that voice to be respected and listened to... definitely being respected develops my professional identity”*. These accounts suggest that respectful engagement played a meaningful role in shaping how students interpreted their place within the professional environment.

In parallel, several students described situations where respect appeared conditional upon their position as learners. Early in training, participants often felt that their contributions were not always taken seriously until they had demonstrated competence within the team. This experience was reflected by S10 (East & South, June 2023), who explained that *“at first, people didn’t really take me seriously because I was ‘just a student’, so I had to prove myself before they’d actually listen to what I was saying”*. Such accounts illustrate how hierarchical expectations within the theatre environment could influence how respect was distributed, particularly for those still developing their professional role. Respect, then, was not simply given or withheld on interpersonal grounds alone. It was also mediated by status, seniority, and assumptions about whose voice counted as credible.

Participants also described how experiences of respect could fluctuate depending on the dynamics of particular teams or shifts. Even within the same clinical setting, respectful interactions were not always consistent. This variability was captured by S6 (West, May 2023), who explained that *“some days you feel part of the team, and other days you feel like you shouldn’t say anything because no one’s really paying attention”*. These accounts suggest that respect was shaped not only by professional role or experience but also by the immediate interpersonal environment within which participants were working. This instability mattered because it meant that legitimacy could feel reinforced one day and unsettled the next.

Across the dataset, respectful interaction appeared closely connected to participants’ sense of belonging within the perioperative team. Moments in which individuals felt listened to or invited to contribute were frequently interpreted as signals that their

knowledge and experience were valued. This relationship between respect and belonging was clearly expressed by A3 (North, May 2023), who explained that “*when people listen to you, it makes you feel like you’re actually part of the team. When they don’t, you feel like you’re not needed*”. In this way, respect was experienced not simply as a matter of politeness but as an interactional process through which individuals interpreted their place within the professional environment.

Taken together, participants’ accounts suggest that respect played a significant role in shaping how professional identity was experienced within perioperative teams. Respect influenced confidence, participation, and the extent to which individuals felt accepted within their professional environment. At the same time, these experiences were not stable or uniform. Respect fluctuated across workplaces, interpersonal relationships, and stages of professional development. I therefore suggest that respect is better understood here as a relational marker of professional legitimacy, one that was continually negotiated through local cultures, hierarchies, and everyday team interaction. These experiences lead into the next theme, value, which explores how participants interpreted the significance of their contribution within the wider structures of perioperative practice.

4.2.3. Theme Three: Value

Professional identity among ODPs extended beyond being recognised or respected to include a deeper sense of value, understood by participants as an appraisal of their contribution, worth, and purpose within the clinical team. Across the dataset, value was not described solely as a personal feeling of confidence or satisfaction, but as something shaped through the extent to which specialist contribution was acknowledged, relied upon, and made meaningful within the wider organisation of perioperative work. Alumni participants in particular frequently described value as central to how they understood themselves as practitioners. For many, this sense of value was closely connected to specialist knowledge and technical competence within the theatre environment.

This relationship between expertise and professional worth was reflected in the account of A4 (North, May 2023), who described their identity by explaining that “*my*

professional identity is that I'm a specialist in the operating department theatre".

Others similarly associated professional value with the ability to perform the role confidently and proficiently. This perspective was illustrated by A5 (West, May 2023), who noted that *"being able to do my job with proficiency makes me an ODP and gives me a professional identity"*. These accounts suggest that value was partly constructed through internal confidence in one's technical capability and specialist contribution.

That said, competence alone did not appear sufficient to generate a sustained sense of value. Participants frequently described how value emerged when their expertise was relied upon within the team. This connection between contribution and team reliance was captured by A6 (North, June 2023), who explained that *"when the team relies on me for my knowledge, that's when I feel valued... like what I bring really matters"*. Experiences such as this indicate that value was constructed not only through what participants were capable of doing, but through the ways their knowledge was incorporated into the functioning of the wider team. In this sense, value appeared closely tied to operational dependence. Participants felt most valued when their contribution was not simply present, but necessary to the delivery of care.

This is important when considered alongside the policy and infrastructural discussion outlined in Chapter 2 (Section 2.4.3.1). There, it was argued that ODPs occupy a position in which their contribution is often essential to service delivery, while the profession itself is not always equally foregrounded within workforce planning, policy discourse, or strategic reform. I interpret the present findings as reinforcing that tension. Participants' accounts suggest that value was often experienced through being operationally necessary at the local level, while remaining less visible or less fully recognised at the structural level.

Participants also described how value was shaped through everyday interactions with colleagues. In some cases, a stronger sense of professional worth developed when others openly acknowledged the importance of the role within the department. This relational dimension was reflected in the account of A8 (West, November 2023), who explained that *"how other people see us, how important our role is within the department, is what builds professional identity"*.

Conversely, where acknowledgement from others was absent, participants described a weakening of this sense of value. This tension was expressed by A5 (West, May 2023), who reflected that *“I know I’m good at what I do, but if nobody else recognises that, it feels like it doesn’t matter”*. In this way, participants’ sense of value appeared to emerge through a combination of personal confidence and external affirmation within the clinical team. These accounts also suggest that interpersonal affirmation carried particular weight because broader institutional affirmation could not always be assumed.

Recognition from senior members of the MDT was also described as particularly influential in shaping feelings of value. Moments in which surgeons or anaesthetists acknowledged the role of the ODP were often interpreted as confirmation that their contribution held significance within the wider theatre environment. This was illustrated by A3 (North, May 2023), who explained that *“being acknowledged by the surgeons and anaesthetists makes a difference. It shows they understand how important our role is”*. Experiences such as this highlight how professional value was reinforced through interactions with colleagues occupying established positions within the perioperative hierarchy. The importance attached to such moments suggests that value was not automatically secured through role title or regulatory status alone, but was often confirmed through relationships shaped by status and hierarchy.

For many alumni participants, this sense of value appeared to develop gradually through repeated engagement within the clinical environment. As familiarity and trust increased, participants described feeling more confident that their contribution was recognised within the team. This gradual development was described by A1 (West, April 2023), who reflected that *“I feel more valued because they ask you about your opinions... they listen to you more... but that came with time. I didn’t feel like that as a student”*. Similarly, the importance of familiarity within teams was described by A2 (North, April 2023), who explained that *“as time went by and people seen my face more, they began to trust me, and value me more as a worker”*. These accounts suggest that value accumulated through repeated interactions and growing professional trust. Value therefore appeared to develop not as an immediate property

of qualification, but as something socially accumulated through opportunities to contribute, be consulted, and become known within the team.

Students also described moments in which they began to experience their contribution as meaningful, particularly as their skills developed during placement experiences. Early signs of this emerging value were reflected in the account of S8 (North, May 2023), who explained that *“I felt they started to see that I can bring value to the team”*. Such experiences suggest that value could begin to develop during training when students were given opportunities to participate meaningfully in clinical practice.

At the same time, explicit references to feeling valued appeared less frequently within student accounts than among alumni participants. Some students described spending significant periods observing rather than actively contributing within the theatre environment. This experience was captured by S3 (West, April 2023), who explained that *“a lot of the time you’re just standing there watching, you’re not really part of what’s happening”*. In circumstances where participation was limited, opportunities to experience one’s contribution as meaningful were also reduced. A similar perspective was expressed by S1 (West, April 2023), who reflected that *“they don’t mean it in a bad way, but they keep the important tasks for the qualified staff. You end up watching more than doing, so it’s hard to feel like you bring any value”*. These accounts suggest that students’ developing sense of value was shaped by the extent to which they were able to participate actively within the team. This indicates that value was linked not only to encouragement, but also to responsibility, trust, and access to meaningful work. Where students were positioned primarily as observers, their ability to experience themselves as consequential contributors was correspondingly reduced.

Taken together, participants’ accounts suggest that value represented a key dimension of professional identity among ODPs, constructed through the relationship between specialist capability, opportunities for meaningful participation, and the extent to which contribution was recognised within clinical teams and wider organisational structures. Where participants were consulted, relied upon, or invited to contribute, they described a stronger sense that their presence within the team

mattered. Conversely, where participation was limited, value was more difficult to articulate, particularly for students positioned primarily as observers rather than active contributors. This is one of the clearest ways in which the shift from reward to value became analytically useful, as participants did not frame professional worth in transactional terms, but through significance, reliance, trust, and whether their contribution genuinely mattered.

At the same time, these experiences were not consistently sustained across all professional contexts. While recognition, respect, and value strengthened participants' sense of belonging and legitimacy, participants also described situations in which these foundations were less secure. In these moments, identity appeared more uncertain, shaped by organisational structures, professional relationships, and working conditions within perioperative practice. The following section therefore explores the challenges that participants associated with sustaining a clear and stable professional identity within practice.

4.3. Challenges in Professional Identity Construction

While the preceding sections identified recognition, respect, and value as key dimensions of ODP professional identity construction, participants' accounts also showed that these dimensions were not experienced consistently or securely. These challenges were linked to professional visibility, clarity of role and responsibility, interprofessional relationships, and perceptions of long-term career development. The following subsections examine how these structural and relational conditions shaped, complicated, and at times destabilised participants' sense of professional identity within perioperative practice.

4.3.1. Recognition and Professional Visibility

A recurring concern across both alumni and student interviews was the limited visibility of the ODP role within wider institutional and public structures. This extended the theme of recognition by showing that professional visibility was not only experienced through interpersonal acknowledgement, but also through the extent to which the profession was represented within institutional systems, public discourse, and organisational practices. Participants described experiences in which their

profession was overlooked or absent from systems that routinely recognised other healthcare roles. These experiences moved beyond isolated frustrations and instead pointed toward broader structural conditions that shaped how the profession was acknowledged within healthcare environments. For many participants, this lack of visibility influenced how they interpreted their place within the wider workforce and the conditions under which their professional identity developed.

Experiences of exclusion from formal classification systems were frequently described by alumni participants. These situations were often encountered in routine administrative processes where the ODP role was not recognised as an occupational category. One participant described the cumulative impact of repeatedly encountering these omissions:

“Whenever I fill out things like... there’s no ODP, and they always ask me, ‘Is it not similar to a nurse?’ Yeah, but no. Yeah, but no... even in the NHS itself. It makes me feel so... sad... like my profession doesn’t mean anything”.

(A1, West, April 2023)

Similar experiences were described by other alumni participants when reflecting on occupational categorisation in everyday systems. This dynamic was illustrated by A3 (North, May 2023), who described discussions within professional communities about how ODPs were required to identify themselves in external systems. The situation was described in the following terms:

“It’s like the Facebook groups where people ask what they should put their occupation down as on the likes of car insurance, and the closest option available is a nurse... we should feel like we’re something. Otherwise, I feel like I’m nothing”.

(A3, North, May 2023)

Other participants highlighted how similar experiences occurred across a range of institutional and commercial platforms. This pattern was reflected in the account of A4 (North, May 2023), who explained that *“I can’t even put ODP into, like, if I’m looking for new car insurance, I have to put that I’m a hospital worker because it doesn’t recognise ODP”*. The repetition of these experiences across multiple

contexts suggested that professional invisibility extended beyond specific organisations and instead reflected a broader pattern in how occupational categories were constructed and maintained.

Taken together, these encounters appeared to shape how participants interpreted the standing of their profession within institutional structures. The absence of an ODP category was not described as a minor administrative inconvenience but as a moment that prompted reflection on how the profession was understood more broadly. The issue, therefore, was symbolic as well as practical. Administrative omission communicated something about whether the profession was recognised as a legitimate category in its own right.

Student participants described comparable concerns, although these were often expressed through public and organisational recognition rather than occupational classification systems. Observing how other professions were publicly recognised sometimes prompted reflection on the relative visibility of the ODP role. This dynamic was illustrated by S6 (West, May 2023), who described noticing the prominence of celebrations for other healthcare professions while ODP recognition remained largely absent: *“I seen everything last Friday for the nurse’s day... and then there was nothing for ODP day apart from on our group chat. There was just nothing... it’s depressing”*.

For students still developing confidence in their professional identity, such experiences appeared to reinforce the perception that their role occupied a less visible position within the wider healthcare culture. Participants described how moments of omission in organisational communications, public messaging, or celebratory events heightened awareness of this difference. These were not trivial disappointments. They functioned as reminders of whose professional identity was publicly affirmed and whose remained comparatively muted.

Alongside this, participants often expressed strong pride in their specialist knowledge and their contribution within theatre teams. At the same time, this pride was frequently tempered by the recognition that the profession remained less visible within the structures surrounding healthcare practice. This dynamic was reflected in

the account of A3 (North, May 2023), who explained that “*we do such specialised work, and I love the role, but people don’t really see it unless they work in theatres*”. These reflections illustrate how pride in the role co-existed with frustration that the profession remained less visible within the wider healthcare environment. As in Section 4.2.1, this tension is analytically important because it shows that strong identification with the role did not protect participants from the effects of repeated institutional invisibility.

Taken together, these narratives suggest that professional visibility operates as a key condition shaping how ODP identity is interpreted and experienced. When the profession was formally recognised within organisational systems and public discourse, participants described feeling more securely situated within the healthcare workforce. When it was absent, participants described questioning how their role was perceived and understood. I therefore argue that visibility functioned here as a mechanism of professional legitimacy, not simply a matter of awareness. These concerns connect closely with the challenges explored in the following subsections, where issues of role specificity, interprofessional dynamics, and opportunities for progression shaped how professional identity was established and sustained within perioperative practice.

4.3.2. Role Specificity

The challenge of role specificity was closely connected to recognition, as participants’ accounts suggested that the ODP role was not always understood as a clear, coherent, and distinct professional category within practice. While Section 4.3.1 examined professional visibility, this section considers how recognition was further complicated by inconsistency in how the ODP role was defined, understood, and enacted across clinical environments. Participants described variation in role allocation, language, and expectations, which shaped whether their contribution was visible as specifically ODP practice or absorbed into broader theatre work.

In this sense, role specificity did not emerge as a separate dimension of professional identity, but as one of the ways recognition was negotiated within everyday practice. The issue was not only whether others knew that ODPs existed, but whether they

understood the breadth, boundaries, and distinctiveness of the role. Where access was restricted, boundaries blurred, or terminology narrowed the role to a single function, professional identity appeared more fragile because the distinctiveness of ODP practice became harder to sustain.

This was particularly evident in accounts where role expectations were clear and supported. A structured rotational model was reflected in one account of moving regularly between scrub and anaesthetics, where *“every two months, I rotate between scrub and anaesthetics, and I feel that that kind of keeps my skills up in both areas”* (A2, North, April 2023). In this context, rotation did more than maintain competence. It appeared to support a broader understanding of what it meant to be an ODP, with versatility recognised as part of the role rather than treated as an informal expectation. The opportunity to move across areas also seemed to strengthen a sense of legitimacy and contribution, as identity was affirmed through active participation in more than one aspect of perioperative care. Where this breadth was supported, the role appeared more closely aligned with the profession-specific expectations set out through education and regulation, as outlined in Chapter 1, Section 1.4.

That said, this experience was not shared across the dataset. In more restrictive contexts, role allocation appeared to narrow both practice and identity. This was conveyed particularly clearly in the reflection, *“I have been kept in scrub since I qualified, and I can’t seem to get out of it”* (A5, West, May 2023). The phrasing here is important. Being *“kept”* in one area suggests reduced agency and a limited capacity to move within the expected breadth of the role. Rather than supporting a coherent professional identity, this form of restriction appeared to confine professional contribution to a single function, creating distance between the broader role presented through education and the narrower role made available in practice. I interpret this not simply as a deployment issue, but as evidence that role identity could be narrowed by organisational decisions about where ODP labour was permitted to operate.

Further complexity emerged where professional boundaries were less clearly maintained. In one department, the relationship between ODP and nursing roles was

described as increasingly fluid, with “*our ODPs are pretty dual skilled*” and “*a lot of nurses within the department*” having completed anaesthetic competencies, meaning that “*they’re doing quite a lot of scrub, recovery and ODP-ing*” (A8, West, November 2023). This account illustrates a tension between flexibility and distinctiveness. On one hand, broad capability may be valued operationally. On the other, when work historically associated with the ODP role is distributed more widely across professional groups, the boundaries through which that role is recognised can become less clear. In this sense, professional identity was shaped not only by what practitioners did, but by whether that contribution remained visible as recognisably ODP work. Considered alongside the policy discussion in Chapter 2 (Section 2.4.3.1), these accounts also suggest that where profession-specific visibility is weaker at a structural level, local interpretation of the role may become more variable, leaving departments to define ODP contribution in uneven ways.

The language used to describe practice further reinforced this narrowing of role meaning. In a student account, rota terminology positioned ODP work as synonymous with anaesthetic practice rather than the wider practitioner role. This was expressed by S5 (East & South, May 2023), who stated: “*Even on the rotas, it’s ODP would be anaesthetics... they would call it ‘ODP-ing.’ So, ‘who’s your ODP today?’ for anaesthetics, as opposed to, ‘who’s your anaesthetic practitioner?’*”. This account is significant because it shows how professional identity was also shaped through everyday language.

Here, “*ODP-ing*” was used as shorthand for a single area of practice, reducing a multi-faceted role to one function. The fact that similar wording also appeared in A8’s account suggests that this was not an isolated expression, but part of a wider linguistic pattern through which the ODP role could be compressed and reinterpreted locally. Such language did not simply describe practice, it participated in constructing what the role was taken to mean within the team. Language therefore appeared to operate as part of the role-making process itself, reinforcing narrower assumptions about where ODP expertise began and ended.

The assumption that versatility automatically represents professional strength also requires careful consideration. Although broad competence may increase

organisational usefulness, it does not necessarily produce equitable opportunities. This tension was reflected in A3's observation that "*everyone says it's a good thing that we can do a bit of everything, but sometimes it feels like that just means you get put where nobody else wants to go*" (A3, North, May 2023). This account suggests that flexibility, while positively framed, could also operate in ways that prioritised service need over individual development.

Where adaptability became a reason to deploy practitioners wherever gaps arose, the apparent value of being able to do many things could conceal more limited access to specialisation and progression. Rather than always strengthening professional identity, versatility could therefore become associated with interchangeability, making it harder for distinctive professional value to be sustained. This is analytically significant as it suggests that breadth of function did not necessarily translate into breadth of opportunity.

However, this tension was challenged directly in the assertion that "*as an ODP, we should be practising in all our three skills*" (A1, West, April 2023). This statement conveyed more than a preference for varied practice, as it expressed an expectation that the role should be understood as a unified professional framework rather than a set of disconnected tasks. When institutions limited ODPs to one area, the role risked being experienced in fragmented ways, with parts of professional identity made more visible than others. The issue was therefore not only whether practitioners could move across anaesthetics, scrub, and recovery, but whether the profession itself continued to be recognised as encompassing all three. In this sense, role specificity was closely connected to professional legitimacy. A role that could only be practised in fragments was also a role whose coherence was harder to sustain.

These tensions were visible even before qualification. Student narratives suggested that future role boundaries were sometimes communicated in advance, shaping expectations of what kind of practitioner they would be allowed to become. This was evident in the account, "*My Charge Nurse has already told me that, 'once you qualify, you will not be working in recovery'*" (S3, West, April 2023). Such early messages indicate that role boundaries were not only organised structurally but also

communicated interpersonally, with senior staff contributing to how students anticipated their place within the profession. Professional identity was therefore being formed not only through participation in practice, but through prior assumptions about where that participation would later be permitted. This suggests that narrowing of role identity could begin before registration, as students learned not only what the profession was meant to be, but what it might realistically be allowed to become in local practice.

Taken together, these accounts suggest that role specificity was socially produced through structures, language, and local workplace expectations. Where the role was organised clearly and practised across its intended breadth, participants described a stronger sense of coherence and legitimacy. Where access was restricted, boundaries blurred, or terminology narrowed the role to a single function, identity appeared more fragile and contingent.

These findings also indicate that inconsistency in role specificity was not simply a local operational issue. It reflected broader ambiguity in how ODP work was organised, recognised, and sustained within service structures, echoing the structural concerns discussed in Chapter 2. I therefore suggest that the issue was not merely inconsistency in deployment, but inconsistency in how the profession itself was understood and validated in practice. As the next section will demonstrate, these tensions formed part of a broader pattern of interprofessional dynamics and constrained opportunities that continued to shape the evolving identity of ODPs.

4.3.3. Interprofessional Disparities

Interprofessional relationships emerged as an important influence on how ODPs understood their professional identity in practice. This challenge was closely connected to recognition and respect, as participants' accounts suggested that professional legitimacy was often negotiated through everyday interactions with other occupational groups. Across alumni and student accounts, participants described experiences that ranged from exclusion and devaluation to support and affirmation. The ways in which ODPs were spoken to, positioned, and recognised

within clinical teams appeared to shape how legitimate and secure their professional identity felt.

In some accounts, these interactions were experienced as openly exclusionary. One student participant recalled being told by a Charge Nurse that “*over our dead bodies will there be ODPs in this department*” (S3, West, April 2023). A similar pattern was evident elsewhere, with another student reflecting that “*they made it quite clear that they didn’t really want ODPs there*” (S8, North, May 2023). Considered together, these accounts suggest that exclusion was expressed directly, positioning ODPs as unwelcome within particular clinical spaces. These were not subtle signals. They communicated that the profession itself was being resisted, rather than merely misunderstood.

A similar sense of devaluation was evident in accounts of how the profession was spoken about by nursing colleagues. This was reflected in the observation that “*they always diminish the ODP as a profession... they [nurses] can be horrid*” (A5, West, May 2023). The significance of such encounters lay not only in their unpleasantness, but in the message they conveyed about the relative standing of the profession within the team. This was reinforced in student accounts of comparison between professional groups, including the reflection that “*it was like their profession [referring to nursing] counted more than ours*” (S1, West, April 2023).

This was developed further in accounts that framed such disparities as part of a broader workplace culture rather than a one-off event. One alumni participant reflected:

“When we first started our training, there was quite a lot of animosity from the nursing staff about ODPs... I think that always will be the sort of slight disparity between ODPs and nurses. I think they think they’re better than us because they hold the ‘nurse’ title... they try push us out the door”.

(A6, North, June 2023)

This account is important because it suggests that such tensions were experienced not as isolated incidents, but as part of a more enduring pattern of professional

disparity. The reference to the “nurse” title also indicates that professional labels could carry unequal recognition, shaping how ODPs felt positioned in relation to other groups within practice. This points to the relevance of status and hierarchy, as the symbolic weight of particular titles appeared to shape whose expertise was more readily taken for granted.

Students described encountering similar disparities early in their development. In one account, a staff nurse was recalled as saying her training was *“far superior than the ODP training”*, which *“significantly dented my professional identity at the time, because I was seen as less of a practitioner”* (S4, North, April 2023). This comment explicitly linked interprofessional comparison to diminished professional confidence. It suggests that students were not only learning the practical aspects of the role, but also absorbing messages about how their professional preparation and future contribution were valued relative to others.

A related form of disparity appeared where participants were not recognised in accordance with their training role. This was reflected in the account, *“I was disregarded as an ODP student and used as a support worker by the nursing staff”* (S7, East & South, May 2023). A similar experience was recalled retrospectively by A6 in relation to her own student placement, where she reflected, *“I wasn’t treated like an ODP student. I was treated like an extra pair of hands”* (A6, North, June 2023). These accounts suggest that the issue was not only a negative attitude, but misrecognition of professional identity in practice. When participants were repositioned into lower-status or less clearly defined roles, the visibility of their intended professional pathway appeared reduced, making it harder for that identity to be affirmed within the placement environment. This is important as it demonstrates how hierarchy operated not only through explicit comparison, but through the allocation of lower-status functions that displaced participants from their intended professional trajectory.

That said, the dataset did not present interprofessional relationships as uniformly negative. There were also accounts in which participants described support, acceptance, and collaborative working across professional boundaries. One alumni participant reflected, *“I don’t think I’ve ever come across anyone being negative*

towards me or any of my colleagues for being ODPs or vice versa" (A2, North, April 2023). Similarly, one student described most interprofessional interactions positively, stating that *"most of them have been very supportive"* (S10, East & South, June 2023). These accounts are important because they show that interprofessional dynamics were not fixed. In some settings, the ODP role appeared to be accepted without tension, allowing identity to develop through participation without the same sense of challenge or defence.

This complexity was also evident in S7's account, where earlier experiences of disregard were contrasted by a later moment of strong interpersonal support:

"I was being pulled from my theatre... and it was the ODP and the staff nurse who was my mentor on the scrub side... who fought for me really hard... they only knew me in passing from the corridor, but to have that support... was really, really nice".

(S7, East & South, May 2023)

This account is significant because it shows that support did not always come neatly from one professional group and hostility from another. Instead, interprofessional relationships could also provide affirmation and protection, even after earlier experiences of marginalisation. In this instance, advocacy appeared to strengthen the student's sense of being recognised and supported within practice. Furthermore, this nuance matters, as it suggests that interprofessional dynamics were locally negotiated rather than uniformly determined by professional category alone.

Taken together, these accounts suggest that interprofessional encounters were important sites through which professional identity was shaped, challenged, and at times strengthened. Negative interactions could leave participants feeling diminished, excluded, or positioned as less legitimate members of the wider clinical team, while more supportive relationships appeared to reinforce confidence and belonging. The findings therefore point not to a single, uniform interprofessional experience, but to a variable and locally mediated set of relationships through which the status and legitimacy of the ODP role were negotiated in practice.

Therefore, I interpret interprofessional disparity not simply as an interpersonal problem, but as one expression of wider status hierarchies through which professional legitimacy was unevenly distributed. As the next section will demonstrate, these interpersonal dynamics were closely connected to wider questions of opportunity and limitation, particularly around career progression and the longer-term conditions through which professional identity was sustained.

4.3.4. Career Progression Constraints

Barriers to career progression emerged as a challenge in the development of ODP professional identity. This challenge was closely connected to recognition and value, as participants interpreted progression opportunities as indicators of how far the profession was acknowledged, trusted, and permitted to develop within the wider healthcare system. Across both alumni and student accounts, participants described frustration with limited mobility, exclusionary job criteria, and wider professional hierarchies that appeared to restrict future opportunities. These constraints were experienced not simply as practical obstacles, but as signals about the profession's institutional standing and longer-term capacity for development. In this sense, progression was not described only as a matter of career ambition, but as an indicator of whether ODP identity could be recognised as expansive, credible, and professionally sustainable over time.

This was reflected in dissatisfaction with the limited breadth of roles available to ODPs in comparison with other professional groups. In one account, the contrast with nursing was expressed directly through the question, *“how come the nurses can have versatility to advanced roles?... They just only put us in one, like surgical or anaesthetics?”* (A1, West, April 2023). Read in the context of earlier findings, this does not suggest that generalist practice was always desirable in itself. Rather, it points to frustration at the unequal distribution of recognised mobility and opportunity.

While earlier accounts showed that being moved to meet service need could be experienced as limiting, here the concern was that ODPs appeared to have less access than nurses to valued forms of progression, movement, and role

development. The issue was therefore not breadth alone, but who was afforded choice, recognition, and advancement through that breadth.

A related concern emerged in student accounts of exclusion through formal role criteria. This was particularly evident in the reflection that *“a nurse and an ODP are pretty much the same thing in theatre, yet they’re excluding a whole profession... they’re excluding people”* (S1, West, April 2023). In the same account, it was noted that a Specialist Nurse in Organ Donation (SNOD) role remained inaccessible because one *“must be an NMC registered nurse”* (S1, West, April 2023). These comments suggest that barriers to progression were not only informal or cultural, but also embedded within job specifications and professional gatekeeping. Participants therefore appeared to experience exclusion not simply because opportunities were scarce, but because access to them was structured around professional titles that did not recognise ODP equivalence. This is analytically important as it suggests that formal professional registration did not necessarily translate into equivalent access to specialist or advanced roles.

This frustration was intensified by the mismatch between educational preparation and perceived opportunity. The same participant (S1, West, April 2023) questioned why ODP students were required to engage with this area of practice during training if related roles remained inaccessible: *“Why do we have to know about organ retrieval and donation within our training, encouraged to try and see a retrieval or speak to the SNOD if there is no possibility to progress to become a SNOD?”*. This account is important because it suggests that exclusion was experienced not only at the point of application, but earlier in the formation of professional expectations. Where training introduced students to areas of practice that later remained closed to them, this appeared to generate frustration and a sense of mismatch between what the profession prepared them for and what it ultimately allowed them to become. Progression constraints therefore appeared to disrupt the relationship between training, identity, and future possibility, making it more difficult for participants to interpret professional development as a coherent pathway.

The strength of this exclusion was further reflected in S1’s observation that *“you would be tempted to alter your own job title to progress”* (S1, West, April 2023). This

is a striking comment because it suggests that professional titles were experienced not simply as descriptors, but as markers that could either enable or restrict access to advancement. In this sense, barriers to progression appeared to shape identity by signalling that ODP status alone might not be sufficient to gain entry to roles that participants felt were relevant to their knowledge and skills. Professional identity was therefore affected not only by what participants believed they could do, but by what their title allowed others to imagine they were entitled to become.

A similar pattern appeared in reflections on other specialist opportunities. In considering roles such as heli-meds, one student observed that ODPs had “*similar responsibilities in terms of airway management and positioning... so it could be something easier to go into after all of this training*” (S7, East & South, May 2023). This account suggests that multiple participants could clearly identify overlaps between ODP competencies and the requirements of specialist roles. Yet the force of the comment lies in its tentativeness. The possibility is imagined rather than established, reflecting uncertainty about whether relevant skills would actually translate into recognised access. Possessing the capability to contribute did not necessarily mean being seen as the right kind of professional to enter such roles. This distinction between competence and recognised eligibility is analytically important. It suggests that participants experienced progression not simply as a function of skill, but as something mediated by wider structures of professional categorisation and workforce legitimacy.

Taken together, these accounts suggest that career progression constraints shaped professional identity by limiting not only what ODPs could do, but what they could reasonably expect from the profession over time. Where routes into advanced or alternative roles appeared unclear, restricted, or reserved for others, participants described frustration, diminished opportunity, and uncertainty about the longer-term value of their professional pathway.

These experiences point to the importance of progression as a form of professional recognition. When opportunities remain narrow or selectively available, they do more than restrict movement. They also shape how the profession is understood, both by others and by those working within it. In this respect, progression constraints can be

read as part of the wider structural positioning of the profession discussed in Chapter 2, Section 2.4.3.1. Therefore, I suggest that limited progression did not simply constrain careers, but also constrained how expansively ODP identity could be imagined and sustained over time.

4.4. Chapter Conclusion

In this chapter, the findings have demonstrated that professional identity among ODPs was constructed through a complex interplay of recognition, respect, and value, alongside the structural and relational challenges shaping their experience in practice. Across student and alumni accounts, identity emerged not as fixed or uniform, but as continually negotiated through workplace interactions, local cultures, professional boundaries, and opportunities for participation and progression.

While participants described moments of affirmation, belonging, and professional pride, they also highlighted the fragility of identity where recognition was limited, role boundaries were unclear, interprofessional relationships were unequal, or future opportunities appeared constrained. Collectively, these findings suggest that ODP professional identity was shaped both by what participants contributed within perioperative practice and by how that contribution was understood, acknowledged, and supported by others. In this sense, identity was influenced not only by interpersonal affirmation within teams, but also by structural conditions through which specialist labour was organised, made visible, and afforded developmental opportunity.

Overall, I argue that this chapter makes two key contributions. First, it shows that ODP professional identity is shaped not only through individual commitment or role performance, but through the extent to which the profession is rendered visible, legitimate, and consequential within local and structural contexts. Second, it demonstrates that replacing reward with value offers a stronger analytical account of how participants understood professional worth, particularly in a public service context where contribution, reliance, and legitimacy were more salient than transactional notions of reward. These findings provide the foundation for Chapter 5,

which examines how these identity dynamics intersect with engagement with higher education feedback provision.

Chapter 5: Professional Identity and Engagement with Higher Education Feedback Provision

5.1. Introduction

This chapter presents the second results chapter, drawing on qualitative interviews with student (S) and alumni (A) Operating Department Practitioners (ODPs). It examines how participants understood and engaged with feedback provision to Higher Education Institutions (HEIs), particularly where such feedback was intended to inform curriculum development and contribute to professional community formation. The focus is not on how participants received feedback, but on how they offered it, and on how their developing or established professional identity shaped their willingness, confidence, and sense of legitimacy in doing so.

This chapter extends the analysis of professional identity from Chapter 4 by considering how recognition, respect, and value shaped participation in educational processes. I argue that feedback provision is better understood here as an identity-relevant form of participation, rather than as a neutral academic or institutional process. In doing so, the chapter shows how engagement with feedback was shaped by participants' sense of voice, legitimacy, and connection to the wider professional community.

The chapter develops this argument by examining how professional identity shaped participants' willingness and confidence to offer feedback, and the conditions that encouraged or constrained engagement. It then considers how feedback was understood as a contribution to the wider ODP professional community, before using three case studies to show how these patterns were experienced unevenly across individual accounts.

5.2. Professional Identity and Feedback Provision Engagement

In this section, I examine how participants' developing or established professional identities shaped their willingness and confidence to provide feedback to HEIs, particularly in relation to curriculum development. Across the dataset, engagement with feedback was not described simply as a matter of individual preference. Instead, participants' accounts suggest that it was closely related to how recognised, respected, and valued they felt within their professional role. Feedback engagement therefore appeared to operate less as a routine educational behaviour and more as a judgement about whether participation was legitimate, worthwhile, and aligned with one's professional standing. The following section explores the motivations that encouraged participation and the barriers that constrained it.

5.2.1. Identity-Driven Motivators

Many participants described feedback provision as closely tied to their developing or established professional identity. For several alumni, offering feedback to the university felt like a natural extension of being an ODP, particularly where feedback was used to align education more closely with the realities of practice. As one participant explained, *"I did give a lot of feedback to the uni when I was a student, because I wanted change... more engagement with the lecturers and the assessments should have been more focused on what we were doing in practice"* (A1, West, April 2023). A1's reflection illustrates how feedback was framed not as a personal preference but as a professional responsibility, grounded in a belief that ODP education should reflect practice expectations.

This concern was echoed by S2, who noted that *"you want it to reflect what actually happens in theatre"* (S2, West, April 2023). Alongside this, A5's comment that *"you want it to be done right"* suggests that feedback was also shaped by pride in the profession and a concern for quality and professional integrity. Collectively, these accounts indicate that feedback was motivated not only by dissatisfaction with specific aspects of education, but by a broader commitment to ensuring that ODP preparation reflected and upheld the standards of practice.

This sense of responsibility was expressed more explicitly by another participant, who stated that *“you should be feeding back, it's part of being a professional”* (S3, West, April 2023), suggesting that participation was not only encouraged, but understood as an expected component of professional identity. Similarly, S1 reflected that *“if something's not right, you should say it”* (S1, West, April 2023), suggesting that feedback was understood not simply as optional participation, but as part of expected professional conduct.

Additionally, in some cases, this expectation appeared to be internalised as a personal disposition aligned with professional identity. As A1 explained, *“I'd always say something if I thought it needed said”* (A1, West, April 2023), indicating that speaking up was not only situational, but reflected how they understood their role and responsibilities as a practitioner.

Participants also described how confidence to contribute could develop alongside growing professional understanding. As A3 noted, *“once you know what you're doing, you feel more able to speak up”* (A3, North, May 2023), suggesting that feedback engagement was linked not only to confidence in general terms, but to developing a clearer sense of one's role within the profession. A similar sense of ownership was reflected in S3's comment that *“it's your training, so you should have a say in it”* (S3, West, April 2023), indicating that participants did not always see themselves as passive recipients of education, but as individuals with a legitimate stake in shaping it.

Across these accounts, feedback provision appeared to be motivated by professional responsibility, pride in standards, and a developing sense of ownership over both training and practice. In this sense, feedback was not only something participants chose to do, but something that aligned with how they understood their role and position within the ODP profession. These motivations were also linked to recognition, respect, and value, as participants appeared more willing to contribute where they understood ODP perspectives, and their own position within that professional group, as deserving to be heard, taken seriously, and treated as consequential in shaping educational provision. However, even where motivation

was high, participants described several obstacles that limited or discouraged their engagement.

5.2.2. Barriers to Feedback Provision

Although many participants expressed a sense of responsibility to provide feedback, several barriers weakened engagement. Across the dataset, these barriers centred on perceived futility, limited confidence, uncertainty about legitimacy, and ambiguity around whether feedback should be offered as an individual or collective voice. Rather than indicating simple disinterest, participants' accounts suggest that non-participation was often shaped by doubts about whether feedback would matter, whether their voice would carry weight, and how participation was expected to operate. These concerns were especially evident where feedback processes appeared opaque, with limited visible follow-up or explanation of how participants' contributions had informed decision-making.

5.2.2.1. Perceived Futility and Lack of Feedback Loops

A recurrent theme in participants' accounts was a sense of futility surrounding feedback processes, particularly when contributions appeared to have little or no visible impact. Although many saw feedback as a mechanism for improving educational experiences, several described feeling discouraged when their suggestions did not lead to observable change. One alumni participant reflected that they *"would like to think my feedback has impact... but I know it hasn't... students are still doing short placements... nothing has changed as far as I've seen"* (A6, North, June 2023). For A6, the absence of visible outcomes appeared to reduce confidence in the process and in the value of their input.

Closer examination of this reflection suggests that the issue was not always a lack of action, but often a lack of communication surrounding the action taken. In A6's example, the continuation of short placements may have resulted not necessarily from a lack of institutional action, but from external constraints such as placement capacity, which may have fallen outside the direct control of the university. However, participants did not always appear to be informed about such limitations. Without clear communication, institutional decisions risk being interpreted as a lack of

response or visible action, reinforcing a perception that feedback is ineffective, even where decisions may have been shaped by factors not visible to contributors. Under these conditions, it may have been difficult for contributors to judge what kind of change individual feedback could realistically achieve. This also highlights a further tension within the process, as the influence of individual feedback may not always be equivalent to concerns raised collectively across a cohort, as discussed further in Section 5.2.2.3.

A similar sense of being “left in the dark” was evident elsewhere. One alumni participant described withdrawing from feedback opportunities because “*I didn’t see much point... it’s not like they tell us of any impact*”, adding that although they had occasionally seen changes happen, “*there’s never any... formal responses from the uni to the feedback given*” (A3, North, May 2023). This lack of follow-up, whether in the form of acknowledgement, rationale, or progress updates, appeared to be a key factor in shaping disengagement. Even when participants recognised that change might be complex or slow, the absence of a clear feedback loop led to feelings of frustration and resignation.

Taken together, these accounts suggest that the feedback process was weakened not only by the challenges of implementing change, but also by the lack of transparent communication around decisions. When contributors did not see their voices acknowledged, or when institutional responses remained opaque, their willingness to re-engage diminished. This does more than interrupt an administrative cycle. It undermines the sense that feedback is meaningful, heard, and worth repeating, thereby weakening the conditions under which participants may continue to see themselves as valued contributors.

Building on these concerns about perceived futility and the lack of feedback loop closure, the next section examines how limited confidence and uncertainty about one’s authority to contribute restricted engagement, even when participants recognised the importance of feedback provision.

5.2.2.2. Lack of Confidence and Perceived Legitimacy

Concerns around legitimacy and voice were particularly evident among student participants, many of whom described hesitancy in offering feedback because they were unsure whether they were in a position to do so. Several located themselves at the lower end of both educational and clinical hierarchies, and this appeared to shape how far they felt able to contribute. As one student reflected, *“I don’t feel like I have a place to give feedback... I’m maybe not quite as confident to put my input in without somebody asking for it first”* (S6, West, May 2023). A similar hesitation was evident elsewhere, with another participant stating, *“I’m only a student, so I don’t really feel like it’s my place to comment on the course”* (S10, East & South, June 2023).

This sense of being positioned as *“only”* a student appeared to shape not just confidence, but whether participants understood themselves as entitled to speak at all, and whether their perspectives would be recognised as legitimate contributions within the feedback process. This uncertainty was also conveyed by S9, who reflected that, *“I feel like as a student my feedback doesn’t have any meaning”* (S9, North, May 2023). Together, these accounts suggest that participation was not constrained by indifference, but by uncertainty over whether student perspectives would be recognised, treated with sufficient respect, or regarded as meaningful within formal feedback structures.

What emerges here is a tension between wanting to contribute and being unsure whether one’s contribution would carry weight. The accounts suggest that some students wished to support programme improvement, yet remained uncertain about whether their views were sufficiently informed or appropriately positioned to matter. This was reflected in accounts where participants described holding back despite recognising areas for improvement, with one noting that *“I wanted to say something, but I wasn’t sure if it would make a difference”* (S6, West, May 2023). In this sense, hesitancy did not appear to arise solely from individual disposition. Rather, it was shaped in relation to whether participants believed their input would be recognised, taken seriously, and ultimately valued within the systems they were contributing to. This is analytically significant as it suggests that participants were not simply judging

what they thought, but whether they were the right kind of person to say it, and whether what they said would be acknowledged as worthwhile.

These reflections also suggest that the issue was not always confidence alone. For some participants, uncertainty appeared to centre on whether student feedback was expected, when it was appropriate to offer it, and whether it would be taken seriously if given. This was reflected in accounts where participants described a lack of clarity around how feedback should be provided, with one explaining that “*no one really tells you how to give feedback well or when to do it. Or when they do tell you, it's last minute so you don't have time to think about it enough*” (S10, East & South, June 2023). Where the purpose and value of feedback were not clearly visible, students could be left unsure whether their contributions would be recognised or lead to meaningful outcomes. As one alumni participant reflected, “*you don't know if anything changes*” (A6, North, June 2023). Viewed in this way, hesitation may reflect not reluctance to engage, but uncertainty about whether feedback would be received with sufficient recognition, respect, and impact to justify participation.

Taken together, these reflections indicate that willingness to contribute feedback was shaped by more than personal confidence. It was also influenced by whether participants experienced the environment as one in which their perspective was recognised as legitimate, treated with respect, and understood as worthwhile. Where students felt peripheral, uncertain of their authority, or unclear about the expectations surrounding feedback, participation appeared more tentative, even where commitment to the programme or profession remained strong. These findings suggest that confidence was not merely an individual characteristic, but a relational and structural condition linked to how voice was positioned, acknowledged, and valued within the institution.

Building on these concerns around confidence and legitimacy, the next section examines a further barrier to feedback engagement: uncertainty around whose perspective feedback represented. Whether participants spoke as individuals, members of a cohort, or in relation to the wider profession emerged as an important factor in shaping how, and whether, they chose to contribute.

5.2.2.3. Boundary Ambiguities: Individual vs. Collective Voices

Beyond questions of confidence and legitimacy, a further complexity arose in how participants understood the nature of the feedback they were expected to provide, specifically whether they should speak as individuals or as representatives of a wider group. Across the dataset, participants expressed uncertainty not only about whether to contribute, but about how their contribution should be positioned in relation to others.

This tension was reflected in accounts that emphasised the limitations of individual voice. One alumni participant explained that they offered feedback “*purely from my own view*”, but questioned whether this was sufficient, adding that “*you need to see what is truly the majority of opinions*” (A2, North, April 2023). Similarly, another participant noted, “*I can only speak from my own experience, so I don’t know if that would be taken seriously*” (A8, West, November 2023). In these accounts, individual perspectives appeared uncertain in status, raising questions about whether personal experience alone carried sufficient legitimacy within formal feedback processes.

In contrast, other participants described feedback as more influential when expressed collectively. This was evident in the view that “*no one will listen to you if you’re just one, but if you represent the whole of your class, you’re one of the voices*” (A1, West, April 2023). A similar position was reflected in the suggestion that “*if other people had said the same thing, I’d feel more confident raising it*” (S10, East & South, June 2023), indicating that confidence in contributing was closely tied to perceived alignment with others. Collective structures were also seen to confer additional legitimacy, with one participant noting that “*if it came through the class rep, it probably felt more official*” (A1, West, April 2023).

At the same time, this collective orientation introduced its own constraints. Participants expressed reluctance to speak on behalf of others without clear consensus, reflected in the concern that “*you don’t want to make it sound like everyone thinks that if they don’t*” (A4, North, May 2023). In some cases, this resulted in withholding feedback altogether, with one participant noting, “*if no one else mentioned it, I’d probably just leave it*” (A2, North, April 2023). These accounts

suggest that while collective alignment could strengthen confidence and perceived legitimacy, it could also limit participation where such alignment was absent.

This ambiguity can be understood in relation to how recognition, respect, and value were experienced within the feedback process. Individual contributions did not always appear to receive immediate recognition when not supported by others, shaping whether participants felt their perspectives would be taken seriously. In turn, perceived value was often linked to collective alignment, with feedback viewed as more meaningful when it reflected shared experience. Under these conditions, participants were required to navigate a feedback environment in which the status of their contribution was not always clear.

Taken together, these findings illustrate how ambiguity around individual and collective voice could constrain participation, even where contributors recognised the importance of feedback. Feedback grounded in shared experience appeared to carry greater legitimacy and potential influence, while individually held concerns were more uncertain in status. This created a tension within the process: although participants recognised the value of contributing their own perspectives, the perceived importance of collective agreement made it less clear whether individual experiences were equally appropriate to raise. As a result, engagement was not determined solely by confidence or perceived impact, but by how participants interpreted the legitimacy of their voice within the feedback process.

It is also important not to overstate this pattern across the wider barriers section. Although many accounts pointed to uncertainty, legitimacy, and limited clarity as barriers to engagement, not every instance of non-participation appeared to carry a deeper explanation. One student reflected that, *“I know the importance of feedback, and sometimes I did it, but sometimes I didn’t... laziness I guess”* (S5, East & South, May 2023). While this comment should be interpreted with care, it suggests that engagement could also vary for more immediate or ordinary reasons, including motivation, competing demands, or simple inconsistency. Recognising this helps retain nuance within the broader pattern, without displacing the more recurrent barriers identified across the dataset. Even so, the weight of the findings suggests

that non-participation was more often linked to uncertainty, vulnerability, and diminished perceived impact than to apathy alone.

Yet these barriers do not fully account for how participants understood feedback. Beyond questions of confidence, legitimacy, and influence, many participants also framed feedback as a way of contributing to something larger than individual experience, namely the wider professional community of ODPs. The following section explores this in greater depth.

5.3. Feedback Provision as Contribution to the Professional Community

Participants frequently positioned feedback provision as more than a procedural requirement. Many described it as a meaningful contribution to the development and continuity of the ODP profession, rather than as a routine educational task, particularly where participants experienced their input as recognised and capable of shaping collective practice. Rather than viewing feedback solely as a mechanism for correcting problems or expressing dissatisfaction, several framed it as part of a wider collective responsibility that could support shared learning, strengthen standards, and contribute to the ongoing development of the professional community.

A notable theme across the accounts was the belief that feedback could benefit not only the individual, but the wider group. One alumni participant reflected on how previous cohorts had shaped their own experience, noting that earlier feedback had *“made my life easier, a bit more enjoyable”*, before adding that *“you’re wanting your colleagues and your peers to be as good as possible... it would make everyone’s lives easier in theatre if everyone was as skilled as they possibly could be”* (A2, North, April 2023). Here, feedback was understood as a way of strengthening collective capability, linking improvements in education directly to improvements in practice.

This collective orientation was also reflected in how participants positioned themselves within the wider system. As A1 explained, *“you’re part of that system”*

(A1, West, April 2023), indicating that feedback was understood as a contribution made from within the professional and educational structure rather than as external commentary. Participation, therefore, was not only about expressing opinion, but about taking part in shaping the conditions of practice and learning.

A similar orientation was evident in student accounts, where feedback was often described as a contribution to those who would follow. This was captured clearly in one participant's reflection that, *"It's a selfless thing... it improves your professionalism... and hopefully lays the path for anybody coming up behind... you would like to think that any feedback that I've given... will make things easier for people coming up behind me"* (S2, West, April 2023). Such accounts suggest that feedback was not always understood in immediate or individual terms, but as a way of contributing to the longer-term development of the programme and the profession.

This forward-looking perspective was further reinforced by a sense of obligation toward those who would follow. As one participant explained, *"you feel like you owe it to the next group"* (A2, North, April 2023), suggesting that feedback was shaped not only by present concerns but by a sense of continuity within the profession. Under these conditions, contribution carried value not simply because it addressed current issues, but because it was understood as shaping future professional experience.

For some, this sense of contribution appeared to be strengthened when they believed the university would act on what was shared. One student expressed confidence that feedback *"will be used in a positive manner to... make an improvement on quality"* (S5, East & South, May 2023). This expectation appeared to reinforce the sense that engaging in feedback was worthwhile and could carry consequence. Where participants believed their input would be taken seriously and acted upon, engagement appeared more meaningful and purposeful. However, as earlier sections have shown (Section 5.2.2.2), this confidence was not shared uniformly, and participants differed in how far they believed feedback would translate into visible change.

Participants also drew on language that conveyed both solidarity and relative invisibility. One alumni participant described feedback as helping to shape *"our*

secret society of a profession", adding that "*people see just a small bit of the picture... but their feedback could steer things*" (A3, North, May 2023). As discussed in Chapter 4, Section 4.2.1, this metaphor suggests a profession experienced as internally close-knit, yet not always fully visible to others. Within this context, feedback appeared to function not only as a way of improving programme experience, but also as a way of strengthening the profession from within. The combination of solidarity and invisibility is significant here because it suggests that feedback could operate as a form of internal profession-building, particularly where wider external recognition remained less secure, and where feedback functioned as a way of reinforcing recognition from within the profession itself.

Some participants also challenged the idea that students should occupy only a passive role within educational processes. This was reflected in one account that their cohort's feedback had "*changed the programme and made it a better programme*", alongside the assertion that "*we're more than just students. We are the future generation*" (S1, West, April 2023). Here, feedback was framed as a way for learners to take part in shaping the conditions of their own education and, by extension, the profession they expected to enter. Participation, therefore, could be experienced as a way of claiming recognition as legitimate contributors within the professional community.

Others described feedback as important in preventing educational or professional stagnation. One student observed that "*everything evolves over time, and so should the course*" (S9, North, May 2023), while an alumni participant suggested that without feedback "*practice will be limited... they would devolve... they become stagnant*" (A5, West, May 2023). These accounts reflect a view that ongoing input was necessary if education and practice were to remain responsive to change, and that feedback formed part of that process.

That said, at times, this collective framing also brought expectations around participation. One student expressed frustration when peers did not engage, describing this as "*leaving the future ODPs... hanging*" (S7, East & South, May 2023). This suggests that feedback could come to be understood not simply as optional participation, but as something tied to responsibility toward the wider group.

While this reflected a strong sense of collective commitment, it also points to a potential tension within the process, as expectations to contribute may not always account for the varied reasons why some participants chose not to engage or felt unable to do so. This demonstrates that feedback could be experienced as both affirming and burdensome: affirming where it enabled contribution to the collective, but burdensome where silence risked being interpreted as letting that collective down.

Taken together, these accounts suggest that feedback was not experienced as a neutral educational transaction, but as a socially meaningful practice through which participants could support collective development, contribute to future cohorts, and shape the professional environment they were part of entering or had already joined. Feedback therefore functioned as a mechanism through which contributors experienced their role as recognised, their input as respected, and their contribution as carrying value within the professional community.

At the same time, this expectation to contribute introduced complexity. Participation could be experienced as affirming where it enabled meaningful contribution, but demanding where contributors felt responsible for supporting others. Therefore, I suggest that feedback provision functioned here not only as a route for institutional improvement, but as a way of enacting professional membership itself.

With these broader patterns established, the following section moves from thematic analysis across the dataset to more detailed individual accounts. Three case studies presented below explore how recognition, respect, value, and differing experiences of professional identity shaped participants' engagement with feedback at a personal level, highlighting the diverse ways ODPs navigated their evolving place within the profession.

5.4. Case Studies

The preceding sections have shown how recognition, respect, and value shaped engagement with feedback provision and informed participants' sense of connection to the wider ODP community. The case studies extend that analysis by examining

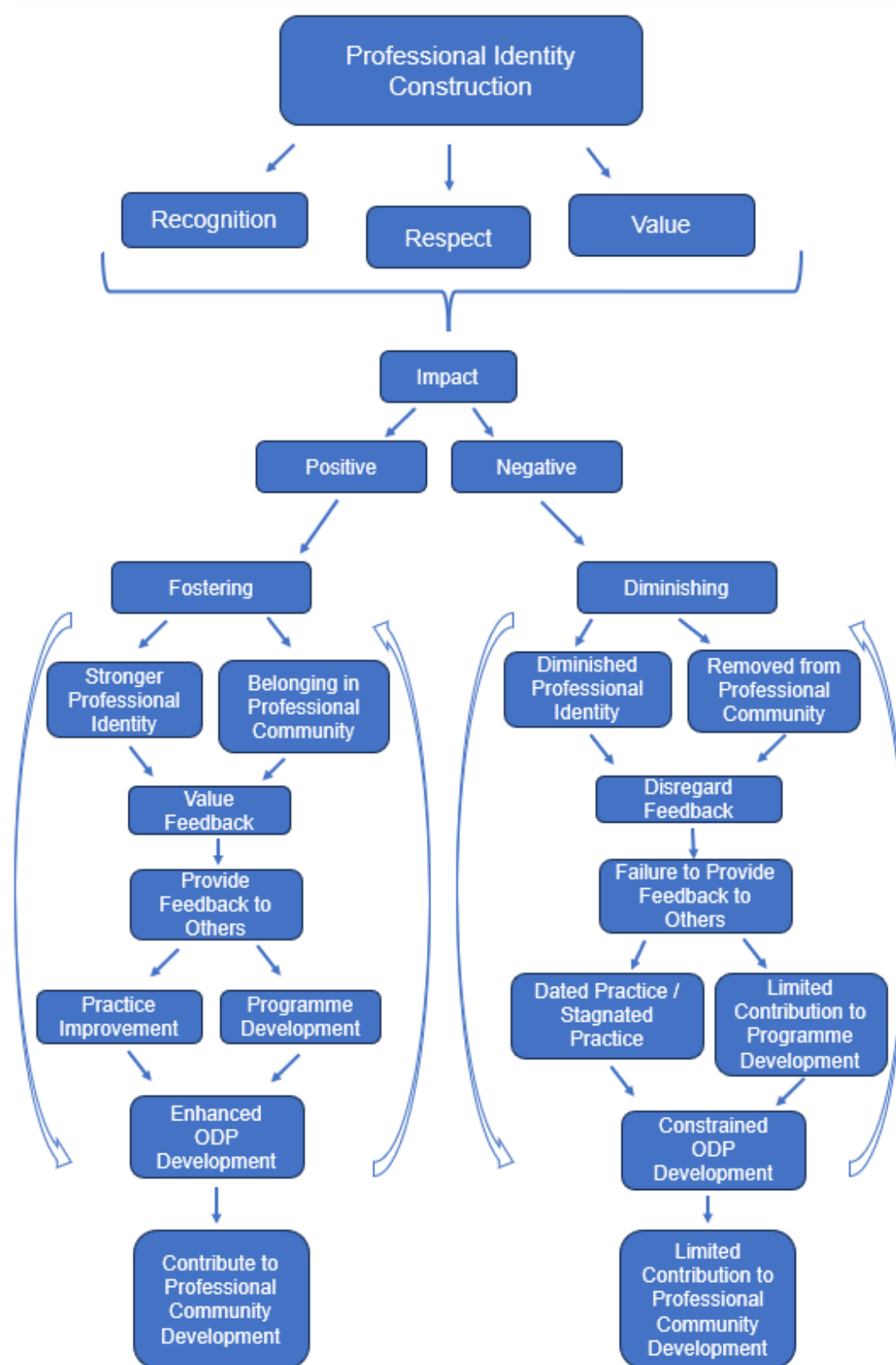
how these dynamics were experienced within individual accounts, allowing closer attention to the conditions in which professional identity and feedback engagement were negotiated.

Figure 5.1 builds on the conceptual outline introduced in Chapter 4 (Figure 4.1) by extending its focus to include feedback behaviours. It represents the relationship between recognition, respect, value, professional identity, and feedback engagement. While this provides a useful conceptual framework, it necessarily presents these processes in a more linear form than participants' accounts reflected.

I therefore use the case studies not to confirm a linear progression, but to explore how these relationships were experienced in practice. They illustrate how recognition, respect, and value were encountered unevenly across contexts, and how this shaped participants' engagement with feedback in different ways. In doing so, they provide a more detailed view of how professional identity and feedback participation were negotiated across individual circumstances, including a more affirming trajectory, a more constrained trajectory, and a more nuanced account situated between these positions. This use of case-based analysis is consistent with professional identity research that foregrounds the relationship between individual experience, structural conditions, and professional formation (Fitzgerald, 2020, pp. 468-469).

Figure 5.1.

Recognition, Respect, and Value (RRV), Feedback Engagement, and Professional Community Development



5.4.1. Case Study One: Limited Recognition and Constrained Participation

Participant A6, an ODP alumni with early post-qualification experience working in a hospital in the north of Scotland, offered an account shaped by challenging workplace conditions, limited recognition, and restricted opportunities for professional affirmation. Their narrative, drawn from a Microsoft Teams interview in June 2023, illustrates how professional identity may be shaped by the environments in which practitioners attempt to establish themselves, particularly where recognition, respect, and value are encountered unevenly across clinical and educational contexts. In A6's case, these conditions appeared to influence both their sense of belonging and their willingness to continue engaging in feedback provision to higher education (HE).

Recognition emerged early as a central issue in A6's account. They defined professional identity as *"people recognising the role that I work in and understanding what it is"*, yet immediately noted that *"a lot of people don't know what an ODP is"*. When describing their role as *"just kind of like a nurse... but I don't do nursing"*, this did not appear to reflect uncertainty about their own profession. Rather, it suggested the repeated effort involved in explaining a role that remained poorly understood by others. Their brief description may also have been shaped by the interview context. Speaking to an ODP lecturer, A6 may not have felt the need to elaborate further, assuming a degree of shared understanding. In this sense, the brevity of their explanation points less to any individual uncertainty than to the wider labour involved in making a profession legible in settings where recognition cannot be assumed.

This limited recognition also appeared within placement experiences, where uncertainty around the ODP role seemed to extend beyond informal misunderstanding. A6 recalled that *"even the mentors said they didn't know what to do with us"*, suggesting that the role was not always clearly understood within the very environments in which students were expected to learn. This does not necessarily point to the shortcomings of individual mentors alone, but also to wider limitations in placement preparation and role clarity. Where expectations are uncertain, students may receive inconsistent guidance and fewer opportunities to

see their role enacted with confidence and continuity. Under such conditions, recognition is weakened not only interpersonally, but also within the structures intended to support early professional formation.

Alongside this, opportunities to experience respect within practice also appeared inconsistent. A6's account suggested that their place within the clinical environment was not always clear or secure, particularly during training. This was illustrated in a recalled interaction from placement, when they introduced themselves by saying, "*Ohh, I'm here, the ODP student*", only to be told, "*Yeah, well, I'm not gonna do anything to help you... you'll just have to wait in the corridor*". While this reflects the behaviour of one practitioner rather than an entire professional group, it nonetheless shaped how A6 was positioned in that moment. Being excluded so directly could reasonably affect whether a learner felt respected, welcomed, or able to participate as a legitimate member of the team. In an account already marked by limited role clarity and uncertain support, this interaction appeared to reinforce distance rather than inclusion. The issue here was not only unkindness, but the denial of a legitimate learner position within the placement environment.

Value was not absent from A6's narrative, but the moments in which it was explicitly experienced appeared limited. The clearest example they offered was that "*the anaesthetists will ask for an ODP over a nurse, which is nice to be valued as a profession*". This moment carries significance because it suggests that profession-specific expertise was, at times, recognised and actively preferred. Yet it also stood out as an isolated example rather than part of a more consistently affirming pattern. In this respect, value appeared to be encountered unevenly. Where recognition, respect, and value are not regularly reinforced, it may become more difficult for practitioners to sustain a stronger sense of professional confidence and belonging.

A6's reflections on professional community formation further illustrate the conditions in which this more limited affirmation was taking place. Although they defined community as "*a community that works together*", they added that "*I wouldn't say we have an ODP community at all*". Their workplace was described as "*very top heavy*", with poor skill mix, high turnover, and low morale. As they explained, "*everyone is just so burnt out... I've never seen so many people leave*". In this context,

opportunities to experience collective identity and professional solidarity appeared restricted. Where teams are unstable and morale is low, the shared environment through which recognition, respect, and value might otherwise be reinforced can become harder to access or sustain.

These conditions also appeared to shape how A6 understood feedback provision to HEIs. They described engaging with feedback during training, but becoming increasingly discouraged when they could not see evidence of change. As they explained, *“I would like to think my feedback has impact, but I know it hasn’t... students are still doing short placements”*. Their reference to being *“shifted every three weeks for eight months”* illustrated how programme structures could disrupt continuity, limit integration, and make it more difficult to settle into the learning environment. At the same time, their account also suggests a tension between the desire for change and the realities of what individual feedback may be able to achieve, particularly where concerns are shaped by wider structural constraints such as placement capacity. Even so, where contributors are not given clear responses or visible explanations, it is understandable that this may be interpreted as a lack of impact. In A6’s case, that perception appeared to matter. As they put it, *“after giving this feedback and nothing changing, I just stopped... I didn’t waste my time”*.

This withdrawal is important to interpret carefully. It does not suggest indifference to feedback or a lack of commitment to improvement. Rather, it appears to reflect disengagement from a process that no longer felt meaningful or responsive. Where recognition is already uncertain, respect unevenly encountered, and value only intermittently affirmed, continued participation in feedback may become difficult to sustain. This seemed particularly relevant where contributors could not clearly see how their views were being acknowledged or acted upon. In this sense, silence can be read less as disengagement from education itself and more as withdrawal from a process that no longer confirmed professional worth.

Taken together, this case suggests that recognition, respect, and value were not wholly absent from A6’s experience, but were encountered inconsistently and within conditions that offered limited reinforcement. Restricted role clarity, uneven support, low morale, and a lack of visible response to feedback appeared to narrow the space

in which professional identity could be more confidently sustained. Under these conditions, reduced engagement with feedback seems understandable, not as a reflection of the individual alone, but as a response shaped by the organisational and relational environments in which that feedback was offered.

It is also important to acknowledge that A6's account was shaped by the circumstances in which the interview took place. At that time, they described working in a setting marked by high turnover and low morale, and this may have influenced the emphasis of their reflections. As with all qualitative accounts, this narrative represents a particular perspective at a particular point in time and should not be read as fixed or universally representative.

Even so, A6's experience draws attention to the structural and relational barriers that can shape how early-career practitioners come to see themselves within the profession and whether they view feedback as worth giving. This case suggests that clearer role recognition, more consistent support, and more visible institutional responsiveness may all matter in enabling practitioners to feel that their voice is both legitimate and worthwhile. Therefore, this case illustrates one of the chapter's central arguments: where recognition, respect, and value are weakened, feedback participation may be withdrawn not because individuals have nothing to say, but because saying it no longer feels meaningful.

In contrast to A6's experience of limited affirmation and constrained participation, the following case study presents a more supportive trajectory. S6's account illustrates how early recognition, affirming support, and visible responsiveness can create conditions in which developing practitioners feel better able to participate in practice and feedback processes within HE.

5.4.2. Case Study Two: Early Affirmation and Emerging Participation

Participant S6, a first-year ODP student undertaking placement in a hospital in the west of Scotland at the time of their individual interview on Microsoft Teams in May 2023, offered a reflective and largely optimistic account marked by early experiences

of recognition, belonging, and voice. Their narrative illustrates how a developing professional identity may be positively reinforced through supportive educational and clinical experiences, even at an early stage of training. Although still in the first year of the programme, S6 described a growing sense of pride, confidence, and connection that appeared to encourage active engagement with feedback processes, particularly within HE.

Recognition emerged as a central thread throughout S6's account. They acknowledged that ODP is "*not a very well-known profession*", pointing to the profession's limited visibility beyond those already familiar with perioperative practice. Yet this broader lack of awareness did not appear to dominate how they experienced the role for themselves. Instead, S6 described moments of everyday affirmation that helped strengthen their developing sense of identification with the profession. One example was their reflection that, "*I'll forgive my husband for calling me an ODP because he says it with pride, which gives me pride to be on the course*". Although the term itself was inaccurate, the significance of the moment lay in the pride attached to it. This suggests that recognition was not experienced only through technical understanding, but also through being associated with the role in ways that felt supportive and affirming. In this account, recognition appeared to operate through small but meaningful interactions that helped make the role feel real, valued, and worthy of pride.

Respect was described most clearly in relation to placement experiences. S6 noted that they were treated "*as a person and not just a student*", suggesting that they were not positioned solely in terms of their novice status. This appeared to matter not only because it was experienced as kind, but because it offered a sense of legitimacy within the team. Their response, "*it's lovely to be treated like that, like I'm actually an ODP*", captures the emotional significance of this treatment and suggests that respect was experienced as both interpersonal and identity-affirming. Where students feel that they are approached as contributors rather than simply observers, the space available for confidence and participation may widen. In S6's case, respect appeared to support a stronger sense of belonging and to make professional identity feel more accessible, even at an early stage.

Value also surfaced in their reflections. S6 explained, *“I’m just a student, but when I do something well or that’s made a difference, that makes me feel good and that builds my professional identity”*. This comment is particularly important because it links value directly to experience rather than abstraction. Feeling that they had made a difference, however small, appeared to reinforce not only confidence in what they could do, but also a sense of themselves as someone becoming part of the profession. Although the phrase *“just a student”* suggests some awareness of their still-developing position, this was counterbalanced by the significance they attached to having a positive impact. Value, then, did not appear to depend on formal status alone, but on whether contribution was seen, acknowledged, and connected to a sense of purpose. This account is especially useful as it demonstrates how developing identity could be strengthened before qualification where contribution was made visible and treated as consequential.

S6’s reflections on professional community were among the most detailed and nuanced across the dataset. Rather than describing the profession as a single, uniform community, they distinguished between perioperative areas, noting that *“recovery is just one big community... Scrub, you’re always part of a team... anaesthetics maybe slightly more challenging... as the anaesthetic assistant... it’s just you”*. This suggests that belonging was experienced unevenly across practice contexts and that the nature of professional connection could shift depending on the specific role or environment. Even within this, however, S6 conveyed an overall sense of integration across the perioperative setting. They also extended this understanding of community to the university, describing feeling part of the *“ODP professional community in uni”*, where shared experiences and common challenges appeared to foster camaraderie. This account highlights that professional belonging may begin to develop across more than one setting at once, shaped through both placement participation and peer relationships within the educational environment.

Although S6 described themselves as still developing confidence in offering feedback in practice, they had already participated in several structured opportunities to do so. These opportunities related to formal feedback processes for other professionals, including nursing revalidation and training portfolio requirements for anaesthetic and surgical trainees. As they explained, *“because I’m a student, I’m*

maybe not quite as confident... but... I've done it about four or five times for an anaesthetic registrar, and then two surgical registrars, and two nurses".

This suggests that their student status was not experienced as a complete barrier to contribution, but rather as a position from which confidence was still emerging. Importantly, these examples also show that S6's perspective had been invited within recognised professional feedback processes, positioning their contribution as useful to the development of others. In this respect, opportunities to contribute appeared to support, rather than simply follow, the growth of confidence. Early participation in feedback processes may therefore have helped reinforce a sense that their perspective could be valid and useful, even before qualification.

S6's engagement with HEI feedback appeared especially proactive and positively framed. They described contributing feedback on assessment formats and noted that visible changes had followed. As they recalled, *"I remember someone fed back that they didn't like essays as much, so they changed the assessment... I wanted to give feedback to make it better for next year's first years"*. Unlike participants who questioned whether feedback led to any meaningful response, S6 appeared able to see a clearer relationship between contribution and outcome. This visibility seemed important. Their comments suggest that feedback was experienced not merely as a means of expressing preference, but as a way of contributing to the development of the programme for those who would follow. This was captured further in their reflection that, *"if that was me, if I was going into first year, I think I would definitely be happier with the changes made from our feedback"*. Here, feedback was framed less as individual complaint and more as a contribution to future cohorts and to the ongoing development of the profession.

In contrast to some participants, S6's account of interprofessional dynamics was largely positive. They referred to one occasion in which a nurse questioned pay banding in relation to educational preparation, but did not interpret the exchange as antagonistic. As S6 reflected, *"I genuinely don't think it was coming from a bad place... I think she was just asking about the differences"*. This suggests a willingness to interpret potentially awkward moments with generosity, but it may also indicate that their broader experiences had provided enough affirmation for such

comments not to unsettle their developing sense of self. In a narrative otherwise marked by recognition, respect, and value, this isolated example did not appear to carry the same constraining force seen elsewhere in the dataset.

Taken together, S6's case illustrates how early affirmation can support the development of professional identity and encourage participation in feedback processes during training. Recognition, respect, and value appeared to be encountered across both clinical and educational settings, and these experiences seemed to reinforce confidence, belonging, and a growing sense of professional responsibility. Importantly, S6's engagement with feedback, particularly within HE, was not framed as a procedural requirement alone. Instead, it was understood as a meaningful way of shaping the experience of future students and contributing to the profession they were entering.

At the same time, this account should be interpreted with caution. S6's positivity may reflect not only individual disposition, but also the supportiveness of the settings in which they were learning. Their placement experiences and university context appeared to provide a relatively affirming foundation, with visible responsiveness, respectful interactions, and opportunities to contribute. It may therefore be that their confidence and willingness to engage were enabled by these conditions rather than arising independently of them. This matters because it suggests that active participation in feedback processes may be easier to sustain where learners feel recognised, respected, and able to see that their contributions carry weight.

Even so, S6's narrative offers an important counterpoint to accounts of uncertainty or withdrawal. It demonstrates that professional identity can be nurtured early through everyday experiences of inclusion, affirmation, and contribution, and that such experiences may help students begin to see themselves as participants in shaping both their educational environment and the future of the profession. This case therefore strengthens the chapter's argument by showing the converse of A6's experience: where recognition, respect, and value are reinforced, feedback becomes easier to inhabit as a legitimate and worthwhile professional act.

In contrast to S6's account of identity formation during training, the following case examines the post-qualification period. A2's narrative illustrates how recognition, respect, and value may continue to support professional identity beyond graduation, while highlighting how responsibility and contribution may be expressed unevenly across educational and clinical contexts.

5.4.3. Case Study Three: Sustained Affirmation and Uneven Feedback Responsibility

Participant A2, an ODP graduate working in a hospital in the north of Scotland, entered their studies with prior perioperative experience as a Healthcare Support Worker (HCSW). Their narrative, drawn from a Microsoft Teams interview in April 2023, illustrates how professional identity may be strengthened through recognition, respect, and value, while also showing that these affirming conditions do not necessarily lead to consistent feedback participation across all contexts. In this sense, A2's account is useful not because it sits neatly between positive and negative experiences, but because it demonstrates that the relationship between identity affirmation, feedback engagement, and wider professional contribution is not always straightforward.

Recognition emerged early as an important theme, particularly in relation to the contrast between the profession's limited public visibility and its stronger recognition within perioperative practice. A2 was clear that operating department practice is "*not a common career, and compared to nurses, everyone knows what a nurse does... We're quite a niche little group*". Yet this wider lack of visibility did not appear to unsettle their sense of professional position. Instead, they emphasised that "*within theatre... the ODP role is widely recognised*". Recognition, then, appeared to be available in the immediate practice setting even where it remained limited beyond it. This suggests that local role clarity and understanding may be sufficient to support a positive sense of identity, even in the absence of broader societal awareness.

Respect was closely connected to professional voice and trust within the team. A2 reflected that, "*I do feel that my voice is heard whenever I need to speak up to my team and my colleagues... They respect me and what I have to say*". This suggests

that they experienced their contribution as welcomed and taken seriously. In the early post-qualification period, being listened to in this way appeared to reinforce a sense of legitimacy within the team. Respect, in this account, was not described in abstract terms, but through the practical experience of speaking and being heard in the workplace.

Value was also strongly present in A2's narrative. They described how ODPs' ability to work across both anaesthetic and scrub roles in their hospital had influenced departmental working, noting that this had "*been beneficial to the department*" and that "*that's made a change in the department*". This suggests that the ODP role was not only recognised at an interpersonal level but seen as making a visible contribution to service organisation. A2 also referred to future opportunities, observing that "*a lot of my managers currently started off as ODPs and have now climbed the ladder*". The profession was therefore experienced not as static or marginal, but as one with visible opportunities for contribution and progression. Collectively, these experiences suggest that recognition, respect, and value were sufficiently present to support a confident and positive sense of professional identity.

That said, A2's reflections on professional community added some complexity to this otherwise affirming account. Although they commented that "*there's no ODP community*" in any formal sense, they nevertheless described the out-of-hours team as a meaningful source of connection: "*I'm part of the out-of-hours team and I feel part of that team or community*". This suggests that belonging was experienced more through immediate working relationships than through a clearly defined profession-wide community. In this account, community appeared local and situated rather than broad and collective. This distinction matters because it suggests that a strong sense of team belonging does not necessarily equate to an equally strong sense of connection to the wider profession.

This complexity became more visible in A2's discussion of feedback. When reflecting on clinical practice, they described feedback as important, calling it "*a massive opportunity for you to progress your skills and your learning*". Yet they also suggested that workplace feedback culture was limited, particularly where competence was assumed rather than explicitly acknowledged. As they explained,

“you’ve got an experienced ODP... they’ve done their job really well for years... it’s just expected of them... you don’t need to go and tell them how good a job they’ve done”. This indicates that while value may have been present within practice, it was not always openly articulated through feedback. More importantly, although A2 clearly appreciated the potential of feedback in clinical learning, they did not describe the same active sense of responsibility to provide feedback within the workplace.

By contrast, A2’s engagement with HEI feedback was much more explicit and proactive. They described having provided both formal and informal feedback during training, noting that *“I really enjoyed the tutorials and gave good feedback on them”*, while also explaining that *“the university were quite good at listening to us”*. Feedback within HE appeared to be experienced as visible, invited, and linked to change in ways that A2 could recognise. Their account also framed this feedback in collective terms. As they put it, *“by not giving feedback, that’s you not helping anyone else in the future... You want to make it as easy as possible for everyone really to improve their practice”*. This suggests that HEI feedback was understood not simply as evaluation of the student experience, but as part of a broader responsibility to support future cohorts and uphold standards within the profession. Their comment that *“a rubbish programme is going to produce rubbish ODPs”*, although colloquial, makes it clear how strongly they linked educational quality with professional practice.

This distinction is central to the value of A2’s case. Their narrative suggests that recognition, respect, and value may support a strong and affirmative sense of professional identity, yet this does not automatically lead to equally strong feedback provision across all settings. A2 articulated a clear sense of responsibility in relation to HEI feedback, but did not describe the same obligation within clinical practice. This implies that professional identity and feedback engagement may not move in a single, linear direction. Instead, participation appeared to be shaped by the particular environments in which feedback was invited, recognised, and understood to matter. This is analytically significant as it complicates any simple claim that stronger identity inevitably produces greater feedback participation.

In this sense, A2’s account adds nuance to any straightforward reading of Figure 5.1. The positive effects of recognition, respect, and value were clearly visible in the

development of confidence, belonging, and commitment. However, these affirming conditions did not uniformly result in feedback provision to others, a fuller workplace feedback culture, or broader contribution to professional community development. Feedback responsibility was most clearly enacted in relation to HE, while its place within clinical practice remained less visible. This suggests that positive identity affirmation alone may not be sufficient to generate wider patterns of feedback participation or professional contribution in all directions.

It is also noteworthy that wider public recognition did not appear integral to the strength of A2's professional identity. More immediate forms of affirmation, including recognition within theatre, respect from colleagues, visible contribution to departmental working, and identifiable progression opportunities, seemed sufficient to sustain confidence in the role. At the same time, the account suggests that these localised affirmations did not necessarily translate into a more expansive sense of feedback responsibility across the wider professional environment.

While A2's account cannot be taken as representative of all ODPs, it offers a valuable illustration of how professional identity may be strongly supported without producing a wholly linear pattern of engagement. Rather than presenting a simple positive trajectory, the case shows that the consequences of recognition, respect, and value may be uneven. This makes the case especially useful in demonstrating that the pathways represented in Figure 5.1 are conceptually helpful, but less tidy in lived experience. Even where identity is well supported, the movement from affirmation to feedback provision and wider professional contribution may remain partial, selective, or context-dependent. This case therefore reinforces my argument that feedback engagement was shaped not by identity in the abstract, but by the specific contexts in which voice was invited, recognised, and seen to matter.

5.5. Chapter Conclusion

This chapter has demonstrated that professional identity influenced engagement with HEI feedback provision. Across the dataset, feedback was often described beyond a neutral or purely procedural activity. Instead, participants' willingness to contribute was shaped by the extent to which they felt recognised, respected, and valued within

both educational and clinical contexts, and by whether they understood their voice as legitimate and capable of making a difference.

The findings indicate that feedback engagement was more readily enacted where participants experienced stronger affirmation of their professional role and a clearer sense of belonging within educational or professional environments. Conversely, engagement became more tentative where role visibility was limited, feedback processes appeared opaque, or participants were uncertain whether their contribution would be taken seriously. Feedback was also frequently understood as extending beyond individual opinion, with many participants framing it as a contribution to future cohorts and to the wider development of the profession.

In parallel, the findings indicate that the relationship between professional identity and feedback provision was not linear or uniform, as would be expected in lived experience. Recognition, respect, and value could encourage participation, but did not necessarily lead to consistent feedback engagement across all contexts. The case studies illustrated that participants' engagement with feedback was shaped by the particular conditions in which their professional identities were formed, affirmed, or constrained.

Taken together, these findings extend the empirical foundation established in Chapter 4 by showing that the identity dynamics shaped through the recognition, respect and value (RRV) framework also influenced engagement with HEI feedback provision. While Chapter 4 examined how professional identity was constructed, this chapter has demonstrated that professional identity also shaped whether participants felt able, willing, and responsible to contribute feedback intended to influence educational development.

More specifically, I argue that this chapter makes two contributions. First, it shows that feedback provision was not a neutral educational process, but an identity-mediated form of participation shaped by legitimacy, relational safety, and perceived worth. Second, it demonstrates that recognition, respect, and value did not simply shape how participants saw themselves as ODPs, but also whether they felt they had the right, the confidence, and a reason to believe that speaking would matter.

Feedback provision therefore emerged as an important site through which professional identity informed participation in educational processes connected to the future of the profession.

Building on the empirical insights presented in Chapters 4 and 5, Chapter 6 critically synthesises the findings with existing literature, examining how the themes identified, particularly professional identity and feedback engagement, align with, extend, or challenge existing theoretical and empirical understandings. In doing so, it positions this study's contribution within the wider literature on healthcare education, identity construction, and professional community development.

Chapter 6: Discussion

6.1. Introduction

In this chapter, I interpret the findings presented in Chapters 4 and 5 in relation to the study's aims and research questions. Whereas the preceding chapters foregrounded participants' accounts of professional identity and engagement with feedback provision, this chapter moves beyond description to analytical synthesis, situating the findings within existing literature and considering how they extend current understandings of professional identity formation, participation, and professional community development among Operating Department Practitioners (ODPs).

The central aim of this research was to examine how professional identity is constructed among student and registered ODPs, and how this identity shapes engagement with feedback provision as a contribution to professional community development. This chapter develops this aim by arguing that professional identity was not fixed or secured by qualification or registration alone, but was constructed through relational and contextual judgements about recognition, respect, value, and belonging.

The central contribution of this chapter is to demonstrate that feedback provision was not simply an educational or administrative activity, but an enactment of professional identity. I interpret this argument through the combined use of Social Identity Theory (SIT) and the Recognition, Respect and Value (RRV) framework. SIT conceptualises identity as rooted in group membership, status, legitimacy, and belonging (Tajfel & Turner, 1979; Haslam et al., 2009), while RRV specifies the relational and institutional conditions through which these identity processes were experienced in this study. Together, these frameworks show how participants' willingness to speak, remain silent, or withdraw from feedback processes was shaped by whether contribution felt legitimate, safe and worthwhile.

This chapter is organised around four interrelated areas of analysis. It first addresses the research questions by examining how professional identity was constructed and

how this shaped engagement with feedback provision. From this analysis, it then develops the refinement from Recognition, Respect and Reward (3R) to RRV, arguing that value more accurately captures the way professional worth was experienced within this study. The discussion then turns to identity hierarchies and the uneven distribution of legitimacy within perioperative environments, highlighting how recognition and value were differentially experienced across professional groups. These findings provide a foundation for considering the role of Higher Education Institutions (HEIs) as identity environments that communicate recognition, respect, and value through curriculum design, feedback processes, and partnership practices.

Together, these sections advance my central argument that professional identity among ODPs is constructed through relational participation within clinical and educational communities, and that engagement with feedback provision reflects how that identity is interpreted, enacted, and made more or less secure.

6.2. Addressing the Research Questions

This section addresses the two research questions guiding this study, drawing together findings from Chapters 4 and 5 to develop an integrated account of how professional identity was understood and negotiated, and how it shaped engagement with feedback provision. I first consider how student and registered ODPs perceived their professional identity, before turning to how these interpretations shaped engagement with feedback to HEIs as a contribution to professional community development. Together, these strands establish the conceptual foundation for the theoretical refinement advanced in Section 6.3.

6.2.1. What Are Student and Registered ODPs' Perceptions of Their Professional Identity?

The findings of this research indicate that student and registered ODPs perceived professional identity as complex and evolving rather than fixed or secured by qualification alone. As demonstrated in Chapter 4, Sections 4.2.1 to 4.2.3, participants consistently described identity as something negotiated through

everyday interaction within perioperative and educational contexts. It was interpreted through cues of recognition, respect, and value, with participants judging their professional standing through whether they were acknowledged, whether their voice was heard, and whether their contribution was understood to matter.

From a SIT (Haslam et al., 2009) perspective, this reflects identity as a judgement about legitimate group membership and standing within a collective. Participants did not position professional identity as a credentialed status automatically conferred through registration. Rather, their accounts suggest that professional identity became secure only when formal membership was affirmed through everyday relational and institutional cues. This interpretation is consistent with wider identity work which suggests that identity salience and enactment are shaped through ongoing evaluation of role legitimacy within social contexts (Stryker & Serpe, 1982), as well as more recent work highlighting identity as layered and nested across multiple forms of belonging (Meisenbach & Kramer, 2014). Additionally, this interpretation aligns with wider professional identity literature, which conceptualises identity as socially negotiated and context-dependent rather than static (Fitzgerald, 2020). Similarly, Cornett et al. (2023) and Lin et al. (2024) emphasise that professional identity develops through interaction with institutional and clinical systems.

Within health professions education, Moseley et al. (2021) describe identity formation as shaped through participation and engagement, while Snell et al. (2020) highlight the importance of relational affirmation in allied health identity. Similarly, Mbalinda et al. (2024) suggest that belonging, role clarity, and mentoring influence how securely professional identity develops. The findings extend this literature by demonstrating that such affirmation was interpreted through three closely related questions: am I recognised here, am I respected here, and does my contribution matter here? As shown in Chapter 4, Section 4.2.1, recognition was tied to visibility, acknowledgement, and inclusion within the team. Furthermore, Sections 4.2.2 and 4.2.3 showed that respect and value were closely connected to being listened to, trusted, consulted, and relied upon. This reinforces findings from Plack (2006), who demonstrates that professional identity develops through participation, communication, and interpersonal engagement within Communities of Practice (CoP), rather than through knowledge acquisition alone. In this sense, I have used

the refinement from 3R to RRV to specify the relational and institutional signals through which professional identity was interpreted in this study.

Research examining the expanding scope of operating department practice provides additional context for these findings. Lowes et al. (2020) document the evolution of ODP roles beyond historically bounded technical functions, and Marshall and Farrington (2024) identify similar developments within critical care settings. Relatedly, Wallis et al. (2024) suggest that students are increasingly drawn to the profession through perceptions of distinctive responsibility. While such expansion may create conditions in which professional identity becomes more secure, participants' accounts in this study indicated that expanded scope alone did not guarantee legitimacy. As demonstrated in Chapter 4, Sections 4.3.1 and 4.3.2, professional standing remained contingent upon how expertise was recognised, how clearly the role was understood, and how far the breadth of ODP practice could be enacted within local environments.

Allied health research further reinforces the relational dimension of identity formation. Lewis et al. (2025) conclude that identity develops through negotiated participation and interpretation of legitimacy cues, while Tong et al. (2020) argue that professional identity is shaped through comparison within multidisciplinary systems. The present findings support this comparative dimension, particularly where ODP identity was interpreted alongside adjacent professional groups. As demonstrated in Chapter 4, Section 4.3.3, interprofessional disparities sometimes positioned ODPs as less visible, less legitimate, or less valued than neighbouring professions, even though other accounts described support and allyship across those same boundaries. The findings therefore suggest that while wider comparison mattered, identity became more or less secure primarily through local experiences of recognition, respect, and value within immediate teams.

Professional identity was therefore experienced as negotiated rather than settled. Organisational identity literature by Brown (2017) conceptualises identity work as an ongoing recalibration in response to ambiguity or threat. Similarly, Caza et al. (2018) describe identity as shaped through dynamic negotiation rather than through a single process of consolidation. Participants' accounts resonate with this view, particularly

where institutional expectations or hierarchical positioning created uncertainty. This pattern is also evident in health professions education literature, where identity fragmentation has been linked to uncertainty, competing expectations, and shifting professional contexts (Sarraf-Yazdi et al., 2021; Lin et al., 2024). In the present study, I found that insecurity appeared to intensify most clearly where cues of legitimacy were inconsistent or undermining. As shown across Chapter 4, particularly Sections 4.3.1 to 4.3.4, limited visibility, blurred role boundaries, interprofessional disparity, and constrained progression complicated how securely participants could inhabit professional membership.

Taken together, this research demonstrates that professional identity among ODPs was not primarily secured through registration, but through ongoing interpretation of recognition, respect, and value within practice. Having established identity as interpretive and relational, the discussion now turns to how it was enacted through participation.

6.2.1.1. Professional Identity as Participatory Practice

While recognition, respect, and value shaped how professional identity was interpreted, participation structured how it was enacted. Wenger (1998) conceptualises identity development as movement from peripheral towards fuller participation within a CoP. Participants' accounts closely reflected this trajectory. Students who were invited to contribute meaningfully to theatre activity described growing confidence and belonging. Conversely, where access to core tasks was limited, participants more often described remaining in a more peripheral position within practice. This was particularly evident in Chapter 4, Section 4.2.3, where student accounts linked value to opportunities for active contribution, and in Section 4.3.2, where restricted role breadth shaped how the profession itself could be experienced.

This interpretation also connects with Dewey's (1938) understanding of learning as grounded in experience and interaction. As discussed in Chapter 2, Dewey's work suggests that the educational significance of experience depends not simply on exposure to a setting, but on the quality of participation and the meanings learners

construct through that participation. This is important here because participants' accounts suggest that clinical participation communicated more than technical learning. As demonstrated in Chapter 4, Sections 4.2.1 to 4.2.3, experiences of visibility, being listened to, being trusted, and being able to contribute meaningfully shaped how participants interpreted their professional standing. Similarly, Chapter 4, Section 4.3.2 showed that restricted access to the breadth of operating department practice could limit how fully students experienced the profession and their place within it. What students were enabled to do in practice therefore signalled whether they were trusted, recognised, and positioned as legitimate emerging members of the ODP community. In this sense, participation carried both pedagogical and identity-forming significance.

This interpretation is supported by more recent CoP research, which similarly positions participation as central to how professional belonging is negotiated. James-McAlpine et al. (2023) demonstrate that participation shapes not only what is learned, but whether participation itself is treated as meaningful within professional systems. Furthermore, Stoffels et al. (2022) show that movement between educational and clinical contexts intensifies identity negotiation. In this study, these boundary transitions required participants to reinterpret their standing repeatedly. Participation made identity more secure when it signalled trust, competence, and meaningful inclusion, as reflected particularly in Chapter 4, Section 4.2.3. Where opportunities to contribute were constrained, participants more often remained in a peripheral position, as shown in Sections 4.2.3 and 4.3.2, with implications for how securely they could inhabit professional membership.

Importantly, participation did not operate independently of status narratives. Adams et al. (2006) argue that professional identity is shaped through perceived occupational standing, while Pimentel et al. (2011) highlight how broader sociocultural positioning influences the valuation of professions. Participants' experiences indicate that access to participation was mediated by how ODPs were positioned relative to adjacent roles. Participation and legitimacy were therefore intertwined. From an RRV perspective, meaningful participation was not simply a learning opportunity, but one of the ways in which recognition, respect, and value were communicated in practice.

I therefore refine participatory accounts of identity by showing that participation mattered not only because it enabled learning, but because it communicated standing. Through participation, participants interpreted whether they were recognised as belonging, respected as trusted contributors, and valued as meaningful members of the professional community. To understand why participation carried such identity significance, it is necessary to examine the relational mechanisms through which recognition, respect, and value were communicated.

6.2.1.2. Relational Mechanisms of Recognition, Respect, and Value

Recognition, respect, and value operated as relational mechanisms through which participants interpreted their professional standing. Although closely connected, each contributed differently to the construction of professional identity.

Recognition was the first mechanism through which professional identity was interpreted. As shown in Chapter 4, Section 4.2.1, recognition was tied to visibility, acknowledgement, and inclusion within the perioperative team. From a SIT perspective, recognition signalled that participants were legitimate members of the professional in-group, rather than peripheral or marginal contributors. Tajfel and Turner (1979) are useful here because they explain why group membership becomes central to self-concept, while Haslam et al. (2009) extend this by demonstrating how perceived status and legitimacy within the group shape participation and behaviour. However, while SIT explains why recognition mattered at the level of group membership, professional identity literature helps explain how recognition was enacted in practice. Monrouxe (2010) emphasises the importance of social recognition in professional identity formation, whereas Trede et al. (2012) locate identity development more specifically within relational participation and professional learning. Furthermore, allied health literature further sharpens this point. Snell et al. (2020) highlight relational affirmation as important in allied health identity development, while Lewis et al. (2025) place greater emphasis on the interpretation of legitimacy cues within practice environments.

Building on the findings presented in Chapter 4, Section 4.2.1, recognition therefore mattered because it communicated whether the ODP role was visible, distinct, and legitimate within the wider team. Where the role was clearly understood and acknowledged, participants were more able to interpret their professional identity as secure. Conversely, where the role was overlooked, misunderstood, or rendered less visible within wider healthcare structures, recognition became fragile (Chapter 4, Section 4.3.1). My findings extend this literature by showing that recognition was not experienced only at the interpersonal level, but was also shaped by wider institutional visibility and role clarity. This suggests that recognition did not simply affirm individual confidence: it signalled whether the profession itself was understood as necessary, credible, and meaningfully situated within perioperative practice.

Respect emerged as a particularly salient relational mechanism. Being listened to and taken seriously functioned as confirmation of legitimate membership. From a SIT perspective, respectful interaction signalled recognised in-group standing (Haslam et al., 2009). Furthermore, Willetts and Clarke (2014) document similar processes within nursing, where belonging is consolidated through respectful relational engagement. In this study, respect mattered because it shaped whether participants interpreted their voice as professionally credible. As shown in Chapter 4, Section 4.2.2, respectful engagement was closely linked to confidence, inclusion, and feeling accepted within the perioperative team.

Conversely, perceived disrespect made identity positioning less secure. Although overt hostility was not universally described, experiences of dismissal or exclusion shaped how some participants interpreted their standing. As demonstrated in Chapter 4, Section 4.2.2 and further illustrated in Section 4.3.3, such moments could weaken confidence and belonging, particularly where participants already occupied less secure positions within the team. This interpretation is supported by wider evidence from hierarchical learning environments, where humiliating or dismissive teaching cultures have been shown to undermine professional confidence and belonging (Wigg et al., 2025).

Value operated as a further signal through which professional identity was interpreted. Participants rarely framed professional identity in financial terms.

Instead, value was understood through usefulness, contribution, and the sense that one's role mattered to team functioning. This emphasis on meaningful contribution aligns with Cruess et al. (2014), who describe professional identity formation as grounded in recognised competence and responsibility. Within a SIT framework, perceived contribution supports the sense that membership is both legitimate and meaningful to successful performance (Haslam et al., 2009). As demonstrated in Chapter 4, Section 4.2.3, value was especially evident where participants were consulted, relied upon, and trusted within the team, and where their expertise carried visible significance within practice.

Differences between students and registered practitioners further illustrate how recognition, respect, and value were experienced unevenly across stages of professional identity development. Registered ODPs more often described a stronger sense of confidence grounded in recognised jurisdiction and trust, particularly in relation to specialist contributions, being relied upon, and being listened to within the team, as demonstrated in Chapter 4, Sections 4.2.2 and 4.2.3 (Molleman & Rink, 2015). That said, legitimacy remained socially negotiated rather than permanently secured (Burford, 2012). Students more frequently described belonging as conditional, consistent with research demonstrating that peripheral status can constrain voice within healthcare education (Van den Broek et al., 2021). Furthermore, Mayer et al. (2025) and Luong et al. (2025) similarly show that belonging may be experienced as conditional within hierarchical learning environments. Across Chapter 4, particularly Sections 4.2.1 to 4.2.3, this difference was visible in the stronger reliance students placed on local signals of visibility, support, and participation as they developed their sense of professional self.

Taken together, these findings indicate that ODP professional identity was not secured through qualification or registration alone, but through repeated judgements about recognition, respect, value, participation, and institutional signalling. SIT explains why these judgements mattered, while RRV specifies the relational cues through which identity was made more or less secure. Having addressed how student and registered ODPs perceived their professional identity, I now turn to the second research question by examining how those same judgements shaped whether feedback engagement felt legitimate, safe, and worthwhile.

6.2.2. How Does Professional Identity Shape Engagement with Feedback Provision to HEIs as a Contribution to Professional Community Development?

Having established in Section 6.2.1 that professional identity among ODPs was socially constructed and interpreted through recognition, respect, and value, I now examine how identity positioning shaped engagement with feedback provision to HEIs. If identity is experienced as a judgement about legitimate membership and standing within a professional collective, then participation in institutional processes cannot be assumed to be straightforward or purely procedural.

The findings indicate that engagement with feedback was interpreted not as an administrative obligation, but as an identity-relevant act situated within broader evaluations of professional standing. This supports emerging higher education (HE) literature which suggests that feedback engagement is contingent upon students' capacity to exercise evaluative judgement and perceive themselves as legitimate contributors to academic dialogue (Tai et al., 2018). As demonstrated across Chapter 5, particularly Sections 5.2.1 and 5.2.2, participants described weighing whether speaking up aligned with credible professional membership and whether their contribution would be recognised as legitimate. In this sense, feedback provision became a site where identity was enacted and assessed rather than a neutral educational exercise.

Organisational literature conceptualises such moments as identity work, where individuals interpret how participation affirms, risks, or re-shapes their professional self-concept (Caza et al., 2018). Furthermore, Carless and Winstone (2023) similarly argue that feedback engagement is shaped by relational and contextual interpretation rather than procedural opportunity alone. Participants' accounts strongly support this view. As explored in Chapter 5, Sections 5.2 and 5.3, feedback was rarely framed as a simple opportunity to comment on curriculum design. Instead, it was evaluated in terms of legitimacy, authority, and whether one's contribution was likely to matter within the professional community. Similarly, Young and Jerome (2020) argue that student voice is shaped not simply by opportunity, but

by whether institutions meaningfully ‘close the loop’ and demonstrate responsiveness to contributions.

SIT provides explanatory clarity for this pattern. As noted previously, SIT proposes that individuals continually evaluate group membership through cues of status and legitimacy (Haslam et al., 2009). Where belonging was experienced as more secure, feedback participation was constructed as an appropriate extension of professional membership. As shown in Chapter 5, Section 5.2.1, engagement was described as stewardship, a responsibility, or a contribution to the future of the profession. In these accounts, voice reinforced identity rather than threatening it. The refinement from 3R to RRV also helps clarify why this occurred: recognition shaped whether participants felt they had the right to speak, respect shaped whether speaking felt safe, and value shaped whether speaking felt worthwhile. This aligns with partnership literature which emphasises that participation becomes meaningful when individuals perceive themselves as legitimate and valued contributors within institutional systems (Mercer-Mapstone & Bovill, 2020). Bringing these strands together, I argue that feedback engagement was mediated through a three-step identity judgement rather than through procedural access alone.

Research on student voice strengthens this interpretation. Student engagement is positioned within the UK Quality Code as part of institutional responsibility for assuring and enhancing the student learning experience, including the expectation that improvements identified through student engagement are implemented where appropriate and communicated to students and staff (Quality Assurance Agency for Higher Education (QAA), 2024a). In Scotland, this aligns with the Tertiary Quality Enhancement Framework, which guides quality arrangements across colleges and universities, and with the Tertiary Quality Enhancement Review, which requires institutions to evidence academic standards, student experience, and enhancement activity (Scottish Funding Council (SFC), 2024, 2025; QAA, 2024b). This policy context establishes student voice as a recognised component of quality and enhancement activity, rather than an optional or informal contribution. However, the findings of this study suggest that formal inclusion within institutional processes did not, in itself, ensure that feedback provision was experienced as legitimate, safe, or influential.

Xiaomei and Deborah (2022) demonstrate that willingness to speak in HE is shaped by perceived credibility and institutional receptivity. Furthermore, Rose et al. (2025) suggest that engagement is filtered through learners' understanding of who they are permitted to be within academic systems. The findings extend this literature by showing that such permission was interpreted not only academically, but professionally. As demonstrated in Chapter 5, Sections 5.2.2.2 and 5.2.2.3, participants assessed whether institutional dialogue recognised them as legitimate members of the professional collective and whether their perspective was appropriate to offer.

At the same time, perceptions of legitimacy were not formed in isolation from wider professional hierarchies. As argued in Section 6.2.1, and examined in more detail in Section 6.4, participants' sense of standing was shaped through interprofessional comparison. Awareness of status asymmetry heightened sensitivity to potential identity threat. Speaking up was therefore interpreted not simply as offering feedback, but as positioning oneself within a stratified professional landscape.

This interpretation is supported by interprofessional research demonstrating that hierarchical structures shape whose voice is treated as credible. While Lingard et al. (2002) and Cavaleiro and Carvalho (2024) show that professional hierarchies influence patterns of communication and authority within healthcare teams, Paradis et al. (2018) focus more specifically on how professional status affects whose contributions are taken seriously. This concern is sharpened in perioperative settings, where authority gradients can discourage upward voice when relational repercussions are anticipated (Khan et al., 2022). Extending this further, psychological safety literature suggests that those positioned lower within perceived hierarchies may self-censor to protect relational standing (Edmondson & Lei, 2014).

Participants' accounts resonate with these findings, yet they also refine them. Engagement was not simply constrained by hierarchy itself. Rather, individuals evaluated whether critique would be interpreted as legitimate contribution or as overstepping one's place. This was particularly evident among student participants, whose membership was often experienced as conditional, as shown in Chapter 5,

Section 5.2.2.2. Similarly, Luong et al. (2025) document comparable patterns among medical students navigating conditional belonging.

In this study, silence at times functioned as identity protection rather than disengagement. This interpretation is also consistent with more recent HE literature emphasising the relationship between feedback, reflection, and psychological safety. In particular, McGuire (2025) argues that feedback engagement is shaped not only by assessment design, but by the emotional and relational conditions within which students are asked to reflect and respond. From this perspective, reluctance to participate may reflect an attempt to manage vulnerability and preserve wellbeing rather than a lack of interest in educational enhancement. In the present study, this helps illuminate why some participants, particularly students, appeared to calibrate their feedback engagement carefully in relation to perceived relational risk.

HE research on feedback engagement further illuminates this interpretive process. While Winstone et al. (2017b) demonstrate that students may avoid engaging where feedback threatens self-concept or lacks perceived utility, participants in this study described weighing effort against anticipated significance. Where participation appeared unlikely to reinforce credible standing or contribute to meaningful change, withdrawal was framed as understandable rather than apathetic. This interpretation was especially apparent in Chapter 5, Section 5.2.2.1, where perceived futility and limited loop closure weakened willingness to continue contributing.

Alternative explanations centred on pragmatic constraints also warrant consideration. While educational literature frequently attributes disengagement to workload, timing pressures, or survey fatigue (Sofroniou et al., 2020), the present findings suggest that such constraints did not operate independently of identity positioning. Participants acknowledged such factors, as indicated in Chapter 5, Section 5.2.2.3, but these appeared to become more decisive where recognition, respect, or value were already uncertain. Conversely, where identity signals were stronger, inconvenience was more readily tolerated. Engagement therefore reflected layered interpretation rather than a simple cost-benefit calculation.

The mechanisms underpinning these decisions can be clarified through the interaction of recognition, respect, and value, with recognition operating as a form of interpretive authorisation through which participants judged whether they were legitimate contributors to institutional dialogue. This aligns with partnership-oriented models which suggest that shared ownership strengthens engagement when contributors perceive themselves as legitimate members of the community (Tschirhart & Pratt-Adams, 2019). The findings build on this argument by showing that being invited to give feedback did not, on its own, make participants feel like legitimate contributors to institutional dialogue. As explored in Chapter 5, Sections 5.2.1 and 5.3, this was particularly evident where feedback was understood as a contribution to future cohorts and to the wider professional community.

Respect, in turn, shaped whether participation felt safe, particularly for students whose professional membership was still developing. Van den Broek et al. (2021) are useful here because they show how less secure positioning within healthcare education can constrain professional voice. Building on this, my findings extend this argument by demonstrating that students did not simply lack opportunities to speak, but actively judged whether speaking might threaten relational standing. As shown in Chapter 5, Section 5.2.2.2, students described calibrating their engagement according to how secure their membership felt, meaning that withholding feedback often reflected an attempt to protect relational standing within educational and professional hierarchies.

Additionally, value influenced whether participation was experienced as worthwhile. Participants were more likely to engage when institutional responses demonstrated that feedback mattered. This aligns with student voice literature, where Young and Jerome (2020) argue that participation depends not only on opportunities to speak, but on whether institutions demonstrate responsiveness and close the feedback loop. Similarly, Carless and Winstone (2023) emphasise that feedback engagement is shaped by learners' interpretation of whether dialogue is meaningful and likely to produce change.

Building on this, the present findings suggest that responsiveness did more than improve the perceived utility of feedback processes: it affirmed that participants and

their perspectives were valued within the educational community. As demonstrated in Chapter 5, Sections 5.2.2.1 and 5.4.2, visible responsiveness reinforced the sense that participants' views were meaningful and worthy of providing. Where feedback appeared to dissipate without acknowledgement or response, disengagement aligned with reduced belief that participation could make a difference. In this respect, responsiveness functioned not simply as quality assurance, but as an affirmation that contributors and their perspectives were recognised as worth engaging with.

Taken together, I argue that engagement with feedback provision was not simply an educational behaviour, but an identity-mediated form of participation. Participants spoke when they felt entitled, safe, and likely to matter, and withheld when those conditions were absent or uncertain. Voice and silence therefore reflected ongoing judgements about recognition, respect, and value rather than motivation or compliance alone. This provides the basis for the following section, which refines the 3R framework and advances RRV as a more accurate model for explaining how professional identity and participation were constructed within this study.

6.3. Refining the 3R Framework: From Reward to Value

The preceding discussion established that professional identity among ODPs was interpreted through recognition, respect, and value, and that these same dynamics shaped engagement with feedback provision. As discussed across Chapter 4, Section 4.2, participants described professional identity through experiences of visibility, respect, trust, reliance, and meaningful contribution. Furthermore, Chapter 5 demonstrated that these dynamics extended into educational settings, where engagement with feedback was shaped by whether participants experienced themselves as legitimate contributors whose views were likely to be taken seriously and to make a difference. At first glance, these findings appear broadly compatible with the 3R framework. Recognition and respect, in particular, resonate closely with how participants described the conditions under which identity became more secure. On closer examination, however, the framework requires refinement if it is to account more precisely for the identity construction processes described in this study.

The relational foundations of the 3R framework nevertheless remain conceptually useful. Working within a CoP perspective, Wenger (1998) conceptualises identity as formed through participation in shared practice, while Trede et al. (2012) emphasise that identity develops through relational negotiation rather than individual achievement. From a SIT perspective, recognition and respect function as important signals through which individuals interpret their standing within a professional community. Tajfel and Turner (1979) argue that group membership shapes self-concept, and Haslam et al. (2009) demonstrate that perceptions of status and legitimacy influence behaviour within professional groups. This is consistent with the findings of this research, as demonstrated in Chapter 4, Sections 4.2.1 and 4.2.2, where participants described professional identity as more secure when their role was acknowledged and their contribution was taken seriously within perioperative teams. In this respect, the 3R framework retains explanatory strength.

The difficulty arose with the third dimension, reward. Participants never framed professional identity construction in transactional or financial terms. Instead, as demonstrated in Chapter 4, Section 4.2.3, professional identity was described through usefulness, trusted responsibility, and meaningful contribution within multidisciplinary teams (MDTs). As noted earlier in this chapter, participants felt more secure in their identity when their expertise was relied upon, when they were consulted, and when their contribution was visible in team functioning. Likewise, Chapter 5 showed that engagement with feedback became more likely where participants experienced their contribution as worth offering and likely to make a difference. Therefore, reward, in its conventional sense, did not adequately capture this pattern.

I argue that inadequacy alone does not go far enough. In the context of this study, reward is conceptually misleading because it directs attention toward incentive and return, while participants described professional worth through significance, reliance, trust, and visible consequence. To retain reward as the third term would therefore risk mischaracterising the basis on which professional identity was interpreted and enacted in this case. I therefore refine 3R to RRV because value, rather than reward, names the form of worth that participants actually described.

This distinction is not merely semantic. Within publicly funded healthcare systems such as the NHS (Roderick & Pollock, 2022), remuneration structures are nationally standardised and progression pathways formally regulated. Under such conditions, reward operates more as a relatively fixed background feature than as a dynamic marker of professional standing. Buchan (2004) observes that such arrangements limit the motivational salience of financial differentiation, while West and Dawson (2012) show that engagement is more closely associated with organisational climate and perceived contribution than with pay alone.

In this context, value more accurately captures what participants described in Chapter 4, Section 4.2.3 and Chapter 5, Sections 5.2.1 and 5.4.2: the extent to which their role carried visible significance within both clinical and educational systems. This interpretation resonates with Dingyloudi et al. (2019), who argue that participation within communities of learning practice becomes significant when it is experienced as creating value for the collective. Similarly, participants in this study described identity and engagement as more secure where their contribution was recognised as meaningful and consequential rather than merely acknowledged.

Organisational and professional identity research supports this refinement because it also locates professional identity in meaningful contribution rather than material reward. Moseley et al. (2021) describe identity development as emerging through participation and reflection within institutional contexts, while Snell et al. (2020) emphasise the importance of relational affirmation in allied health education. Earlier work by Ibarra (1999) and Pratt et al. (2006) likewise suggests that professional identity develops through iterative alignment between self-understanding and collective expectations. Within healthcare contexts, Monrouxe (2010) highlights the importance of social recognition, whereas Chow et al. (2025) underline the significance of competence being affirmed within authentic practice. This literature supports the argument that professional coherence is anchored less in reward accumulation than in recognised contribution, meaningful participation, and perceived impact, a point reinforced by Lewis et al. (2025) in relation to allied health identity stability.

My findings extend this argument by showing that value was not only relationally experienced, but structurally mediated, and this is where the original 3R framework is more limited. By locating reinforcement largely within affirmation and reward, it risks underplaying the extent to which professional standing is shaped by wider institutional arrangements. As demonstrated across Chapter 4, Section 4.3, ODP identity was influenced not only by interpersonal acknowledgement, but also by how securely the profession was recognised within wider institutional systems, how far the breadth of its role could be enacted in practice, how legitimacy was negotiated across occupational groups, and whether progression appeared to offer a credible professional future. These were not simply interpersonal issues. Rather, they show that value was mediated through how the profession was positioned, organised, and afforded legitimacy within service structures.

Bucher and Strauss' (1961) account of professions as internally segmented is useful here because it helps explain why value was unevenly experienced across practice settings. Rather than treating ODP identity as uniform across the profession, their perspective draws attention to the stratified conditions through which professional standing is interpreted. In this study, segmentation was visible in the differing conditions under which ODPs could enact their role. For example, Chapter 4, Section 4.3.2 showed that some participants could move across the intended breadth of ODP practice, while others were confined to narrower functions. Additionally, Section 4.3.3 showed that legitimacy varied depending on how ODPs were positioned in relation to nursing and other professions within local teams. In this sense, membership was not simply secured by registration, but interpreted through stratified conditions of practice. From a SIT perspective, such segmentation matters because it shapes how collective status is perceived and defended.

Regulation and autonomy further clarify how value became structurally visible. Cruess et al. (2016) argue that identity develops through alignment with institutional expectations, while Monrouxe and Rees (2017) emphasise that professional standing is negotiated within systems of authority extending beyond immediate peer interaction. Similarly, Waring and Bishop (2011) show that contemporary professionalism is shaped by organisational arrangements and managerial structures, reinforcing the point that professional standing is not produced through

individual competence alone. In this sense, regulation and organisational structures communicate who is authorised, accountable, and trusted. In the present study, value became visible where participants experienced role clarity, trusted responsibility, delegated authority, and opportunities to exercise judgement, as shown in Chapter 4, Section 4.2.3. Conversely, where contribution was restricted, role breadth narrowed, or authority remained uncertain, identity became more tentative. This reinforces the central refinement advanced here: reward implies reinforcement through incentive, whereas value captures the socially and institutionally mediated experience of one's contribution carrying significance within systems that matter.

This refinement also strengthens the framework's explanatory power in relation to feedback engagement. As discussed in Section 6.2.2 and demonstrated across Chapter 5, recognition shaped whether participants understood themselves as legitimate contributors to institutional dialogue. Respect shaped whether giving feedback felt safe, particularly for students whose professional membership was still developing. Value shaped whether participation was experienced as worthwhile, especially where institutions responded visibly and where participants could see that their views mattered. Chapter 5, Section 5.2.2.1 showed that disengagement often followed where feedback appeared to disappear without acknowledgement or response. By contrast, Sections 5.2.1, 5.3, and 5.4.2 showed that engagement became more likely where feedback was understood as meaningful contribution to future cohorts and to the wider profession. The refinement from 3R to RRV therefore does more than rename a category: it helps explain why participation fluctuated across contexts even where formal opportunities to contribute were present.

I therefore refine the original framework in two ways. First, it shows that reward does not merely lack salience in this context, but risks misdirecting analysis away from the forms of professional worth that mattered most to participants. Second, it demonstrates that value links identity and participation more coherently because it captures why individuals were more willing to speak when their contribution was experienced as consequential and likely to matter. Conceptually, replacing reward with value allows the framework to account more accurately for how professional worth was interpreted. Empirically, it reflects how participants' sense of self as ODPs

depended upon being recognised, respected, and able to see their contribution as meaningful within clinical and educational settings. My findings therefore support RRV not as a preferable alternative to 3R, but as the more conceptually accurate framework for this context.

Having established the rationale for 3R to RRV refinement, the discussion now turns to how professional identity signals were unevenly distributed within interprofessional practice.

6.4. Interprofessional Identity Hierarchies and the Distribution of Legitimacy

Participants' accounts of interprofessional disparity revealed a perioperative environment characterised neither by uniform hostility nor uncomplicated harmony, but by patterned variability in how professional legitimacy was conferred and experienced. As demonstrated in Chapter 4, Section 4.3.3, alumni participants described moments of status-based dismissal, including suggestions that ODPs would not be accepted within certain departments or that nursing education was inherently superior. Students similarly recounted being repositioned as support workers or treated as lesser practitioners. These encounters were interpreted not as isolated disagreements, but as signals about professional standing within the wider hierarchy.

This reflects the concept of professional identity threat described by McNeil et al. (2013), whereby individuals experience challenges to their professional legitimacy when their role is devalued or misunderstood within interprofessional contexts. Interprofessional disparity therefore mattered not only because it shaped workplace relationships, but because it influenced how recognition, respect, and value were distributed across practice.

Perioperative literature has long documented hierarchical cultures in which authority gradients shape relational dynamics within theatre teams (Dunn, 2003). In this study, I found that hierarchy was experienced less through sustained hostility than through

subtler forms of status differentiation, as demonstrated in Chapter 4, Section 4.3.3. Such moments align with professional socialisation research suggesting that tacit norms and power relations are communicated through everyday interactions (Clouder, 2003). The issue, therefore, was not intermittent conflict alone, but the ongoing negotiation of legitimacy within hierarchical practice environments.

Interprofessional research further emphasises that professional identities are co-constructed through communicative exchange, where narrative positioning shapes how roles are understood (Clark, 2014). This was evident in Chapter 4, Section 4.3.3, where participants described how ODPs and ODP students were positioned by colleagues within everyday interprofessional interactions. Professional standing was shaped not only by formal role title, but by how others affirmed, questioned, or constrained the legitimacy of the ODP role in practice. This complicates a simple hierarchy-based interpretation, as legitimacy was not only imposed through occupational status, but negotiated within local team relationships. The central issue was therefore not simple disagreement, but the uneven allocation of legitimacy within MDTs.

Much of the perioperative literature explains MDT tension through communication breakdown, role ambiguity, and uncertainty around team processes. Katz (2007), Hall and Tobias (2016), and Almghairbi et al. (2019), for example, identify unclear communication and role expectations as recurrent challenges, while Attri et al. (2015) and Khan et al. (2022) show that authority gradients, time pressure, and unclear accountability can intensify MDT friction. These explanations are useful because they illuminate structural and organisational sources of disruption. Nevertheless, they do not fully account for the identity-related interpretation evident in the present data.

Interprofessional literature offers a more relational account. Payne and Farrell (2015) show that professional roles are often negotiated within conditions of ethical uncertainty, while Sabone et al. (2020) demonstrate that collaboration involves ongoing negotiation of legitimacy rather than stable or uncontested role positioning. These perspectives help explain why, in this study, accounts of inferior training or assumed nursing authority extended beyond miscommunication into symbolic status

allocation. The issue was not only that roles were unclear, but that some roles appeared to carry greater assumed legitimacy than others.

SIT offers explanatory clarity here. Professional identity was shaped not only through internal cohesion, but through comparison with salient out-groups. Tajfel and Turner (1979) argue that group membership acquires meaning through social comparison, and Ashforth and Mael (1989) emphasise that perceptions of prestige and distinctiveness influence identification within organisational settings. This is important in this study because participants' accounts often involved comparison with nursing, a profession with greater historical and institutional visibility (Chapter 4, Section 4.3.3).

Kingma (2006) helps explain this symbolic prominence by showing how nursing's regulatory visibility and international recognition have strengthened its professional status, while Corbett (2017) brings this issue closer to operating department practice by showing how credential visibility influences perceptions of legitimacy. Where educational pathways were unevenly recognised, assumptions about competence appeared tethered to title rather than scope of practice.

Viewed through the refinement from 3R to RRV, these accounts suggest that interprofessional hierarchy mediated the identity signals through which professional membership was interpreted. Recognition was not automatically afforded where professional titles differed in institutional prominence, respect could be unsettled where comparisons implied subordinate status, and value was especially vulnerable where ODP contribution was understood as supplementary rather than specialist. In this way, RRV helps specify the relational mechanisms through which hierarchy was experienced, while SIT explains why those mechanisms mattered to professional identity construction.

In this context, the vulnerability described by some ODP students appears less an issue of individual insecurity than a response to perceived differences in symbolic and institutional standing. Brown (2017) is useful here because identity work is conceptualised as ongoing recalibration in response to ambiguity or threat, while Caza et al. (2018) extend this by emphasising the dynamic negotiation of identity

within unstable or contested work contexts. I use these perspectives to interpret students' vulnerability as a response to uneven professional standing, rather than as individual insecurity alone. Participants' sensitivity to legitimacy cues reflected social comparison processes, with voice enacted more confidently where standing felt secure and more cautiously where it did not.

Student status also shaped how access to participation was granted and interpreted. Students who were restricted to more routine or low-status tasks encountered not only status differentiation, but fewer opportunities to engage in core clinical activity. Wenger's (1998) account of movement towards fuller participation is useful here because it links identity development to access to meaningful practice. Yet my findings suggest that such movement was not automatic: it was mediated by local judgements about role legitimacy and readiness. As demonstrated in Chapter 4, Sections 4.2.3 and 4.3.2, participants' sense of value and belonging was closely tied to whether they were able to participate meaningfully rather than merely observe or assist at the margins of activity.

James-McAlpine et al. (2023) support this interpretation by showing that participation within health systems is frequently shaped by hierarchy and boundary control, while Squires et al. (2025) further demonstrate that interprofessional learning environments can either reinforce or challenge these hierarchies depending on whether students are positioned as active contributors or peripheral observers. Exclusion from central tasks therefore signalled restricted professional authority and recognised standing rather than isolated supervisory preference.

That said, moments of allyship carried particular significance because they showed that legitimacy could be actively renegotiated within local practice. When colleagues reinstated students within legitimate roles, they did more than offer support: they enabled identity enactment. Legitimacy was extended across professional boundaries, challenging assumptions of fixed in-group and out-group divisions. These interactions demonstrate that hierarchy, while structurally embedded, remained open to local renegotiation. As explored in Chapter 4, Section 4.3.3, such moments of advocacy could reinforce recognition and belonging even within settings where professional standing was otherwise uncertain. These moments of allyship

are important because they show that legitimacy was not fixed, but could be actively extended within local practice. However, they also need to be understood against a longer history of boundary negotiation between nurses and ODPs, where questions of jurisdiction, specialist knowledge, and professional ownership have shaped how the ODP role has been positioned.

Historical accounts of boundary tension between nurses and ODPs highlight earlier jurisdictional anxieties. Timmons and Tanner (2004) are useful because they show that nurse-ODP boundaries have long been shaped by questions of jurisdiction and professional ownership, while Clarke (2007) and Evans (2007) illustrate how claims to specialist knowledge have also been publicly defended and contested. My findings do not suggest that such protectionism defined contemporary practice.

As demonstrated in Chapter 4, Section 4.3.3, participants more often described occasional moments of dismissal alongside routine collaboration. This distinction matters because it prevents the analysis from overstating conflict while still recognising persistent asymmetry. Coe and Gould (2008) and Taylor et al. (2019) help explain this residual imbalance by suggesting that asymmetrical patterns of interprofessional engagement may persist even when overt conflict is less visible. My findings refine this literature by suggesting that hierarchy more often operated as an uneven background condition than as sustained antagonism.

These patterns reflect the segmented character of professional systems described by Bucher and Strauss (1961), in which authority and legitimacy are unevenly distributed across occupational categories and settings. Participants' varied experiences across departments indicate that professional standing was contingent upon local configurations of power and recognition. In some contexts, ODPs were treated as integral members of the team. In others, their legitimacy required more active justification. Hierarchy therefore functioned less as a fixed structure and more as a variable condition through which legitimacy was unevenly distributed.

Workforce transformation initiatives further complicate this landscape. Marshall and Farrington (2024) demonstrate how ODP roles are expanding into critical care and extended practice, signalling evolving jurisdiction, while Lowes (2019) positions

ODPs as central to perioperative capacity and service resilience at workforce level. Yet strategic recognition did not automatically translate into local legitimacy. Participants' accounts suggest that where expanded roles were understood and supported, legitimacy was reinforced; where awareness lagged, identity affirmation remained contingent upon local interpretation. This distinction is important because it shows that formal workforce recognition and everyday professional recognition are related, but not equivalent.

Importantly, I do not interpret these findings as supporting a deterministic account in which hierarchy inevitably undermines ODP identity. Interprofessional disparity was unevenly experienced rather than constant, and could be challenged within local practice. Hierarchy therefore operated not as a fixed barrier, but as a structural condition through which professional identity was continually interpreted, negotiated, and at times defended.

Taken together, these findings indicate that interprofessional hierarchy shaped ODP identity through uneven assumptions about authority and legitimacy rather than overt hostility. Titles, regulatory prominence, and historical positioning influenced how ODP contribution was recognised, respected, and valued, although these patterns remained open to local renegotiation. My findings extend perioperative literature by showing that hierarchy mattered not only for teamwork, but for the identity conditions through which ODPs judged their legitimacy. The next section considers how HEIs also shape these conditions through recognition, respect, and value communicated within educational environments.

6.5. HEIs as Sites of Identity Stewardship

Reframing feedback engagement as an enactment of professional identity extends the implications of this study beyond individual participation to institutional responsibility. If engagement reflects how learners interpret legitimacy, relational safety, and whether their contribution matters, then HEIs cannot be understood as neutral contexts. Rather, they are active environments in which cues of membership are structured, encountered, and interpreted. Scholtens et al. (2023) are useful here because they show how curriculum design, assessment practices, placement

partnerships, and pedagogic interaction shape how professional standing is recognised and negotiated. Similarly, Pach et al. (2025) position HE environments as active contributors to identity formation through participation, dialogue, and perceived legitimacy.

This institutional role is reinforced by the wider HE policy context. As discussed in Chapter 2, student engagement is embedded within UK and Scottish quality enhancement frameworks, including the UK Quality Code, Scotland's Tertiary Quality Enhancement Framework, and the Tertiary Quality Enhancement Review (QAA, 2024a, 2024b; SFC, 2024, 2025). These frameworks position student voice as part of institutional responsibility for quality, standards, and enhancement. However, the findings of this study suggest that institutional responsibility extends beyond providing mechanisms for feedback, to shaping the conditions in which students experience their contribution as legitimate, safe, and worthwhile.

This interpretation aligns with professional identity formation research, which increasingly conceptualises identity as ongoing identity work rather than a fixed developmental outcome (Reissner & Armitage-Chan, 2024). From an SIT perspective, professional programmes operate as sites of self-categorisation, where learners continually evaluate their place within the group. Oosterbaan-Lodder et al. (2025) extend this argument by showing that educational environments are spaces in which learners assess whether their contributions are recognised and treated as meaningful. In this study, the refinement from 3R to RRV sharpens that interpretation: recognition shaped whether learners understood themselves as visible and entitled to contribute, respect shaped whether participation felt safe, and value shaped whether contribution was experienced as worthwhile.

My findings support this argument by showing that feedback engagement was shaped not simply by procedural opportunity, but by how institutional structures communicated recognition, respect, and value. As demonstrated across Chapter 5, particularly Sections 5.2.1 to 5.2.2, educational design influenced whether voice was experienced as professionally legitimate and worth offering. When dialogue was framed as partnership, participation aligned more readily with professional identification. Where institutional responses were opaque or distant, contribution was

more likely to be interpreted as marginal. Lewis et al. (2025) support this wider point by demonstrating that placement design and interprofessional exposure shape how belonging is interpreted within allied health education. My research extends this argument by showing that identity signals were communicated not only through formal curriculum structures, but also through responsiveness and institutional follow-through.

Narrative research in interprofessional education further supports this relational interpretation. Clark (2014) emphasises that identity is co-constructed through communicative exchange, where roles are negotiated through interaction. In this study, dialogue was important, but not sufficient on its own. Communication became identity-relevant when it conveyed status, safety, and responsiveness. Within the RRV framework, institutional dialogue therefore functioned not merely as a conversational practice, but as an identity signal. This was visible in Chapter 5, Section 5.2.2.1, where participants' disengagement often followed not simply from lack of change, but from the absence of visible response over time.

At the same time, engagement cannot be reduced solely to identity positioning. Kahu and Nelson (2018) highlight structural constraints such as workload and access, and these factors were also acknowledged by participants, particularly in Chapter 5, Section 5.2.2.3. Yet SIT helps explain why similar constraints were interpreted differently across contexts (Haslam et al., 2020). Where institutional cues reinforced legitimate membership, practical barriers were more readily tolerated. Where legitimacy felt uncertain, the same barriers more easily justified withdrawal. Educational environments therefore shape not only participation opportunities, but also the meanings attached to them.

Within this context, patterns of participation and silence become analytically useful, not because they reveal identity directly, but because they indicate how institutional cues may be interpreted. The case studies presented in Chapter 5, Section 5.4 showed that professional identity negotiation became visible through patterns of engagement rather than through self-description alone. Participants who contributed actively framed feedback as stewardship, responsibility, and contribution to the future of the profession, as shown in Sections 5.2.1, 5.3, and 5.4.2. By contrast, those who

refrained from feedback more often described uncertainty around entitlement, authority, or relational risk, as demonstrated in Sections 5.2.2.2 and 5.4.1. Young and Jerome (2020) help explain this pattern by suggesting that disengagement often reflects lack of perceived impact rather than absence of interest. In this study, silence was therefore rarely framed as apathy: more often, it reflected careful calibration of voice in light of perceived vulnerability.

This interpretation aligns with wider research on student voice and feedback literacy. Xiaomei and Deborah (2022) show that decisions to speak or remain silent are shaped by perceptions of credibility and relational safety rather than by opportunity alone. Carless and Boud (2018) similarly argue that feedback engagement depends on learners developing the capacity to participate meaningfully in feedback dialogue, while Carless and Winstone (2023) emphasise that engagement is shaped by whether learners perceive themselves as legitimate participants within that dialogue. Vanuytrecht et al. (2026) extend this further by showing that structured relational support and meaningful participation opportunities influence identity development in nursing education. Building on this literature, I argue that institutional responsiveness to feedback can itself function as an identity signal. When institutions responded visibly, learners were more likely to interpret their voice as meaningful, as demonstrated in case study two, Section 5.4.2. When they did not, participation became more tentative, as demonstrated in case study one, Section 5.4.1.

Identity stewardship within HE should therefore not be understood as measuring or managing learners' internal states, since identity remains relational and continually negotiated. Instead, patterns of participation may offer insight into how recognition, respect, and value are being interpreted. Sustained silence, selective engagement, or fluctuating contribution may reflect uncertainty around legitimacy and belonging rather than lack of commitment. Interpreted carefully, such patterns invite institutional reflection on relational and structural conditions rather than individual correction.

This is where educational leadership becomes important. If engagement reveals how legitimacy, safety, and worth are being interpreted, then leadership cannot remain confined to procedural co-ordination. Curriculum structures, assessment design, feedback responsiveness, and placement partnerships all communicate signals

about whose voice carries weight and whose contribution is recognised. To et al. (2025) support this argument by showing that collaborative feedback processes enhance willingness to contribute when learners are positioned as partners in educational development. Within a SIT framework, such positioning functions as a cue of legitimate membership. Wenger's (1998) CoP theory similarly emphasises that trajectories of participation are structured through opportunities for meaningful engagement. Therefore, leadership practices that normalise shared responsibility shape the conditions under which participation becomes intelligible as professional action.

However, professional identity research rightly cautions against overreach. Reissner and Armitage-Chan (2024) argue that identity emerges through authentic participation rather than institutional engineering, while Monrouxe and Rees (2017) emphasise negotiated experience over prescriptive design. Cruess et al. (2016) similarly warn that professional identity construction risks distortion when reframed as performance management. These cautions matter because they guard against reducing belonging to compliance or measurable output. I therefore do not argue that institutions produce identity directly, but that they shape the conditions within which identity signals are distributed and interpreted.

Educational leadership as identity stewardship can therefore be understood as institutional reflexivity. It involves ongoing attention to how recognition is communicated, how relational safety is fostered, and how professional contribution is made visible. Furthermore, this reflexive process should include consideration of how HE policy (QAA, 2024a, 2024b; SFC, 2024, 2025) is practically applied within institutions to support these principles. That said, within this framing, patterns of participation should be approached as prompts for institutional attentiveness rather than mechanisms of surveillance. This suggests that sustained silence or uneven contribution may indicate a need to reflect on whether recognition, respect, and value are coherently distributed across educational environments. Therefore, HE leadership cannot determine identity alone, but can influence how membership is interpreted and enacted.

Taken together, these findings suggest that HEIs participate in professional identity formation not by dictating who learners become, but by shaping the conditions through which belonging, legitimacy, and contribution are understood. Feedback engagement therefore operates as an interpretive lens through which those conditions become visible. I therefore argue that HEIs are not peripheral to professional identity formation, but active sites in which the right, safety, and worth of speaking are communicated and tested. By conceptualising institutional responsibility as stewardship, this study extends the discussion from individual participation to the educational environments in which professional community is negotiated and sustained.

6.6. Chapter Conclusion

In this chapter, I have argued that professional identity among ODPs is best understood as socially negotiated, context-dependent, and shaped through recognition, respect, and value across clinical and educational environments. Drawing together Chapters 4 and 5, I have shown that identity was not secured through qualification or registration alone, but through everyday judgements about legitimacy, belonging, trust, and whether one's contribution was understood to matter.

In addressing the research questions, the findings demonstrated that ODPs interpreted professional identity through visibility, inclusion, participation, and professional standing. Students more often described belonging as conditional and still developing, while registered ODPs described greater confidence grounded in recognised contribution and trust. Across both groups, however, identity remained socially mediated and sensitive to whether participants were listened to, relied upon, and able to participate meaningfully.

Furthermore, the findings have established that engagement with feedback provision to HEIs was not simply an educational behaviour, but an enactment of professional identity. Decisions to speak, remain silent, or withdraw were shaped by whether participants felt legitimate, safe, and likely to make a meaningful contribution. Feedback engagement therefore reflected professional standing, interprofessional

comparison, and institutional responsiveness, rather than motivation or opportunity alone.

A central contribution of this chapter is the refinement of the 3R framework to RRV. While recognition and respect remained analytically useful, reward did not adequately capture how participants understood professional worth in this context. Replacing reward with value offers greater conceptual precision because it reflects the importance participants placed on trust, usefulness, meaningful contribution, and visible impact within both practice and education. This refinement is particularly relevant within publicly funded healthcare systems, where professional standing is more closely associated with recognised contribution than material differentiation.

Finally, this chapter has extended the analysis beyond individual accounts of identity and feedback engagement by demonstrating how professional identity is shaped through the conditions in which participation becomes possible, credible, and consequential. In doing so, it has positioned clinical teams and HEIs as environments that do not simply receive professional identity, but actively shape how legitimacy, voice, and contribution are interpreted. The chapter therefore advances the thesis argument by showing that feedback provision is identity-mediated and institutionally situated, rather than a neutral mechanism for educational enhancement. The following chapter draws these arguments together by setting out the research's contribution to knowledge, implications, limitations, and directions for future research.

Chapter 7: Conclusion and Recommendations

7.1. Introduction

In this final chapter, I outline the thesis contribution to knowledge and identify its implications for policy, higher education (HE), clinical practice, and future research. I also consider the study's strengths and limitations before closing with a final reflection on my doctoral journey.

7.2. Contribution to Knowledge

In this thesis, I explored how professional identity is constructed among student and registered Operating Department Practitioners (ODPs), and how this shaped engagement with feedback provision to Higher Education Institutions (HEIs). In doing so, I addressed an underexplored area by bringing professional identity formation, feedback engagement, and professional community development into closer analytical conversation within operating department practice. By positioning ODP as a focused case, this thesis also contributes to wider understanding of how smaller, specialist healthcare professions negotiate recognition, legitimacy, and voice within hierarchical clinical and educational systems.

The central contribution of this thesis is the refinement of the Recognition, Respect, and Reward (3R) framework (Aalders, 2023) to Recognition, Respect, and Value (RRV). This refinement reflects the meanings participants attached to professional identity and professional worth. While recognition and respect captured important relational conditions through which participants interpreted their professional standing, reward did not adequately reflect how they described the development, affirmation, or disruption of their professional identity. Participants did not frame professional identity in transactional or financial terms. Instead, identity was strengthened where participants experienced value through trust, reliance, meaningful contribution, and visible impact within clinical and educational settings. The move from reward to value therefore provides a more contextually grounded framework for interpreting how professional identity is constructed, negotiated, and

sustained within publicly funded healthcare systems, where remuneration is structured and standardised (Roderick & Pollock, 2022).

Extending this contribution, RRV also demonstrates how professional identity shaped feedback engagement. Participants' accounts suggest that feedback provision was not simply an educational or administrative process, but an identity-relevant and identity-revealing form of professional participation. Recognition shaped whether participants felt entitled to contribute, respect shaped whether contribution felt safe, and value shaped whether participation felt worthwhile. In this way, RRV provides a framework for interpreting not only how professional identity was constructed, but also how participation in educational processes was understood, enacted, or withheld.

Empirically, this thesis contributes an in-depth, contextually situated account of ODP professional identity across student and registered practitioner groups within Scotland. This is significant given the comparatively limited body of research focused specifically on ODPs, particularly compared with more established healthcare professions such as nursing and medicine. Additionally, this study captures how participants interpreted identity construction during a period of professional and educational transition, including changing routes of entry, evolving expectations of practice, and ongoing questions of visibility, legitimacy, and professional standing.

Theoretically, this thesis demonstrates the usefulness of Social Identity Theory (SIT) (Haslam et al., 2009; Tajfel & Turner, 1979) for interpreting how professional identity shapes participation within clinical and educational communities. Participants' accounts suggest that engagement with feedback was influenced by how they interpreted group membership, legitimacy, and belonging. Communities of Practice (CoP) (Lave & Wenger, 1991; Wenger, 1998) further supported interpretation of identity as enacted through participation, while Bucher and Strauss' (1961) account of professions-in-process helped illuminate the uneven and contested conditions through which professional legitimacy was experienced.

Taken together, these conceptual, empirical, and theoretical contributions offer a more integrated understanding of the relationship between professional identity,

feedback engagement, and professional community formation within operating department practice. The contribution of this thesis lies in showing that professional identity and participation are closely intertwined, and that recognition, respect, and value operate as key conditions through which ODPs interpret belonging, legitimacy, and voice. In doing so, the thesis offers a contextually grounded account of how an emerging healthcare profession was experienced and interpreted by participants, while also providing a basis for rethinking how educational and clinical environments might better support voice, belonging, and professional development.

Having outlined the contribution this thesis makes to knowledge, the following section considers the implications of these findings and sets out recommendations for policy, HE, clinical practice, and future research.

7.3. Implications and Recommendations

The findings of this thesis carry implications and recommendations across policy, clinical practice, ODP education, HE, and future research. Collectively, they indicate that professional identity is central to how ODPs understand their role, interpret their place within perioperative and educational systems, and engage in processes intended to shape the future of the profession. The recommendations that follow focus on strengthening the conditions through which recognition, respect, value, and professional voice may be more consistently supported.

Regarding policy, the findings suggest a need for more explicit recognition of ODP contribution within workforce planning and professional discourse. Participants described a profession that was essential in practice, yet not always equally visible within wider strategic structures. This matters because policy recognition helps shape how a profession is understood, supported, and developed. In England, ODPs have been given clearer workforce visibility through the NHS Long Term Workforce Plan, which explicitly identifies them within future expansion (NHS England, 2023). In contrast, Scottish workforce strategy has tended to address the workforce in broader terms, without the same profession-specific recognition of ODPs (Scottish Government, 2022a). I therefore recommend that Scottish workforce planning gives more explicit attention to the ODP profession, not only regarding staffing capacity,

but also professional visibility, legitimacy, and longer-term development. This is particularly relevant given evidence that emerging or less visible professions may experience forms of identity threat where recognition is unevenly distributed across professional groups (McNeil et al., 2013).

For clinical practice and ODP education in practice, the findings suggest that placement environments should not be treated solely as sites of skill acquisition or assessment. They are also pedagogical spaces in which professional identity, belonging, and membership of the professional community are actively negotiated. How students are introduced, supported, included, and enabled to participate may influence not only learning, but also whether the profession is experienced as valued and worthy of identification. This reflects broader findings that interprofessional roles are frequently negotiated within conditions of ambiguity, where legitimacy and authority are not always clearly defined or consistently enacted in practice (Payne & Farrell, 2015; Sabone et al., 2020). Drawing on Dewey's (1938) view that learning is grounded in experience and participation, what students are enabled to do in practice becomes central to what they learn about the profession, their place within it, and whether they can imagine themselves as legitimate members of the ODP community. I therefore recommend that practice-based educators give explicit attention to the identity-forming dimensions of placement learning. This includes articulating the ODP role clearly, enabling meaningful participation across appropriate areas of practice, and positioning students and newly qualified ODPs as legitimate emerging members of the profession.

Relatedly, role clarity within practice remains important. Where the ODP role was narrowed, blurred, or locally interpreted, participants described difficulties in sustaining a clear sense of professional distinctiveness. This has implications for departments in which role allocation, local custom, or workforce pressures may unintentionally weaken the breadth and coherence of ODP practice. I therefore recommend more explicit attention to interprofessional understanding within perioperative environments. Practice settings may benefit from approaches that clearly articulate the distinct contribution of ODPs within multidisciplinary teams and challenge taken-for-granted assumptions that position neighbouring professions as more inherently visible or legitimate. More broadly, ODP visibility should be

embedded within interprofessional education, including relevant nursing and medical education programmes, so that future colleagues encounter the ODP role as a distinct, legitimate, and integral part of perioperative care. This is not simply a matter of professional esteem, but of creating conditions in which role clarity, participation, and voice can be more securely sustained beyond ODP education alone.

For HEIs, the findings suggest that universities should be understood not only as sites of knowledge delivery and quality assurance, but also as environments in which professional identity is shaped (Rose et al., 2025). This is particularly relevant to feedback provision, as engagement was influenced by whether participants experienced their voice as legitimate, respected, and capable of making a difference (Ramani et al., 2017a). Feedback processes therefore carry significance beyond administrative function: they may also shape whether students understand themselves as meaningful contributors to their own professional formation and to the wider profession. I therefore recommend that HEIs approach feedback processes as part of professional formation rather than as isolated enhancement mechanisms. Students may benefit from more explicit support in understanding feedback provision as a legitimate form of professional participation, particularly where professional identity is still developing. Consequently, HEIs may need to reconsider the mechanisms through which feedback is gathered. Reliance on impersonal or standardised online surveys may be insufficient where students do not yet experience themselves as legitimate contributors. More meaningful forms of communication, such as facilitated dialogue, small-group feedback conversations, student-led feedback generation, and peer-mediated consultation, may better support feedback as a relational and identity-forming practice. In this framing, students are not merely asked to complete feedback, but are supported to recognise feedback as part of their developing professional responsibility, collective voice, and contribution to the educational community.

The findings also highlight the importance of institutional visibility and responsiveness. Where participants could see that feedback had been heard, acknowledged, or acted upon, engagement was more readily framed as worthwhile and professionally meaningful. Where institutional responses remained opaque, feedback was more likely to be experienced as inconsequential or symbolic

(Winstone et al., 2017a). I therefore recommend that HEIs make closure of feedback loops more explicit by communicating not only where change has occurred, but also where structural, regulatory, or practice-based constraints limit what can reasonably be altered. More broadly, however, universities may need to reconceptualise student feedback as an ongoing, relational, and pedagogical process rather than as an annual or compliance-driven quality assurance activity. This would involve creating more meaningful opportunities for students to participate in course development, curriculum reflection, and educational decision-making, thereby positioning them as co-constructors of their learning rather than as respondents to institutional surveys. A more visibly dialogic and responsive approach may support both educational engagement and identity development, by enabling students to experience themselves as active members of the educational and professional communities to which they are learning to belong.

A further implication for HEIs relates to the relationship between university-based and practice-based formation. This thesis has shown that professional identity was shaped across both environments rather than in one sphere alone. Closer alignment between HEIs and practice partners may therefore support more coherent messages about ODP role legitimacy, contribution, and professional future. While the present study did not examine partnership working directly, I recommend that HEIs and practice partners continue to strengthen communication around role expectations, placement learning, feedback processes, and professional development opportunities. Students may experience identity formation more securely where educational and placement environments offer consistent signals about belonging, value, and opportunity.

Lastly, this study points to several recommendations for future research. Research across other HEIs would help explore whether the relationship between professional identity and feedback engagement is interpreted similarly in different institutional contexts. There is also value in longitudinal research following learners within the newer Graduate Apprenticeship (GA) BSc route from pre-registration education into early practice, particularly given the structural differences between that model and the DipHE route. Such research would allow comparison of how professional identity and engagement with educational processes are shaped across programme routes

over time. More broadly, comparative research across the UK, or across professions with differing levels of visibility and consolidation, may further illuminate how professional identity, participation, and legitimacy are shaped within emerging healthcare professions.

Taken together, these implications and recommendations reinforce the central argument of this thesis: professional identity matters not only because it shapes how ODPs understand themselves, but also because it shapes how they participate within the educational and professional structures that contribute to the future of the profession. Recognition, respect, and value are therefore not peripheral concerns, but part of the conditions through which voice, belonging, and professional community formation become possible.

Before concluding this thesis, I consider the strengths and limitations of the research to locate these implications and contributions within their appropriate methodological and contextual boundaries.

7.4. Strengths and Limitations of the Research

This research has several notable strengths. First, I brought together the perspectives of student and registered ODPs, enabling examination of professional identity across different stages of formation and consolidation. This allowed the research to move beyond a single point in the professional journey and offer a more layered account of how identity is understood by those in training alongside those already practising within the profession.

A further strength lies in the integration of clinical and educational contexts. Rather than treating identity formation and feedback engagement as separate processes located in different environments, I examined how they intersect across settings. This was central to the argument of the thesis, as it enabled feedback provision to be understood not as an isolated educational activity, but as part of the broader social and professional conditions through which identity is negotiated.

This study is also strengthened by its social constructivist and exploratory design. This approach supported examination of professional identity and feedback engagement as socially situated, relational, and context-dependent processes. Furthermore, Stebbins' (2001) exploratory framework provided a suitable structure for investigating an underexplored intersection, while the qualitative design allowed for depth, nuance, and close attention to participants' meaning-making. In addition, I recruited participants from multiple NHS boards across Scotland, offering wider experiential variation than a single-site study. Although not intended to be statistically representative, this distribution enhanced the breadth of insight within the qualitative sample.

Despite these strengths, I acknowledge several limitations. The participant sample was drawn from a single HEI, which shaped the institutional context within which feedback provision and professional identity were explored. While this supported coherence with the research focus, the findings are therefore grounded in one educational setting and should not be assumed to represent the experiences of all ODP students or registrants.

A related limitation is that all participants were connected to the DipHE model in place at the time of data collection. The findings reflect identity construction and feedback engagement within this specific period of ODP education in Scotland and do not capture the experiences of those entering through the newer GA BSc route. Given the structural differences between these models, future cohorts may experience professional identity, belonging, and educational participation in different ways, as discussed in Section 7.3.

A further limitation is that, although this study is situated within the contemporary HE context, it does not provide a detailed policy analysis of the HE sector. The focus remained on how ODP students and alumni interpreted professional identity and feedback provision within one professional education context. Wider HE conditions, including quality assurance, student voice, student engagement, and institutional responsiveness, are therefore considered as contextual influences rather than as the primary object of analysis.

The study is also situated within the Scottish context, including its specific professional, regulatory, and workforce conditions. While this provides depth and contextual relevance, it also places limits on transferability. My aim was not to produce statistically generalisable claims, but to develop a deeper understanding of how professional identity and feedback engagement are experienced and interpreted within this setting. The value of the study therefore lies in the depth and contextual richness of the insights generated.

Finally, my positionality as a registered ODP and academic formed part of the research process. This provided strengths in contextual understanding and sensitivity to the professional environment, while also requiring careful reflexive consideration, as discussed in Chapter 3, Section 3.10.

Taken together, these strengths and limitations help to situate the contribution of the study. The research offers a contextually grounded and theoretically informed account of how professional identity and feedback engagement are understood within operating department practice, while remaining attentive to the boundaries where those insights were developed. I now turn to a final reflection that draws together the wider meaning of the research and reflect on my doctoral journey.

7.5. Final Reflection

As I reflect on this research, I am left with a stronger appreciation of how professional identity is constructed not only through what practitioners do, but through how they are positioned within the environments in which they learn and practise. Across this thesis, it became clear that identity, voice, and belonging are closely connected. Participation did not depend simply on individual willingness, but on whether participants experienced themselves as legitimate members of this professional community.

This understanding has not remained confined to the data, but has also shaped my development throughout the doctoral journey. At the outset of this research, my perspective was more individualised and less critically attuned to the structural and relational conditions shaping professional experience. I entered the study with prior

experience of conducting research, but I had not yet fully appreciated the intellectual, methodological, and personal demands of undertaking doctoral work. As the study progressed, my engagement with the literature, data generation, analysis, and writing process challenged me to think more critically about how identity, legitimacy, and participation are negotiated within Scottish healthcare and HE contexts.

The doctoral journey also took place alongside significant personal and professional change. During this research, I experienced significant life events, bereavement, and personal challenges, all of which shaped the conditions in which this thesis was completed. These experiences did not sit separately from the research process. Rather, they formed part of the wider context through which I came to understand resilience, commitment, and the emotional labour involved in sustaining a long-term professional doctorate. While the empirical work was intellectually energising, the process of writing, refining, and articulating the contribution of the thesis was often demanding. It required persistence, discipline, and a willingness to revisit and rethink my own assumptions.

Engaging with participants' accounts also prompted deeper reflection on my position as both an insider and a researcher. Their accounts reflected not only moments of frustration, uncertainty, and uneven recognition, but also purpose, resilience, commitment to patient care, and belief in the value of ODP practice. Rather than assuming shared understanding because of my own professional background, this research required me to attend carefully to how my experiences and assumptions shaped interpretation. In this respect, the doctorate has been as much a process of reflexive development as one of empirical investigation.

As a registered ODP with a well-established professional identity across both clinical practice and HE, this thesis has strengthened my commitment to supporting ODP education and contributing to the profession's future. Importantly, it has also reshaped how I understand that contribution. My focus has moved from individual practice alone towards the structural, educational, and relational conditions that enable professional voice, participation, and belonging. I have also become more aware of how this work influences my interactions with academic colleagues, clinical

partners, and students, particularly in the importance I place on ensuring that others feel recognised, respected, and valued.

Looking back, I can see considerable personal and professional development throughout this doctorate. This process has changed not only what I know, but how I think, how I question, and how I understand my responsibilities as an educator, researcher, and member of the ODP profession. It has reaffirmed the importance of extending the still limited body of literature in this field, so that the experiences, challenges, and distinct contribution of ODPs are more fully represented within academic and professional discourse.

I therefore conclude this thesis by seeing this research not as an endpoint, but as a foundation for future work. I recognise a responsibility to disseminate and publish this research, and to continue contributing to the visibility and development of operating department practice across Scotland and the wider UK. This doctoral journey has strengthened my determination to advocate for ODPs to be recognised, respected, and valued within perioperative environments, HE, workforce planning, and public understanding. Therefore, I conclude with a more critically informed perspective, alongside optimism, professional pride, and a continued commitment to supporting the future of the ODP profession.

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Appendices

Appendix 1: Letter to Gatekeeper Requesting Permission

Miss Kelly Y Porteous

Uni. E-mail: Kelly.Porteous@strath.ac.uk

Date: 12 December 2022

Dear Sir/Madam,

As part of my doctorate degree in Education, which I am studying at the University of Strathclyde, I am required to conduct my own research project for my thesis. My academic supervisors, Dr Mariya Ivancheva and Professor David Kirk, whose contact details can be found at the bottom of this letter, will be supporting me during my study.

My thesis is titled, "Impact of Professional Identity of Registered and Student Operating Department Practitioners (ODP) on Engagement in Feedback Contributing to the Professional Community".

Aim:

This investigation aims to explore contributing factors relating to Operating Department Practitioner (ODP) professional identity: how professional identity is developed from student to registered practitioner, and if professional identity has an impact on engagement with feedback contributing to a professional community.

Research Questions:

1. What are registered ODPs perceptions of their professional identity?
2. What are student ODPs perceptions of their professional identity?

3. Does professional identity have an impact on engagement with feedback contributing to a professional community?

I would greatly appreciate your permission to conduct my research study within your regional area/University and ask you to support students/staff in attending interviews wherever possible.

Recruitment and Participants:

Target recruitment will be 10 student ODPs and 10 registered ODPs as this would provide adequate volume of data for analysis.

- Inclusion criteria: Current student ODPs at the participating institution, and HCPC-registered alumni ODPs who graduated from the same institution since 2020.
- Exclusion criteria: Nursing staff due to ODP professional identity focus.

With your permission and support, I will post on the Community Feed on Aula, as well as emailing potential participants to recruit.

Execution:

I will be undertaking one-to-one online interviews on Microsoft Teams where video and audio recording will take place. Furthermore, participants will be sent their transcript for review to ensure there is no misinterpretation or misrepresentation of their discussion.

Questions:

If you have any questions or concerns regarding this research, you can contact myself on the details provided at the start of this letter, either of my supervisors,

which details are below, or if you wish to contact a third party whom has no involvement in the research, please contact: hass-edu-ethics@strath.ac.uk

Yours sincerely,

Kelly Y Porteous

MSc PgCAP BSc RODP FHEA

Part-time EdD Student (Research Phase) at the University of Strathclyde

Supervisors

Dr Mariya Ivancheva

Professor David Kirk

E-mail:

E-mail:

mariya.ivancheva@strath.ac.uk

david.kirk@strath.ac.uk

Appendix 2: Recruitment Advertisement (E-mail)

Dear Sir/Madam,

I hope you are well.

Please ensure you read this e-mail carefully, and access the documents attached.

1. Would you like to participate in ODP research?

I am currently undertaking a Doctorate in Education at the University of Strathclyde, and as fulfilment for my thesis, I am required to conduct research. As research on the ODP profession itself is scarce, I am enthusiastic to add to the undoubtable gap in the literature.

2. What is the research about?

This investigation aims to explore contributing factors relating to Operating Department Practitioner (ODP) professional identity: how professional identity is developed from student to registered practitioner, and if professional identity has an impact on engagement with feedback contributing to a professional community.

If this is something you are interested in, **please read the Participant Information Sheet, and Consent Form attached for more information.**

Questions?

If you have any questions, concerns, require support in accessing any of the materials, please do not hesitate to contact me: Kelly.Porteous@strath.ac.uk.

Furthermore, you can contact either of my Supervisors:

Dr Mariya Ivancheva: mariya.ivancheva@strath.ac.uk OR

Professor David Kirk: david.kirk@strath.ac.uk

If you wish to speak to someone out-with the research team, you can contact the University of Strathclyde's Educational Research Department: hass-edu-ethics@strath.ac.uk

What do I do next?

If you wish to participate: please contact me: Kelly.Porteous@strath.ac.uk to let me know. Please note: You can withdraw your consent in participating at any time **before** 1st January 2024 with no given reason and without penalty. After this date, your data will have been analysed, and therefore cannot be removed.

If you are **not** interested in participating, I thank you for your time and attention.

Thank you for your time in reading this e-mail and for considering participation.

Kindest regards,

Kelly Y Porteous

MSc PgCAP BSc RODP FHEA

Part-time Doctorate of Education Student (Research Phase) at the University of Strathclyde

Appendix 3: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Name of department: School of Education

Title of the study: Impact of Professional Identity of Registered and Student Operating Department Practitioners (ODP) on Engagement in Feedback and Contributing to the Professional Community

Introduction

My name is Kelly Porteous, and I am a postgraduate doctoral student on the Doctor of Education programme at the University of Strathclyde, and I am conducting a study to fulfil the requirements of my thesis. My e-mail address is:

Kelly.Porteous@strath.ac.uk.

What is the purpose of this research?

This investigation aims to explore contributing factors relating to Operating Department Practitioner (ODP) professional identity: how professional identity is developed from student to registered practitioner, and if professional identity has an impact on engagement with feedback towards creating a professional community. I aim to utilise the results found to inform future practice in the ODP Programme to address any contributing factors and promote fostering of a professional community.

Do you have to take part?

No. It is up to you to decide whether or not to take part. Furthermore, your decision to participate or not participate will have no impact on your previous, current, or future studies at the participating institution or any other institution.

If you decide to participate, you will be invited to complete a consent form detailing your informed consent in participating. Furthermore, you can stop taking part in the study (withdraw your consent) at any time before 1st January 2024, without giving a reason and without consequence. After this date, your data will have been analysed and therefore could not be removed. However, if you request to withdraw your

consent **before** 1st January 2024, any data I had collected from an interview with you would be destroyed immediately.

What will you do in the project?

If you are interested in taking part, you are asked to attend an online interview on Microsoft Teams with me and discuss your thoughts, feelings and experiences of professional identity, feedback and professional community. I have prepared questions which are open ended to keep the interview on topic and allow me to fully answer my research questions. The interview will take approximately 60 minutes to complete and will be recorded for data analysis purposes. Before the interview begins, you will be asked to sign a consent form and I will be able to answer any questions you have.

After the interview has taken place, and following word-for-word transcription of our interview, I will send you the transcript which you are welcomed to read to ensure I have not misunderstood or misrepresented your discussion. This is a method to ensure accuracy of the data gathered. If there are any discrepancies, please inform me as soon as possible and I will rectify.

Why have you been invited to take part?

You have been invited to take part in this research as you are a current student or recent graduate (alumnus) of an Operating Department Practice (ODP) programme at the participating institution and would therefore hold valuable insight relevant to answering the research question.

What are the potential risks to you in taking part?

You might find some questions ask you to reflect on your time as a student, or since graduating and consider possible factors which have impacted your professional identity which may be upsetting. You are able to decline to answer any question without giving a reason. If you feel unable to continue the interview, the interview will be stopped immediately, and you will be given the opportunity to reconvene another

time or withdraw from the study. At the end of the interview, I will provide you with advice on how and where to seek free and confidential counselling, alongside contact details for a mental health helpline available 24 hours a day, 7 days a week, 365 days a year. Both services are provided by the participating institution. Please note that these counselling and helpline services are entirely separate from the researcher's role as a lecturer and will remain confidential. In addition, information on external occupational health counselling services will also be made available.

Other risks may be sitting for too long and/or eye strain as interview conducted on Microsoft Teams. This will be mitigated by limiting the interview to 1 hour.

What information is being collected in the project?

Information collected will include your name, age and regional area (North, East/Boarders, or West of Scotland). All information that could be utilised to identify you will be changed or removed entirely. Additionally, a pseudonym will be utilised in the thesis, presentation or publications following the study.

Who will have access to the information?

Those who will have access to the data include myself, Kelly Porteous, the Chief Investigator, and my first supervisor, Dr Mariya Ivancheva, and Internal Investigator, and my second supervisor, Professor David Kirk.

Ethical and legal practice will be followed, and all of your information will be handled in confidence. Names are stored securely and will be destroyed 5 years after the study has been completed. The responses that you provide will be treated in confidence. Your rights are protected under the Data Protection Act 1998 and the General Data Protection Regulation 2018. Any information that might identify you will not be shared outside of the project team. No identifying information will appear in any documents or in the final report.

Where will the information be stored and how long will it be kept for?

Data will be stored on a password protected computer, a password protected OneDrive and in password protected folders. Furthermore, all passwords for each will be different to ensure safety of data. All printed copies of data will be stored in a locked cabinet only accessible by the researcher. Data will be stored and then securely destroyed no later than 5 years following successful completion of this investigation, in case of subsequent publications.

What happens next?

If you have any questions, concerns or are interested in participating, please contact me, Kelly Porteous, on my e-mail address as provided below. From here, I can answer any questions you may have, and we can arrange a date and time suitable to you for the interview to take place.

Alternatively, if you wish to speak with a third party outside of the investigation, please contact: hass-edu-ethics@strath.ac.uk

Outcomes of this investigation will be disseminated through a thesis with the possibility for further publications and presentation at academic conferences. Presentation and publications may also be undertaken for professional audience. Furthermore, I will provide you a summary of the investigation and provide a full copy of the completed thesis upon request.

If you are not interested in participating, I thank you for your time and attention.

Researcher contact details:

Name: Kelly Y Porteous

E-mail address: Kelly.Porteous@strath.ac.uk

Chief Investigator details:

Name: Mariya Ivancheva

E-mail address: Mariya.Ivancheva@strath.ac.uk

Internal Investigator details:

Name: Professor David Kirk

E-mail address: David.Kirk@strath.ac.uk

This research was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee
Research & Knowledge Exchange Services
University of Strathclyde
Graham Hills Building
50 George Street
Glasgow
G1 1QE

Telephone: 0141 548 3707

E-mail: ethics@strath.ac.uk

Appendix 4: Consent Form

CONSENT FORM

Name of department: School of Education

Title of the study: Impact of Professional Identity of Registered and Student Operating Department Practitioners (ODP) on Engagement in Feedback Contributing to the Professional Community

Researcher: Kelly Y Porteous

Student ID: 202093951

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time **before** 1st January 2024 where data analysis will take place, without having to give a reason and without any consequences.
- I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
 - video recordings that identify me;
 - audio recordings of interviews that identify me;
 - my personal information from transcripts.
- I understand that my anonymised data (i.e. data that do not identify me personally) cannot be withdrawn after 1st January 2024 once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project.
- I consent to being audio and/or video recorded as part of the project.

(PRINT NAME)	
Signature of Participant:	Date:

Appendix 5: Recruitment Advertisement (Aula)

Research Participation Opportunity

Dear Student,

I hope you are well.

Please ensure you read this post carefully, and access the documents attached.

Would you like to participate in ODP research?

I am currently undertaking a Doctorate in Education at the University of Strathclyde, and as fulfilment for my thesis, I am required to conduct research. As research on the ODP profession itself is scarce, I am enthusiastic to add to the undoubtable gap in the literature.

What is the research about?

This investigation aims to explore contributing factors relating to Operating Department Practitioner (ODP) professional identity: how professional identity is developed from student to registered practitioner, and if professional identity has an impact on engagement with feedback contributing to a professional community.

If this is something you are interested in, **please read the Participant Information Sheet and Consent Form:**

[Participant Information Sheet and Consent Form documents inserted]

Questions?

If you have any questions, concerns or require support in accessing any of the materials, please do not hesitate to contact me: Kelly.Porteous@strath.ac.uk.

Furthermore, you can contact either of my Supervisors:

Dr Mariya Ivancheva: mariya.ivancheva@strath.ac.uk **OR**

Professor David Kirk: david.kirk@strath.ac.uk

If you wish to speak to someone out-with the research team, you can contact the University of Strathclyde's Educational Research Department: hass-edu-ethics@strath.ac.uk

What do I do next?

If you wish to participate: please contact me: Kelly.Porteous@strath.ac.uk to let me know. Please note: You can withdraw your consent in participating at any time **before** 1st January 2024 with no given reason and without penalty. After this date, your data will have been analysed, and therefore can no longer be removed.

If you are **not** interested in participating, I thank you for your time and attention.

Thank you for your time in reading this post and for considering participation.

Kindest regards,

Kelly Y Porteous

MSc PgCAP BSc RODP FHEA

Part-time Doctorate of Education Student (Research Phase) at the University of Strathclyde

Appendix 6: Interview Schedule

INTERVIEW SCHEDULE

Name of department: School of Education

Title of the study: Impact of Professional Identity of Registered and Student Operating Department Practitioners (ODP) on Engagement in Feedback Contributing to the Professional Community.

Researcher: Kelly Y Porteous

Student ID: 202093951

BEFORE RECORDING

Formal consent form given:

- Talk through each section of the consent form ensuring the participant has informed consent, understand all information regarding the study and understands their rights to withdraw themselves and their data from the study at any time **before** 1st January 2024 with no given reason, as data analysis will have taken place, and therefore, data could not be removed following 1st January 2024.
- Allow any questions to be asked regarding consent, confidentiality, anonymity and their rights.
- Highlight participant will be addressed throughout the interview and study as participant one, two etc.
- Obtain signature.
- Remind participant they can skip or terminate the interview at any time.
- Ensure documents (information sheet and consent form) are available throughout interview for participants' reference.
- Confirm participant is aware and consents to video recording taking place.
- Start recording.

START RECORDING

Verbally confirm the participant has completed the consent form and agree to video and audio recording of the interview for analysis.

Questions

Category 1: Professional Identity

1. What experience in your life made you want to pursue a career as an Operating Department Practitioner.
2. What do you understand by the term “Professional Identity”?
3. Based on your experience, what factors do you believe contribute to your professional identity?
4. Tell me about your experience of professional identity from early on in your training until now.

Category 2: Feedback

- Tell me about your thoughts on feedback within University.
- Based on your experiences, how do you feel your role and professional identity has impacted your thoughts on feedback?
- Based on your experiences, what are your perceptions on how the University utilise your feedback?
 - o Prompt: How do you think your feedback contributes to curriculum development?

Category 3: Professional Community

1. What is your understanding of a professional community?
2. What do you think contributes towards developing a professional community?

Closing Question

1. Is there anything you would like to add that I have not asked you?

STOP RECORDING

Debrief:

The participant will be offered a short period of time to reflect on their experience, discuss how the interview went, and consider how they are feeling. Most importantly, they will be reminded of, and provided with, self-referral information for the participating institution's counselling services and 24/7 emotional support helpline. Participants will also be provided with information on accessing external Occupational Health counselling services.

Appendix 7: Approved Ethics Application

Ethics Application Form

Please answer all questions

1. Title of the investigation
Impact of Professional Identity of Registered and Student Operating Department Practitioners (ODP) on Engagement in Feedback Contributing to the Professional Community
Please state the title on the PIS and Consent Form, if different:

2. Chief Investigator (must be at least a Grade 7 member of staff or equivalent)
Name: Dr Mariya Ivancheva ☐ Professor ☐ Reader ☒ Senior Lecturer ☐ Lecturer ☐ Senior Teaching Fellow ☐ Teaching Fellow Department: School of Education Telephone: E-mail: mariya.ivancheva@strath.ac.uk

3. Other Strathclyde investigator(s)
Name: Professor David Kirk Status (e.g. lecturer, post-/undergraduate): Professor Department: School of Education Telephone: 0141 444 8038 E-mail: david.kirk@strath.ac.uk Name: Kelly Y Porteous Status (e.g. lecturer, post-/undergraduate): Postgraduate Student Department: School of Education

Telephone:

E-mail: kelly.porteous@strath.ac.uk

4. Non-Strathclyde collaborating investigator(s) (where applicable)

Name:

Status (e.g. lecturer, post-/undergraduate):

Department/Institution:

If student(s), name of supervisor:

Telephone:

E-mail:

Please provide details for all investigators involved in the study:

5. Overseas Supervisor(s) (where applicable)

Name(s):

Status:

Department/Institution:

Telephone:

E-mail:

I can confirm that the local supervisor has obtained a copy of the Code of Practice: Yes ☐ No

☐

Please provide details for all supervisors involved in the study:

6. Location of the investigation

At what place(s) will the investigation be conducted

Locations for investigations will be online via Microsoft Teams, and therefore participants can join online from where they are most comfortable, and most convenient.

If this is not on University of Strathclyde premises, how have you satisfied yourself that adequate Health and Safety arrangements are in place to prevent injury or harm?

All public spaces have Health and Safety legislation in place. Alternatively, as an adult, the participant will be responsible for their own health and safety within their own home should they decide this to be the location they undertake the interview.

7. Duration of the investigation

Duration(years/months) : 31 months

Start date (expected): 09 / 01 / 2023

Completion date (expected): 30 / 08 / 2025

8. Sponsor

Please note that this is not the funder; refer to Section C and Annexes 1 and 3 of the Code of Practice for a definition and the key responsibilities of the sponsor.

Will the sponsor be the University of Strathclyde: Yes ☒ No ☐

If not, please specify who is the sponsor:

9. Funding body or proposed funding body (if applicable)

Name of funding body:

Status of proposal – if seeking funding (please click appropriate box):

☐ In preparation☐ Submitted☐ Accepted

Date of submission of proposal: / /

Date of start of funding: / /

10. Ethical issues**Describe the main ethical issues and how you propose to address them:**

As a lecturer in the ODP programme herself, the researcher understands the potential for prejudice during this investigation. It is imperative the researcher is not attempting to overcome current positionality, but to observe and where possible, implement safety measures, for example, the researcher will participate in critical reflexivity throughout the investigation as a way to identify and mitigate potential prejudice. Furthermore, there may be tension between information participants disclose and what the researcher believes, and to lessen this, critical reflexivity is pertinent in presenting the beliefs, values and experiences of each participant accurately.

Additionally, the researcher will only be able to ask prompting questions as outlined in the interview schedule to avoid implementing bias.

Additionally, pre-existing relationships must be considered, particularly the power dynamic between lecturer and student. Although power dynamics are complex, this is not an issue that can simply be “overcome”. Instead, it is important to recognise the positionality already in place and mitigate its potential influence where possible. Through awareness of unequal power relationships, the risk of unconscious coercion, the challenges associated with anonymity and confidentiality, and the need to ensure fair treatment, multiple measures will be implemented.

Participation in this investigation will be entirely voluntary, and each participant will be invited to provide informed consent. Participants will also be advised that their consent can be withdrawn at any time before 1 January 2024, when data analysis will commence, without the need to provide a reason, and their data will subsequently be destroyed. Participants will not be coerced into participating. For example, the research will not be discussed with students unless they specifically request further information, and potential participants will be reminded that their decision to participate, or not participate, will have no impact on their current or previous studies at the participating institution or any other educational establishment.

Furthermore, permission will be sought from relevant stakeholders, such as the Programme Lead and each potential participant’s Regional Educator. To support fair treatment, all eligible participants will be invited to participate through their institutional email address, which uses a unique student identification number rather than their name. Therefore, no names will be identifiable unless a potential participant communicates directly with the researcher, and the identities of those who do not wish to participate will remain unknown to the researcher.

During this investigation, participants will be asked to explore their personal beliefs, aspirations for joining the profession, professional identity, and factors that may have influenced the development of that identity. This exploration may elicit a range of emotions. Participants will therefore only be asked to share information they feel comfortable discussing and will be made aware that they are under no obligation to answer any question. Should there be any indication of distress, the interview will be terminated immediately.

To ensure appropriate psychological and emotional support, participants will be provided with information on where to seek support for their health and wellbeing through the participating institution. This includes access to free and confidential one-to-one counselling provided by staff independent of the programme team, should this be required. Participants will also be provided with details of a 24/7 mental health support helpline, available free of charge throughout the year.

It is important to acknowledge that disclosures relating to practice may arise during the investigation which suggest that a participant, or another individual, may be at risk. In such

circumstances, the researcher will follow the relevant procedures and policies of the participating institution, including those relating to the reporting of concerns and dignity and respect.

11. Objectives of investigation (including the academic rationale and justification for the investigation) Please use plain English.

There has been a longstanding hierarchy between nursing and ODP colleagues over the years with research commenting ODP's are not as highly skilled as nurses, are merely instrument passers and are not degree educated for the role. Despite the support for the ODP role increasing over the years, literature published as little as 3 years ago, and the researcher's personal experience of this challenge, provides evidence this issue is still occurring. With this in mind, the impact of this hierarchy on ODPs professional identity must be considered.

Through the researcher experience as a lecturer, the end of module survey, known as the Module Evaluation Questionnaire (MEQ), response rate was disappointing (less than 10%). Furthermore, the researcher is responsible for producing a Module Review Form (MRF) detailing proposed changes to the module following the feedback from students who have imminently completed the module. This illuminates questions such as: what do the ODP students perceive the University do with that survey data? Fundamentally, do they know the influence their feedback has on improving our programmes curriculum? Furthermore, are there methods for educators in leadership positions to increase their engagement, and foment the curriculum and our professional community? To explore this further, could there be a link between professional identity - an issue which the nurse verses ODP culture could be contributing to - and lack of engagement?

This investigation aims to explore contributing factors relating to Operating Department Practitioner (ODP) professional identity: how professional identity is developed from student to registered practitioner, and if professional identity has an impact on engagement with feedback contributing to a professional community.

Through this investigation, the following research questions will be explored:

1. What are registered ODPs perceptions of their professional identity?
2. What are student ODPs perceptions of their professional identity?
3. Does professional identity have an impact on engagement with feedback contributing to a professional community?

12. Participants

Please detail the nature of the participants:

Participants will be student and HCPC registered (Alumni) Operating Department Practitioners (ODPs).

Summarise the number and age (range) of each group of participants:

Number: 20 Age (range) 18+

Please detail any inclusion/exclusion criteria and any further screening procedures to be used:

Inclusion criteria:

- Current student ODPs at the participating institution.
- HCPC-registered alumni ODPs who graduated from the participating institution since 2020.

Exclusion criteria:

- Nursing staff due to ODP professional identity focus.

13. Nature of the participants

Please note that investigations governed by the Code of Practice that involve any of the types of participants listed in B1(b) must be submitted to the University Ethics Committee (UEC) rather than DEC/SEC for approval.

Do any of the participants fall into a category listed in Section B1(b) (participant considerations) applicable in this investigation?: Yes ☐ No ☒

If yes, please detail which category (and submit this application to the UEC):

14. Method of recruitment

Describe the method of recruitment (see section B4 of the Code of Practice), providing information on any payments, expenses or other incentives.

This investigation will utilise multiple sampling methods such as snowball sampling, convenience/purposive sampling and stratified sampling to recruit participants. Before commencing recruitment, access to the field will be achieved through seeking permission (Appendix 2) from those who safeguard potential participants, for example, Programme Leader, and Regional Educators (RE).

Once gatekeeper access is provided, initial invitation to participate in this investigation will be through an advertisement posted on the potential participants learning platform, Aula (Appendix 3), and through a generic e-mail sent to all potential participants e-mail addresses (Appendix 4). Potential participants will not be coerced or pressured to participate and will be reassured that their decision to participate, or not participate, will have no impact on their previous, current, or future studies at the participating institution. Furthermore, participants will be informed that they are able to withdraw their consent at any time before 1st January 2024 when data analysis will take place with no explanation required.

Any individual who volunteers to participate will be able to make their interest in participation known through e-mail or phone call to the researcher via their contact details. At this time, all information such as the PIS, consent form and recruitment e-mail will be sent to potential participants to read, and consider if they wish to proceed. The manner in which participants contact the researcher will be assumed as their preferred method of contact, and all personal information in the form, including names and e-mail addresses will be safely stored on OneDrive under a password protected file. Furthermore, these will be kept separately from the anonymity code book.

15. Participant consent

Please state the groups from whom consent/assent will be sought (please refer to the Guidance Document). The PIS and Consent Form(s) to be used should be attached to this application form.

All participants will be required to provide a voluntary and informed consent by signing a consent form (Appendix 1). Informed consent ensures the research participants are not coerced into participating and that individuals thoroughly comprehend the implications of participating (Hammersley, 2025). To ensure this is understood, consent would be taken at the time of data collection and emphasis was placed on voluntary participation (Cohen et al., 2018). Furthermore, participants would be asked to sign two consent forms: one for the researchers records and the other for the participants record. This will ensure participants have access to the information outlined in the consent form throughout the interview and throughout the study's progress.

Before signing the consent form, participants will be provided all information regarding the investigation, which will be provided in the participation information sheet (PIS) (Appendix 5) that is written in plain English, and presented in a form that is readily understood by potential participants. The PIS will identify and provide contact details for all those involved in the investigation. Furthermore, the PIS will state the purpose, nature, and requirements of the investigation, taking into account vulnerability of participants as disclosure of personal

dispositions, beliefs and values that the participant may have may occur, but highlights the participant is able to opt out of answering any questions during the investigation. The PIS will identify the potential for discomfort and provide details of where to seek support, which in this case includes access to free and confidential one-to-one counselling through the participating institution, delivered by a trained staff member independent of the ODP lecturing team. Furthermore, the PIS will identify policies in place which will be followed if concerns of welfare arise. Lastly, the PIS will acknowledge that participants are invited to participate with informed and voluntary consent, are under no obligation to participate in all or part of the investigation, are able to withdraw their consent at any time before 1st January 2024 when data analysis will take place without consequence and their data destroyed.

16. Methodology

Investigations governed by the Code of Practice which involve any of the types of projects listed in B1(a) must be submitted to the University Ethics Committee rather than DEC/SEC for approval.

Are any of the categories mentioned in the Code of Practice Section B1(a) (project considerations) applicable in this investigation? Yes ☐ No ☒

If 'yes' please detail:

Describe the research methodology and procedure, providing a timeline of activities where possible. Please use plain English.

As the thoughts, feeling and perceptions of ODP students and HCPC registered (alumni) ODPs are being explored, a qualitative research methodology will be utilised, specifically, exploratory qualitative research. This investigation would be separated into two stages:

- Stage 1:

Explore registered ODPs (alumni) perceptions of their professional identity. Approximately 10 participants sought. This is fundamental to utilise their experience of their professional identity and demonstrate if training is essential to building a strong professional identity.

- Stage 2:

Explore student ODPs perceptions of their professional identity and explore the relationship between professional identity and engagement in feedback. Approximately 10 participants sought.

Following gatekeeper approval, recruitment will commence, as discussion in section 14.

Furthermore, once potential participants contact the researcher to participate, consent will be sought as discussed in section 15. To generate data for this research, for both stages 1 and 2, one-to-one, semi-structured interviews will be conducted online, through Microsoft Teams. This data collection method was chosen as although this may be time consuming, I have sufficient time to

conduct the individual interviews and I could arrange to meet with participants at a time which suits them without having to organise the attendance of multiple participants.

Additionally, for this research study, a semi-structured interview method will be utilised to guide the interview whilst allowing flexibility for participants feelings and perceptions to be discussed as required in the research aims. An interview schedule can be found in Appendix 6.

Typically, interviews take place face-to-face, which is the preferred method, as this allows the researcher to observe details such as body language and also may help in interpreting emotion. However, as the ODP programme is delivered pan-Scotland, having students and registered ODPs pan-Scotland, and to facilitate a large number of eligible population, having face-to-face interviews would be both time consuming and costly for either researcher or the participant to travel. Furthermore, students are currently familiar with utilising Microsoft Teams as this is the main online platform utilised for any form of meeting or teaching. A date and time for the interviews to take place will be selected based on participants availability. Additionally, the ease of recording the interview would be beneficial as Microsoft Teams has this functionality pre-installed.

It is imperative power dynamics are considered throughout the data collection and analysis. Reflexivity is described as the process of a continuous critical self-evaluation of the researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome. In order to achieve this, the researcher will highlight to participants that their participation is voluntary, will have no impact on their current or previous studies, and is confidential. Furthermore, the researcher will continue to utilise a reflective journal which has been used since starting their research journey in 2019. A flexible route for reflection would be most beneficial utilising word documents to type reflections, and utilising voice or video/vlog notes with accompanying word documents highlighting minute markers for key incidents.

In order to analyse the data collected, interview's will be transcribed utilising word-for-word transcription and Braun and Clarke's (2022) six-stage thematic analysis for both stage 1 and stage 2 of the research will be utilised. The six stages have been outlined in figure 1. The researcher selected this tool as they have previous experience utilising this for analysing data for a previous master's dissertation research.

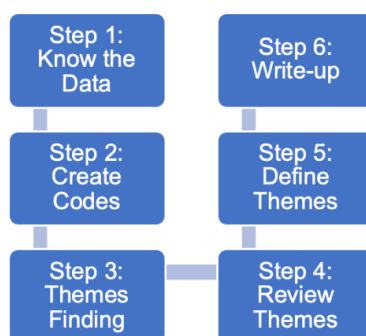


Figure 1: Braun and Clarke's (2022) six-stage thematic analysis.

Immersing the data generated following interviews is imperative to ensure full understanding of the participants meaning and no errors in translation occurs. Once confident in level of knowledge of the data, initial codes of commonly occurring concepts/topics discussed can be generated. Selective coding would be most appropriate as it allows an inexperienced researcher, to focus on the codes that the data is producing without introducing bias is generally less time consuming than complete coding. To code the data, each code would be allocated a colour for manual highlighting of the sentences to ensure each key component of the data are highlighted for use at the analysis stage. Following this, generation of themes would occur. This would re-focus the analysis to the broader themes rather than codes from which the data has produced. To generate the themes, themes repeatedly mentioned throughout all participants data would be selected. These themes, once reviewed, would then be allocated a new colour to assist with the final stage of Braun and Clarke's (2021) thematic analysis framework, the write-up/reporting of the findings.

There are ethical considerations of data analysis, for example, ineffective interpretation due to misunderstanding. To mitigate this, video recording as well as audio recording of the participant will be undertaken to cross reference their words with their facial expression and tone. Furthermore, participants will be sent their transcript for member checking, to which it is their responsibility to highlight any changes which require to be made.

Provisional Timeline

- Ethics: December 2022 - February 2023.
- Recruit participants and schedule interviews: February - April 2023.
- Conduct interviews: April – July 2023.

What specific techniques will be employed and what exactly is asked of the participants? Please identify any non-validated scale or measure and include any scale and measures charts as an Appendix to this application. Please include questionnaires, interview schedules or any other non-standardised method of data collection as appendices to this application.

1. Consent form
2. Gatekeeper access request letter
3. Recruitment Advertisement (Aula)
4. Recruitment Advertisement (E-mail)
5. Participant information sheet (PIS)
6. Interview transcript
7. Risk Assessment Form (S20)

Where an independent reviewer is not used, then the UEC, DEC or SEC reserves the right to scrutinise the methodology. Has this methodology been subject to independent scrutiny? Yes

☐ No ✓

If yes, please provide the name and contact details of the independent reviewer:

17. Previous experience of the investigator(s) with the procedures involved. Experience should demonstrate an ability to carry out the proposed research in accordance with the written methodology.

The researcher has previously engaged with primary qualitative research through her Master's-level dissertation and has experience as a lecturer on an ODP programme in Scotland.

Mariya Ivancheva is a Senior Lecturer at the University of Strathclyde. She has a range of experience research, publication and public engagement on topics related to higher education and professional identities in higher education, and high-skills labour sectors.

David Kirk is a Professor at the University of Strathclyde. He has over 30 years of extensive experience in research in teacher education in physical education within the school setting. Additionally, he has extensive experience in the use of qualitative methodologies. Furthermore, David has expertise in academic writing and publication in education having authored and edited in excess of 20 books, 50 book chapters, and 130 papers in peer reviewed journals.

18. Data collection, storage and security

How and where are data handled? Please specify whether it will be fully anonymous (i.e. the identity unknown even to the researchers) or pseudo-anonymised (i.e. the raw data is anonymised and given a code name, with the key for code names being stored in a separate location from the raw data) - if neither please justify.

Participants will select a random number form 1-20, and this number will be utilised as their pseudonym. This will be beneficial as if any participants wish to withdraw their consent at any time before 1st January 2024 when data analysis takes place, their data can be removed and destroyed. All information that could be utilised to identify participants such as name, age, locations will be changed or removed entirely. All participant information, including their name, contact details and the number they selected to represent their data, will be stored in a separate and password protected location from the data. Furthermore, only pseudonyms will be utilised in the thesis, presentations or publications related to the study.

Further information on data collection technique and data analysis can be found in section 16.

Explain how and where it will be stored, who has access to it, how long it will be stored and whether it will be securely destroyed after use:

Data will be stored on a password protected computer, a password protected OneDrive and in password protected folders. Furthermore, all passwords for each will be different to ensure safety of data. All printed copies of data will be stored in a locked cabinet only accessible by the researcher.

Data will be stored and then securely destroyed no later than 5 years following successful completion of this investigation, in case of subsequent publications. Furthermore, any participants who decide to withdraw their consent will have their data destroyed immediately.

Will anyone other than the named investigators have access to the data? Yes ☒ No ☐

If 'yes' please explain:

Examiners will potentially have access to the data.

19. Potential risks or hazards

Briefly describe the potential Occupational Health and Safety (OHS) hazards and risks associated with the investigation:

Potential hazards and risks include:

- Sitting for too long and/or eye strain as interview conducted on Microsoft Teams.
- Uncovering information of participants at risk, for example, bullying risks which may arise when discussing professional identity and exploring the challenges (Nurses versus ODP).

These potential hazards and risks are considered unlikely and will be mitigated through the relevant institutional reporting procedures and by limiting the interview duration to no more than one hour. Risk assessment can be found in Appendix 7.

Please attach a completed OHS Risk Assessment (S20) for the research. Further Guidance on Risk Assessment and Form can be obtained on [Occupational Health, Safety and Wellbeing's webpages](#)

20. What method will you use to communicate the outcomes and any additional relevant details of the study to the participants?

All participants will be provided with a summary of the investigation and provided a full copy of the completed thesis upon request.

21. How will the outcomes of the study be disseminated (e.g. will you seek to publish the results and, if relevant, how will you protect the identities of your participants in said dissemination)?

Outcomes of this investigation will be disseminated through a thesis with the possibility for further publications and presentation at academic conferences. Presentation and publications may also be undertaking for professional audience. All data will continue to be anonymised to protect the identities of participants.

Checklist	Enclosed	N/A
Participant Information Sheet(s)	✓	☐
Consent Form(s)	✓	☐
Sample questionnaire(s)	☐	✓
Sample interview format(s)	✓	☐
Sample advertisement(s)	✓	☐
OHS Risk Assessment (S20)	✓	
Any other documents (please specify below)	✓	☐
Gatekeeper access request letter	✓	☐
	☐	☐
	☐	☐
		☐

22. Chief Investigator and Head of Department Declaration

Please note that unsigned applications will not be accepted and both signatures are required

I have read the University's Code of Practice on Investigations involving Human Beings and have completed this application accordingly. By signing below, I acknowledge that I am aware of and accept my responsibilities as Chief Investigator under Clauses 3.11 – 3.13 of the [Research Governance Framework](#) and that this investigation cannot proceed before all approvals required have been obtained.

Signature of Chief Investigator



Please also type name here:

Dr Mariya Ivancheva Date: 12/12/2022

I confirm I have read this application, I am happy that the study is consistent with departmental strategy, that the staff and/or students involved have the appropriate expertise to undertake the study and that adequate arrangements are in place to supervise any students that might be acting as investigators, that the study has access to the resources needed to conduct the proposed research successfully, and that there are no other departmental-specific issues relating to the study of which I am aware.

Signature of Head of Department



Please also type name here

Linda Brownlow

Date:

/ / 27/01/2023

23. Only for University sponsored projects under the remit of the DEC/SEC, with no external funding and no NHS involvement**Head of Department statement on Sponsorship**

This application requires the University to sponsor the investigation. This is done by the Head of Department for all DEC applications with exception of those that are externally funded and those which are connected to the NHS (those exceptions should be submitted to R&KES). I am aware of the implications of University sponsorship of the investigation and have assessed this investigation with respect to sponsorship and management risk. As this particular investigation is within the remit of the DEC and has no external funding and no NHS involvement, I agree on behalf of the

University that the University is the appropriate sponsor of the investigation and there are no management risks posed by the investigation.

If not applicable, tick here ☐

Signature of Head of Department

Please also type name here

Date:

/ /

For applications to the University Ethics Committee, the completed form should be sent to ethics@strath.ac.uk with the relevant electronic signatures.

24. Insurance

The questionnaire below must be completed and included in your submission to the UEC/DEC/SEC:

Is the proposed research an investigation or series of investigations conducted on any person for a Medicinal Purpose? Medicinal Purpose means: ▪ treating or preventing disease or diagnosing disease or ▪ ascertaining the existence degree of or extent of a physiological condition or ▪ assisting with or altering in any way the process of conception or ▪ investigating or participating in methods of contraception or ▪ inducing anaesthesia or ▪ otherwise preventing or interfering with the normal operation of a physiological function or ▪ altering the administration of prescribed medication.	No
--	----

If **“Yes”** please go to **Section A (Clinical Trials)** – all questions must be completed

If **“No”** please go to **Section B (Public Liability)** – all questions must be completed

Section A (Clinical Trials)

Does the proposed research involve subjects who are either:	Yes / No
i. under the age of 5 years at the time of the trial;	
ii. known to be pregnant at the time of the trial	

If **“Yes”** the UEC should refer to Finance

Is the proposed research limited to:	Yes / No
iii. Questionnaires, interviews, psychological activity including CBT;	
iv. Venepuncture (withdrawal of blood);	
v. Muscle biopsy;	
vi. Measurements or monitoring of physiological processes including scanning;	
vii. Collections of body secretions by non-invasive methods;	
viii. Intake of foods or nutrients or variation of diet (excluding administration of drugs).	

If **“No”** the UEC should refer to Finance

Will the proposed research take place within the UK?	Yes / No
--	----------

If **“No”** the UEC should refer to Finance

Title of Research		
Chief Investigator		
Sponsoring Organisation		
Does the proposed research involve:		
a) investigating or participating in methods of contraception?	Yes / No	
b) assisting with or altering the process of conception?	Yes / No	
c) the use of drugs?	Yes / No	
d) the use of surgery (other than biopsy)?	Yes / No	
e) genetic engineering?	Yes / No	
f) participants under 5 years of age (other than activities i-vi above)?	Yes / No	
g) participants known to be pregnant (other than activities i-vi above)?	Yes / No	
h) pharmaceutical product/appliance designed or manufactured by the institution?	Yes / No	
i) work outside the United Kingdom?	Yes / No	

If **“YES”** to **any** of the questions a-i please also complete the **Employee Activity Form** (attached).

If **“YES”** to **any** of the questions a-i, and this is a follow-on phase, please provide details of SUSARs on a separate sheet.

If **“Yes”** to any of the questions a-i then the UEC/DEC/SEC should refer to Finance (insurance-services@strath.ac.uk).

Section B (Public Liability)	
Does the proposed research involve :	
a) aircraft or any aerial device	No
b) hovercraft or any water borne craft	No
c) ionising radiation	No
d) asbestos	No

e) participants under 5 years of age	No
f) participants known to be pregnant	No
g) pharmaceutical product/appliance designed or manufactured by the institution?	No
h) work outside the United Kingdom?	No

If **“YES”** to any of the questions the UEC/DEC/SEC should refer to Finance (insurance-services@strath.ac.uk).

For NHS applications only - Employee Activity Form

Has NHS Indemnity been provided?	Yes / No
Are Medical Practitioners involved in the project?	Yes / No
If YES, will Medical Practitioners be covered by the MDU or other body?	Yes / No

This section aims to identify the staff involved, their employment contract and the extent of their involvement in the research (in some cases it may be more appropriate to refer to a group of persons rather than individuals).

Chief Investigator		
Name	Employer	NHS Honorary Contract?
		Yes / No
Others		
Name	Employer	NHS Honorary Contract?
		Yes / No
		Yes / No
		Yes / No
		Yes / No

Appendix 8: University of Strathclyde Risk Assessment Form (S20)



ID: 7582: Impact of Professional Identity of Registered and Student Operating Department Practitioners (ODP) on Engagement in Feedback Contributing to the Professional Community

Research will be conducted online at home ,

This investigation aims to explore contributing factors relating to Operating Department Practitioner (ODP) professional identity; how professional identity is developed from student to registered practitioner, and if professional identity has an impact on engagement with feedback contributing to a professional community.

Online 1-1 Interviews

Hazards Identified

Sitting for too long and/or eye strain.

Who might be harmed and how?

Participant or researcher: Interview being conducted on Microsoft Teams.

Existing Risk Control Measures

Interview will be limited to no longer than 60 minutes.

Likelihood: 1:very unlikely

Severity: 1:insignificant

Risk Rating: low

Hazards Identified

This exploration could elicit a range of emotions for participants.

Who might be harmed and how?

Participant: Uncovering information of participants at risk, for example, bullying risks, or uncovering of practice, which may arise when discussing professional identity and exploring the challenges (Nurses versus ODP).

Existing Risk Control Measures

UWS reporting procedures. Participants will be provided information on where to seek support for their health and wellbeing through UWS, which includes the provision of one-to-one, free and confidential counselling with a member of staff, should they require it. In the event the participant requires immediate support, UWS has a 24/7 mental health helpline which is free and accessible 365 days of the year.

Likelihood: 1:very unlikely

Severity: 2:minor

Risk Rating: low



Risk Assessment 7582

Participant Coercion

Hazards Identified

Participants may feel pressured to take part.

Who might be harmed and how?

Participant: Power dynamic between researcher (lecturer) and participant (student)

Existing Risk Control Measures

Potential participants will be sent the PIS and consent form to be fully aware of the research and provide informed consent. If evidence emerges that a participant is feeling pressured to take part, the researcher will immediately allow them to withdraw from the study without penalty. Continuous critical reflexivity by researcher. Gatekeeper access.

Likelihood: 2:unlikely

Severity: 2:minor

Risk Rating: medium

Data Storage/Management

Hazards Identified

Participants may feel that other parties might have access to their data.

Who might be harmed and how?

Participants may be concerned their data is accessible to others, and their anonymity unprotected leading to a lack of trust.

Existing Risk Control Measures

All participants given a pseudonym. Data will be stored on OneDrive in password protected files and removed and destroyed 5 years following completion of the research. Only the researchers will handle and store data.

Likelihood: 3:possible

Severity: 2:minor

Risk Rating: medium

Hazards Identified

Breach of confidentiality of case material, description of participants through unauthorised access to recordings, transcriptions or coursework.

Who might be harmed and how?

Participants may experience lack of trust/protection.

Existing Risk Control Measures

Pseudonyms will be stored in separate password protected files from the pseudoanonymised data. Data will be handled, stored, and analysed by the researchers only. Audio/Video files will only be transcribed by the researchers.

Likelihood: 1:very unlikely

Severity: 2:minor

Risk Rating: low

Data Analysis

Hazards Identified

Misrepresentation

Who might be harmed and how?

The participants might feel that their participation has been misrepresented/misinterpreted.

Existing Risk Control Measures

The participants will be shown the analysis for member checking. They will have the possibility of suggesting changes if they feel they have been misrepresented.

Likelihood: 1:very unlikely

Severity: 1:insignificant

Risk Rating: low



Risk Assessment 7582

Section 3

Identified Actions to Improve Control of Unacceptable Risks

No unacceptable risks

Section 4

Significant Findings

Additional Information

Linked files

* Ethics_Application_Form_1.docx

* Principles_and_Practice_of_Risk_Ass.pdf

These documents are an integral part of the risk assessment so it is important that you read them on the online version before signing.

Section 5: Signatories

Name
Mariya Ivancheva
David Kirk

Signed
12/12/22
12/12/22

Appendix 9: Email Confirmation That Separate Institutional Ethical Review Was Not Required

 Outlook

RE: Ethics Question

Your ethics application has already been reviewed by the UoS ethics committee and received approval, so we at UWS would accept the decision of that committee. This is to avoid double reviewing.

Please make sure that all access permissions are in place before you begin data collection.

Thanks and best of luck, Gordie (Co-chair of HLS Ethics).

Appendix 10: Medical Research & NHS Health Research Authority Decision Tool / Checklist



UKRI
Medical Research Council



NHS
Health Research Authority

Is my study research?

i To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Impact of Professional Identity of Registered and Student Operating Department Practitioners (ODP) on Engagement in Feedback Contributing to the Professional Community

IRAS Project ID (if available):

You selected:

- 'No' - Are the participants in your study randomised to different groups?
- 'No' - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- 'No' - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the [HRA](#) to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at Queries@hra.nhs.uk.

For more information please visit the [Defining Research](#) table.

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Appendix 11: O'Brien et al. (2014) Standards for Reporting Qualitative Research (SRQR)

Item No.	Topic	Item	Page No.
S1	Title	Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended.	v-vi, 77-78, 88-90
S2	Abstract	Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions.	v-vi
S3	Problem formulation	Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement.	13-16, 27-72
S4	Purpose or research question	Purpose of study and specific objectives or questions.	16-18, 74
S5	Qualitative approach and research paradigm	Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale.	75-78
S6	Researcher characteristics and reflexivity	Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual	2-4, 83-85, 93-98

		interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability.	
S7	Context	Setting/site and salient contextual factors; rationale.	78-90
S8	Sample strategy	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale.	78-82
S9	Ethic issues pertaining to human subjects	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues.	93-98
S10	Data collection methods	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale.	88-93
S11	Data collection instruments and technologies	Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study.	88-93
S12	Units of study	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results).	85-90
S13	Data processing	Methods for processing data prior to and during analysis, including transcription, data	88-93

		entry, data management and security, verification of data integrity, and anonymization/deidentification of excerpts.	
S14	Data analysis	Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale.	90-93
S15	Techniques to enhance trustworthiness	Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale.	92, 95-98
S16	Synthesis and interpretation	Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory.	100-158, 174-178
S17	Links to empirical data	Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings.	100-158
S18	Integration with prior work, implications, transferability, and contribution(s) to the field	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/ generalizability; identification of unique contribution(s) to scholarship in a discipline or field.	161-188, 190-192
S19	Limitations	Trustworthiness and limitations of findings.	196-198
S20	Conflicts of interest	Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed.	13-16, 78-85, 95-98
S21	Funding	Sources of funding and other support; role of funders in data collection, interpretation, and reporting.	iii