

Research paper

Learning behind the curtains – becoming health care assistants in Sweden

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This article examines workplace learning in health care organisations, particularly focusing on the forming of occupational identities of health care assistants in Sweden. The specific aim is to deepen the understanding of health care assistants' learning of occupational identities in daily health care practices and the potentials for developing their occupational identities.

The article focuses on two interrelated concepts: workplace learning and occupational identity. It is based on case studies of four different health care wards within two clinics at two hospitals in Sweden. The results show that health care assistants' learning is related to their participation in daily work where the ways of organising work, as well as the social interaction and relationship with registered nurses and physicians are crucial. Previous

life and work experiences are also of high importance for their motivation to learn in both formal settings and in their daily work. The identity of the health care assistant are reproduced and governed by routines on the one hand, and flexible in both adapting to other groups, urgent situations or to other needs at the ward on the other.

From the results four contradictions are found as potentials for developing occupational identities: formal versus informal learning, adaptive versus developmental learning, formal versus informal legitimacy and weak status versus strong identity. One conclusion is that they adapt to other groups, are practice oriented and learn behind the curtains. These are aspects of their history as a group which is evident in the individual adaption to a hierarchical system of professions.

Introduction

This article examines workplace learning in health care organisations, particularly focusing on the forming of occupational identities of health care assistants in Sweden. There are two categories included in this occupational group: nurse assistants and the assistant nurses. They are together the most common occupational groups for women in Sweden (SCB, 2007). Gustafsson (1987) claims that both assistant nurses and nurse assistants are subordinated in a hierarchy of medical professions despite differences in for example formal education. Two studies of Lindgren (1988; 1992) show that health care assistants are subjected to gender stereotypes, referred to as "girls" in daily health care practices (Lindgren, 1988; 1999). There are few studies focusing health care assistants in Sweden. Two studies by Hochwalder (2007), and Sundin et al (2007) show a high range of burnout related to poor empowerment at work. There are no studies focusing the learning of occupational identities for health care assistants which makes this study an important contribution.

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In the following sections a brief description about the history of health care assistants will be outlined. Thereafter, the interrelated concepts learning and occupational identities are defined for being used as analytical tools in relation to the empirical data. Then, the method used is described more in detail. The results relates to three aspects, learning, occupational identities and potential for developing occupational identities. Finally the findings are further discussed in the last section.

The history of health care assistants

Before 1850, nurse assistants were working class women that worked as maids, took care of patients, supervised, cleaned and cooked at the hospitals (Gustafsson, 1987). When registered nurses, often unmarried middle class women began to work at hospitals, they typically perceived the nurse assistants as dirty and uneducated. The nurse assistants in 1923 started their own union but were not incorporated in the traditional labour union association until 1945, and according to Emanuelsson (1990) this was primarily because they were women. Assistant nurse was an occupation created due to a shortage of registered nurses in health care, after the Second World War. Today, they have a formal education of three years in upper secondary school (SKOLFS, 2006). During the 1990's several changes in Swedish health care were undertaken. The total amount of personnel was cut, nurse assistants were replaced by assistant nurses and assistant nurses by a small number of registered nurses. This was seen as a way of cutting costs and at the same time increasing the level of formal competence. (Herrting, et al, 2005). The difference in salaries between different categories of nurses in Sweden was not considered large enough to afford keeping them employed. In UK a new category of health care assistants were instead introduced during the 1990's as a way of reducing costs of the health care system. There health care assistants were used flexible and different in different health care practices (Thornley, 2000).

Interrelationship between learning and occupational identity

This article focuses on two interrelated concepts: workplace learning and occupational identity. Workplace learning research departs from different definitions and perspectives concerning both learning and workplaces. Discussions whether workplace learning is related to outcomes or processes, development or

adaption seem to blur the territory (Fenwick, 2006A). In this article a situated learning perspective (Lave & Wenger, 1991; Wenger, 1998) is used for capturing the interrelationship between learning and identity. In order to define a situated learning perspective, Lave (1997) raises three questions relevant for analysing workplace learning: *what is learnt? How? What are the potentials for learning?* The question *what is learnt* is related to aspects of learning to be (Bruner, 1990), of becoming something and the outcome of this process (Billet, 2006) in terms of an occupational identity. Moreover, the question of *how* is related to the ongoing process of forming occupational identities by participating (Lave & Wenger, 1991) and negotiating (Wenger, 1998) in communities of practices. Finally the question of potentials for learning could be understood both in relation to access and contradictions.

Recent years critique against the perspective on situated learning have been raised that relates to a reproductive character of learning (Fenwick, 2004), and a neglecting of the individual agent (Billet, 2004). In this article I use Mead's (1934) perspective of forming a self together with Goffman (1959) for a deeper understanding the acting agent and his/her experiences as part of the learning process. The analysis of contradictions in occupational identity, mainly a contribution from activity theory is used to overcome the reproductive critique (Engeström, 1987; 1999). Other critique raised against the perspective is a neglecting of aspects such as "habitus" (Bourdieu, 1980; Sawchuk, 2003) and power (Fenwick, 2006B). The critiques are not directly handled in this article.

Learning occupational identities

Learning is within a situational learning perspective defined as a continuous process of participation and negotiation in communities of practices (Lave & Wenger, 1991; Wenger, 1998). A community of practice is characterized by mutual engagement, a joint enterprise and a shared repertoire. A community of practice is contextually embedded socio-culturally and historical-materially (Lave, 1993). Learning in a community of practice is defined as a legitimate, peripheral participation (Lave & Wenger, 1991). Legitimate refers to being a legitimate member for participating, peripheral means on the one hand that a person participating moves from a peripheral position in the community of practice towards a full membership of the community, on the other, as the community is always changing in relation to ongoing participation and negotiations, there is no clear, full membership. Learning is related to these processes of ongoing participation and here social identities are formed, maintained and changed. Wenger (1998) defines the forming processes in terms of a negotiating process:

Building an identity consists of negotiating the meanings of our experience of membership in a social community (Wenger, 1998, pp145).

The participation and negotiating of identity have similarities with Mead's (1934) formulated relation between the acting "I" and the socialised "me", where previous experiences as well as significant others are part of the negotiation process. Burkitt (1991) describes the relation between them as follows:

Both faces are social and only emerge together in discourse,

but the "me" represents the unique identity a self develops through seeing its form in the attitudes others take towards it, while the "I" is the subjective attitude of reflection itself, which gazes on both the objective image of the self and its own responses. The "I" makes possible the inner dialogue between the responses to others, on the one hand and self-consciousness on the other. The latter, having been established through language, reflects the meanings, morals and values contained in discourse (Burkitt, 1999, pp 38).

There are similarities with Mead's perspective and the situated learning perspective that relates to the social nature of learning and the ongoing negotiation in forming identity. A difference is however that the situated learning perspectives to a larger extent focus on the ongoing practice while Mead is focusing on the acting agent in ongoing practices. Personal experiences are thereby crucial in the forming process.

Occupational Identity

In this article occupational identity is used as a concept for understanding the relation between expectations categorized on a general level concerning what a health care assistant are and ought to be, the ongoing participation and negotiation in different work settings, as communities of practices and the personal experiences of being a health care assistant.

Both Wenger (1998) and Billet (2006) refer to the concept of identity as a fulcrum between personal and societal dimension. This allows one to avoid viewing identity in a dichotomous manner. Wenger (1998):

The concept of identity serves as a pivot between the social and the individual, so that each can be talked about in terms of the other. It avoids simplistic individual-social dichotomy without doing away the distinction (Wenger, 1998, pp 145).

Billet (2006) further develops the concept by linking it to subjectivity:

Associated also with subjectivities is the concept of identity that has both personal and societal connotations. Socially, there are forms of institutional, normative and discourse practices that are associated with individual's identity. Occupations for instance, provide examples of these, and are ordered and valued in particular ways. So, there are societal expectations about and identifiable factors associated with those who wish to identify as a car mechanic, medical doctor, nurse, hairdresser, and so on, as indeed there are about broader categories (e.g. masculinity). The other account of identity is that aligned with how individuals present themselves to (i.e. identify with) the social world and with the social practices they wish to be associated. This is a product of how individuals present and negotiate their self to the social world, in terms of what they do and how they go about it. ... In this way, identity is seen as an outcome, a narrative construction that is a product of this process (Billet, 2006, pp 7)

Potentials for learning and development

Returning to the question of learning occupational identities and the potentials for learning and development it is fruitful to use Ellström's (2006) analytical distinction between adaptive and developmental learning. Adaptive learning relates to the mastering of already existing tasks in relation to the workplace,

whereas developmental learning relates to the processes of developing work practices. Fuller & Unwin (2004) stress that the potentials for learning lies both in an analysis of access in every day practice (Lave 1997) and in the contradictions related to that practice (Engeström, 1999). I relate Lave and Wenger's (1991) use of access as a potential for adaptive learning and developmental learning (Ellström, 2006) with expansive learning, defined by Engeström, (1999; 1987). Access relates to the legitimate peripheral participation in specific situations related to a work practice or occupation. Contradictions are seen as a way of analysing potentials for development. These are traced by analysing minor disturbances encountered by the actors or found in daily activities (Engeström, 1999).

A theoretical- analytical model

When analysing the learning of occupational identities for health care assistants their narratives' of their experiences of learning and their participation and negotiation are focused (Lave & Wenger, 1991; Wenger, 1998). Moreover, their occupational identities are analysed in both expressions given and expressions given off (Goffman, 1959) in relation to others and how others are categorizing them in terms of what they expect them to be and do in their daily work (Mead, 1934). Finally, access is used for identifying the learning situations embedded in daily work practices (Lave, 1997) and contradictions for identifying the potentials for developing occupational identities and work practices (Engeström, 1999).

Research questions

Out of the theoretical framework the aim to deepen the understanding of health care assistants' learning of occupational identities in health care practices is specified further in the following three research questions:

- How do health care assistants learn their occupational identities in daily work practices?
- What characterises their occupational identities?
- What potentials for developing occupational identities can be found in their learning of occupational identities?

Method

The design applied here is a multiple case study (Yin, 1988). I have used data from two different clinics within two hospitals in Sweden collected in the 1990's during a two year period of time (Thunborg, 1999). One is the clinic of Anaesthesia at a university hospital. The other is a clinic of Medicine at a small country hospital. At the clinic of Anaesthesia there are only assistant nurses that are rotating between two wards: the intensive care ward and the post-operative ward. At the intensive care ward the patients need 24 hours of supervision and urgent care. At the post-operative ward patients are waking up after surgery. At the clinic of Medicine, there are both nurse assistants and assistant nurses that work either at ward number 5 or ward number 8. Ward number 5 is a general medical ward with a few beds for handing heart diseases. At ward number 5 one assistant nurse and one registered nurse work in pairs. Ward number 8 is specialised on basic rehabilitation. This ward has mostly elderly people. At ward number 8 one registered nurse and three health care assistants work together as a group.

In all, we were two researchers that interviewed four nurse assistants and five assistant nurses used in two different dissertations (Rönnqvist, 2001; Thunborg, 1999). They had worked between 5 and 18 years in their occupation. Seven assistant nurses wrote diaries during a two week work period of time. We also interviewed four managers, six physicians and six registered nurses for getting their perspective of the health care assistant groups. We used mainly semi-structured interviews and self-observations in forms of diaries. The interviews concerned questions about their work and learning, an ideal health care assistant and what competence a health care assistant should have. The diaries had structured categories: What time is it? What do I do? Where am I? With whom or what am I interacting? Comments!

Data is analyzed as a thematic cross-case analysis (Yin, 1988) where the narratives from the health care assistants at the different wards are analyzed together with the narratives from other occupational groups and the diaries concerning patterns of actions and interactions in time and space. Together the different data are supposed to form themes that finally are related to the theoretical framework.

Research findings

In the following sections the occupational identities of the health care assistants, their learning in daily work and the potentials for developing their occupational identities are further analysed.

Learning occupational identities as a health care assistant

The health care assistants view their daily work and especially their relation to other professional categories in the ward as crucial for their learning. They claim that older health care assistants are of importance for helping the younger assistants to learn routines, answer questions and solve problems. In interactions with patients, they form a relation to the patients and learn how to behave as a good health care assistant. Registered nurses, hence, are the major actors in the learning of routines, equipment etc, for health care assistants. They also assign them new tasks individually:

...when you know the nurse and she has a lot to do, she can delegate work tasks that she is certain that I can do and I am certain that I can do too. (Assistant nurse, intensive care ward).

(Assistant nurse, intensive care ward) physicians also instruct and delegate tasks when it is urgent.

It was an emergency, the patient had to have drugs very fast and the doctor was in the room asking me to do it intravenously. Then I did it, when I get order from the doctor and he can see exactly how much I give. (Assistant nurse, intensive care ward.)

The work organisation at the wards seems to have an impact on their learning. At ward number five they work close to the registered nurses and get access to almost the same work tasks. They cooperate with the registered nurse in planning their work. At ward number eight they work with traditional tasks like serving patients and the registered nurses. At the intensive care ward they are bounded in time and space and have no opportunity

to leave the patients room until another person replaces. More than 80 per cent of their total working time is limited to the patient rooms. They also describe that they usually get to do new things quite often because of the emergency orientation at the ward. The principal for delegation at the ward also seems to be informal rather than formal.

At the workplace, there is one very accomplished assistant nurse, who has been working here for many years, has it in her hands and her head and can show it. .. Step by step the nurse tells her to do this and that, and then it turns into an unwritten rule to do it and after a while they come to me and say that this assistant nurse does this and that. Then I formally delegate.. (Manager, clinic of Anaesthesia).

In describing their experiences of learning, the health care assistants view the formal education as important for getting access to work. Some of them also find some aspects useful in their work practice. When discussing planned training activities at the ward, they are never initiated by themselves and as a consequence the usefulness in their daily work differs.

There are differences between individual care workers related to previous learning experiences. "Younger" health care assistants consider formal education and training more important than the "older". The "older" have experienced many training activities never leading to any changes at work and are sometimes fed up with the training activities. Formal training activities could however also be a door opener for learning in their daily work. One "older" health care assistant describe that she from being an outsider concerning medical issues have become part of a new world and increased as a person:

Now, I am more curious than I used to be, because I am about to join the training programme...I have a friend that is an assistant nurse that I work with...I ask her a lot. I also ask the doctor if we are standing together with the patient and they use a lot of words in Latin and I do not understand half of it and then I ask over and over again to learn. (Nurse Assistant, ward no 5).

To sum up, the learning of the health care assistants is to a high degree related to their participation in daily work. The ways of organising work, as well as the social interaction and the forming of a relationship with registered nurses and physicians at work are crucial for their learning. Previous life and work experiences are on the one hand of high importance for the motivation to learn in formal learning settings, but the participation in formal settings could also be of high importance for their motivation to learn in their daily work, on the other.

The occupational identities of health care assistants

The expressions given by the health care assistants relates to their patients. To take the patients perspective, be the voice of the patients, help them out and understand them is expressed as the basis of who they are and are supposed to be:

I think that you ought to treat people the way that you want to be treated yourself. When you are taking care of these old men and women that you want to take care of them the way you want them to take care of your own parents. That your heart is in the right place (Assistant nurse, ward no 5).

In daily work, they spend most of their working time with

the patients. In table 1, I show that they spend between 49 and 76 per cent of their working time directly together with the patients. (Table 1)

As could be seen in table 1 there are differences between health care assistants at different wards. They also have differences in what they identify as their work, their competence and their identity. At the intensive care and post-operative ward they regard themselves as observant and flexible in relation to emergencies, unplanned events:

At this place you have to be calm but quick, percept things very fast. You have to be observant and fast to see if the blood pressure sinks and know what to do. (Assistant nurse, intensive care ward).

In their daily work at the intensive care ward the health care assistants are bounded in the patient's room, observing and documenting what is going on and control regularly the medical status of the patients. At ward number five the health care assistants work together with a nurse and share medical issues, nursing and administration during the work day. At ward number eight the health care assistants wash, clean and serve patients at the ward. Some describe themselves like the midwives at the ward. What is similar between the health care assistants is that they see themselves as followers of rules and routines in daily work:

We are coming here and the patients are supposed to be washed in the morning and they ought to have breakfast and they are going to therapy, to physiotherapy and then they have to visit the toilette, and then it is lunch and then it is rest and then... the day is somehow quite routinized (Nurse assistant, ward no 8)

Some health care assistants refer to regulations about what they are not allowed to do which from their perspective is contradictory to what they can do:

I am not allowed to dress a wound any longer, due to new regulations, but when I started to work here, that was what I did, dressed wounds. I know I can do it, but the papers says I am not allowed to, even if I did it before, when they did not have registered nurses and assistant nurses it was okay. (Nurse assistant, ward no 8).

Finally the interviewed health care assistants express themselves to be adaptive to other occupational groups at the wards. As an ideal health care assistant, you should not take any initiative but adapt to other groups:

Table 1: The health care assistants' work directly related to the patients in per cent of their total working time during a two weeks working period.¹

Health care assistants work directly related towards the patients			
Intensive care ward	Post-op ²	Ward no 5	Ward no 8
67	76	49	64

¹The time for activities noted in the diaries directly related to patients were in per cent of the total working time was counted at each ward for health care assistants and registered nurses.

² Post-op is the post-operative ward.

You have to understand that you can't do this because of a lack in education. You also have to understand the work of other groups and that it could be urgent sometimes when we have a lot to do. (Registered nurse, intensive care ward).

They also express that they have to adapt to every nurse individually:

If you work with the ordinary registered nurse then you know how it should be, but if someone new is turning up, you have to adapt to another system and do this and that instead. It is hard not to have the same nurse (Assistant nurse, ward no 5)

In their self-observations they often describe that a registered nurse or a doctor ask them to do something that they then carry out.

To conclude, the identity of the health care assistant are reproduced and governed by routines on the one hand, and flexible in both adapting to other groups, urgent situations or other needs at the ward on the other. Their identity seems to be weak in relation to other professional groups in health care but at the same time well defined as a common shared way of seeing themselves as oriented towards patients. At the intensive and post-operative wards they express a strong identity as a flexible observant with a high level of medical and technical competence. This identity is far from being midwives at ward number eight. The closeness to the registered nurses at ward number five seems to blur the strong occupational identity of the health care assistants but also strengthen the identity of the individual health care assistant. Their identity seems to have an inner strength and but a weaker outer identity.

Potentials for developing occupational identities

When analyzing the results at least four contradictions could be found as potentials for developing occupational identities: Formal versus informal learning, Adaptive versus developmental learning, formal versus informal legitimacy and weak status versus strong identity.

Formal versus informal learning

There is a contradiction between formal and informal learning in the narratives of the health care assistants. Previous life and work experiences are therefore of high importance for the motivation to learn in formal learning settings, but the participation in formal settings could also be of high importance for motivation to learn in their daily work.

On the one hand they basically in their daily work and in relation to others. Furthermore they have experienced many formal learning not leading to any changes in practice. Though their occupational identity to a large extent is seen as related towards patients, there are no training activities directly relating to care-taking which could lead to the conclusion that the orientation towards patients is not seen as something to be developed and especially not by the health care assistants. On the other hand even the offer to participate in formal learning activities in one of the stories seem to be of importance for motivate to learn in daily work activities as it open access to problems, questions and perspectives that was not considered her issues before.

Adaptive versus developmental learning

Using Ellströms (2006) distinction between adaptive and developmental learning the learning of the health care assistants on the one hand is adaptive. The health care assistants to a high extent relate and are expected to adapt to other professional groups in their work their learning can be described as adaptive. Using Mead's (1934) concept significant others, patients are most important in their work, and registered nurses for their learning at work. The different expectations from others can and are also contradictory to the needs of the patients, and the perception of the assistant nurses vis a vis their work. By taking the perspective of the registered nurses they both adapt to the professional hierarchy and therefore reproduce their occupational identity as subordinated. Even if health care assistants themselves are oriented towards patients they are also to a high degree governed by others expectations, rules and routines.

On the other hand their learning could also to a certain extent seem to be developmental (Ellström, 2006). Their relation to the registered nurses creates access to learning situations questioning the rules and routines. They form a relation to each assistant nurse and learn how to adapt individually. From that point of view the relation in itself forms a situation of mutual learning which gives access to new tasks and problems and potentials for developing their occupational identities (Lave & Wenger, 1991; Engeström, 1999). How work is organized and the character of the situations that they get involved in seem to be important for accessing them to learning and development. The intensive care ward with its emergent situations as well as the organizing in pair at ward number five is more developmental workplaces for the health care assistants than ward number eight in this respect.

Formal vs. informal legitimacy

There is a contradiction between formal rules and what the health care assistants informally do in their daily work. Speaking with Lave & Wenger (1991) the legitimate peripheral participation of health care assistants could be talked of as both formal and informal. On the one hand the health care assistants themselves, as well as other professional groups express that health care assistants are governed by formal rules relating to medical tasks. New rules changes and decrease what they shall do even if they know they can. In their expressions of who they are they talk about governed by rules and routines all day long. The studied health care assistants however get access to and learn to do tasks they are not formally legitimated to do on the other hand. Using Goffman's distinction (1959) their "expressions given off" differs between different situations concerning when, with whom and in what situations they work, but their "expressions given" refers to formal rules. The contradiction between the formal and informal legitimacy gives opportunities for development but are seldom formally legitimized. Health care assistants seem to know things they do not talk about, but also to talk about things they can do but are not allowed to. They learn to adapt to an informal order by reproducing the formal. To know things they don't talk about and referring to the formal. The example of turning the informal into the formal could however be seen as one example of solving the contradiction. This is only talked of at the intensive care ward, whilst the both

wards at the clinic of medicine seem to decreasing the access for health care assistants by formalizing. The conclusion is therefore that they seem to learn behind the curtains.

Weak status versus strong identity

The identity of the health care assistants on the one hand seems to have an inner strength. They have a well defined identity in a common shared way of talking about their patients, following rules and adapting to other occupational groups. On the other hand their status in relation to other professional groups and in the health care system seems to be weak in that they are subordinated in the medical hierarchy of professions.

Discussion

There seems to be burdens of history in the occupational identity of health care assistants that relate to being working class women (Gustafsson, 1987; Lindgren, 1988). Despite the increased number of assistant nurses and the decrease of nurse assistants their occupational identity seems to be related to the same history. Thornley (2005) points out, that health care assistants are used very flexible in the UK even in a Swedish perspective. This study seems to verify this conclusion. In their occupational identity, flexibility is formed as an aspect of relating and being adaptive to other occupational groups. Being adaptive is also an aspect of the medical hierarchy that seems to be reproduced at different wards and under different conditions. Moreover, this is also part of the rule system, where the assistant nurses are governed. The health care assistants learn to both adapt to patients, other groups and formal and informal rules of the care system. However, the results also show a situational and relational character of learning, where identities are formed in daily work. To form a good relation to registered nurses are an important way of getting access to learning situations, a way of learning to handle the subordination in a developmental order. There seems to be contradictions between adaptive and developmental learning (Ellström, 2006).

From the results in this article, occupational identity is both individual and institutional (Billet, 2006). What is however meant by an institutionalised identity? In my view both the orientation towards the patients and the following of rules seem to be institutionalised and seen as a product of different work practices and expectations from other groups in the health care system. At the same time, health care assistants negotiate who they are, in work settings that seem to be changing, in relation to other work groups, ways of organising work, emergent situations and changes in how rules are interpreted in daily work (Strauss et al, 1997). The construction of a collective "we" could be related to the local practice as well as to general expectations in the society as a whole and about the social status of health care assistants.

For the individual, a tension between different expectations apparent in daily work practice and the discursive and practical aspects of identity is formed (Giddens, 1984). Each assistant nurse is formed by their experiences which affect their motivation to learn. Collin (2009) means that motivational aspects are often neglected in theories of communities of practice. However, motivation seems to be a practice related issue. This study

shows that learning is related to work and to the institutional character of the occupation that also has its history which is linked to social class and gender (Sawchuk, 2003).

Finally, to adapt to other groups, to be practice oriented and to learn behind the curtains may be aspects of their history as a group which is evident in the individual adaption to a hierarchical system of professions.

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