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Veterinary Professionals' Workplace Learning in a Corporate Organization: An Ethnographic Study

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VETERINARY PROFESSIONALS' WORKPLACE LEARNING

IN A CORPORATE ORGANIZATION: AN ETHNOGRAPHIC STUDY

by

JAMES F. STEELE

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Presented to Educational Foundations and Leadership Department
and the Graduate School of George Fox University
in partial fulfillment of the requirements
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Abstract

The purpose of this study was to investigate learning orientations, strategies and tactics of veterinarians, and generate explanatory theory grounded in ethnographic data. A theory of approaches to transdisciplinary and disciplinary learning emerged from qualitative analysis of interviews, learning journals and field observations. Eleven subjects in 4 regions were newly employed by a corporate veterinary practice. This research is framed by theories of adult learning, workplace learning, and occupational community.

The study was guided by 3 research questions about learning orientations, approaches, strategies and tactics veterinarians applied in the workplace. Question 1 asked about orientation toward learning. Question 2 aimed to uncover differences between learning clinical and practice management roles. Question 3 inquired about interaction of occupational communities and organizational context. Through recursive analysis question 4 emerged, seeking the role of professional socialization and identity in learning.

Participants had balanced, positive orientations toward learning. Strategies and tactics differed between application to medical learning vs. the social, organizational and financial aspects of practice management. Subjects learned medical content formally and informally, but relied mostly on informal and incidental learning for practice management. Six areas where profession and organization interacted contributed both positive and negative effects to learning. Veterinarians’ understanding of medical and business roles exposed conflicting perceptions that could impact desire to pursue learning in content areas
inconsistent with professional identity.

Theory from these findings explains learning behavior through the interaction of professional identity and workplace context. This study posits that increased organizational focus on content perceived as beyond the professional’s discipline, including practice management, is insufficient. Perception of professional identity must expand to include additional disciplines before transdisciplinary learning is pursued. This study advances Hoskin and Anderson-Gough’s theory (2004) that disciplinary learning occurs in isolated, specific channels that must be integrated for transdisciplinary learning to occur.
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I thank my professors and colleagues in the George Fox University School of Education and School of Management for the encouragement, inspiration, guidance and support you have all provided. I am grateful in particular to my advisor and committee chair Dr. Scot Headley and committee members Dr. Gary Railsback and Dr. Dirk Barram for your patience and generous feedback throughout the process of this research.

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Dedication

This work is dedicated to my beloved and patient wife, Debbie, who provided the encouragement and support I needed to make the leap from a long and fruitful career in business to a vocation in teaching. God in His wisdom has given me a perfect partner and helpmate. Soli Deo gloria.
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CHAPTER 1

Introduction

The workplace is one of the most important environments where adult learning occurs. Globalization, increased competition, and the velocity of change have all focused attention on the importance and value of having a workforce that possesses a capacity for learning (Rowden, 2002, p. 158). All sorts of organizations, profit-making and non-profit, public and private, have discovered that programs of training and education are essential to their ability to pursue common objectives and improve overall performance (Merriam & Caffarella, 1999). In the majority of workplaces, education is not the primary mission (Hodkinson et al., 2004). However, there is broad recognition that workplace learning can be a means to a desired end.

Each year, more dollars are spent by U.S. corporations on training and education than the combined budgets of every public school system in the country (O'Connor, Bronner, & Delaney, 1996). Organizations with large workforces and extensive means have developed Corporate Universities offering a wide variety of education and training tailored to the specific objectives and tasks demanded by their work, which might involve anything from semiconductor manufacturing to healthcare to national defense. In 1988, 400 Corporate Universities were in existence; by 2002 that number had quadrupled to 1600 (Antonacopolou, 2002). Despite the investment of billions of dollars annually on training
and educating the workforce, concerns about effectiveness remain. Some researchers estimate that the amount of training that actually transfers into behavioral change on the job is as little as ten percent (Kupritz, 2002; Montesino, 2002).

Given the widely-held assumption that training and education in an organizational setting must contribute to organizational strategies and objectives, it should come as no surprise that a large segment of the published research in this field is quantitative in nature. The “bottom line” may be profit, customer satisfaction, quality, output, time-to-market, or any number of other indicators. Educational practitioners in organizational settings have learned that they must demonstrate the value of learning initiatives in terms such as return on investment (ROI) and growth in human capital. In order to demonstrate this principle, the American Society for Training and Development (ASTD) publishes case studies documenting the ROI of learning and performance improvement initiatives. In one such series of 31 case studies, the stated ROI of workplace learning initiatives ranged from 3 to 2981 percent, with an average return on investment of 733 percent (Sugrue, 2004). While numbers like these may seem too good to be true, they demonstrate a distinct tendency of some research in workplace learning toward a results-oriented type of quantitative analysis.

Another form of practitioner research common to workplace settings falls into the category of action research, where educators systematically study data in their own work environment that will help them to understand and improve their practice (Gay & Airasian, 2003). While practitioner research contributes to the body of literature on workplace learning, its integrity is highly dependent on the practitioner’s ability to gather quality data which is analyzed within its specific context. Jacobson (1998) observes that this type of
research does not necessarily lend itself to the same tests of validity as more conventional forms of research, mainly because its underlying assumptions are not the same.

Knowing exactly what should be studied or measured leads to a common limitation found in research on workplace learning. While formal learning, delivered in classrooms or over corporate intranets, is often the most visible and widely recognized type of learning, research has shown that the majority of learning that takes place in organizations is the result of informal learning (Rowden, 2002). Informal learning happens as a matter of course, often during the daily routine of work. Learners may or may not be conscious that learning has occurred at the time it is triggered. Informal learning is highly contextual, often connecting the learning of one individual to the learning of others. Incidental learning, a specific type of informal learning, generally occurs as a by-product of some other activity (Marsick & Watkins, 2001). Neither of these is typically classroom-based or highly structured, often occurring serendipitously in a workplace setting.

It is all too easy to assume that workplace learning is a highly controlled process that results in predictable outcomes such as skills, knowledge and work practices. The risk, however, is that this view assumes that pedagogical interventions are predictable across a population of workers in a given context. Because workplace learning involves individuals who operate in complicated contexts where relationships, power, environment and the cumulative impact of each learner’s life course each influence the learning process, these simplistic assumptions are likely to lead the researcher astray (Hodkinson et al., 2004).

One way the researcher might attempt to avoid this risk is through the use of a qualitative research technique, grounded theory. Gay and Airasian (2003) explain that
grounded theory, also known as recursive analysis, is a process by which a researcher
"strives to identify patterns, themes, and categories from the qualitative topic and data" (p. 17). What makes this method unique from other types of qualitative research is the intent to develop theory from the analysis of the data. As data is collected and analyzed, the researcher constantly compares what appears to what is known, developing hypotheses or "hunches" and testing them until a recognizable pattern appears (LeCompte & Schensul, 1999).

Through the use of grounded theory, observation and interview techniques will provide the unique opportunity to understand the process of workplace learning in a situated context, through the reflections and experiences of individuals who participate in the whole life of the organization, not only those activities which are commonly identified as educational (Gay & Airasian, 2003). Such qualitative research also has limitations. While using grounded theory to study workplace learning in a particular organization may identify meanings and processes at work in that context, it is unlikely to be able to measure the extent to which the actions of the organization and the individuals within it coincide with these meanings, if at all (Jacobson, 1998).

The application of this approach to veterinarians' workplace learning provides a purposeful and systematic way to generate concepts and theories directly from the data gathered through qualitative social research (Glaser & Strauss, 1967). In this context, theory is an unfolding process, described by Glaser and Strauss as "an ever-developing entity, not as a perfected product" (1967, p. 32). The results of this research may enlighten, but should not be construed as final. They are likely to pose questions that might be
explored further through quantitative or other investigative means.

*Description of the setting*.

Banfield, The Pet Hospital®, also referred to in this document as *the practice*, operates over 500 company-owned and franchised pet hospitals throughout the United States. Founded in 1955, Banfield is headquartered in Portland, Oregon, and is the largest privately-owned provider of veterinary services in the United States. Banfield employs more than 5000 Team Members and is adding approximately 80 hospitals to its network annually (A. Jaffe, personal communication, June 20, 2005).

Banfield invests heavily in education, development and training for its growing cadre of veterinary, clinical and office staff. Training opportunities available to employees include regular symposia, mentoring, online learning and support for external continuing education (Banfield, 2004b). This resource-rich environment is a likely location for the investigation of how and why veterinary healthcare professionals take advantage of these and other learning resources. In the interest of better understanding its own processes for workplace learning, the company has demonstrated willingness to provide this researcher with access to its employees, workplace and training data.

Banfield provides a unique opportunity for the study of workplace learning. It is desirable for its leadership position in the veterinary healthcare industry, as well as its corporate commitment to the education and development of its workforce. Doctors of Veterinary Medicine (DVMs) enter the organization as highly educated professionals, many with prior experience managing their own practice. As these doctors practice medicine in Banfield’s veterinary hospitals across the country, they learn to apply knowledge specific to
their medical discipline as well as a variety of skills and behaviors required to succeed in the local organizational setting that is part of a larger corporation.

The company has two overarching needs for educating these individuals: continuing clinical education to support Banfield’s commitment to quality medical care, and business education that enhances the ability of these professionals to successfully operate a hospital and staff within the context of a multimillion dollar international corporation (T. Mooney, personal communication, October 10, 2005).

Statement of the problem

Banfield, like many organizations, is highly dependent on its ability to attract, develop and retain educated and qualified knowledge workers. In this case, the critical position around which the hospital operates is the veterinary doctor. The company’s business plans for growth involve a continuous stream of new and experienced DVMs entering the organization that must not only maintain and develop their clinical expertise, but must also develop business acumen while becoming socialized into a new and unfamiliar working environment.

Existing research in this area tends to focus either on the organizational learning environment (workplace) or on a specific occupational category of learner such as nurses, factory workers, or teachers, but generally not on both vectors at the same time. This research seeks to enhance our understanding of the interplay between workplace learning and professional occupational learning communities by investigating the learning orientations and behaviors of members of a cohort of veterinary professionals during their first six months of employment in a corporate hospital environment.
Research questions

This inquiry, directed specifically toward Doctors of Veterinary Medicine who are in their first six months of employment at Banfield, is guided by the following research questions:

1. What learning orientations (Knowles, Holton, & Swanson, 1998; Webber, 2004) do individual DVMs bring to the task of workplace learning?

2. Are there differences in ways that DVMs at Banfield approach workplace learning when comparing their clinical/medical role to their practice management role?

3. How do strategies and tactics for learning in a corporate work environment interact with membership in a professional occupational community during the first six months of employment for DVMs at Banfield?

Due to the recursive nature of the grounded theory approach, a fourth research question emerged after initial data had been gathered and analyzed.

4. Does professional socialization and identity play a role in the learning process that might either enhance or become a barrier to acquiring knowledge and skill outside of one’s primary discipline?

Definition of terms

Workplace learning involves both formal and informal learning processes and the dynamic interaction between them in the context of a working environment. Organizational or individual objectives, or a combination of both, may be addressed through workplace learning (Rowden, 2002).
Webber (2004) defines the concept of *learning orientation* as “rooted in a social cognitive model of learning which emphasizes the dynamic nature of the engagement between learner and environment" (p. 259). Additionally, Webber defines *social cognition* as “the way in which people interpret, analyse (sic), remember and use information about their social worlds” (p. 259).

An *occupational community* is defined as a “group of people who consider themselves to be engaged in the same sort of work; whose identity is drawn from the work” (Van Maanen & Barley, 1984). Community members share common values, norms and perspectives relative to work and also extending to personal matters, often blurring the boundaries between social relationships, work and leisure.

A *professional* is defined as a person who has been educated through a preprofessional preparation program resulting in certification or licensure into a specific professional career such as medicine, law or teaching. These individuals are engaged in the practice of *professions* that are typically sanctioned by the government and may also be represented by one or more professional organizations that participate in defining expectations for knowledge, acceptable practice, professional ethics and service (Hoskin & Anderson-Gough, 2004). Workers engaged in professional careers such as nurses and attorneys often align their self-image more closely with their professional work than with an organization to which they belong (Daley, 2002).

A *discipline* is a closely related concept to a *profession*. For the purposes of this research, a *discipline* is defined as the historically grounded frame within which members who share a common pursuit maintain their identity and lay formal and/or informal ground
rules that determine who is included in that particular discipline (Hoskin & Anderson-Gough, 2004).

In this study, the term *disciplinarity* is used for the tendency to behave according to the norms of a particular discipline. Also, the term *home discipline* indicates the discipline with which a professional's identity is most closely associated.

*Transdisciplinary learning* as identified by Hoskin and Anderson-Gough (2004), is the process of acquiring and integrating the knowledge, skill and identity of two or more disciplines that are practiced by the same person in close proximity or simultaneously.

*Practice management*, in the context of this research, refers to the non-medical aspects of operating a for-profit veterinary healthcare practice. Practice management includes the organizational, social and financial aspects of medical practice (Jennett, Jones, Mast, Egan, & Hotvedt, 1994).

*Limitations and delimitations*

This study, situated in the U. S. operations of a single organization, is limited in scope to a particular cohort of Doctors of Veterinary Medicine, who entered the organization between May and July, 2005. The demographics of that group represents only the result of Banfield's hiring during that time and have not been selected in a way that was intended to represent all DVMs or any other specific population of people who might be found in the workplace. While the organization studied employs people in a variety of other occupations, the focus of this research was incumbents who are professionally engaged in the licensed practice of veterinary medicine, a core competency of the organization.

Banfield as an organization is somewhat unique in the practice of veterinary
medicine. While it is not the only large corporate practice operating in the United States, it is the largest privately-held veterinary practice in the country. At this point in time, the majority of American veterinarians practice in small, locally-owned hospitals and clinics (T. Mooney, personal communication, October 10, 2005).

This researcher gained access to Banfield through a longstanding friendship with the company’s Senior Director of Education, Development and Training. This relationship was disclosed to all participants in the research. Banfield contributed financially to this research through partial payment of the researcher’s travel expense and honoraria to the study participants; however the company’s financial contributions were in no way contingent upon any particular result. This researcher has agreed to provide Banfield with results of this research while maintaining the strict confidentiality and anonymity of all study participants. Finally, this researcher is a pet owner, but is not a client of Banfield, the Pet Hospital.
CHAPTER 2

Review of the Literature

This review of literature emerged from a growing collection of books and articles that have come to the attention of the author through graduate courses in education. It was further expanded through library and database searches for studies and other references relevant to the topic of adult learning in the workplace. Searches of online databases included educational (EBSCO, ERIC, Education Full Text and Professional Development Collection) and business sources (Business Source Premier, SAGE), delimited to include only articles appearing in peer-reviewed journals. Relevant references have also been gleaned from the bibliographies of those articles and studies which appeared in database searches.

The works reviewed may be classified into three main categories: adult learning, workplace learning, and occupational communities. Adult learning theory, while much too diverse to be covered comprehensively here, lends several theoretical perspectives that inform this research, including andragogy, self-directed learning, informal learning and context-based learning theories, including feminist learning theory. Workplace learning sources include a compilation of research that explores the uniqueness of learning experiences that take place within an occupational framework, and the interaction between the learner and the workplace context. Finally, theories about occupational communities are
particularly relevant to adult learning that occurs in and beyond the workplace among members of a specific profession (see Figure 1).

Figure 1.
*Theoretical Framework for Ethnographic Investigation at Banfield, the Pet Hospital®.*

Adult learning

The field of adult education is primarily concerned with the distinctive qualities of adults as learners. It is closely associated with the study of adult development and the processes and changes unique to adulthood (Tennant & Pogson, 1995). Modern adult education first emerged as a professional field of study in its own right in the 1920s. While a number of theories and models have emerged since that time, there is no single theory or
model that explains what is known about how adults learn (Merriam, 2001).

Knowles proposed andragogy as a “new label and a new technology” for adult learning in 1968, distinguishing it from much of the previous research and practice based on childhood education. He defined the concept of andragogy as “the art and science of helping adults learn” (Merriam, 2001, p. 5). The andragogical model as revised by Knowles in 1989 is based on six fundamental assumptions that are distinct from the pedagogical model (1998). These are:

- Adults need to know the reason why they should know something before they invest energy into learning it. A key task for facilitators is to raise the awareness of learners to the value that might accrue as a result of learning.

- Adult learners’ self-concept is one of responsibility for themselves, their decisions, and their lives. Systems of training and education that place learners in a dependent or subordinate role may face resistance and resentment unless learners are able to experience some level of self-direction.

- Adult learners enter the learning process with a different quantity and quality of experience than do learners in childhood or adolescence. Adult education, therefore, requires greater individualization due to increased diversity among learners that is the cumulative result of varied life experiences.

- The tasks and experiences of life are precursors of adult readiness to learn. Learning that is coincidental with developmental or other important life tasks is most likely to be met with readiness.

- Adults’ orientation to learning is life-centered, which differs significantly from a
pedagogical approach which assumes a subject-centered orientation. Adults learn most effectively in the context of application to real-life tasks or problems.

- The most powerful sources of motivation for adult learners are internal. While the desire for adults to grow and develop continuously is normative, this desire is sometimes thwarted by barriers such as poor self-esteem, constraints on time, and inability to access educational resources and opportunities.

Tough (1979), a contemporary of Knowles, was the first to comprehensively describe self-directed learning as a specific form of learning. His work documented a type of learning that is not dependent upon the presence of an instructor, classroom, or curriculum, yet occurs as a natural part of adults’ everyday lives. Despite the lack of reliance upon professional educators in order for self-directed learning to occur, it has become one of the predominant thrusts of adult education in the last thirty years (Merriam, 2001; Merriam & Caffarella, 1999; Tough, 1979).

While numerous models of self-directed learning have been proposed, Candy (1991) developed a useful description based on the review of several definitions:

- Self-directed learning is an attribute describing adult motivations to learn.
- Self-directed learning is an ability acquired by individuals as they progress from dependency in youth to maturity in late adulthood.
- Self-directed learning is a form of self-education with the content, timing, location and purposes of learning determined by the learner.
- Self-directed learning is both a means of instruction and an end result.

Self-directed learning is paradoxical in that it is both a process employed by
individuals and a trait possessed by them. Adults engaged in self-directed learning develop the capacity to challenge assumptions, gather relevant information, and critically reflect on their experience as a way of developing new understandings, skills and actions (Rusaw, 2000). The promotion of self-direction in traditional classroom environments is a challenge for instructors, requiring application of a critical approach to their own areas of expertise (Tennant & Pogson, 1995).

The relationship of formal and informal learning is of specific interest in this research. In organizations, much attention is paid to formal training courses, programs and curricula, as these are the most visible (and costly) elements that contribute to workplace learning. Informal learning occurs independently of extrinsic stimuli such as job descriptions or corporate objectives, yet it has the ability to serve both individual and organizational objectives (Rowden, 2002). Informal learning does not necessarily replace formal learning, but both types can be combined in ways that complement one another in organizational settings (Cofer, 2000; Engeström & Young, 2001).

Reflection that takes place throughout the process of completing various life tasks is a key component of informal learning. Schön (1983) describes this reflective conversation using the example of a practitioner who, drawing on experience, frames a problem, suggests action and then re-interprets the entire situation in light of how the action played out. This capacity to reflect is essential to the process of informal learning. Research in workplace settings indicates that the majority of learning comes from job experiences and relationships with others, while only a small fraction can be attributed to formal training (Cofer, 2000; Marsick, 1987). Reflection is the process that allows these experiences and interactions to
become transformed into learning.

Informal learning, while predominantly experiential and not dependent upon institutional programs, may come upon the learner either intentionally or unintentionally. Incidental learning is a specific type of informal learning that happens unintentionally as a by-product of some other activity (Marsick, Volpe, & Watkins, 1999). This spontaneous form of learning can occur through learning from mistakes, networking, or personal experimentation, such as trying different behaviors that lead to the adoption of those which produce desirable results. In an organizational context, meaning is often tacitly internalized, creating patterns of assumptions, beliefs, and constructions formed within a context of people, tasks and structures. Marsick and Watkins (1987) posit that incidental learning is the means by which individuals assign meaning to organizational policies, structures and procedures.

Context-based theories of learning emerge from the fundamental concept of situated cognition – the understanding that learning is inherently social in nature. In this school of thought, learning is not seen as a purely individual exercise, but as a process of interaction among learners, the tools and resources they use, work itself, and the social context in which it takes place (Hansman, 2001; Wenger, 1998). These contextual perspectives on adult learning have been informed by several philosophical and theoretical orientations, including Marxism, critical theory, multiculturalism, postmodernism and feminist theory (Merriam & Caffarella, 1999).

An understanding of contextual learning includes recognition that learning is shaped by the context, culture and resources in the learning situation, as well as by the learner’s
own unique background which includes gender, ethnicity, religion, and socio-economic status as well as individual life history (Daley, 2002; Hansman, 2001; Wenger, 1998). This approach stands in stark contrast to what Friere (2000) describes as the “banking” concept of education, where the teacher is the active agent while learners passively receive, organize and store deposits of knowledge. Contextual theories explore the liberating nature of learning, empowering people to develop the capacity to act for themselves within potentially oppressive structures of power (Merriam & Caffarella, 1999).

The study of professionals as communities of practice has shed light on the importance of contextual learning for people who perceive that they are part of a specific profession, vocation or calling. Daley (2002) describes the importance of contextual learning for ensuring the efficacy of continuing professional education (CPE) within occupational communities.

Although CPE programs do, in reality, play a vital role in providing new and up-to-date information to professionals, the context in which professionals practice also has a vital role in framing what professionals learn, and how they use the information they gain from a CPE program (p. 79).

As a result of their research among accountants, Hoskin and Anderson-Gough (2004) posit that these “disciplinary ways of being” (p. 71) that encompass context, power and perspective are central to our understanding of how professionals learn.

The list of theoretical perspectives cited here is by no means comprehensive. They have been chosen, however, by the author to provide a theoretical background that includes some of the most widely understood perspectives, as well as those that may be most likely
to shed light on the specific research questions of this study.

Workplace learning

Consistent with the enormous investment that organizations make in education and training, a growing body of research is directed toward improving our understanding of learning in the workplace. Included in this body are several topics of particular interest relevant to this study, including learning as an organizational attribute, the relationship of learning to organizational strategy, job satisfaction, and worker commitment.

The topic of learning organizations has become a sort of bridge between educational research and organizational research. The learning organization has been defined by Watkins and Marsick (1993) as

one that learns continuously and transforms itself. Learning takes place in individuals, teams, the organization, and even the communities with which the organizations interact. Learning is a continuous, strategically used process (p. 8).

Senge’s bestselling book *The Fifth Discipline* (1990) has been an important factor in raising the issue of learning within both for-profit and non-profit organizations. Senge posits that the discipline of personal growth and learning is central to creating organizations that possess the creativity and flexibility to advance in an increasingly complex and hostile environment. While Senge’s assertions have generated some skepticism about whether organizations can actually learn, it is important to recall that at the center of his theory is the belief that “organizations learn only through individuals who learn” (p. 139).

Decision-makers, in order to ensure organizational survival, tend to be pragmatic
about where they invest resources. In other words, that which is perceived to increase the probability of success in accomplishing the organization’s overall strategy receives funding. Considering the extensive investments made in training and education, it is logical that alignment between training and organizational strategy would be the subject of research. Montesino’s (2002) findings based on the study of pharmaceutical sales trainees and their supervisors suggest that both are more likely to participate in behaviors that encourage training if they perceive that the training program is aligned to organizational strategy.

Rowden’s (2002) study of small to midsize businesses examined the relationship between workplace learning and job satisfaction. While highly subjective in nature, workers’ perception of wellbeing in their career has been explored in connection with numerous other factors (pay, benefits, supervision, etc.) but rarely with regard to its relationship with learning. Earlier studies tended to focus only on formal training programs; this research was unique in that its approach included informal learning. Rowden’s results indicated a positive relationship between job satisfaction and formal, informal, and incidental learning. Informal and incidental learning were found to have twice the power (19 percent for each, compared to 9 percent) of formal learning as a predictor of job satisfaction.

Bartlett & Klein’s (2001) study of the relationship between training and organizational commitment is of interest not only because of its topic, but the context of the research. Their study of registered nurses is especially relevant to this study, as it examined professionals in a health care field. They found that several factors related to training – perceived access, social support for training, motivation to learn, and perceived benefits of
training – were positively related to organizational commitment.

Wilson (2000) expressed concern over the growing impact of organizations on the autonomy and decision-making ability of professionals, particularly in corporate healthcare systems. He questioned whether the historic social contract under which professionals were trusted to exercise their expertise in the best interest of the client had been eroded in today’s working environment where professionals may be organizational employees rather than autonomous decision-makers. The power relations incumbent in employment relationships are an essential element for investigation in order to understand their impact on learning in an organizational context (Rainbird, Munro, & Holly, 2004). Daley (2001) observed further that organizational context may affect different professions in ways that are unique to each profession.

In their research among new graduates entering the accounting profession, Hoskin and Anderson-Gough (2004) observed that professionals operating in a workplace environment may be required to master additional disciplines. They refer to this phenomenon as transdisciplinary learning, a process which involves moving knowledge from the isolation of the disciplines in which they are often taught, such as in a professional school, or formal workplace training, into an “integrated code” (p. 84-85) where these disciplines are practiced not only simultaneously, but in ways that make connections between disciplines.

Where adult learning theory provides breadth to the theoretical grounding of this study, research conducted in an organizational context adds depth. For those engaged in full-time employment, a place of work becomes a dominant locus of energy, activity and
investment of time during the longest stretch of adulthood. Despite the importance of learning in the context where the discourse of a knowledge-based economy has become commonplace, the topic, according to Evans and Rainbird (2002) “is poorly understood and under-researched” (p. 7). The research that has been conducted, however, makes it clear that workplace environments have a unique relationship to the process of learning.

*Occupational community*

Membership in an organization may have a significant impact on the learning processes experienced by individuals within it, but it is not the only contextual element to have such an impact. Adult learners may also participate in communities of practice, forming bonds with others who share with them the commonality of work and identity. These communities may be *ad hoc* or highly formalized, but they share the common ability to embody the beliefs and behaviors held by their members (Evans & Rainbird, 2002; Wenger, 1998).

The notion of occupational communities, described extensively by Van Maanen and Barley (1984), emerges from the study of sociology. They are formal or informal associations among people who share common values, interests, and traditions that define their own boundaries for membership. It is important to note that the relationships that these communities foster are not limited to the work setting; rather, distinctions between work and leisure, professional and personal are blurred as individuals form bonds based on occupational commonalities.

Occupational communities might consist of fishermen, schoolteachers, dentists, stay-at-home mothers, or in the case of this study, veterinarians. The key element in
understanding these communities is that their boundaries are not defined by the observer, but by the shared perceptions of their members. These boundaries are further described by Van Maanen and Barley (1984), who maintain that “occupational communities represent bounded work cultures populated by people who share similar identities and values that transcend specific organizational settings” (p. 314).

The process of entering an occupational community is one of socialization and learning. Novices tend to move from the periphery toward the center of the community as they become increasingly engaged and active in the culture. Those who achieve centrality in the community enjoy the favored status of expert or old hand, along with increasing influence within the community (Evans & Rainbird, 2002). Social identity is constructed within the occupational community through regular interactions between its members, who develop a “complex system of codes which enable the members of an occupation to communicate to one another an occupationally specific view of the work world” (Van Maanen & Barley, 1984, p. 299).

Davis and Sumara (2001) identify the occupational community as a form of complex learning system that is capable of responding creatively to circumstances that emerge, depending upon the diversity of its own resources. For such structures to exist within a workplace setting is nothing new; people have always organized themselves into subgroups within larger groups. They liken the self-organizing properties, or autopoiesis, found in these systems to those of flocking birds or foraging ants, other systems found in nature that take cohesive collective action, although no centralized directive may be apparent. The investigation of a specific profession as a subculture of the organization in
which it is employed may clarify how organizational culture impacts professional learning, since the combination of these significantly influence the key contexts in which professionals practice their craft (Daley, 2002).

Conclusions from the literature review

Against a backdrop of rich and diverse theoretical development in adult learning, the study of workplace learning has emerged as a related, yet distinct field of study. Investigation of learning situated in organizations has revealed a unique relationship between workplace environments and the process of learning. Public and private organizations expend billions of dollars and countless hours on the education, training and development of the workforce with limited success transferring desired behaviors from the classroom into the everyday work environment. Applying theoretical principles that have originated in the fields of education, sociology, and organizational behavior, researchers in workplace learning are beginning to discover key characteristics of the relationship between learning and the organizations in which it might occur.

The context in which adults learn is more complex than the relationship between employee and organization alone can define. Adults balance multiple roles including worker, spouse, parent, professional, as well as identities based on gender, race, socio-economic status and sexual orientation, with each playing a part in the process of learning (Merriam & Caffarella, 1999; Vella, 2002). Current research has revealed that occupational learning communities can have an important influence on learning within organizations. In professional occupations, membership in these communities can be such a defining element to individual identity that the influence of the professional community exceeds the influence
of the employing organization. Membership in an occupational community that provides a distinct and valued social identity, according to Van Maanen and Barley (1984), whose work cultures are characterized by “people who share similar identities and values that transcend specific organizational settings” (p. 314).

This research was intended to add unique perspectives to the literature on workplace learning in a variety of ways. Researchers have studied the effects of occupational communities such as nurses, social workers, accountants, fishermen and attorneys and found that these communities may be more influential than the organization, but few studies found in current literature have explored the interaction of organizational and professional influences on the learning process. Further, the workplace learning orientation, activities and strategies of veterinarians have not been studied as a professional group by any researcher whose work can be found in current literature. Finally, only limited research on professional occupational communities has been conducted within a corporate environment.

By using grounded theory as the primary methodology for investigative research, this study was conducted to better understand the interaction of a corporate work environment and a well-defined professional occupational community of Doctors of Veterinary Medicine that had recently joined a corporation focused on the delivery of veterinary care. Through qualitative methods including observation and interviews, this researcher sought to explore the experiential nature of the learning process through individuals who were experiencing a period of major change in their professional and possibly their personal lives, both of which are known to be significant triggers for adult learning (Knowles, 1990; Knowles et al., 1998; Tennant & Pogson, 1995).
CHAPTER 3

Methods

This study applied grounded theory (Gay & Airasian, 2003; Glaser & Strauss, 1967) to explore the learning orientations, strategies and tactics employed by Doctors of Veterinary Medicine (DVMs) who have recently joined a corporate organization, Banfield Pet Hospitals®. Existing research tends to focus either on the organizational learning environment (workplace) or on a specific occupational category of learner such as nurses, factory workers, or teachers, but generally not on both vectors at the same time. The intended contribution of this study is an enhanced understanding of the interplay between workplace learning and professional occupational learning communities in a corporate environment.

Research questions

This inquiry was directed specifically toward Doctors of Veterinary Medicine who were in their first six months of employment at Banfield. The ethnographic research was guided by the following questions:

1. What learning orientations (Knowles et al., 1998; Webber, 2004) do individual DVMs bring to the task of workplace learning?

2. Are there differences in ways that DVMs at Banfield approach workplace learning when comparing their clinical/medical role to their practice management role?

3. How do strategies and tactics for learning in a corporate work environment interact
with membership in a professional occupational community during the first year of employment for DVMs at Banfield?

4. Does professional socialization and identity play a role in the learning process that might either enhance or become a barrier to acquiring knowledge and skill outside of one's primary discipline?

Setting

Banfield, The Pet Hospital® is a network of over 500 company-owned and franchised pet hospitals located throughout the United States, with international expansion underway in the United Kingdom and Mexico. In an industry dominated by single-proprietor operations, Banfield, a privately-held enterprise, is the largest provider of veterinary services in the United States, with five times the market share of its nearest privately-held competitor. Founded in 1955, Banfield is headquartered in Portland, Oregon. The company’s current phase of rapid expansion began through a partnership with PetSmart®, America’s largest retailer of pet-related products and supplies, with in-store pet hospitals in PetSmart retail stores nationwide (Banfield, 2004a). Banfield employs over 5000 Team Members and is adding approximately 80 hospitals to its network annually (A. Jaffe, personal communication, June 20, 2005.)

Banfield, like many organizations, is highly dependent on its ability to attract and retain educated and qualified knowledge workers. In this case, the critical position around which the hospital operates is the veterinary doctor. The company’s business plans for growth involve a continuous stream of new and experienced DVMs entering the organization that must not only maintain and develop their clinical expertise, but must also
develop business acumen while being socialized into a new and unfamiliar working environment.

Banfield invests heavily in education, development and training for its growing cadre of veterinary, clinical and office staff. Continuing education programs offered to veterinarians, who enter the organization academically credentialed as Doctors of Veterinary Medicine (DVMs), include:

- Academy, a mentor-based orientation program which includes an intensive anesthesia certification;
- Symposium seminars designed to advance medical skills;
- Banfield Learning Center, a personalized computer based interactive career-growth curriculum;
- A chief-of-staff certification program; and
- Up to $1,200 per year in continuing education assistance (Banfield, 2004b).

Banfield provides a unique opportunity for the study of workplace learning. It is desirable for its position as a leader in the veterinary healthcare industry, as well as its espoused corporate commitment to the education and development of its workforce. Banfield’s core competency is in its DVMs who enter the organization as highly educated professionals, many with prior experience managing their own practice. The company has two overarching needs for educating these individuals: continuing clinical education to support Banfield’s commitment to quality medical care, and business education that enhances the ability of these professionals to successfully manage a hospital and staff within the context of a multimillion dollar international corporation (T. Mooney, personal
Banfield offers a wide variety of training opportunities which include regular symposia, mentoring, online learning and support for external continuing education. This resource-rich environment is a likely location for the investigation of how and why veterinary healthcare workers take advantage of these and other learning resources. Their geographically dispersed work environment, with a relatively small staff in each hospital, provides the added challenge of learning both locally and across distance. Finally, the company has demonstrated willingness to provide a researcher with access to its employees, workplace and training data in the interest of better understanding its own processes for workplace learning.

Participants

The participants chosen for this study were a purposive sample (Berg, 2004) of twelve Doctors of Veterinary Medicine who had been employed by Banfield Pet Hospitals between zero and three months at the beginning of the study. All participants were members of a cohort of recently-hired employees, who attended Banfield Academy together in Portland, Oregon in July, 2005. Thirty-two Academy participants who were doctors of veterinary medicine were sent letters of invitation to consider participation in this research. Seventeen doctors responded indicating willingness to participate.

Twelve participants were selected to approximate the demographic mix of recent organizational hiring patterns in terms of gender, ethnicity, and previous professional experience beyond veterinary school. Participants were selected from four geographic regions in the United States where the company operates veterinary hospitals.
Veterinarians, like most medical professionals, are subject to specific requirements for continuing education in order to maintain licensure in the state where they practice. While this research explored forms of learning that extend beyond formal continuing education (CE) requirements, it is helpful to understand the basic requirements applicable to the profession. State CE requirements vary from 7 hours annually in Iowa to as much as 20 annual hours in Alabama, Arkansas, Arizona, Indiana, Kansas, Minnesota, Oklahoma, Oregon and Tennessee. The average CE requirement for all states is 15 hours annually. States commonly restrict the number of hours that may be earned through courses in practice management or by non-contact means such as online or through self-study (AAVSB, 2005). All state CE regulations reflect a strong preference for medical/scientific content delivered through traditional, face-to-face methods.

Candidates were chosen from a list of all US-based DVMs who met the employment criteria of zero to six months. A list was developed based on the availability of participants that represented the desired mix of gender and ethnicity, limiting the pool of active participants to four geographic regions in order to facilitate efficient travel for workplace observations and interviews. Candidates whose demographic attributes (gender, ethnicity, location) are comparable were randomly assigned to an order of priority on the list. If a candidate declined to participate in the study, the next candidate on the list who most closely met the criteria for demographic diversity was selected.

Human subjects safeguarding

Each participant in this study signed an informed consent document detailing the voluntary nature of this study and any risks associated with participation in it, as well as a
description of the time and availability that was expected of participants. The only risk that was anticipated was the potential inconvenience of scheduling interviews, observations, and limited review of study documents.

Participants were asked to voluntarily allow this researcher to access training-related records held by their employer. These records included records and results of training completed as well as the results of specific assessment instruments including the Keirsey Temperament Sorter II (Keirsey, 1998), a measure of Jungian personality type similar to the Myers-Briggs Temperament Inventory, and the BarOn Emotional Quotient Inventory (Bar-On, 2002), a measure of emotional intelligence. All participant records were held in secure storage by the researcher and kept confidential. Participants were identified by pseudonyms of their own choosing in research documents; those who elected not to choose a pseudonym were assigned a pseudonym by the author. Participant responses have not and will not be shared with representatives of the employer in any form that identifies the respondent by his or her real name.

During the course of the study, interview participants were consulted to clarify any portions of their transcribed interviews that required clarification for accuracy and completeness. Following completion of the study, the researcher has offered to make one or more presentations of the study findings at organizational gatherings upon Banfield’s request.

This study was authorized through the human subject review procedure of George Fox University and was conducted with the approval of the Human Subjects Research Committee.
Data gathering for this research was conducted in three modes: a preparatory mode, which included document review and interviews with key informants, followed by an investigative mode, which included participant interviews, learning journals and field observations. Finally, the validation mode included participant review of investigative results for accuracy and process review by members of the dissertation committee.

The document review did not require any specific forms or materials, since a wide variety of documents were read for the purpose of gaining familiarization with the organization’s strategies, objectives, and programs related to training. Field notes were collected in the researcher’s journal and files created for specific documents that were retained for further analysis.

Interviews with key informants were informal, with questions directed at each informant’s specific areas of expertise. Key informants interviewed included members of Banfield’s executive management responsible for medical quality, veterinary career development, human resources, and education, training and development. For the purpose of learning more about the veterinary profession apart from Banfield, I also included an independent veterinarian as a key informant; Dr. Gary Wood is a board-certified veterinary cardiologist who lectures at Oregon State University’s veterinary school. Unlike study participants, key informant interviews did not carry the expectation of confidentiality and key informants employed by Banfield are identified by position in the final study.

Participant interviews were conducted at the beginning and the end of the research subjects’ participation. The foundation of the questions (Appendix A) for the initial
interview was developed from Marsick & Watkins’ “Conceptual Framework for Studies of Informal Learning in the Workplace” (1987, p. 177), supplemented by Van Maanen and Barley’s conceptual descriptions of occupational learning communities (1984). Both the initial (Appendix B) and the follow-up interviews (Appendix C) were semi-structured, utilizing open-ended questions developed by the researcher (Berg, 2004; LeCompte & Schensul, 1999).

Concurrent with the initial participant interviews, additional data about participant learning orientations was collected using an instrument called the Approaches to Study Skills Inventory for Students (ASSIST) developed by Tait, Entwistle and McCune (1998). This instrument, developed for use in a postsecondary education setting, was chosen in hopes of gathering useful information that would supplement what was generated through interviews. A predecessor of this instrument, the Approaches to Studying Inventory (ASI) has been used with working professionals by Kostrzewski and Dhillon in their study of hospital pharmacists (cited in Aggarwal & Bates, 2000). Because the ASSIST was developed for use in an academic setting by British authors, modifications were made to several of the ASSIST questions in order to increase readability and comprehension in an American workplace setting. Modifications were shown to three independent reviewers, a professor of education, an English Language Learning specialist who was born in the United Kingdom and immigrated to the United States as an adult, and a board-certified veterinary cardiologist. Feedback from these reviewers was incorporated into the final wording of the questionnaire.

In order to capture participants’ learning experiences during the period of three to
four months between interviews, participants agreed to keep learning journals, the contents of which were submitted to the researcher by e-mail approximately every two weeks. Learning journals, according to Hiemstra (2001), provide learners with a means to record “thoughts, reflections, feelings, personal opinions, and even hopes or fears during an educational experience” (p. 20). A variety of media can be used effectively for input, including handwriting, voice recording, or a computer keyboard. Learning journals were employed as a method for qualitative data collection in a study of U. K. music students’ experiences at a summer music program (Pitts, 2004). A similar technique was employed in a study of chronic illness in midlife women through the use of correspondence between the researcher and 80 subjects (Kralik, Koch, & Brady, 2000).

The use of documents as a qualitative data source is consistent with standard research procedures (Gay & Airasian, 2003). Advantages of using learning journals include the stability and exactness of documents, although subjects’ biases are likely to be reflected in their writing, just as would likely be the case with interview data (Yin, 2003). In order to encourage regular recording of significant learning experiences, subjects were given the option to submit entries by e-mail, fax, or voicemail. All participants selected e-mail as the preferred method for submitting journal entries.

Consistent with the grounded theory approach used in this study, the questions for the follow-up interview were developed based upon recursive analysis of the themes that emerged from the initial interviews, journal entries and field observations (Berg, 2004; Gay & Airasian, 2003; LeCompte & Schensul, 1999). The researcher occasionally contacted participants during the time between the first and final interviews, either to clarify journal
entries or to make arrangements for the in-hospital observation and final interview.

In grounded theory, research questions are the starting point of inquiry. The researcher constantly compares themes that emerge from that data collected with initial expectations and assumptions in order to develop theories that emerge from the contextual experiences of the study participants and the researcher (Gay & Airasian, 2003). This research employed an inductive approach to grounded theory, beginning with immersion in the documents and exposure to organizational experts and historians in order to identify dimensions that appeared to have importance in the research context (Berg, 2004). As a recursive process, data were examined in relation to prior data, and the field of inquiry was narrowed as the research progressed and key aspects of emergent theories that addressed the research questions were identified. It should be noted that during recursive analysis it is possible that the research questions may evolve as information is gathered, analyzed and more fully understood (Glaser & Strauss, 1967; LeCompte & Schensul, 1999). This was the case, as a fourth research question was added during the course of this research.

Field notes, written journal entries and digital voice recordings of interviews were transcribed and analyzed using N6 qualitative data analysis software (QSR International, 2002). Surveys were conducted and results returned using Test Pilot (ClearLearning, 2002), an online survey software package. Survey results were tabulated and analyzed using SPSS Graduate Pack 12.0 for Windows statistical data analysis software (SPSS, 2003).

Research design

Learning in the workplace is at the same time an individual and a social phenomenon. In order to understand the process of workplace learning, therefore,
individuals must be studied as they interact with the social structures and processes of the work environment. The agency of individuals and structure of organizations are so thoroughly intertwined that some researchers view an attempt to separate them as artificial (Hodkinson et al., 2004). A qualitative research design utilizing grounded theory was chosen as the means by which to study the workplace learning process among newly-hired veterinarians in a corporate organization.

Qualitative studies are not new to the organizational context. They have been used by feminist researchers to study the experience of women in the workplace (Howell, Carter, & Schied, 2002), cognitive scientists to explore the intellectual implications for machinists when new technology is introduced (Martin & Scribner, 1991), and by educators to study phenomena including the learning orientations of working managers (Webber, 2004) and development engineers’ conceptions of learning in the workplace (Collin, 2002). Daley (2002) pointed out the explanatory value of studying professions as subcultures of the organizations in which they are practiced in order to clarify the impact of organizational culture on professional learning. Hodkinson and associates (2004) called for more qualitative research in organizational settings, addressing the need to better understand the reflexive interaction between education, the workplace, and the labor market and how this interaction shapes the life course. Educational researchers for the American Medical Association (Jennett et al., 1994) indicate that a qualitative, ethnographic approach may be the most powerful method for understanding physicians’ learning in the workplace.

The design of this study employed seven methods of data gathering in an inductive, interactive and recursive process to understand and explain the learning behaviors and
beliefs of the subjects (LeCompte & Schensul, 1999). The methods employed included:

1. document review
2. interviews with key informants
3. participant interviews (initial and follow-up)
4. ASSIST inventory
5. Participant learning journals
6. field observations
7. validation

Using a constructivist (also called interpretive) approach, the research began with a review of organizational documents relating to education, training and development in order to identify the program objectives, content, schedule and evaluation strategies that are in place. The document review also included a review of training participation records and evaluation surveys completed by company employees who have participated in program similar to those experienced by the subject group. A similar document review was conducted by Daley (2001) in her comparative ethnographic study of learning in four professions in order to develop an in-depth understanding of the continuing professional education to which subjects were exposed. A final preparatory step included interviews with key informants within the organization who were not study participants, but possessed extensive cultural and historical knowledge of the organization (LeCompte & Schensul, 1999).

Two recorded in-depth interviews were conducted with each participant. The initial interview was conducted during Banfield Academy, a company-sponsored orientation and
training event for which the DVMs traveled to the corporate headquarters in Portland, Oregon. The final interview was conducted in the locale where each participant worked, either in or near the hospital where each was employed. Between these interviews, participants maintained an informal journal of significant learning experiences, which were submitted via e-mail to the researcher, approximately biweekly. At the time of the final interview, field observations were conducted in the workplace of each subject.

Role of the researcher

As the sole researcher in this study, I assumed roles that were relevant to each of the various phases of the study. As an interviewer, the role is consistent with a constructivist-interpretive approach. This researcher arrived at each interview armed with contextual knowledge gleaned from the document review and interviews with key informants. At the beginning and end of the process, I became involved through participant-observations at a training event at corporate headquarters, and in individual veterinary hospitals. This researcher’s personal experience of interaction with study participants thus became an important element in the process of data gathering (LeCompte & Schensul, 1999). This participatory model was designed to reduce the perceived power differential that may exist between researcher and subject, creating a collegial research relationship free of the perception of manipulation (Berg, 2004).

Data analysis

Thematic analysis was conducted recursively throughout the data-gathering process, utilizing N6 (QSR International, 2002) to facilitate the organization and classification of documents, field notes, and interview transcripts. Themes, according to Berg (2004) are a
useful unit of analysis that can be located in a variety of places in various types of sources. Open coding of thematic "nodes" (see Appendix E) was used in order to avoid limiting the number and types of themes that might emerge from the data; N6 qualitative data analysis software was used to facilitate the process.

Three quality control mechanisms were incorporated in this research. First, participants were consulted in order to clarify any interview results that were unclear or questionable, for accuracy and completeness. Second, the researcher enlisted professors to review data analysis processes to confirm that the data gathered are dependable and confirmable (Daley, 2001). Finally, the researcher's coding was reviewed by a professor to ensure that coding has been practiced consistently and in a systematic manner.

Correlational analysis using Spearman's $\rho$ was applied to results from the Approaches and Study Skills Inventory for Students (ASSIST) (Tait, 1998), the Keirsey Temperament Sorter II (1998), an inventory of Jungian type, and the BarOn Emotional Quotient Inventory (Bar-On, 2002), a measure of emotional intelligence. As part of a qualitative study, statistics were not intended to make inference to a larger population, but were used as a means to search for useful comparisons between specific elements of three sets of participant data. Positive or negative relationships at statistically significant levels were identified and investigated further for possible connections between assessment results. Spearman's $\rho$ is a correlational method developed for analysis of small samples with ordinal data (Gay & Airasian, 2003). Correlational analysis was conducted with SPSS 12.0 software (2003).

Due to the recursive nature of the study, the design of the final interview
questionnaire was not completed until the initial interviews and the bulk of journal entries had been reviewed and analyzed. One example of where the use of the constant-comparative method (Gay & Airasian, 2003; Glaser & Strauss, 1967; LeCompte & Schensul, 1999) resulted in a significant change to the original research question was the addition of an open-ended “word association” question (Appendix C, question 10) that was used to elicit participants’ perceptions of members of the veterinary profession and business people. The addition of this question was a direct result of the recursive nature of this research. Responses to this question were grouped into thematic categories and analyzed according to frequency as well as the relative order in which they appeared in subjects’ responses.

**Procedures**

This research was completed on a timetable that spanned from June, 2005 through February, 2006. It should be noted however, that contact with Banfield and informal data gathering began as early as the summer of 2004. The elements of this study were chosen to allow completion in a relatively short timeframe of less than one year. Elements of a compressed design that apply to this study include (1) an emphasis on familiarization with the research site and culture early in the project, possibly even before the research is formally begun, (2) focus on a single aspect of the culture, which is workplace learning among DVMs, and (3) enlisting the assistance of key informants, or “cultural experts” who share a common culture with the research participants (LeCompte & Schensul, 1999).
The timetable for completion of this research:

Document Review:       June – July 2005 (began informally in
                        summer 2004)
Key informant interviews:  June – July 2005
Participant selection:    June – July 2005
Initial participant interviews    July 2005
ASSIST inventory            July 2005
Field observation 1 (Academy)  July 2005
Participant learning journals  August 2005 – October 2005
Recursive analysis          August 2005 – January 2006
Field observation 2 (Hospital)  October - November 2005
Follow-up interviews        October - November 2005
Process Validation          December 2005 - January 2006
Document results            January - February 2006

What contribution might the study provide?

This topic of study has been chosen specifically because of its relevance in two
academic fields: adult education and organizational theory. The pursuit of a terminal
degree in education was, for this researcher, a conscious departure from a graduate degree in
management and more than two decades of practice as a Human Resources professional in
for-profit, corporate environments. The degree of departure, however, was not as severe as
one might assume.

Workplace learning is an emerging field of study that has significant implications
for the academic fields of education and business as well as for practitioners. This study will add one more set of scholarly findings to a nascent body of research on the interaction of learning and organizational structure, as well as adding to the literature on occupational learning communities, specifically those made up of professionals. It offers a unique contribution in the understanding of workplace learning among veterinarians, a group in which organizational and learning processes have not previously been explored.

Finally, this study presented a unique opportunity to enter an organization at the top of its field during a period of growth and expansion. While the primary emphasis of this study is on workplace learning, the fields of human resource development and organizational behavior may also benefit from the contribution of this research.

Professionally, my goal is to apply this newly developed expertise in adult learning as a member of the business faculty of a university that espouses a mission to serve adult learners through professionally relevant higher education. Rather than departing from the academic foundation laid while earning an undergraduate degree in Christian education and a graduate degree in management, this research is the logical continuation of a professional and academic career focused on the human element in organizations for nearly thirty years. The experience and knowledge gained through this study will be of profound value both as an academic and as a content expert in the field of management.
CHAPTER 4.

Findings

Banfield, The Pet Hospital depends completely on its ability to attract, develop and retain highly educated and qualified doctors of veterinary medicine. The company’s business plans for growth involve a continuous stream of new and experienced DVMs entering the organization that must not only maintain and develop their clinical expertise, but must also develop their knowledge and abilities in practice management while becoming socialized into a new and unfamiliar working environment. This research seeks to better understand the interplay between workplace learning and professional occupational learning communities by investigating the learning orientations and behaviors of members of a cohort of veterinary professionals during their first six months of employment in a corporate hospital environment.

Research questions

This study of Doctors of Veterinary Medicine in their first six months of employment at Banfield is guided by the following research questions:

1. What learning orientations (Knowles et al., 1998; Webber, 2004) do individual DVMs bring to the task of workplace learning?

2. Are there differences in ways that DVMs at Banfield approach workplace learning when comparing their clinical/medical role to their practice management role?
3. How do strategies and tactics for learning in a corporate work environment interact with membership in a professional occupational community during the first six months of employment for DVMs at Banfield?

A fourth research question emerged after initial data had been gathered and analyzed.

4. Does professional socialization and identity play a role in the learning process that might either enhance or become a barrier to acquiring knowledge and skill outside of one’s primary discipline?

**Research findings**

Conducted over a period of five months, this study resulted in a wealth of rich data about the learning orientations, strategies and tactics used in the workplace by the doctors of veterinary medicine who participated. Research subjects were candid in their reports, and provided this researcher every opportunity to observe their daily work routine in as typical a manner as possible. Banfield also provided a significant amount of data that were not only useful in the analysis process, but also helped provide the researcher with a more complete understanding of each of the eleven subjects as unique human beings.

**Demographics**

Eleven of the twelve original participants completed all phases of this study. One doctor voluntarily withdrew from the study following the initial interview, citing personal reasons. Data from that doctor’s initial interview was excluded from the study. All eleven remaining participants were licensed doctors of veterinary medicine. Four doctors had between three and twenty-three years of prior veterinary practice experience (mean = 11.6 years) and seven were recent graduates. The eleven participants were graduates of nine
different accredited university veterinary schools. All participants were hired by Banfield in May, June or July 2005 and attended the same orientation session, called *Academy*, for one week in July.

While a sample of this size was never intended to statistically represent a greater population of veterinarians, an effort was made to approximate Banfield’s veterinarian population by including sufficiently diverse individuals so that the sample was not exclusively skewed to a particular demographic. Table 1 contains demographic data for the eleven doctors including geographic region, professional experience, gender and ethnicity.

*Table 1.*

**Demographic Analysis of Participants**

<table>
<thead>
<tr>
<th>Geographic Region</th>
<th>Professional Experience</th>
<th>Gender</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experienced</td>
<td>New Graduate</td>
<td>Female</td>
</tr>
<tr>
<td>Pacific Northwest</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Rocky Mountain</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Midwest</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Southeast</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>

<p>| | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>36.4%</td>
<td>63.6%</td>
<td>81.8%</td>
<td>18.2%</td>
<td>9.1%</td>
<td>18.2%</td>
<td>63.6%</td>
<td>9.1%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Given the relatively small number of subjects, the ethnic makeup of the group fairly represented Banfield’s recent hiring. Banfield records indicate that 75% of the veterinarians hired between January 2004 and June 2005 were white/Caucasian, while 23% were minorities and 2% declined to disclose ethnicity. The study group included 63.6% white/Caucasian participants, 27.3% minority participants and one doctor of mixed race who chose to identify as “other,” accounting for the final 9.1%. The research subjects’ ethnicity is a reasonably close approximation of the ethnic diversity seen in Banfield’s hiring.
Decisions about the geographical distribution of participants were made to balance the need for sufficient diversity to reflect Banfield’s nationwide workforce with the practical issue of travel so that on-site observations could be conducted in each hospital where participants worked. Participants selected worked in hospitals clustered in four geographic regions, including Pacific Northwest, Rocky Mountain, Midwest, and Southeast. Seven participants worked in suburban hospitals, two in large urban cities, one in a small city, and one split her time between two hospitals, one located in a large city and the other in a small city. This geographic distribution generally reflected the locations of Banfield Pet Hospitals, most of which share space with PetSmart retail stores in suburban shopping centers. Ten doctors in the study group were employed at hospitals located in PetSmart stores, only one worked in a free-standing hospital.

Two areas where the study group differed from Banfield’s recent hiring patterns were gender and professional experience. While veterinary industry sources estimate that between 65% and 80% of all graduates from U.S. and Canadian veterinary programs are female, (Kogan, McConnell, & Schoenfeld-Tacher, 2005; Lofstedt, 2003), incumbents in the profession and Banfield’s workforce are generally more balanced between men and women. During 2004 and the first half of 2005, 60% of all veterinarians entering practice at Banfield were female. This group of subjects, however, was over 80% female. The large number of new graduates (63.6%) is primarily a result of the time of year that participants were selected; new graduates tend to be inducted into Banfield in the summer months. Despite these two anomalies, sufficient diversity existed within this group of participants to proceed in confidence that the sample had not been skewed by exclusively selecting
members with a particular demographic trait.

Examination of participant profiles as measured by the Keirsey Temperament Sorter II (KTS) (1998) revealed some dominant personality traits existed in the sample group. Closely related to the Myers-Briggs Type Inventory (MBTI), the KTS is an indicator of personality type along four continua:

- Extraversion (E) v. Introversion (I)
- Sensation (S) v. Intuition (N)
- Feeling (F) v. Thinking (T)
- Judgment (J) v. Perception (P)

Each of the pairs listed above indicates a preference for a specific approach to life. As described by Hirsch and Kummerow (1993, p. 4), the first pair, E-I, reflects whether a person is energized by social interaction (Extraversion) or solitude (Introversion). The S-N relationship is an indicator of what captures a person’s attention, data that is accessed through the senses (Sensation) or concepts (Intuition). The third pair, F-T, reveals a preference for decision-making that is based on objectivity and logic (Thinking) or personal values (Feeling). The J-P relationship indicates whether the life style that a person chooses is marked by organization and planning (Judgment) or flexibility and spontaneity (Perceiving).

Five of the eleven participants in this study had the same profile, ISFJ, characterized by loyalty, responsibility, sympathy and consideration for others (Hirsh & Kummerow, 1993; Keirsey, 1998). Of the remaining subjects, four had profiles that differed from the dominant ISFJ in only one area. All eleven participants shared the same preference for a
lifestyle characterized by organization and planning (Judging).

Banfield’s director of veterinary career development indicated during key informant interviews that Introversion was a classic personality trait for veterinarians. She mentioned that there was anecdotal evidence of a shift toward more DVMs that exhibited Extraversion (K. Engler, personal communication, June 20, 2005). Participants in this sample, eight of eleven with a preference toward Introversion, did not reflect that shift.

Aside from understanding the composition of the group, it is also important to recognize that each veterinarian who became a subject of this study was a unique individual. A brief biography of each participant provides a point of connection to their individual histories and characteristics. The biographical details have been intentionally limited to preserve the anonymity of study participants.

**Doctor Berger**

Dr. Berger, age 27, was entering his first professional practice. He graduated from the veterinary school of a Midwestern state university in 2005. Dr. Berger’s decision to become a veterinarian came in high school; he had also considered sports medicine as a career. His profile on the KTS was ISFJ, the most common profile for participants in this study.

**Doctor Dana Rosa**

Dr. Dana Rosa, age 38, was one of four experienced veterinarians in this study. She joined the practice with over ten years of professional veterinary experience, mostly working with large animals. She graduated from veterinary school in Latin America and pursued additional education at a university in the U. S. in order to qualify for licensure.
Being a veterinarian was the only career she remembered wanting since childhood. Dr. Dana Rosa was the only subject whose KTS profile was ENFJ.

**Doctor Delta**

Dr. Delta, age 27, was entering her first professional practice. She graduated from a regional veterinary school in the eastern U. S. in 2005. As a child, Dr. Delta was interested in science and medicine, but decided after experiencing a cadaver lab in high school to pursue veterinary medicine rather than human medicine. She was the only subject whose KTS profile was ESTJ.

**Doctor Fox**

Dr. Fox, age 26, was newly graduated from a state university veterinary school in the central U. S. Her career choice was influenced during high school as she gained hands-on experience in a veterinary practice through an organization called “Explorer’s Club.” Dr. Fox’ profile on the KTS was ISFJ.

**Doctor Gengler**

Dr. Gengler, age 26, was entering her first professional practice upon graduation from the veterinary school of a Midwestern state university. She was interested in medicine in grade school, deciding on a veterinary career as a result of a job shadow experience in high school. Dr. Gengler worked in a small veterinary practice for seven years during her undergraduate and graduate studies. Her KTS profile was ISFJ.

**Doctor Lily**

Dr. Lily, age 32, had been a licensed veterinarian for three years prior to joining this practice; her prior professional experience included another corporate practice as well as an
animal shelter. She graduated in 2002 from the veterinary school of a state university in the eastern U. S. Her interest in becoming a veterinarian started at an early age, perhaps six or seven years old; she recalled that her father encouraged her to pursue that interest. Dr. Lily shares a KTS profile of INFJ with one other subject in this study.

Doctor Madigan

Dr. Madigan, age 30, was entering her first professional practice after graduating from the veterinary school of a state university in the central U. S. Raised in Europe, she loved animals since childhood but initially pursued nursing as an undergraduate. During her undergraduate studies, she transferred to a university in the U. S. where she decided instead to enter a pre-veterinary program. Dr. Madigan’s KTS profile was INFJ.

Doctor McKenzie

Dr. McKenzie, age 27, had recently graduated from the veterinary school of a Midwestern state university. Growing up in a farming family, she developed respect for the veterinarian’s vital role as it related to the health of the family business. This influenced her decision in high school to pursue a career in veterinary medicine. Dr. McKenzie’s KTS profile, similar to four other subjects in this study, was ISFJ.

Doctor Murray

Dr. Murray, age 37, had been a veterinarian for five years prior to joining this practice. She graduated in 2000 from the veterinary school of a state university in the central U. S. Her decision to pursue veterinary medicine came after she completed an undergraduate degree in economics and had been working in her field for some time. She chose to become a veterinarian because it was a career that allowed her to be a medical
consultant and advisor to people while she worked with animals. Dr. Murray's KTS profile was ISFJ.

**Doctor Schwartz**

Dr. Schwartz, age 54, had over twenty years of veterinary experience since graduating from the veterinary school of a state university in the central U. S. She decided in her youth to become a veterinarian, explaining, "It's all I ever thought of after about the eighth grade." Dr. Schwartz joined the practice after a hiatus of approximately two years during which she had not practiced medicine. She was the only subject in this study with the KTS profile of ESFJ.

**Doctor Smith**

Dr. Smith, age 27, began his first professional practice after graduation from the veterinary school of a state university in the western U. S. in 2005. He described an emerging childhood interest in science and medicine, leading to his career choice. He did not identify a specific time for that decision, but indicated that he chose veterinary medicine over human medicine because humans were overly opinionated about "how they wanted their medicine." Dr. Smith was the only subject in this study with the KTS profile of ISTJ.

**The nature of the data collected**

Text documents containing field notes, transcribed interviews, and participants' learning journals comprised the greatest volume of data collected for qualitative analysis. Forty-five documents were coded using N6 (QSR International, 2002), a qualitative analysis software package, using an open tree structure to facilitate thematic coding (see Appendix E). Text documents included for qualitative analysis included:
1. Researcher’s field notes from Banfield Academy, July 17 – 22, 2005.
2. Eleven transcribed initial interviews, conducted July 17-22, 2005 (one per subject).
3. Eleven learning journals, submitted by participants via e-mail between July 23 and November 13, 2005.
4. Researcher’s field notes from eleven observations in Banfield hospitals, conducted between October 24 and November 17, 2005.
5. Eleven transcribed final interviews, conducted October 24 – November 17, 2005.

These forty-five text documents included for thematic analysis accounted for 16,007 Text Units, the term in N6 for a single printed line of text (QSR International, 2002). This translates to approximately 400 single-spaced, typed pages of text data that were analyzed qualitatively to produce the results listed below.

In addition to the text data, the following quantitative data were collected and analyzed:

1. Results from the Approaches and Study Skills Inventory for Students (ASSIST), conducted as a part of this research (Tait, 1998).
2. Results from the Keirsey Temperament Sorter II (1998), an inventory of Jungian type, collected by Banfield and provided to this researcher with the subjects’ consent.
3. Results from the BarOn Emotional Quotient Inventory (Bar-On, 2002), a measure of emotional intelligence, collected by Banfield and provided to this researcher with the subjects’ consent.
4. Training records indicating use and successful completion of modules in the Banfield Learning Center, an online self-paced learning environment. These records were
Research question one: Learning orientation

What learning orientations do individual doctors of veterinary medicine bring to the task of workplace learning?

This initial guiding question addressed the learning orientation of the doctors of veterinary medicine who were subjects of this inquiry. Learning orientation, according to Webber, is “rooted in a social cognitive model of learning which emphasizes the dynamic nature of the engagement between learner and environment” (2004, p. 259). As adult learners, do these veterinarians, as Knowles, et al. (1998) suggest, bring a life-centered or problem-centered approach to learning? And are individual learning orientations, as observed by Entwistle and McCune (2004), characterized by approaches that can be deep and meaning-seeking, strategic and achievement-oriented, or merely superficial?

In order to determine what orientations to learning might exist within the subjects, participants were asked to complete a version of the Approaches and Study Skills Inventory for Students (ASSIST) (Tait, 1998). The ASSIST was used in this research to measure two elements of learning orientation. The first section of the inventory measures conceptions of learning, based upon similarity or dissimilarity with statements indicating either an instrumental approach focused on learning as reproduction of information, or a personal and developmental approach that is focused on satisfying a desire for understanding. The second section measures approaches to learning, with results that reflect agreement or disagreement with statements indicating a deep, meaning-seeking approach, a strategic, achievement-oriented approach, or a “surface apathetic” approach (Entwistle & Ramsden,
A statistical correlation of the results for conception of learning (instrumental or personal/developmental) and learning approach (deep, strategic, or surface) revealed a statistically significant negative relationship between holding a concept of learning that is personal and developmental in nature and a surface, or perfunctory approach to learning. A correlation using Spearman’s rho, a technique developed for correlational analysis using small samples (Gay & Airasian, 2003 p. 318) resulted in a correlation coefficient of -.820, indicating that subjects whose responses reflected a personal/developmental concept of learning were highly unlikely to identify with surface approaches to learning (see Table 2). These tests were not intended to make inference to a larger population, but were used as a means to search for useful comparisons between specific elements of the empirical participant data that was collected.

Table 2.

Correlation of ASSIST participant results: Understanding of v. approaches to learning

<table>
<thead>
<tr>
<th></th>
<th>Surface/</th>
<th>Deep</th>
<th>Strategic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correlation Coefficient</td>
<td>-.354</td>
<td>-.160</td>
<td>.460</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.285</td>
<td>.639</td>
<td>.155</td>
</tr>
<tr>
<td>Personal/Developmental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correlation Coefficient</td>
<td>-.820**</td>
<td>.443</td>
<td>.539</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.002</td>
<td>.172</td>
<td>.087</td>
</tr>
</tbody>
</table>

N=11. Spearman's rho.
**Correlation is significant at the 0.01 level (2-tailed).

A second strongly negative relationship existed between the surface/apathetic and strategic approaches to learning, with a correlation coefficient of -.756 (see Table 3). Both
relationships were significant at the level of 0.01 using a two-tailed test. Like the prior result, this indicates that the same subject would be unlikely to agree with statements about his or her learning approach that reflected both a surface and a strategic approach. No other relationships between orientations to learning were statistically significant. The two that were significant, however, were related in ways that would be consistent with Entwistle and Ramsden's (1983) understanding.

Table 3.
Correlation of ASSIST participant results: Approaches to learning

<table>
<thead>
<tr>
<th></th>
<th>Surface/Apathetic</th>
<th>Deep</th>
<th>Strategic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Correlation Coefficient</strong></td>
<td>1.000</td>
<td>-.258</td>
<td>-.756**</td>
</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td>-</td>
<td>.444</td>
<td>.007</td>
</tr>
<tr>
<td>Deep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Correlation Coefficient</strong></td>
<td>-.258</td>
<td>1.000</td>
<td>.177</td>
</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td>.444</td>
<td>-</td>
<td>.603</td>
</tr>
<tr>
<td>Strategic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Correlation Coefficient</strong></td>
<td>-.756**</td>
<td>.177</td>
<td>1.000</td>
</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td>.007</td>
<td>.603</td>
<td>-</td>
</tr>
</tbody>
</table>

N=11. Spearman's rho.
**Correlation is significant at the 0.01 level (2-tailed).

Responses about what learning meant to participants tended to agree with statements indicating an instrumental as well as a personal, developmental understanding of learning. As a group, the eleven participants tended to agree more strongly with statements associated with an instrumental view of learning (mean = 1.42 on a five-point scale where 1 = Very Close, standard deviation = .32) than a personal and developmental view (mean = 1.89, standard deviation = .57). New graduates’ levels of agreement were slightly higher than those of the four experienced doctors (see Table 4).
Of the three learning approaches measured by the ASSIST, the strongest agreement (mean = 2.01 on a 5-point scale where 1 = Agree, standard deviation = .57) was associated with the deep learning approach, characterized by seeking meaning, using evidence, relating and taking an interest in ideas. It should be noted that on this measure, the four experienced doctors’ level of agreement was stronger (mean = 1.79) than their recently graduated colleagues (mean = 2.12), however, agreement for both groups was more pronounced for the deep approach to learning than to either of the other two.

Participants also tended to agree with statements indicating a strategic approach to learning (mean = 2.33, standard deviation = .56). Responses aligning with a strategic approach to learning reflect organized studying, time management, alertness to the demands of assessment, an orientation toward achievement, and self-monitoring. Responses to the surface/apathetic approach, characterized by lack of purpose, rote memorization, concentration on rules and fear of failure tended to be neutral or in disagreement (mean = 3.58, standard deviation = .44). In both of these categories, there was virtually no difference between the mean responses of experienced and new graduate doctors (see Table 4).
Table 4.

Orientation to Learning: Participant Responses to ASSIST

<table>
<thead>
<tr>
<th></th>
<th>Concept of Learning</th>
<th>Approach to Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Instrumental</td>
<td>Personal/Developmental</td>
</tr>
<tr>
<td>All Doctors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.42</td>
<td>1.89</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>0.32</td>
<td>0.57</td>
</tr>
<tr>
<td>Experienced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.75</td>
<td>2.17</td>
</tr>
<tr>
<td>New Graduates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.24</td>
<td>1.81</td>
</tr>
</tbody>
</table>

Concept of Learning: 1 = Very close, 5 = Very different.
Approach to Learning: 1 = Agree, 5 = Disagree

Correlational analysis was also conducted between results of the ASSIST (Tait, 1998) and two assessments that Banfield conducts routinely with new hires: the Keirsey Temperament Sorter (KTS-II) (1998), which is an indicator of Jungian personality type, and the BarOn Emotional Quotient Inventory (EQ-i) (Bar-On, 2002), an assessment of emotional intelligence. Correlations were calculated using Spearman’s rho, as before. No statistically significant relationships were found to exist between the ASSIST results and either the KTS-II or BarOn EQ-i.

Doctors’ comments during interviews provided insight into their orientation toward learning in the workplace. One common theme was the desire to persevere in learning, consistent with a disciplined, instrumental concept of learning. Some relayed this theme through stories of past learning in veterinary school or work experience prior to graduation. Dr. Gengler offered this evaluation of her early workplace learning at Banfield.
The biggest understanding I’ve gotten out of the last four months is that you’ve got to fight what’s happening and problems and everything else, you still learn. Whether you’re trying or not. If you try to learn something, you’re going to learn it. It’s just a matter of wanting to do it.

Doctors also provided information about their personal learning styles in their interviews and journals. Ten of eleven indicated a preference for learning by doing, while only one indicated that a hands-on learning style was problematic, preferring more “formal” methods. In addition, six indicated that they were visual learners, preferring to observe a demonstration, while five preferred written information that they could read. One doctor self-identified as an auditory learner, for whom it was helpful to hear things explained. Two doctors, both new graduates, said that they get nervous when observed while learning.

This level of agreement with both deep and strategic approaches to learning is consistent with a strong and balanced commitment to learning. Considering the length and rigor of the educational process required to become a doctor of veterinary medicine, this result was not surprising. In relation to this research on workplace learning, these results did not indicate any significant barriers that would stem from the research subjects’ understanding of learning or their approach to learning.

Research question two: Clinical versus practice management role

Are there differences in the way doctors of veterinary medicine at Banfield approach workplace learning when comparing their clinical/medical role to their practice management role?

The veterinarians in this study consistently reported taking actions directed toward
expanding clinical skill and knowledge in the workplace. The second research question explores the similarities and differences between the subjects’ approaches to medical learning as compared to the acquisition of skill and knowledge in the non-medical aspects of veterinary practice. A statement from Banfield’s website aimed at DVMs who might consider joining the practice reflects the priority that the organization places on the medical aspects of veterinary practice.

You'll have practice management and administrative support. We'll take care of the bookkeeping, payroll, benefits administration, technical support, and more. This keeps you free to concentrate on what you do best - delivering quality healthcare to Pets. What's more, your finance team at CTS (Central Team Support) will prepare reports and statistics for you, to help you make informed practice management decisions (Banfield, 2006).

Table 5 displays the topical nodes most frequently coded in order of appearance in research documents, and ranked by the volume of text devoted to that topic. When ranked by the number of documents in which a topic appeared, five of the top ten were primarily related to clinical learning, four were related to non-medical learning (i.e., practice management) and one, Learning Style, was not specific to either. However, when topics were ranked by the number of text units found that related to each, six of the top ten were related to practice management and the remaining four to medical/clinical learning.
Three of the six most frequently mentioned topics in field notes, participant interviews and journals related primarily to clinical learning. Statements about developing professional confidence appeared in 71% of all documents and accounted for 3.2% of all text units. The mentor relationship, related to clinical learning in the majority of cases, appeared in 69% of documents, accounting for 4.8% of all text units – the second highest topic by volume of text. Finally, clinical learning was mentioned in 62% of all documents and comprised 3.5% of all text units (see Table 5).

Learning about non-medical aspects of practice management, however, was at least as prevalent in the data as were references to clinical learning. The most frequently mentioned subject with the largest number of text units was learning about relationships with hospital staff, appearing in 76% of all documents and accounting for 5.1% of all text units. Learning about relationships with clients appeared in 62% of all documents and 3.5% of all text units. Learning about dealing with conflict also appeared in 62% of documents,
making up 3.0% of all text units.

Several doctors in the study commented about the amount of non-medical learning that took place during their first months at Banfield. In a journal entry, Dr. McKenzie reflected,

Looking back, I am really surprised that most of the learning issues and difficulties I am having has been with interpersonal relationships and not with medicine. Vet school has prepared me well for the medicine, if not in the specifics, by giving me the logic that I need to reason my way through things, but they should have given us some psychology classes.

Dr. Lily, admitting in the final interview that she was learning more than she had expected, also noted the significance of both medical and non-medical learning.

I expected less learning. That’s why I am learning a lot about myself, and my personal relationships with people. And I’m learning a bit about veterinary medicine, too, which, I thought, “Eh, it’s a day practice, how hard can it be?” I’m learning about that, too...vaccines, dentals, getting better on my spays and neuters, that sort of thing.

All the doctors spoke enthusiastically about medical learning on the job. Experienced doctors and new graduates alike demonstrated intent to pursue learning through a variety of specific strategies to improve their skill and medical knowledge.

Specific clinical learning strategies employed by participants included:

- Taking on novel and interesting cases
- Learning from a mentor
- Improving technique through repetition of procedures (such as spays and neuters)
- Observing or volunteering to assist other doctors
- Checking diagnoses and treatment plans with colleagues or mentors
- Referring to medical reference books
- Use of the Banfield Learning Center, a library of interactive online tutorials
- Reading professional journals

Not all medical learning was the result of planning and intent. The most common form of incidental learning that participants experienced was learning through mistakes, both their own and those of others. Two of the four experienced doctors and five of seven new graduates noted that mistakes contributed to their learning. Dr. Delta recounted the experience of miscalculating a dosage of medication, “It wasn’t so bad where one decimal spot would have killed the pet, but it was one of those things that, you wanted to stay in the appropriate range, period.” Besides learning a lesson about medications, she also learned about client relations, adding, “I think that by admitting (to clients) that you’re wrong sometimes, it makes them feel more comfortable with you, because they know you’re not going to lie to them.”

Two experienced doctors entered the practice expressing concern about their medical abilities; one had practiced large animal medicine and was apprehensive about making the transition to small animal practice, and the other had not been practicing medicine during a hiatus of approximately two years. Both were pleasantly surprised to find they were able to apply their medical knowledge successfully in this new environment. Dr. Dana Rosa commented, “I don’t want to say this, because it doesn’t sound good, but I
learned that I am a much better small animal veterinarian than I thought I was.” Dr. Schwartz’ experience was similar, “Coming from not practicing and having the assumption that I wasn’t going to practice anymore, it’s just been easier than I thought it would be.”

Each of the eleven doctors reported that successful learning was a confidence building experience. Sixty-six per cent of these experiences mentioned as contributing to professional confidence involved clinical/medical learning, compared with 30% involving practice management. Four per cent of confidence building experiences were not specific to either medicine or practice management.

Of the eleven doctors, only two had a relatively even balance between comments about developing confidence in both their medical and practice management roles. Dr. Murray is an experienced veterinarian who had taken on an acting Chief of Staff role in the hospital where she works. In her journal, she recorded,

Although I am tired from the week, I am happy to be in this new position.

The opportunity to hone my leadership skills and build my medical knowledge has been refreshing and boosts my confidence that we can become a successful and trusted hospital in the community.

Dr. Murray expanded on the importance of her leadership role in the final interview.
I have a lot of job satisfaction, more than I’ve ever had, and I think the primary reason for that is the fact that I have more of a leadership role, and it scared me to be a leader. But what I’ve found out is that it’s really empowering. It makes you realize your potential, and it pushes you in areas that you maybe would avoid. Like dealing with staff conflict, or upset clients.

Dr. Gengler, a new graduate, noted the need for building confidence in her leadership role as a doctor.

This will be my first job where I’m really in a leadership position. You know you walk in the door the first day and everyone assumes you’re a god and you’re a doctor and its like, “Eh, maybe not so much.” So that’s probably going to be the one that’s going to take the most time to be comfortable in the role.

Approaches taken by the doctors to learn non-medical components of their practice were not as varied or robust as strategies they employed to facilitate medical learning. The only strategy applied consistently by all participants was learning by doing, such as learning through personal experience, experimentation or by trial and error. Dr. Lily provided an example of an informal learning experiment that a doctor might conduct.
I noticed that if I just say, "I think you should do a cytology on this mass," one way to a client, I can tell that I can get them to put it off a week. Or if I say, "I think that we should, and let's do it, let's just go do it," I've noticed that I get way more response, and obviously productivity, but I'm just kind of doing that as a little experiment.

When compared to the rigor that subjects applied to clinical learning, their approach to learning about practice management was less organized, lacking commonly and intentionally applied strategies and tactics.

A second learning strategy reported by a majority of subjects was informal observation. All seven newly graduated doctors reported learning non-medical information and/or skill by observing others, as well as three of the four experienced doctors, although the experienced doctors that mentioned informal observation did so less frequently than their early-career colleagues. Participants rarely sought or conducted formal observations for non-medical purposes, although these were used regularly for learning medical procedures. The observations commonly reported, while informal, were not simply serendipitous; doctors appeared to be paying attention to things that were going on in the hospital that might be instructive, particularly as it related to interpersonal relations with staff and clients.

Not all learning through observation involved learning by emulation. A new graduate, Dr. Fox's observations of staff behavior led to conclusions about her own personal and professional development.
I had an experience last week where one of the nurses was insubordinate to
me, and doing things on my patient that could have harmed my patient…and
it got me thinking that I should use my status more in the hospital, you
know, I’m a doctor now, and I should gain the self-confidence to address
issues as they occur, instead of thinking about them over and over again, and
kind of letting them ruin my day.

The third learning strategy employed by half of the experienced doctors and a
majority of the new graduates was learning from hospital staff. This type of learning varied
from simple issues such as how the hospital’s supplies were organized to more complex
topics like client relations and the correct use of organizational procedures and systems. Dr.
McKenzie, a new graduate, was sorry to see the office manager, a licensed veterinary
technician, leave her hospital to go to work at another practice. She noted in her journal, “I
am going to miss her a lot because she’s been doing a lot of my mentoring.” Another new
graduate, Dr. Fox also mentioned the value of experienced staff that are, “able to teach me
certain things, because at this point I think they know more about how the hospital runs than
I do.”

A variety of other learning strategies were employed by doctors, although no single
strategy other than the three mentioned previously was utilized by a majority. Other
learning strategies reported by subjects for non-medical issues included the following:

- Receiving feedback from clients
- Advice from a mentor
- Asking questions
• Using/reflecting on information from Academy
• Online learning modules (Banfield Learning Center)
• Formal observation
• Applying past experience (gained prior to veterinary practice)
• A binder containing information about the hospital

A final theme that appeared in the context of learning approaches was avoidance. The concept of avoiding a subject did not appear in the context of medical/clinical learning; however, doctors mentioned avoidance both in terms of interpersonal relations and the financial operation of the hospital. Avoidance is relevant in a discussion of learning strategies because it represents an intentional effort to not learn about a particular subject. Understanding the learning that these doctors avoid may be as revealing as understanding the learning that they pursue.

Avoidance was mentioned several times in the context of the financial aspect of the practice, particularly as it related to the cost of service. This may have been somewhat intentional on the part of Banfield, where standard operating procedures dictate that a paraprofessional, rather than the doctor, normally reviews the cost of treatment with each client. Several comments from doctors, however, suggest that avoidance of financial matters is the result of more than simply following procedure.

• Dr. Gengler: “I try not to look at prices, so it doesn’t affect my decisions.”
• Dr. Schwartz: “Because I’m a float doctor and not a partner or even an associate, I don’t have to understand the financial end of it as much as other doctors do.”
• Dr. Fox: “I try to stay away from the finances as much as possible.”
Dr. Lily: “I don’t want to come across as a money-grubbing veterinarian.”

The other aspect of practice management where avoidance appeared was interpersonal relationships, specifically those with staff and clients, and often related to conflict. Dr. Dana Rosa, who worked at multiple hospitals noted conflict with a staff member but did not seek a strategy to resolve it, stating, “I do not plan on working at this hospital many more times.” Dr. Berger chose not to address the issue of certain difficult clients, and resolved, “If they’re that picky or crazy then I don’t want to deal with them. It just stays with me more, and makes things worse. So I brush it off.” In both the cases of interpersonal relationships and practice finances, subjects who reported avoidance generally did not pursue learning strategies in the same areas that they had avoided.

The findings of this research indicate that there were differences between the approaches employed by these eleven doctors, depending upon whether the learning was intended to support their role as medical clinicians or their role in managing the non-medical aspects of veterinary practice. Doctors approached learning about their medical role intentionally, applying a variety of formal and informal strategies to improve their skill and knowledge. Their approach to learning to navigate the social, financial and organizational elements of the practice were largely informal, and they employed a less diverse range of strategies in their pursuit. No doctor reported avoiding a situation that might result in medical learning, but avoidance appeared in situations that may have been opportunities for learning effective ways of addressing both social and financial aspects of the practice.
Research question three: Interaction of organizational v. professional context

How do strategies and tactics for learning in a corporate work environment interact with membership in a professional occupational community during the first six months of employment for DVMs at Banfield?

While the second research question probed for comparisons between the approaches to learning applied by the doctors in this study, the third question was directed toward understanding the interaction between learning as a professional and learning in the context of a corporation. Responses to questions three and four of the final interview (see Appendix C) provided information about specific themes where organizational and professional learning had intersected. Question three was unprompted, “What have been your most important learning experiences so far at Banfield?” The fourth question asked, “Are you reminded of anything else that has been significant to your learning?” While probing for similar information to the earlier question, participants were prompted with a list of workplace learning themes (see Appendix A) grouped into three categories: Learning the Profession, Learning the Organization, and Learning About Oneself (Marsick, 1987; Van Maanen & Barley, 1984). Subjects were not asked to respond to every item that appeared on these lists, only those that reminded them of a significant learning experience.

Six themes in which participants reported learning that was both organizational and clinical emerged from responses to the third and fourth final interview questions. These themes, listed in order of the frequency of their appearance were:

1. Mentoring relationships (mentioned 15 times by two experienced doctors and five new graduates.)
2. Productivity (mentioned 10 times by one experienced doctor and six new graduates.)

3. Working with hospital staff (mentioned seven times by one experienced doctor and two new graduates.)

4. Participation in the professional/occupational community (mentioned six times by three experienced doctors and two new graduates.)

5. Concern over unnecessary vaccines or treatment (mentioned six times by three experienced doctors and one new graduate.)

6. Working at multiple hospitals (mentioned six times by one experienced doctor and three new graduates.)

Learning reported in these six areas was predominantly informal, although some formal learning strategies were evident. The mentoring process is by definition a formal learning strategy, but several subjects applied informal learning strategies in their application of the mentoring process. Doctors mentioned a recently-initiated formal system of feedback reports in the context of learning about productivity. Formal treatment and vaccination protocols are integrated into the organization’s proprietary practice management software used by all employees in the course of their work; learning in this area, however, was more focused on the informal process of reconciling personal knowledge and beliefs to the organizational expectations reflected in the protocols. Learning about working with staff, participation in occupational community, and working at multiple hospitals was almost exclusively informal.

In each of these six areas, the interaction of participants’ identity as members of a professional occupational community and as employees of a corporation resulted in both
positive and negative learning outcomes.

*Mentoring Relationships*

The mentoring relationship was the second most frequently mentioned theme overall, accounting for 4.8% of text units coded. All seven new graduates were able to identify a specific mentor, and some reported having multiple mentors. Only one experienced doctor reported having an assigned mentor, and another reported being mentored by corporate staff including the medical director and field director assigned to that geographic region. Two of the experienced doctors indicated that they did not have a mentor. Two experienced doctors were also engaged in mentoring less experienced doctors.

The availability of mentoring by experienced doctors was mentioned repeatedly as a factor in doctors’ decision to join this practice, particularly by recent graduates. All seven new graduates and two of four experienced doctors reported positive learning experiences that resulted from working with capable mentors who used thoughtful, organized methods. The majority of these experiences related to medical learning, although doctors occasionally reported that mentors were instrumental in helping them to learn about functioning in the organizational context. Dr. Smith offered a definition of what he considered to be a good mentor, “somebody that can answer questions, takes the time to answer questions, and also gives me the freedom to learn on my own and make my own decisions and ultimately learn that way as well.”

Some mentoring relationships became problematic. Doctors reported deficiencies in two forms: quantity and quality. The issue of quantity was generally related to a new
graduate doctor’s access to mentoring. Three doctors reported that scheduling pressures resulted in having to work independently before they felt competent to do so without a mentor present. Dr. Gengler reported such an experience in her journal:

The hospital director approached me about working Monday alone. He was having trouble finding a replacement doctor and simply wanted to get out of doing any more work on the subject. We had a discussion on my comfort level and the possibility of endangering the lives of hospital patients.

Eventually I agreed to be a single doctor for the day so long as the hospital director kept the patient load within my comfort zone.

Dr. Gengler’s reaction was typical of colleagues with similar experiences. She wrote, “I came to work for Banfield because they have a structured mentorship program. I wasn’t getting mentored today and I think the associate needs an appropriate mentorship.” All three doctors reporting insufficient access to mentors recounted that mentorship had been a consideration in their decision to join the practice. Dr. McKenzie assessed her situation in this way, “if Banfield had told me I would be by myself one day a week, I would’ve left.”

One doctor reported that she and another new graduate, who worked at hospitals in neighboring communities, negotiated a partial solution to working without a mentor by agreeing to work together at a hospital, “so we can at least help each other.”

Two doctors reported losing a valued mentor, one mentor left the organization and a second transferred to another hospital. The doctor whose mentor left the organization was unhappy with the quality of mentorship provided by the doctor who was assigned to replace her original mentor. The outcome of the doctor whose mentor transferred to another
hospital was unknown, since the change had only happened recently at the time of the final interview.

Two new graduate doctors reported that the mentorship experience was of poor quality, causing their learning to suffer. In both cases, these doctors also reported positive mentoring experiences, one with a previous mentor who left the practice, and another who was coached by a different mentor doctor while her regular mentor was on vacation. In both cases, doctors complained about the mentor’s style being overly directive and abrupt, not spending enough time to discuss cases. Dr. Madigan speculated on her mentor’s reasons for this behavior,

I think from his point he was trying to be nice, and it was a time management thing, because he’s big into time management. I think a lot of it was just to get stuff done quicker maybe, instead of having a discussion.

Dr. McKenzie recalled that her “mentor doctor has mentioned several times that it is difficult for her to remember how she felt when she was a new grad.” Dr. Madigan concluded, “Some people are just made more to be mentors, and some are not.”

Productivity

All eleven doctors commented on their learning about productivity during the course of this study. The reports differed between experienced doctors, who generally spoke in terms of productivity relative to their prior practice experiences, and recent graduates, whose expectations were unlikely to have been based upon experience in a comparable work environment.

Dr. Dana Rosa was the only doctor to have operated her own veterinary practice
prior to joining Banfield. She credits her learning about productivity to that experience:

I got my own business, and that’s how I learned productivity the hard way.

Veterinarians are not trained for that, we don’t want to learn that, and we really don’t care about it... I don’t want to have to think about it, but I do it anyway.

At Banfield, she reported being told that she was doing well on production, “which is important in the long run but I am not worried at this point.” Each of the other three experienced doctors noted the impact of learning a new system on their personal productivity. They added that the compensation system allowed for this, paying a fixed salary during the first year. All eleven doctors were aware of this system, as well as the fact that within a year their compensation would change to a production-based system.

During their first weeks of employment, new graduates demonstrated awareness that productivity in the workplace would be quite different from what they had experienced in veterinary school. Dr. Gengler explained in her initial interview,

Productivity. It’s certainly something I’m going to have to learn, not necessarily a concern of mine. I guess I just assume with the profession, they know you’re coming out of school. We don’t always have the best or the most relevant learning experience in veterinary school. It’s not very real world based.

New graduates’ awareness of their need to increase productivity was sometimes tempered by the understanding that focusing other parts of their development was more important at this stage. Dr. Berger described his experience in this way,
I’m not worrying about the production aspect right now. When I did look at my production, there were times at night when I began to wonder if I did things that day to help the patient or simply to boost production. No worrying about production has helped because since then my only concern has been helping the patient and learning the aspects of the job.

A contrasting experience was reported by Dr. McKenzie, who, in her initial interview indicated somewhat sardonically that her perception of productivity had related to her ability to, “sell people things that have an effect on my livelihood.” Four months later, she admitted, “I didn’t realize I would get quite so sucked into the, ‘how much money am I making for Banfield?’” As she described her excitement upon learning that her average charge for service was significantly higher than a colleague’s, she caught herself, adding, “It’s not something I really should care about, you know.”

During the course of this research, a formal system of feedback called the Weekly Associate Doctor Milestone Report was initiated by the organization. This report arrived via e-mail to each associate doctor and his or her mentor. While doctors realized that this mechanism was in its infancy, all were aware of its presence and paid attention to its content. Dr. Smith spoke favorably about having objective data to monitor doctors’ development, but was the most outspoken critic of the report.
The main reason I say that is because the report includes a lot of financial
data, in particular averages for production and charges in different situations.
I would rather say that at my current level, I should be more concerned about
going the medicine done properly, rather than concentrating on my net
charges. I should be more worried about having the proper diagnostics done
on a sick pet instead of the number of diagnostics done.

Doctors who regularly worked at multiple hospitals were also critical of the report.
While interested in the report’s content, they were frustrated that the data did not include
their work in each hospital, making it incomplete and/or inaccurate. Despite their
frustration, these doctors indicated that they were still able to receive useful feedback by
informal means. Dr. Gengler explained that despite the fact that none of her reports had
been accurate up to this point,

So far as productivity, I mean, I feel like I’m doing OK and my mentor tells
me I’m doing OK. I haven’t heard anything from anyone higher up so it’s
like, OK. I feel like I’m doing OK, but I don’t really have the hard evidence
because there’s pretty much no way of tracking it at this point.

Medical and organizational learning also intersected as doctors learned the impact to
their personal productivity of utilizing staff. Dr. Delta realized that when she failed to
utilize staff resources, her own productivity suffered. She explained, “That’s a major thing
I’ve learned, just being here, just realizing that you have your nurses and the rest of your
team to work on this.” In some cases, a shortage of trained staff was the cause of a doctor’s
inability to utilize staff. Dr. Smith described the impact of staff shortages:
Being understaffed usually decreases my efficiency. So I spend a bit more time taking care of little side tasks, and tidying things up right afterwards, and sometimes starting an exam by myself, and of course sometimes that affects productivity as well.

Hospital Staff

Learning about working with hospital staff was the single most frequently mentioned topic in this study, accounting for 5.1% of all text units coded. Not surprisingly, this was also mentioned by doctors as one of their most significant areas of learning. Dr. McKenzie reflected, “I am really surprised that most of the learning issues and difficulties I am having has been with interpersonal relationships and not with medicine.” She went on to explain that staff relationships were more difficult to deal with than clients. In her experience, learning about working with staff is what, “really taught me the most, you know, about what it is like to work in a private practice.”

The importance of interaction with hospital staff has already been mentioned as it relates to mentoring relationships (i.e., learning from staff) and the impact of proper staffing levels and utilization on doctor productivity. Three additional themes emerged from doctors’ learning: relationships with staff, setting expectations for staff, and training staff.

Learning about staff relationships was a large component of the experiences reported. Doctors learned important lessons about teamwork and collaboration, voicing unanimous agreement on the value of a staff that worked together effectively. Dr. Murray gave the example of a newly-formed team in her hospital that was, “beginning to develop a rhythm, which can only occur with consistent team interaction.” Dr. Fox determined that,
"If I treat my nurses well, communicate with them well, then they are happier and they want to help you out more." Dr. Delta observed, however, that the level of teamwork in the hospital depends on the individuals involved, "There are so many different attitudes and different behaviors, and I've just learned that some people will go all out to do everything that they can, and some individuals you need to tell them everything that you want done."

Conflict was the most common experience by which doctors reported that they learned about working with staff. Nearly every doctor reported that they had been involved in or observed conflict involving co-workers. The strategies that they adopted to cope with or resolve conflict varied. Dr. Murray relied on coaching from regional staff to turn around a situation with a staff member who had developed a pattern of resentfully resisting improvements to office procedures. Dr. Fox, a new graduate, came to the conclusion on her own that she ought to assert her status when a staff member was insubordinate. "I'm a doctor now," she pointed out, "and I should gain the self-confidence to address issues as they occur, instead of thinking about them over and over again, and letting them ruin my day."

Dr. Lily, an experienced veterinarian, resigned herself in frustration to the lack of teamwork she encountered, recording in her journal,

Since I am not the leader, my say is not very important. I'm definitely not in control of my own workday, and my emotions are often being led around by a 19 year old customer service coordinator or a nurse that has very little veterinary experience, as they both often go over my head or get huffy if I decide things should be done in a different way.
In another case, two new graduates decided that the best way to overcome conflict with an office manager was persistence. Dr. Gengler reported that “it’s a struggle to get him to agree to anything we recommend, even though in the end, after arguing with him for a while, he says, ‘OK, fine.’” Dr. McKenzie recognized the role that office gossip played in fomenting conflict, “you can’t say anything in confidence and not expect it to get back, not only to the person you were talking about, but to everyone else in the entire hospital.” In a journal entry, Dr. Smith pondered the role he should take in an office conflict, “It’s difficult to decide whether or not I should be interjecting to prevent such discussions from occurring, or allowing it to be done and over with so team members can move on.”

One finding that was somewhat unique for a large corporation is that traditional supervisory lines were rarely mentioned by doctors and appeared to be somewhat ambiguous during the hospital observations. Only one doctor functioned in a line management capacity, as acting chief of staff, none of the other ten appeared to have any formal supervisory responsibility. Despite the absence of formal authority doctors became aware that they were responsible for setting expectations for support staff. Like their learning about working relationships in general, this lesson was largely informal.

The concept of taking responsibility to set expectations was foreign to recent graduates. Dr. Fox related the importance of effective communication with staff, “I remember a mistake that one of my nurses did and I had to write a note saying, ‘communication is key,’ and I stuck it on the front.” Dr. Schwartz, an experienced veterinarian, realized that she learned best visually, rather than aurally, but that the nurses tended to rely on spoken communication almost exclusively. She applied this self-
knowledge by requiring nurses to adapt to her learning style.

Today I initiated a new format with the pet nurses. I need them to write down their exam findings at the bottom of the authorization sheet. If they walk up to me and tell me orally everything they saw, it goes in one ear and out the other. This will lessen my frustrations by quite a bit, if they will do it.

During hospital observations it became apparent that training staff was a critical function for doctors, as nearly every hospital had at least one staff member who was new to his or her role. Doctors developed their own style and techniques; none reported receiving any formal methodological training for coaching support staff. Dr. Fox developed a technique of quizzing nurses about the dosages of medications they were preparing. She had been warned by her mentor “to be very patient with the staff here, and that they have a long way to go.” She explained her method,

So you have to quiz them often – even if it’s the same question every day…If they’re off by a decimal place, that has really, really bad repercussions on the pet. It’s part of the training, I think, and it’s part of my job as the doctor, to make sure that they’re giving the right amount every time. And of course I make it fun.

Dr. McKenzie familiarized herself with online learning modules in the Banfield Learning Center (BLC) for nurses, combining them with the training she delivered personally. She recalled, “When teaching the new pet nurse to draw blood, I told her to do the venipuncture BLC and afterward we would draw blood on a dog.” Dr. Smith admitted regret that he did
not spend more time becoming familiar with the BLC content for nurses, which would have been helpful in his training role.

It is notable that formal tactics for learning to manage relationships with staff were largely absent from the doctors' reports. Beside the mentoring received by Dr. Murray, the only other formal learning experience reported that involved staff relations was completion of a required online module on harassment. One doctor made reference to a course she attended at Academy that related to personality type. Every other reported instance of learning about working with others occurred informally through experience or observation.

**Occupational/Professional Community**

Investigation into the doctors' participation in professional and occupational community focused specifically on social forms of learning that occurred through relationships and interactions with professional colleagues and co-workers. Participants' responses in this area reflected three distinct but overlapping working definitions of professional or occupational community:

- Veterinarians outside the organization, including professional colleagues, former co-workers and classmates, and veterinary school faculty.
- Veterinarians inside Banfield, including those who worked at the same hospital as well as those at other hospitals and in corporate positions.
- Hospital co-workers, including doctors, paraprofessionals, and support staff.

Each network of relationships, as defined by the subjects' experience, met Wenger's (1998) criteria for a community of practice: shared identity, purpose and resources, each developed over time.
Of the eleven participants, only Dr. Murray reported an active network of professional colleagues outside of Banfield with whom she stayed in regular contact. The most common response, given by four doctors when prompted about their participation in a professional or occupational community, was that there was none. And the most common reason given was lack of time. Dr. Smith, a new graduate, expressed suspicion that veterinary students' expectations of maintaining a professional network after graduation were unrealistic:

Social identification with the profession...in school you have this idea of what it's going to be like, or how you'd want it to be like, and the first thing you're going to learn is that it's probably a pipe dream to start with.

Dr. Lily indicated that she had avoided contact with other veterinarians, admitting, "I kind of hide out from most of the veterinary community, because I'm spending so much time at work. I just want to get away from it." The four experienced doctors used nearly identical terminology to describe how veterinary practice could be an isolating experience.

Participants were more likely to refer to professional relationships with other doctors inside Banfield than elsewhere. Dr. Delta appreciated the fact that she worked with professional colleagues at the same hospital,

One of the benefits of having two (other) doctors here is that they both get the same goals, they both meet the same thing, the end result is still the same, yet they work it up in two different ways. So for me it's been great in terms of that situation, just learning from them, that's my way of learning, learning two different ways of doing the same thing.
Dr. Schwartz, whose previous experience had been in a small, rural clinic, noted the value of both professional and paraprofessional colleagues within the Banfield system. As she worked in multiple hospitals, she also developed a network, recalling, “I’ve met a lot of other doctors and nurses that have helped me with understanding this and that. It’s very interesting how they do things differently at different practices and yet we’re all following the same basic agenda.” Another function of a professional community is the formal and informal enforcement of membership standards (Hoskin & Anderson-Gough, 2004; Wenger, 1998). Dr. Fox noted the need to protect her reputation within the organization, because “the veterinary community is very tight knit, so it’s not uncommon for vets to be blacklisted.”

The third occupational community reported by doctors included all co-workers in the hospitals where they worked. Dr. Smith, who said he had no regular professional contact with doctors outside Banfield, found satisfaction in the contribution he makes to the team he works with. As he described it,

I love it, and I’m pretty happy. I get to go to work and do what I want to do, and team relationships – I have seen that I’ve taken a hand in mentoring others, kind of guide them along in different techniques, and so I’ve done my own teaching now.

Dr. Schwartz noted “the group feeling and the bonds that you make with co-workers” as a benefit of her current job that her previous practice lacked. Dr. Murray describes a good day in the hospital in terms of the whole team:
It was an amazing day for us as a team. We worked together so efficiently, bouncing ideas off one another, forging new ground…and beginning to develop a rhythm, which can only occur with consistent team interaction.

For doctors in this study, the operative definition of community always included the immediate workplace, commonly extended beyond it, but rarely exceeded the boundaries of the corporate organization. Due to the size and diversity of the organization, doctors were able to enter into professional occupational communities and participate in joint learning within the system. Some found, however, that working in the organization could be isolating with regard to developing an external professional network.

_Treatments and Vaccines_

One of the most complex interactions appeared in doctors’ attempts to resolve real or perceived discrepancies between their medical training, personal values, and certain protocols that were prescribed by the organization as the standard operating procedure. Protocols at Banfield provide a structured starting point for most medical procedures. These protocols are contained in the proprietary practice management software, PetWare, used by all hospital staff throughout the course of each patient’s treatment. The protocols in the system prompt the doctor with various information and procedural steps depending on the diagnostic code entered, which the doctor may accept, reject, or change. Dr. Delta, a new graduate, offered this description of working with protocols:
You still have to be the doctor, and make the decision... Now that I know, just because you have a protocol to follow, does not mean that you have to do everything in that protocol. Sometimes it may have ten things listed, and you really only need to do two. Sometimes there will be ten things listed and there may be something else complicating the case that you need to do something else in addition.

Dr. Delta’s description appeared to reflect words that Banfield’s CEO, Dr. Scott Campbell, offered to all study participants on the last day of Academy. Dr. Campbell, himself a veterinarian, told the doctors present that he was “giving them the authority and responsibility to do the right thing” (personal communication, July 22, 2005).

Despite the apparent permission for doctors to depart from or modify protocols according to their best professional judgment, some subjects perceived pressure to deliver services, particularly vaccines that they considered unnecessary. Three of the four experienced doctors mentioned this, as well as two recent graduates. Dr. Schwartz indicated that cost influenced her concern:

For some people it seems like we’re taking advantage of them financially, by recommending everything for every pet. And there is a wide range of economic levels of our clients, and some of them cannot afford everything. And it’s not that there’s a lot of pressure, because it is still up to the client what services they do have...

During the same interview, Dr. Schwartz recalled that in one case, she had recommended a “least cost scenario and did not recommend blood work on a dog.” The dog’s condition
worsened, and it might have been diagnosed earlier had blood tests been completed. Dr. Schwartz concluded, “This was a good lesson for me on Banfield Basics.” She acknowledged that it takes time to “fully grasp the concept of recommending everything for every pet,” adding, “because that is the ultimate care.”

Both Dr. Lily and Dr. Madigan expressed concern over what they considered to be “a tendency to over-vaccinate,” but opted to address their concerns by spreading vaccines out over time rather than giving them all at once. Despite her concerns, Dr. Madigan acknowledged the organization for research that had been conducted to support its vaccine protocols, “Banfield has some studies on vaccination reactions, and we’re not pre-medicating a lot of pets that are high risk category. They have done a study to see what breeds and what type of pets are more at risk for vaccines.”

Dr. Fox, a recent graduate, developed different strategies for clients who had purchased wellness plans that covered the cost of vaccines and those who did not purchase that coverage. For those with wellness plans, she said, “I stick with Banfield’s policy of vaccinations, simply because the client has already paid for these vaccinations and if something happens to that pet, Banfield will stand behind me because I followed Banfield’s protocol.” For those not subscribed to a wellness plan, she had a different approach.
And that's where client education comes in. I tell them about the diseases that the vaccines protect against and how well the vaccines work to do its job, and then let the client decide what they want for their pet. Personally, there are vaccines that I would rather do without, probably because either they don’t work that well or their purpose isn’t to prevent—their purpose is to make the symptoms milder when the pet does get infected.

Dr. Fox admitted that she felt conflict over keeping costs down for patients versus offering all available treatment options. Sharing this dilemma with her mentor, she received this advice, “If I don’t recommend the gold standard, then I’m shortchanging the pets. I don’t really have the pet’s best interest in mind – I have the client’s pocketbook in mind.” Dr. Fox continued, recalling her mentor’s advice to “recommend what I think is best for the pet. If the client can’t afford the best, then give them options.”

Concerns about delivering unnecessary services were based on the financial or medical impact, and sometimes a combination of both. In both cases, doctors demonstrated some degree of ambivalence. Concerns about taking advantage of clients financially were generally followed by comments about the need to provide the best care by offering all options, and letting the client make the decision. When concerns about vaccinations were based on medical implications, doctors generally found ways of working around them, such as spreading vaccines out over several visits. Regardless of the source, doctors who expressed these concerns perceived pressure from the organization. None, however, specifically identified by whom or in what way this pressure was exerted.
Multiple Hospitals

The sixth area where medical and organizational learning intersected was working in multiple hospitals, a practice that some doctors called “hospital jumping.” Two experienced doctors and three recent graduates reported that working at multiple hospitals was a routine occurrence. The accounts of experienced doctors and new graduates differed considerably.

Both experienced doctors entered the practice knowing that they would be working at multiple hospitals, at least for some time. Dr. Dana Rosa worked at several hospitals over a period of three to four months until she accepted an assignment to what became her home hospital. Having experienced the working environment in different hospitals, her decision to accept a permanent assignment was strongly influenced by her perception of that hospital’s staff and management. “I could feel that people were all friends,” she said, describing her home hospital, “they were relaxed, and although they were swamped with work, they were talking, and laughing, you know, they got along really well.” She was also attracted by the quality of management she observed in both the Chief of Staff and the Office Manager, saying, “not only do they get along well, they know how to handle people…and having positive leadership, not just leadership, I think that’s important.”

Dr. Schwartz was in the somewhat unique position of being hired as a “float” doctor whose job description was based on working in multiple hospitals to provide coverage during other doctors’ absences. She chose this position and schedule for both personal and professional reasons and was satisfied with her choice. “I was the kind of person that they were looking for,” she recalled, “Which has kind of worked out pretty well, because I’m a
float doctor so I’m always going into a new situation.”

For three recently graduated doctors, the practice of “hospital jumping” was a frequent source of irritation. Unlike their experienced colleagues, they complained that this was not a choice they made, but something that the organization had imposed on them. Dr. Delta described her experience, “I’ve just been thrown around to work at other hospitals, ‘you’re going here, you’re going there,’ you know. No asking if that’s OK, just, ‘OK, you’re working here, you’re working there.’” Dr. McKenzie reported that “we get calls from other hospitals all the time to fill in and that sort of thing.” She expressed concern about unwritten rules governing coverage, “making sure you’re being fair so people cover for you when you go on vacation.”

The negative impact on performance feedback of working at multiple hospitals was documented previously. In addition to difficulty caused by incomplete or inaccurate performance reports, the practice caused Dr. Gengler to question the motives behind verbal feedback she received, speculating,

I hear it from more than one person, “Oh, you’re doing fine, you’re exceeding our expectations.” But in the same sentence, they say, “but will you work here for a day?” So do you really mean I’m doing fine, or are you buttering me up so I’ll go willingly and help you with your schedule?

Despite concerns, these doctors also admitted learning from the experience of working in multiple hospitals. Dr. McKenzie made this observation about learning to work with others, “It’s dealing with a lot more than just your own staff. It’s dealing with everybody else’s staff too.” Dr. Gengler noted, “Every situation I got thrown into, I learned
a new way to deal with it, or where to draw the line or that sort of thing.” On balance, however, she reckoned that “the hospital jumping and the lack of staff has actually been more a barrier to learning than helpful. That’s one thing I’ve definitely discovered in the last four months.”

Research question four: Impact of disciplinary learning

Does professional socialization and identity play a role in the learning process that might either enhance or become a barrier to acquiring knowledge and skill outside one’s primary discipline?

This fourth question emerged from recursive analysis of the data during the journaling phase of data collection. This type of analysis allows time for the researcher’s cognitive processes to reflect on the data as it is being collected and identify patterns as they begin to emerge (LeCompte & Schensul, 1999, p. 158). This question emerged as evidence mounted indicating that the doctors approached the task of learning differently, applying different strategies and tactics, depending upon whether or not the object of learning might be considered part of the professional discipline of veterinary medicine. By adding this question, I sought to expose a relationship, if one existed, between these doctors’ professional identities and their willingness and ability to learn about the portions of veterinary practice that are not clinical in nature.

Several comments from subjects provided clues that there could be a clear cognitive distinction between the medical and business sides of veterinary practice. One recurring behavior was a tendency for doctors to add a dismissive comment when discussing their involvement with the business aspect of their profession, as if to distance themselves from
the appearance of taking an interest. Some examples:

- Dr. Smith described investigating the hospital’s financial reports to learn more about them, “I had mainly been focusing on the medicine I was practicing, but I started asking questions as to what those digits meant in that column, et cetera.” He added, “However, my interest is not so much in the business as it is trying to determine if I have made a positive impact on practice in my time.”

- Dr. McKenzie expressed satisfaction in her production statistics, “I know I told you that was one of the first days my average pet charge was over a hundred dollars and I was kind of excited about it.” But with her next breath she dismissed it, saying, “It’s not something I really should care about, you know.”

- Dr. Dana Rosa, describing her prior experience of owning a veterinary practice, explained, “I got my own business, and that’s how I learned productivity the hard way. Veterinarians are not trained for that, we don’t want to learn that, and we really don’t care about it...I don’t want to have to think about it, but I do it anyway.”

Another clue about the possible impact of professional socialization came from subject accounts of opinions voiced by professional colleagues, including the veterinary schools they had attended. Two of these comments were attributed directly to veterinary school. In both cases, the doctors immediately made comments indicating that their experience was not what they had been told.

- Dr. Lily: “School said bad things about corporate medicine...It’s not just a corporation. It’s a huge corporation, but it takes medicine seriously.”

- Dr. Madigan: “At vet school they tell you that, ‘Oh, at Banfield they have specific
protocols that you have to follow.’ But that’s not really true.”

Participants attributed similar comments to peers:

- Dr. Gengler: “You always hear people say, ‘the corporate practice – you have to deal with the corporate.’” As in the previous comments, Dr. Gengler immediately continued, “And while there are frustrating things dealing with corporate, I also feel like I have a huge support network behind me.”

- Dr. Delta: “When I first interviewed, everyone at school was like, ‘I would never work for Banfield, because of all those protocols they have, and I just want to practice my own medicine.’” Dr. Delta also added, “It’s definitely not cookbook medicine. You still have to be the doctor, and make the decision...I would stand up to anyone that said that, because now I’m on the other side of the fence, and I am able to see.”

- Dr. Delta mentioned additional concerns from peers: “I’ve actually talked to several of my classmates, but they weren’t the ones making statements about the cookbook medicine per se, their biggest thing was about working at a national corporation, just in terms of the hours, and it was other various situations.”

- Dr. Lily: “Peers said, ‘why would you want to do that?’ (i.e., work for Banfield.)”

While only a minority of the subjects described these influences, the content was highly consistent, despite the fact that these doctors had attended different veterinary schools in different parts of the country.

A two part open-ended question was included in the final interview (see Appendix C) in order to elicit possible differences between the way that doctors viewed their medical
and the non-medical roles. To represent the medical role, I chose the title “veterinarian,” and I used the generic title “business person” to represent the non-medical aspects of practice management. The two parts of the question were, “What words would you use to describe a good veterinarian?” and “What words would you use to describe a good business person?”

Responses to these questions were grouped into thematic categories and analyzed according to frequency as well as the order in which they were mentioned by each doctor. The eleven subjects provided sixty discrete responses to the part A of the question (good veterinarian) and forty-two to Part B (good business person). Responses were grouped into themes, with the following lists of themes emerging from each question (see Table 6).

Table 6.

**Disciplinary Themes Ranked by Frequency**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
<th>Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Good Veterinarian</td>
<td></td>
<td>B. Good Business Person</td>
<td></td>
</tr>
<tr>
<td>Compassion</td>
<td>14</td>
<td>Communication</td>
<td>14</td>
</tr>
<tr>
<td>Communication</td>
<td>9</td>
<td>Business skills, positive connotation</td>
<td>12</td>
</tr>
<tr>
<td>Open/Improving</td>
<td>8</td>
<td>Profit concern, negative connotation</td>
<td>6</td>
</tr>
<tr>
<td>Ethical/Honest</td>
<td>6</td>
<td>Uncompassionate</td>
<td>4</td>
</tr>
<tr>
<td>Knowledge</td>
<td>5</td>
<td>Knowledge</td>
<td>3</td>
</tr>
<tr>
<td>Charisma</td>
<td>5</td>
<td>Charisma</td>
<td>2</td>
</tr>
<tr>
<td>Business skills, positive connotation</td>
<td>4</td>
<td>Calming Influence</td>
<td>1</td>
</tr>
<tr>
<td>Advocacy</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical/medical skills</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cope with frustration</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calming Influence</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observant</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>60</strong></td>
<td><strong>Total:</strong></td>
<td><strong>42</strong></td>
</tr>
</tbody>
</table>

*N=11. Themes in bold appeared in both lists.*
Five themes were common to both lists: communication, business skills, knowledge, charisma, and a calming influence. The theme of charisma, which included friendliness and being personable, was mentioned by five new graduates as a trait of a good veterinarian and by two new graduates as a trait of a good business person, but was never mentioned by an experienced doctor in either context. Having a calming influence on people was listed by one doctor, a new graduate, in response to both questions.

Communication, the most frequently mentioned theme, was attributed to good veterinarians by one experienced doctor and five new graduates, and to good business people by two experienced doctors and six new graduates. Professional knowledge appropriate to the discipline in question was used to describe a good business person by all four experienced DVMs and three recent graduates; as a descriptor for a good veterinarian, this trait was mentioned by two doctors, both experienced. All comments grouped into the “business skills” theme were positive in nature, unlike comments that were included in the theme “profit concern” which typically held a negative connotation.

In order to better understand the relationship of these themes, particularly those that were unique to each discipline, a second level of analysis was conducted to determine the order in which responses were given. Since the question was open-ended, the number of responses given by each doctor to each part of the question varied. The sequence of responses was weighted to the mean for each response so that it was possible to determine how early or late in subjects' lists each theme tended to appear. Bubble charts (see Figures 2 and 3) display the relative order in which themes were mentioned on the Y axis, themes on the X axis, and the number of times each theme was mentioned is represented by the
relative size of each bubble.

Topics that tended to be mentioned first generated high centile scores, while those mentioned toward the end of doctors' lists generated low centile scores. The three highest ranking themes attributed to good veterinarians, in order mentioned, were (1) ethical and honest, cited by two experienced DVMs and three recent graduates, (2) professional knowledge, mentioned by four recent graduates but no experienced doctors, and (3) continuously improving and open to new ideas, listed by three experienced doctors and three new graduates. Compassion and communication, the themes mentioned most frequently, were ranked sixth and seventh out of twelve themes describing good veterinarians, indicating that while these were mentioned frequently by doctors, they did not have a strong tendency to be mentioned either first or last. It should be noted that all responses describing subjects' perception of a good veterinarian were positive traits, consistent with the tone of the question.
The highest ranking descriptors that doctors attributed to a good business person were, in order of mention, (1) professional knowledge, mentioned by one experienced doctor and two recent graduates, (2) a lack of compassion, noted by two experienced and two recently graduated doctors, and (3) a concern for profit, listed by one experienced doctor and three new graduates. The third theme, concern for profit, carried a connotation that profit would be placed ahead of concern for patient care. A key observation is that two of the first three themes doctors used to describe a good business person were clearly not good.
In a pattern similar to the one seen in responses to the first part of the question, the two most frequently mentioned attributes, communication and business skills, were ranked fourth and fifth out of seven themes used by subjects to describe a good business person. Additionally, the two themes bearing negative connotations, lack of compassion and concern for profit over care, were the only themes appearing in part B that were not common to subjects’ descriptions of both good veterinarians and good business people.

These findings address the final research question, suggesting possible differences in doctors’ perceptions of the medical role, presented as consistent with professional identity, and the non-medical disciplines involved in the practice of veterinary medicine in a for-profit organization. Patterns in some subjects’ responses reflect a cognitive separation
from a business role that differs from professional identity. Some doctors’ descriptions of
the business role, an element of practice management, reveal negative perceptions that
could be in direct conflict with an identity based on the preferred medical role.

Conclusion

A variety of methods were used to analyze the qualitative and quantitative data
gathered during this research. Although this study was primarily qualitative in nature,
quantitative techniques such as correlational analysis were employed when appropriate for
the type of data. Through this careful analysis, the data revealed information that was useful
in addressing each of the four research questions.

The first question was designed to gain understanding of the learning orientations
that veterinary doctors brought into a workplace setting. The findings indicated that these
doctors, individually and as a group, were learners with a balanced understanding of the
nature of learning as both a developmental process that enhances understanding and a
process that demands reliable reproduction of a specific body of information. Further, these
subjects demonstrated that they practiced learning in ways that were strategic in nature, yet
still pursued depth of meaning and understanding. It did not appear that subjects’
orientation toward learning would present barriers to their learning in the workplace; to the
contrary, their orientations indicate that these doctors would be highly likely to pursue
learning successfully.

The second research question asked if the approaches doctors used to learn in their
clinical role was different from those used in pursuit of learning the non-medical elements
of practice management. Doctors consistently and intentionally used a variety of formal and
informal methods to achieve medical learning, however, the tactics applied to learning practice management were largely informal and less diverse. Doctors also revealed that they were twice as likely to attribute confidence-building with successful learning about medical matters as they were to make the same connection when learning about non-medical roles. Despite this bias toward learning the medical role, doctors reported experiences of non-medical learning at least as much as medical, and in some cases, more.

Question three asked specifically about learning in areas where the medical and practice management roles intersect. Six key areas where this occurred emerged from the data: mentoring relationships, productivity, working with hospital staff, participation in professional/occupational community, concern over unnecessary vaccines and treatment, and working at multiple hospitals. In each area, doctors reported both positive and negative learning outcomes associated with the confluence of medical practice and organizational context. Positive outcomes tended to relate to situations where organizational systems and medical practice were in alignment. When these were in conflict, the barriers that emerged made the intended learning process difficult or in some cases impossible.

The fourth question, developed after the research had been underway, probed a possible connection between doctors’ professional identities and their willingness and ability to learn about roles that are inside or outside of their home discipline. The data revealed that while doctors’ perceptions of the medical role and business role appear compatible in several ways, some subjects harbored impressions of the business role that were in direct conflict with their perception of a good veterinarian.
CHAPTER 5

Discussion

This research sought to increase understanding of the interplay between workplace learning and professional occupational learning communities by investigating the learning orientations and behaviors of members of a cohort of veterinary professionals during their first six months of employment in a corporate hospital environment. The first contribution this research offers is the addition of an ethnographic study of veterinarians to the literature on adult learning in the workplace.

Occupational communities, particularly those based on professional disciplines, have been the object of research in the past, but this application of an ethnographic method to a population of doctors of veterinary medicine is unique. This research complements a growing body of literature that explores workplace learning experiences in professions that include accountants (Hoskin & Anderson-Gough, 2004), teachers (Lohman, 2000; Martin & Scribner, 1991; Williams, 2003), attorneys, nurses (Daley, 2001), engineers (Collin, 2002), pharmacy students (Aggarwal & Bates, 2000), as well as physicians practicing human medicine (Davis & Fox, 1994; Fox, Mazmanian, & Putnam, 1989).

Research focusing on individual learners indicates that the learning process is integral to the workplace context and social interactions that take place within it. Hodkinson and associates called for ethnographic and biographical research because
workplace learning is significantly more complex than the commonly held notion that it is
merely “the controlled acquisition of predetermined skills, knowledge and working

For the field of Human Resource Development, this research expands our understanding of medical professionals in a corporate workplace environment during a time when the pros and cons of “corporate medicine” are hotly debated. By exposing attitudes about corporate practice held by doctors and the subsequent learning strategies and tactics applied in that context, this research contributes an improved understanding of the learning experiences of professionals entering corporate practice. This research has also clarified potential barriers to learning that include predispositions that doctors may bring into the workplace, as well as those erected by organizational processes and systems that at times do not integrate well with the professional’s identity or disciplinary objective, which in this case was to provide quality medical care to their patients.

For the field of veterinary medicine, this research extends our understanding of how veterinarians both perceive and pursue their medical and non-medical roles in the workplace. By comparing the accounts of experienced veterinarians to those of new graduates, this study has revealed that for those coming out of smaller private practice, joining a large corporate practice was less of a leap than expected. In all cases, and to varying degrees, doctors struggled with the integration of their medical identity and role with others that were also essential to their ability to practice successfully, specifically practice management roles dealing with social, organizational and financial issues. One possible outcome of this research for the veterinary profession is a clearer focus on the
totality of roles of the veterinarian, in which medical, social, organizational and financial roles can be better integrated, leading to a more fully effective professional.

Resolution of issues raised in research questions

Each of the four research questions represented a different vantage point from which to look at the same overriding question: what might be found out about the orientation, approach, strategies and tactics of veterinary professionals learning to practice their discipline within the organizational context of a corporate practice? The research questions themselves suggest that there might be a problem.

1. What learning orientations do individual DVMs bring to the task of workplace learning?
2. Are there differences in ways that DVMs at Banfield approach workplace learning when comparing their clinical/medical role to their practice management role?
3. How do strategies and tactics for learning in a corporate work environment interact with membership in a professional occupational community during the first six months of employment for DVMs at Banfield?
4. Does professional socialization and identity play a role in the learning process that might either enhance or become a barrier to acquiring knowledge and skill outside of one’s primary discipline?

The nature of this problem was mentioned repeatedly and in various ways during preliminary interviews with key informants. In one form or another, each expressed concern that the transition of DVMs into the organization was difficult. In their collective experience, if the transition was ineffective, it became more likely that retention would
become a problem for the organization.

The issue resolved by findings relevant to the first research question was whether doctors’ understanding of or orientation toward learning might be a potential barrier to their learning in the workplace. Collectively and individually, the answer was no. These doctors tended to have a balanced understanding of learning as practical acquisition and use of knowledge as well as a personal, developmental experience. Only one of the eleven doctors’ ASSIST scores resulted in a neutral result on personal/developmental understanding of learning, while all eleven agreed strongly with a pragmatic, instrumental understanding. These doctors (ten of eleven) also tended toward either a deep or strategic (nine of eleven) approach to learning, if not both, but none of the eleven doctors’ results reflected a surface, perfunctory approach to learning. The significance of this finding is that it excludes the ways that the doctors understood or approached learning as a potential cause in areas where learning was hindered. This leads to the second research question.

Findings related to the second research question revealed that doctors tended to use a combination of formal and informal learning strategies and tactics in pursuit of medical learning, while they relied almost exclusively on informal and incidental learning experiences in the non-medical aspects of practice management. Everyday learning in the workplace is commonly informal, consisting of a combination of observation, imitation and trial-and-error. Engeström (cited in Fuller & Unwin, 2002) points out that deep, investigative learning “is relatively rare without instruction or intentional self-instruction” (p. 99). Informal and incidental learning are useful, but the quality of learning is greatly enhanced when the learner’s approach includes a combination of formal instruction and
informal learning tactics.

These findings are consistent with Eraut’s (2002) observation that when certain occupational qualifications are perceived as having higher value and importance, others may be devalued as a result. Hoskin and Anderson-Gough (2004) found in their study of accountants that professional identity in the workplace environment had an impact on attainment, in particular, what types of content were perceived to matter versus those that did not. The physician’s practice environment has also been shown to impact motivation for self-directed learning (Mann & Ribble, 1994), as interaction with patients and colleagues provide an implicit set of expectations.

This is not to imply that informal or self-directed learning are either unimportant or invalid methods for a workplace setting. Bennett and Hodtvedt’s (1989) research involving physicians in the practice of human medicine revealed that 60% of early-career learning came through experiential learning activities, while mid-career physicians reported half of what they learned occurred through non-formal learning by experience (p. 70). What is notable about the reported experiences of the veterinarians in this study is the combination of learning methods employed to increase medical skill and knowledge, in contrast to the paucity of formal learning methods applied to learning practice management.

Workplace behavior as well as subject statements imply that some doctors were responding to cues about what types of learning really matter. The evidence suggests that these cues did not originate from a single source, but were repeated in various ways, resulting in a cumulative impact on learning behavior. Sources of these cues included:

- Individual: doctors expressed unfamiliarity, discomfort and a tendency to avoid
learning about certain social, organizational and economic aspects of practice.

- Professional: doctors were influenced to some extent by attitudes and beliefs of colleagues outside the practice and veterinary school professors that tended to question the validity of practicing medicine in a corporate organization.

- Environmental: doctors joining the practice found themselves under the tutelage of others who were products of the same system. Implicit messages conveying that only medical learning really matters were communicated through observed behavior and decisions.

- Organizational: statements used in recruitment identify corporate support for various administrative processes as a benefit of the practice, but may not communicate an equal emphasis the importance of developing competence in the non-medical aspects of the role. Also, certain organizational procedures, such as restricting discussion of financial arrangements with clients to paraprofessionals, may be interpreted to imply that parts of practice management lie outside the doctor’s domain.

The volume of data that related to learning about the social, organizational and financial aspects of veterinary practice indicates that learning beyond the medical role did occur. It is not surprising that medical learning was the foremost recipient of doctors’ attention. However, these doctors’ behavior implies a hierarchy where learning practice management was not only a low priority, but in some cases may not have been a priority at all until the need to resolve a workplace problem pushed such learning into the limelight.

If, as Mann and Ribble (1994) suggest, physicians’ motivation to learn is related to a
perceived performance gap between their current reality and desired state, it would appear that the perceived gap in medical performance was more compelling than the gap in practice management. After years of formal medical education culminating in certification by a state board of licensure, and admittedly little training in the non-medical aspects of veterinary practice, might these doctors still perceive that their most urgent learning needs are medical? Or are they responding to personal preferences and environmental cues that tend to focus their attention in one area to the exclusion of others? These finding imply that the choices doctors make in pursuit of learning are motivated primarily by personal preference and environmental cues rather than their perception of a performance gap.

The most expansive set of findings related to the third research question. The nature of these findings was somewhat unexpected, as the focus of the question was to explore the impact of the corporate environment and professional community on the learning strategies and tactics that doctors used. The most meaningful results, however, were related to the areas of convergence rather than specific strategies and tactics. From these findings, I identified six areas in which the convergence of the organizational context with professional practice created the need for learning. Areas where medical learning converged and sometimes collided with social, economic and organizational learning were:
- Mentoring relationships
- Productivity
- Working with hospital staff
- Occupational and professional community
- Procedures for treatments and vaccines
- Working in multiple hospitals

In each of these six areas, subjects reported both beneficial and harmful impacts to learning at work. Table 7 summarizes the most commonly mentioned impacts resulting from each point of convergence between medical and non-medical elements of practice.
**Areas of professional and organizational convergence and impact to learning.**

<table>
<thead>
<tr>
<th>Point of Convergence</th>
<th>Positive Impacts to Learning</th>
<th>Barriers to Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentoring relationships</td>
<td>Observation, coaching and feedback from experienced doctors. Learning includes both medical and non-medical elements.</td>
<td>Quantity: limited access due to schedule and staffing constraints. Quality: mentoring ineffective or poorly matched to mentee.</td>
</tr>
<tr>
<td>Productivity</td>
<td>Feedback provides a connection between medical and organizational outcomes. Productivity impact to personal income delayed during first year of practice.</td>
<td>Feedback sometimes inaccurate or incomplete. Perception that productivity focus conflicts with providing quality medical care.</td>
</tr>
<tr>
<td>Working with hospital staff</td>
<td>Desirable impact of positive team relations to medical outcomes. Importance of training and delegation to support staff. Learning from experienced staff. Effect of positive staff relations on personal outlook/attitude.</td>
<td>Negative impact of inadequate or untrained staff on medical outcomes. Negative staff relations contributing to disempowerment and poor morale. Lack of clarity about personal role in staff. Conflict avoidance.</td>
</tr>
<tr>
<td>Occupational and professional community</td>
<td>Availability of professional resources and specialists within the organization. Development of a beneficial network of colleagues and co-workers.</td>
<td>Isolation from professional contacts outside the organization. Delay or difficulty when accessing corporate resources.</td>
</tr>
<tr>
<td>Procedures for treatments and vaccines</td>
<td>Recognizing structure as a means of ensuring medical quality in a large organization. Sense of empowerment to choose how closely to follow protocols.</td>
<td>Personal desire to minimize cost to clients. Concern that protocols are financially, rather than medically motivated. Variance between organization and vet school’s approach or previous practice.</td>
</tr>
<tr>
<td>Working in multiple hospitals</td>
<td>Choice made by doctor for personal or professional reasons. Exposure to a variety of situations, methods and procedures. Development of a beneficial network of colleagues and co-workers.</td>
<td>Doctor feels “forced” to work at different hospitals for staffing purposes. Limited contact with mentor. Working solo before doctor is confident to do so. Negative impact to quality and completeness of feedback.</td>
</tr>
</tbody>
</table>
One way to understand the variety of impacts that result from these situations is to identify which are common to organizations in general, versus those that are specific to this organization at this point in its development. Several of these convergences that contribute positively to learning (see Table 7) are intentional elements of the organization’s structure and practice.

- Structured mentorship program for new graduates
- Formal feedback mechanisms
- Availability of support staff and training resources for them
- Structured protocols that are integrated into the practice management software utilized in all hospitals
- Availability of a variety of professional resources, including specialists in medical and practice management disciplines

Similarly, a number of barriers to learning appear to be unique to this organization’s situation. Some of these might be attributed to the fact that the organization is growing rapidly, causing resources to be stretched more thinly than anticipated.

- Scheduling of doctors that limits access to competent mentors and disrupts the flow of feedback
- Shortage of trained support staff
- Role ambiguity relative to authority (staff, decision-making, etc.)
- Unavailability or delayed response time from corporate support functions
- Difficulty reconciling apparent conflicts between organizational protocols and those learned in veterinary school or previous practice
The remaining impacts to learning appear to fall into two categories: those that are common to many organizations, and those that are specific to particular learners. Productivity, for example, is an issue common to all veterinary practice, not only large corporate practices. Predictably, recent graduates were most likely to report positive or negative learning experiences relative to productivity, as the expectations and impact in private practice differed significantly from what they experienced in veterinary school. Another area not unique to this research environment is staff relations, which are encountered in any practice that employs more than a single veterinarian.

An area of convergence that appeared to be unique to specific individuals was personal conflict over controlling the cost of service versus offering the best possible treatment. This conflict reported by several subjects is consistent with pricing behavior noted in the Brakke study (Cron, Slocum, Goodnight, & Volk, 2000), finding that doctors’ perception of client ability to pay impacted both services offered and pricing, as well as the KPMG LLC study (Brown, Silverman, & KPMG, 1999), indicating that female veterinarians may price their services lower than male counterparts. Some doctors reporting this conflict were able to resolve their hesitancy about recommending potentially costly treatment by accepting that they were offering the highest standard of care rather than limiting the client’s options based on what they perceived the client would be willing to pay. Others, however, continued to struggle in this area throughout the study.

The fourth research question emerged through recursive analysis of the data. The purpose of this question was to determine the impact that professional socialization and identity might have on doctors’ desire and ability to learn the non-medical aspects of
veterinary practice. An extensive study of veterinary practice conducted by KPMG LLP (Brown et al., 1999; Kogan et al., 2005) listed a number of requirements for successful veterinary practice that are not part of a traditional veterinary school curriculum, including “business, administration, personnel management, sales and marketing, and financial skills” (cited in Kogan et al., 2005, p. 1). Contrary to Montesino’s (2002) findings, alignment with organizational strategy did not lead to increased participation in learning behaviors geared toward increasing competency in practice management. Findings relevant to the fourth research question may shed light on reasons why these doctors’ approaches to learning about practice management were markedly different from the ways they approached learning about the medical aspects of their profession.

Senge describes mental models as the “images, assumptions, and stories” that unconsciously influence how people think and act (1990, p. 175). Doctors revealed disciplinary schema, or mental models, when asked to describe both a “good veterinarian” and a “good business person” (see Table 8). Five of the seven descriptor categories used for a good business person were similar to words used to describe a good veterinarian: communication, business skills, knowledge, charisma, and a calming influence. The other two were not only unique to DVMs description of a good business person, but stood in stark contrast to the corresponding descriptions used to describe a good veterinarian. These two descriptive categories were not mentioned by all subjects, but tended to be listed early, indicating that for those who held these mental models, they were near the front of their awareness. The first of these two was the tendency to be concerned about profit more than patient care, mentioned six times by four doctors; the second was a lack of compassion,
mentioned four times by four doctors. Only one experienced and one recent graduate doctor used both descriptions; six of the eleven doctors mentioned at least one of these two descriptors.

*Table 8.*

**Common and unique descriptors for Good Veterinarian and Good Business Person.**

<table>
<thead>
<tr>
<th>Good Veterinarian Only</th>
<th>Common to Both</th>
<th>Good Business Person Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion</td>
<td>Communication</td>
<td>Profit Concern, negative connotation</td>
</tr>
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<td>Knowledge</td>
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<tr>
<td>Observant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have previously pointed out that the two unique descriptors used for a good business person were *not good*. Even more striking is the fact that these are mutually exclusive of descriptors that appear only on the “good veterinarian” list. It is impossible to be both compassionate and uncompassionate at the same time. Nor is it possible to place profit concern over patient care and still consider oneself an advocate for the patient, or for that matter, ethical and honest. It is important to note that subjects identified business skills as positive attributes of both veterinarians and business people. The conflict between doctors’ perceptions of veterinarians and business people appears to focus less on what they do (business skills) than the kind of people that someone engaged in business is perceived to be (uncompassionate and overly concerned about profit).

These conflicting mental models shed light on the cognitive dissonance that several doctors experienced between their clinical and practice management roles. This dissonance
was evident in dismissive statements made by doctors in the same breath that they indicated an interest in learning or performing well in non-medical roles. It was also evident in recollections of critical statements about corporate practice made by peers and professors, which turned out to be inconsistent with their experience in this practice.

As a member of an occupational community, a professionals’ personal identity becomes situated in a social identity that transcends the workplace environment (Van Maanen & Barley, 1984). This socially-situated identity is a critical defining element of each subject in this research, and must be taken into consideration in order to fully understand the phenomena that were observed and reported. If, then, a shared concept of identity includes specific characteristics that are generally understood as desirable for the profession, then these characteristics become a way that members of the community identify themselves and others as being in or out.

Few doctors involved in this research appeared to recognize the knowledge and skills associated with practice management, essential for successful practice (Kogan et al., 2005; Lewis & Klausner, 2003), as an important element of their professional identities as veterinarians. This disconnect with competency in practice management is reflected in recent large-scale studies of the veterinary profession conducted by KPMG LLC, Brakke Consulting and Personnel Decisions International, all revealing that veterinarians, as a rule, tend to enter practice without the appropriate training and skill to manage others and administer a business (Brown et al., 1999; Cron et al., 2000; Lewis & Klausner, 2003). In fact, the negative attributions that subjects associated with the business roles of practice are in some cases antithetical to their perception of the medical role.
One exception from this research stands out: Dr. Murray. Aside from being an experienced veterinarian, a characteristic she shared with three other doctors in the study, Dr. Murray was unique by virtue of her undergraduate education. Unlike the other ten DVMs, all of whom had completed undergraduate studies in traditional scientific disciplines, she held a bachelor's degree in economics. Also unlike most of her colleagues, Dr. Murray did not appear to harbor negative assumptions about the business role, describing a good business person as “thorough, articulate, able to multi-task, and an excellent communicator.” Dr. Murray was exceptional in another way; more than any of her colleagues, she demonstrated an integrated approach to her work and learning with little evidence of the dichotomy between her clinical and practice management role that was common among other subjects.

If, as the old adage insists, “the exception proves the rule,” then Dr. Murray provided an example of a veterinarian whose professional identity was more integrated and holistic than what was described by and observed in the majority of her colleagues. In most cases this research showed that doctors’ professional identity was centered around the medical aspects of their discipline, while the social, organizational and economic aspects of veterinary practice were foreign, encountered episodically rather than intentionally and strategically. A commonly-held understanding of “business” as partially antithetical to their espoused identities as practitioners of quality medicine is an appealing suspect for a reason why they approached learning the non-medical aspects of their profession so differently from the clinical role.
Conclusions and theoretical implications

Qualitative research is interpretive in nature. It is unlike quantitative research, in which large populations (or scientifically selected representative samples) are assessed in order to provide objective results that are as free from bias as possible (Gay & Airasian, 2003). In ethnographic research, a form of qualitative research, the researcher focuses on a limited number of subjects in context (LeCompte & Schensul, 1999), which in this case was specific to both an organization and a particular career event. Grounded theory, a specific approach to qualitative research, was employed in this research in order to capture an in-depth perspective of veterinarians as they operate within their working context, adjusting to the culture and structure of a large corporate practice. By constantly comparing findings as they were gathered, the data itself provided clues to location of potentially more revealing findings (Gay & Airasian, 2003; Glaser & Strauss, 1967). This approach, while not intended to produce results that were statistically representative of anything beyond the eleven doctors who participated, allowed the researcher to not only observe what was happening in the workplace, but gain insight into possible reasons why.

From the beginning, before research subjects were selected, evidence indicated that there might be problems associated with how veterinarians adapt to the workplace environment, and that a better understanding of how these professionals learn in that environment might shed light on these problems. Once the subjects' understanding of learning and orientation toward learning was eliminated as a potential stumbling block, further investigation led to consistent and observable differences between these doctors' approaches to learning that varied according to the content learned.
Once I had identified the difference between DVMs’ approaches to learning skills and content that fit within their medical/clinical role and those associated with the organizational, social and economic aspects of practice management, the focus of investigation turned to the context. Six specific areas where medical and organizational learning converged were identified. In each of these areas, however, it became evident that the organizational context could either facilitate or erect barriers to effective learning.

While context played a role in workplace learning, these results led to a new line of investigation. If the organizational context accounted for some, but not all of the positive or negative impact on learning, what might be the contribution of the subjects’ thoughts, assumptions and beliefs? The relationship of various types of disciplinary content to each doctor’s concept of professional identity emerged as a key variable interacting with motivation to learn as well as specific tactics and strategies employed. This was particularly true of the aspects of veterinary practice management that doctors might associate with business.

Based on the findings of this research, I have concluded that the veterinarians in this study approached the task of learning in the workplace differently according to two key variables: perceived alignment with professional identity and perceived importance to professional practice. The most apparent differences were evident when comparing how DVMs approached learning about the medical aspects of their profession in contrast to practice management, made up of non-medical disciplines that are also a part of veterinary practice (Brown et al., 1999; Kogan et al., 2005).

In order to develop a theoretical framework with which to explain the interaction of
professional identity and practice, a helpful foundation has been laid by Hoskin and Anderson-Gough (2004). Through their study of transdisciplinary learning by accountants, they provided a theoretical explanation for the effect of disciplinarity on workplace learning. The educational systems that produce members of established disciplines tend to be highly specialized and exert significant influence on the type of content that is transmitted in the process of becoming qualified to practice a professional discipline. This narrow focus appears not only in the content delivered, but in the accepted delivery mechanisms and infrastructure that sustains the professional discipline. When this type of highly controlled and specialized system is the prevalent means for producing professionals as is found in the veterinary profession (Kogan et al., 2005), the need and opportunity for transdisciplinary learning may not appear until after the professional enters the workplace.

Transdisciplinary learning is an integrative approach that may shake the foundation of traditional “disciplinary ways of being” (Hoskin & Anderson-Gough, 2004, p. 71) by breaking the perceived monopoly that a particular discipline may hold on a profession. According to Lewis and Klausner (2003), veterinary schools in the United States recognize their role “as gatekeepers to the profession,” and are beginning to understand “their responsibility for selecting candidates who have the skills to capitalize on their education and build successful careers” (p. 1690). Despite this recognition, veterinarians who participated in focus groups conducted by KPMG (Brown et al., 1999) indicated that “they did not get enough management, communications, and other skills” (p. 163). However, the same DVMs also indicated that it would be difficult for veterinary schools to add training in these skills due to their already crowded curricula.
Hoskin and Anderson-Gough’s (2004) insight that disciplinary learning tended to occur in isolated, specific channels they referred to as “collection code” (p. 84), led me to an understanding of how the doctors involved in this study frame their professional identities. Each appeared to have a well-formed concept of their home discipline, i.e. that discipline with which they identified with most strongly on a personal and professional level. Based on these observations, when a professional’s concept of his or her home discipline is narrowly defined, the chances increase that there are other disciplines necessary for successful practice that fall outside of this self-defined home discipline. In this group of subjects, it was common for DVMs to associate their professional identity with scientific, medical, clinical disciplines but not as common for them to include non-medical disciplines.

Figure 4 is a theoretical model based on the observations in this study that demonstrates the interaction of professional identity, based on the professional’s perceived home discipline, and the professional’s perception of how important particular content is relative to the demands of practice. Position on the grid indicates the professional’s likely approach to learning a particular type of content that could be perceived to be outside or inside the home discipline.
Figure 4.
Approaches to transdisciplinary and disciplinary learning

A brief description of each quadrant of the grid follows:

- Low identity alignment and low importance to practice: *Unconnected*. The professional sees little connection with self or application in the work environment, so the most typical approach would be to ignore content in this quadrant.

- High identity alignment and low importance to practice: *Complementary*. The professional takes a personal interest in this content, but there is no urgent need for application in the workplace. A typical approach would be to explore this content as time permits.
• Low identity alignment and high importance to practice: Conflicting. The professional does not see a clear connection with the home discipline, but its importance for practice results in external pressure to learn, leading to conflict between practice demands and professional identity. A typical approach would be to avoid learning this content unless the pressure becomes too great.

• Moderate identity alignment and moderate importance to practice: Contrasting. The professional sees some connection with his or her home discipline, and the content has some relevance in the practice environment. This content may not be a perfect match with the professional’s interests, but learning will be tolerated if the need or opportunity is present.

• High identity alignment and high importance to practice: Crucial. There is both a strong connection with professional identity and an urgent need in the practice environment. Content meeting these criteria is likely to be pursued seriously, often to the exclusion of other types of content.

In this study, subjects’ approaches to medical content tended to fall in either the Crucial or Complementary quadrants. In the Crucial quadrant, doctors pursued medical learning relevant to their practice on a daily basis, using a combination of formal and informal methods. In one case, a doctor who had assumed a leadership role in the hospital sought mentoring from multiple resources in order to address a critical employee issue. This was the only obvious example of a case where a practice management skill (personnel management) was approached as a crucial learning experience.

In some cases, content held minimal relevance to the immediate practice
environment. Despite high alignment with professional identity, this learning fell into the Complementary sector. Examples in this quadrant included a doctor who wanted to learn more about treating reptiles, but could not arrange the time, and another doctor who enrolled in courses in veterinary acupuncture on her own time.

Participants’ approaches to practice management content tended to fall in either the Contrasting, Conflicting or Unconnected quadrants. Doctors tolerated, for example, mandatory online courses on safety, harassment, and various corporate policies, indicating that these topics may have fallen into the Contrasting quadrant – neither essential to nor in conflict with professional identity, but important enough to the organization that it seemed prudent to comply with this minimal training requirement.

Despite a tendency to avoid content in the Conflicting quadrant, some of the most dynamic interactions occurred there. Doctors who demonstrated reticence about recommending services to clients they perceived as being unable to pay struggled with the practice’s mandate to offer the best possible care versus a value system that equated charging expensive fees with taking advantage of clients. This conflict appeared to be difficult for some doctors to resolve, although several reported that they were aware of it.

The organization had established a system that would allow productivity to remain in the Unconnected quadrant during the doctors’ initial learning phase on the job. By providing a fixed salary for the first year, the intent was to decrease the environmental pressure for productivity during the period of time that doctors joining the practice would be focused on learning tasks that might have a negative impact on compensation under a productivity-based system. In at least one case, however, a doctor’s approach to
productivity moved from the Unconnected quadrant to the Complementary quadrant as she learned upon receiving performance feedback that she was more competitive than she had anticipated.

An obvious feature of this theoretical model is that the most desirable approaches to learning are located in the top two quadrants (see Figure 4), indicating high alignment with the professional’s home discipline. The impact of professional identity on workplace learning becomes evident: content that is perceived to be in alignment with one’s professional identity will be learned willingly and actively, while that which is not will be learned passively, grudgingly, or not at all. It is important to note that increasing the importance of certain content in the practice environment is unlikely to create a substantial improvement in professionals’ approach to learning.

Despite the presence of sound research results from KPMG, Brakke and others indicating that the veterinary profession suffers from a lack of knowledge and skill in practice management (Brown et al., 1999; Cron et al., 2000; Lewis & Klausner, 2003), there was negligible evidence that knowledge of these findings has had an observable impact on doctors’ behavior. I propose that the reason these studies have contributed minimal pedagogical value is that they focus on the financial impact of these deficiencies rather than their relationship to professional identity. Data from these studies indicate that earnings are not a powerful motivator in the veterinary profession, ranking seventh of eight as a reason for entering the profession (Brown et al., 1999, p. 168). Women, whose participation in veterinary medicine is steadily increasing, were less likely than men to have chosen the profession because of its financial attractiveness (Lofstedt, 2003), and as was observed in
the Brakke study, "it will be women who determine the overall income levels and expectations for the entire profession" (Cron et al., 2000, p. 337).

Implications for practice

What then, are the implications for the veterinary profession as well as for educators whose work involves professionals in the workplace? This research, while narrow in scope, has revealed that alignment with professional identity is a key factor affecting the learning behavior of professionals in the workplace. Prior research has demonstrated that practice management skills are not only critical to successful veterinary practice, but the lack of them is holding back the entire profession (Brown et al., 1999; Cron et al., 2000; Lewis & Klausner, 2003). Despite this evidence, in-depth ethnological study of eleven veterinarians joining a practice rich in resources has revealed that their intentional learning activity was predominantly geared toward the medical aspects of their work.

For the veterinary profession, the leverage in the system will be found in changing their occupational community’s shared definition of the disciplines that are essential to the professional identity of veterinarian. This is not a simple task, since the protection of existing professional standards is a role the academic institutions that produce professionals guard closely (Hoskin & Anderson-Gough, 2004). At least one veterinary school, Colorado State University, has taken on the challenge of filling this gap by making business-related curriculum available to its students as well as practicing veterinarians (Kogan et al., 2005). This is a concrete step in the difficult process of reframing the identity of a profession that has been in existence for centuries. Universities are advised to reconsider the role of non-medical coursework in both pre-veterinary and graduate veterinary curricula in order to
produce DVMs who are prepared to deal with all phases of veterinary practice.

If the profession is in agreement that there is a need to increase DVMs’ competency in practice management, this is cause to re-evaluate the continuing professional education (CPE) requirements of state licensing authorities. Policies that restrict the number of non-medical CPE hours that can be counted toward license renewal, particularly for early-career veterinarians, may discourage such education at a time in a professional’s career when it is needed. If the intent of these policies is to ensure that veterinarians stay medically current, the first renewal cycle following graduation from professional school may be an opportune time to encourage learning in practice management content not typically emphasized in the graduate veterinary curriculum.

Implications applicable to Banfield may also be appropriate for broad consideration in private veterinary practice, particularly practices that employ multiple doctors and staff. First, it will be useful to devise opportunities for doctors in private practice to expose assumptions and beliefs about their professional identities as early as possible. This could be accomplished through a structured interview process, or in organizations large enough to induct several doctors at the same time, in a facilitated group discussion. By exposing ways that doctors identify themselves as professionals early, a practice could provide the opportunity to address the pitfalls of an unrealistically narrow self-perception in the workplace.

A second implication for Banfield and other practices has to do with the way in which non-medical competencies are recognized by the organization. If, as this study has demonstrated, doctors’ identities are strongly aligned with medicine as the home discipline,
additional disciplines must offer demonstrable support to achievement in the home discipline. In other words, if skills such as learning to manage people or understand practice finances are important, their importance must be explained in ways that show how application will lead to high quality medical practice. Conversely, practice owners and leaders must be aware of behaviors that devalue transdisciplinary learning. For example, employment marketing messages commonly used by large corporate practices may overemphasize the availability of centralized support services, implying that doctors need never concern themselves with anything beyond the practice of medicine.

The use of mentors is a powerful tool for bringing new professionals into an organization. If mentorship is to result in the development of professionals with competence in multiple disciplines, this practice and others using this tool should be explicit in their expectations of mentors. Mentors who are veterinary doctors may have more experience in practice, but are products of the same system of professional education that produced the novices in their charge. Practices should provide the opportunities for mentors to expose and analyze their professional identities in light of the totality of learning required for effective practice, and select mentors who demonstrate a holistic understanding of their roles as professionals.

Finally, Banfield stands to benefit by examining both positive and negative effects of the organizational environment on how professionals learn. By emphasizing those attributes that facilitate learning and seeking solutions for those that erect barriers, the workplace context can become more conducive to effective learning. Of particular concern are the areas of conflict (see Table 7) that are rooted in stretched resources resulting from
the organization's rapid rate of growth. Doctors whose learning and development has been hindered by growth-related problems may be unlikely to align with organizational strategies designed to produce additional growth.

There are additional implications for educators and human resource development practitioners whose organizations employ members of professional disciplines. First, professional identity must be comprehended when designing educational and developmental programs and resources for users who identify with a specific discipline. These disciplinary "ways of being" (Hoskin & Anderson-Gough, 2004, p. 71) exert powerful influence on the choices and approaches that professionals make with regard to their learning activities. Second, it is wise to expect tension between traditional disciplinary roles and the increasing need for transdisciplinary attainment that modern organizations and economies demand. In organizations where multidisciplinary competence is a prerequisite for success, it is essential that existing disciplinary frames be exposed and where necessary, expanded to include a well-rounded self-image that is better aligned to the needs of both the profession and the organization in which it is practiced.

Recommendations for future research

The findings of this study suggest a number of possibilities for future research that could be conducted in the same organizational context or in different and more diverse organizational and professional contexts. One possibility flowing naturally from this research would be a validation study on the theoretical model presented earlier in this chapter. Through use of survey and quantitative analysis techniques, this model could be tested against a variety of populations, including Banfield veterinarians, a broader
population of veterinarians, as well as populations of professionals from other disciplines. Results from such a validation study would be an indicator of the theoretical model’s usefulness for predicting learning behavior in professional practice.

A complement to this research, which focused on veterinarians who were in their first few months of employment in a corporate practice, would be a similar ethnographic study of veterinarians who had been employed for some length of time. A purposive sample including doctors who had, at some point in their careers, successfully integrated practice management disciplines into their repertoire could provide clues as to the reasons and circumstances under which they were able to become transdisciplinary learners. Understanding these doctors’ learning behavior relative to their professional self-image would also provide a further opportunity for validation of the theoretical model presented here.

Replications of this research might be conducted among populations of other professionals, including dentists, physicians, attorneys, architects, engineers, professors or any professional discipline that is employed in sufficient numbers by corporate, governmental or academic organizations in which they practice their specialty. While each discipline has its own specific characteristics, the relationship of occupational community to organizational context would be a worthwhile endeavor for understanding the workplace learning behavior in a variety of professions.

Finally, this study could serve as a springboard for practitioner-based action research to be conducted in the same organization, as programs of selection, onboarding and professional development are continuously modified and improved. Action research based
on this study would provide the opportunity to experiment with interventions aimed at improving the alignment between professional identity and practical importance for content areas that have been identified as critical to the profession but are not yet consistently embraced by those entering the profession.

This research has demonstrated the ability to probe deeply into the behaviors, attitudes and approaches that a cohort of veterinary professionals applied to the task of learning to practice in a new and unfamiliar working environment. This deep investigation, situated in the workplace context and daily experience of the subjects, has provided clues to the reasons behind behaviors that have been observed for some time but not well understood. These clues have led to the development of a theoretical proposal for understanding the nature of professional learning behavior as it is influenced by each individual’s professional identity and the expectations of the workplace context in which his or her discipline is practiced.
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APPENDIX A

Framework for initial participant interviews

Learning the profession:

A. Personal and social identification with the profession
B. Role performance: professional knowledge, application and innovation
C. Participation in an occupational community (Van Maanen & Barley, 1984)
D. Productivity

Learning the organization:

A. Commitment, job satisfaction
B. Team relationships, including networking, coaching, mentoring, role modeling, power and politics, status
C. Philosophy, mission and goals, roles, rules and how they are interpreted, negotiated and modified

Learning about oneself:

A. Confidence building or undermining
B. Competence building or undermining
C. Identification with organization
D. Dealing with authority
E. Coping with unfair treatment, rejection, ambiguity, failure or competition
F. Coping with personal tragedy
G. Progress within organization
H. Changes in values, belief system, or self-concept
I. Dealing with discrepancies between personal values and those of the organization
J. Changes in orientation toward the job, the organization, career or role (Marsick & Watkins, 1987, p. 177)
APPENDIX B

Initial interview questions

Start recording

State Subject, Date, Time

1. For the record, would you tell me about how you decided on a career in veterinary medicine?

2. This study is about how veterinarians at Banfield learn in the workplace. How would you describe your own learning style?

3. I am going to show you three lists of topics that have been identified as typical areas where professionals experience learning in the workplace. These topics are grouped into “Learning the Profession,” “Learning the Organization” and “Learning about Oneself.” Please review each list and comment on areas that you anticipate will involve significant learning for you in the next three to four months.

   A. Learning the Profession: when finished ask, are there any other areas of professional development where you anticipate learning will occur?

   B. Learning the Organization: when finished ask, are there any other things about working in this practice that you anticipate you will be learning?

   C. Learning about Oneself: when finished ask, are there any other areas of personal learning and development you anticipate?

4. (if time permits) Can you tell me about a significant learning experience you have had that would help me understand you better as a learner?

5. Is there anything else you would like for me to know about you as a learner?

End recording
Final interview questions

1. [Prior to start of recording] Clarify any questions from first interview transcripts.

2. [Start recording] Questions from observations in the hospital during the day.

3. Unprompted question: “What have been your most important learning experiences so far at Banfield?”

4. Prompted question: [Provide list of workplace learning categories used in first interview] “Are you reminded of anything else that has been significant to your learning?”

5. Questions based on themes from journal entries or quantitative analysis.

6. “How has your learning experience practicing at Banfield compared to your initial expectations?”

7. “How has your learning experience practicing at Banfield fit with your learning style?”

8. “How has your learning experience practicing at Banfield influenced your identification with your profession?”

9. “How has your learning experience here influenced your identification with Banfield?”

10. “What words would you use to describe a good...
   a. Veterinarian
   b. Business person

11. Is there anything else you would like to tell me that I have not asked about?

[End Recording]
Approaches and study skills inventory for students (ASSIST)

The following is a learning styles and approaches inventory for participants in the Banfield Workplace Learning Study.

This questionnaire has been designed to allow you to describe, in a systematic way, how you go about learning and studying. The technique involves asking you a substantial number of questions which overlap to some extent to provide good overall coverage of different ways of studying. Most of the items are based on comments made by students. Please respond truthfully, so that your answers will accurately describe your actual ways of studying, and work your way through the questionnaire quite quickly.

When you think about the term ‘LEARNING’, what does it mean to you?

Consider each of the six following statements carefully, and rate them in terms of how close they are to your own way of thinking about it.

Very close Somewhat close Not so close Somewhat different Very different

1. Making sure you remember things well.
2. Developing as a person.
3. Building up knowledge by acquiring facts and information.
4. Being able to use the information you’ve acquired.
5. Understanding new material for yourself.
6. Seeing things in a different and more meaningful way.
The next part of this questionnaire asks you to indicate your relative agreement or disagreement with comments about studying again made by other learners. Please work through the comments, giving your immediate response. In deciding your answers, think in terms of learning in your professional practice at Banfield. It is also very important that you answer all the questions: please check that you have completed each question.

Please avoid the middle answer, "unsure" unless you really have to, or if it cannot apply to your situation

Agree   Agree somewhat   Unsure or does not apply   Disagree somewhat   Disagree

1. I manage to find conditions for learning which allow me to get on with my work easily.  
2. When solving a problem that requires learning, I keep in mind how best to impress those who evaluate my performance.  
3. Often I find myself wondering whether the work I am doing here is really worthwhile.  
4. I usually set out to understand for myself the meaning of what I have to learn.  
5. I organize my time devoted to learning carefully to make the best use of it.  
6. I find I have to concentrate on just memorizing a good deal of what I have to learn.  
7. I go over the work I've done carefully to check the reasoning and that it makes sense.  
8. Often I feel I'm drowning in the sheer amount of material I have to cope with.  
9. I look at the evidence carefully and try to reach my own conclusion about what I'm learning.  
10. It is important for me to feel that I'm doing as well as I really can on what I am learning here.  
11. I try to relate ideas I come across to those in other topics whenever possible.  
12. I tend to read very little beyond what is actually required of me.  
13. Regularly I find myself thinking about ideas from what I've learned when I'm doing other things.  
14. I think I'm quite systematic and organized when it comes to preparing for examinations, such as veterinary boards.  
15. I pay careful attention to my superiors' comments on my work to see how to do better the next time.  
16. There's not much of the work here that I find interesting or relevant.  
17. When I read an article or book, I try to find out for myself exactly what the author means.  
18. I'm pretty good at getting down to work whenever I need to.
19. Much of what I'm learning makes little sense: it's like unrelated bits and pieces. 

20. I think about what I want to achieve to keep my time spent learning well focused.

21. When I'm working on a new topic, I try to see in my own mind how all the ideas fit together.

22. I often worry about whether I'll ever be able to cope with the work properly.

23. Often I find myself questioning things I hear from my superiors or mentors, or read in books.

24. I feel that I'm getting on well, and this helps me put more effort into the work.

25. I concentrate on learning just those bits of information I have to know to succeed.

26. I find that learning can be quite exciting at times.

27. I'm good at following up some of the reading suggested by mentors or instructors.

28. I pay attention to who is going to evaluate my performance and what they're likely to be looking for.

29. When I look back, I sometimes wonder why I ever decided to come here.

30. When I am reading, I stop from time to time to reflect on what I am trying to learn from it.

31. I work steadily until my work is complete, rather than leave it all until the last minute.

32. I'm not really sure what's important in what my mentors or instructors say, so I try to write down all I can.

33. Ideas in books or articles often set me off on long chains of thought on my own.

34. Before starting work on an assignment or problem, I think first how to tackle it.

35. I often seem to panic if I get behind in my work.

36. When I read, I examine the details carefully to see how they fit in with what I am told.

37. I put a lot of effort into learning because I'm determined to do well.

38. I gear my learning to match how my performance will be evaluated.

39. I find some of the ideas I come across in my work really fascinating.

40. I usually plan out my week's work in advance, either on paper or in my head.

41. I keep an eye open for what my superiors seem to think is important and concentrate on that.

42. I'm not really interested in everything I learn, but sometimes I have to learn it anyway.

43. Before tackling a problem or assignment, I first try to work out what lies behind it.

44. I generally make good use of my time during the day.
45. I often have trouble in making sense of the things I have to remember.

46. I like to play around with ideas of my own even if they don't get me very far.

47. When I finish a piece of work, I check it through to see if it really meets the requirements.

48. Often I lie awake worrying about work I think I won't be able to do.

49. It's important for me to be able to follow the argument, or to see the reason behind things.

50. I don't find it at all difficult to motivate myself.

51. I like to be told precisely what to do in projects or other assignments.²

52. I sometimes get 'hooked' on academic topics and feel I would like to keep studying them.

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1 Indicates this statement was changed from the original to reflect American language usage, replacing words that are more common to British idiom.

2 Indicates this statement was changed from the original to be appropriate for a workplace context, replacing words that are specific to an academic context.
APPENDIX E

*Topical tree nodes*

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