Chapter 6
Becoming a Practitioner: Professional Learning as a Social Practice

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Abstract A practice-based interpretative framework for reading the process of becoming a professional as a social practice is developed to examine the ecology of the human and non-human actors involved in induction to the organization and seduction by the profession. We argue that professionals undergo induction into the organization while they undergo seduction by the profession. The chapter illustrates the situatedness of this process in relation to different types of organizations (private, public, network) in order to analyse the relation between the induction process and the actors that influence it. Three different models of induction are described: (a) in a professional bureaucracy, socialization precedes selection, and the key actor is the profession; (b) in a small private organization, induction is almost exclusively managed by the community of practice in the form of seduction by the profession; (c) in a large network of organizations, induction is explicitly managed by the organization and becomes a means to transmit the organizational culture.

Because the process of becoming a professional is a continuous process throughout working life, the tensions and contradictions that characterize its accomplishment are discussed in relation to the issues of behaviour control versus professional control, managerialism versus professionalism and identity work.

This chapter proposes that induction is not solely the effect of encounters between individuals and organizations, because two other agents are involved in the process: the profession and the community of practice.

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6.1 Introduction

The process of becoming a professional is usually described as a socialization process whereby novices learn how to perform a series of occupational tasks and how to develop appropriate identities as practitioners. Usually, sociology of work and sociology of occupation use the term 'socialization' to describe the reciprocal accommodation between an organization and an individual during the life-time of a presumably long-term work relation. Typically, it is the point of view of the individual that is privileged in this analysis, and from this point of view the socialization process resembles a trajectory or a stage model starting with anticipatory socialization. This occurs during the educational process: upon entry into an organization the individual assumes the social position of the novice; then later becomes an insider; and finally gets ready to leave the condition of employee through a process of gradual disinvestment from the working context. More recently, and especially within organization studies, it seems as if the scientific community is seeking to renew its lexicon so that it can continue to reflect on the same phenomenon but with new concepts. The term 'induction' seems to have arisen from this dynamic and the organizational point of view, and it is assumed as the main agent of the process.

The strength of the new term 'induction' lies in the semantic openness deriving from its scant definition. Whilst studies on socialization (e.g. Van Maanen 1976) have moved through the development of diverse conceptual models and methodologies of analysis including those from socialization as an independent variable affecting numerous organizational factors, through to models privileging the organization/individual relation viewed as a problem-solving process, to a model where socialization is an ongoing process and not an individual trajectory, induction is a notion still to be fully modelled and elaborated. For the initial purposes of this chapter, we adopt the definition of induction put forward by Skeats (1991: 16) as "any arrangement made to familiarise the new employee with the organization, safety rules, general conditions of employment, and the work of the section or department in which they are employed". This is a minimal definition, in that 'any arrangement' may vary from mere information lasting as long as an interview to a training course of even very long duration. This minimal definition is based on the implicit assumption that induction consists in a series of activities deliberately and formally undertaken by the organization to integrate new employees efficiently and effectively once they have been recruited. Therefore, the main aim of the managerial literature on staff induction is to provide normative advice on how new employees can be better integrated into their new working environment (Major 2000; Ardts et al. 2001; Tuttle 2002). At least four dimensions relating to the introduction of new employees have been explored in empirical research: (i) socialization tactics (Ashforth and Saks 1996; Allen 2006), (ii) newcomer adjustment (Cooper-Thomas and Anderson 2002;

Bauer et al. 2007), (iii) newcomer's commitment (Allen and Meyer 1990; Bauer and Green 1994) and (iv) identification (Pratt 2000).

A recent review of empirical research in the field of induction and socialization (Antonacopoulou and Güttel 2010) identifies three main strands. Firstly, the individual and organizational antecedents, i.e. the newcomer's predispositions and the firm's practices which govern staff induction, secondly, the inductee's adjustment and, thirdly, learning behavior over the course of their socialization; the outcomes of staff induction and socialization, especially in terms of person-organization fit. Moreover, Antonacopoulou and Güttel (2010) point out that the majority of researches undertaken are focused on the individual inductee as the main unit of analysis and thus are conducted with a dominant focus on psychological aspects.

Yet, if induction is to be understood in a specific but highly reductive sense, we fail to understand why the term is used synonymously with socialization, and why the management literature has sponsored it, thereby presenting in new guise a worn-out concept disciplinarily connoted in sociological and psychological terms. We are critical of such a narrow definition. For instance, consider the Latin etymology of the term: *in-ducere* is composed of the verb *ducere*, i.e. 'to lead' and the preposition *in*, which denotes place change. Induction thus signifies 'to lead in', i.e. to lead along the right path. The role of leadership is thus foregrounded, together with passivity and the passivization of those inducted. This linkage with the theme of leadership may explain the preference of management scholars for this term. We shall assume the term 'induction' in accordance with the etymological derivation of a process that leads along the right path, but we shall also correlate it with another term only apparently distant from it: seduction. The etymology of *se-ducere* comprises the same verb of motion, but the preposition denotes taking away, i.e. leading away from the straight and narrow path. Hence, seduction is an action that distracts the subject, who – seduced – is induced to follow the seducer away from the right way to the world of their passions. Leadership and seduction are, therefore, not distant or incompatible terms, as Calàs and Smircich (1991) have already noted adopting a deconstructionist methodology.

We shall discuss the process of induction/seduction in terms of the becoming of the relation among an organization, a profession and individual professional identities. The notion of "becoming" draws attention to movements, emergence, flux, process and organizations as "worldmaking" activities (Chia 2003; Carlsen 2006). Becoming denotes the emergence of a sociology of verbs that in organization studies began with Karl Weick's (1979) work, which introduced the terms 'organising' and 'sensemaking'. It continued with the sociology of translation (Law 1994: 103) – that is, a sociology of 'contingent ordering' that interprets society as a relational achievement and ordering effect – and then underwent the 'narrative turn' which emphasised that storytelling – i.e. the performance of stories – is a key aspect of organizational members' work lives (Boje 1991; Czarniawska 1997). The concept of becoming finally underwent what, at present, appears to be its latest turn, the 'practice turn', which has completed the change from knowledge to knowing. This transition from nouns to verbs has produced an epistemological shift to the analysis of processes, temporality, and the negotiation of meanings. Our aim is,

therefore, to elaborate a theoretical framework for the study of induction as a situated practice. The practice-based approach to induction that we propose is grounded in organization studies, and it conceives organizations as flows, as verbs in the process of always becoming (Chia 1995; Clegg et al. 2005; Gherardi 2011). Professional learning is a process of becoming that does not end with the acquisition of the status of insider, nor is it a linear process, nor is it a stable end-state.

Through brief illustration of an empirical research study, we shall show how individuals undergo induction (to the organization) when they undergo seduction (by the profession) within the power structure of a field of situated working practices. Our empirical field is the world of the health-care professions. In particular, three case studies conducted at centres for medically assisted reproduction will illustrate three ideal-typical models of becoming a professional. This empirical field will enable us simultaneously to show the action of the organization and the action of the profession in inducting/seducing newcomers. Before presenting the empirical cases, we shall describe our theoretical-methodological framework, which is situated within practice-based studies (Corradi et al. 2010). We then familiarize the reader with the dynamics of becoming a professional through a fine-grained description of the ecology of forces at play across three case studies before discussing the main sources of tensions that arise through these processes.

6.2 A Practice-Based Approach to Induction/Seduction

Returning for a moment to studies on socialization, we would point out that they connect closely with the idea that, during the socialization process, novices 'learn' the tricks of the trade that others 'teach' them (Van Maanen and Schein 1979: 211). Also, when socialization is conceived as a continuous process, we find this link, defined as the mobilization of knowledge as a result of interactivity between the newcomer and more experienced members (Danielson 2004). It is, therefore, easy to establish a connection between learning viewed in the context of studies on socialization and the context of studies on situated learning and knowing in practice (Lave and Wenger 1991; Elkjaer 2003; Gherardi 2009). The connection is made by conceiving the learning process as competent participation in work practices and as the simultaneous development and performance of a practitioner identity. Moreover, if we consider the verb form 'to practise', practice is seen as "undertaking or engaging fully in a […] profession" (Brown and Duguid 2001: 203). Becoming a practitioner, therefore, involves the learning and development of competences which are professional in the strict as well as relational and identitarian sense. This process is simultaneously explicit and conscious, and implicit and unconscious. Becoming competent in the working practices of a profession entails mastering the coordinated activities that a community of professionals builds in sustaining the traditions of a profession (including tools, artefacts, discourses) and the practising that re-creates connections in action in the everyday texture of workplace knowing and learning (Gherardi 2006).

The practice of a profession consists of both canonical elements – what we can identify as formal prescriptions of tasks and jobs – and non-canonical ones (Brown and Duguid 2001: 203). While the former can be defined and abstracted within formal prescriptions and, therefore, expressly transmitted through formalized education and training, the latter are transmitted during participation in working practices and in the development of practitioner identity, and they are to a large extent implicit and also unconsciously learned and transmitted. When people becomes professionals, the socialization process that precedes their actual entry into an employment relation is highly important and controlled by professional associations, by ethical norms, and by the culture of the profession. For example, the socialization process in medicine has received close attention in the literature (Becker et al. 1961; Atkinson 1995; Witman et al. 2010). The way in which future doctors learn to behave according to the non-canonical norms of the profession is considered as important as their formal education. This socialization process has been called 'the hidden curriculum' (Hafferty and Franks 1994) through which doctors internalize norms of ethical behaviour, power relations and collegial manners. The medical habitus (with a reference to Bourdieu) is the effect of a socialization process (Luke 2003). It can be seen in the liturgy of the clinic, the meetings, the patient rounds and the medical talk (Atkinson 1995; Freidson 1970). Despite medical practice in different organizations, despite changes in health care, despite generational changes, this pre-organizational socialization to the profession remains quite stable. Becoming a practitioner within a community of practice entails, in fact, recognizing and actively participating in discussion on the professional norms that define what are typical and good professional practices (Lave and Wenger 1991). The competence of the practitioner recognized as a full participant in the professional community is, therefore, a social, technical, as well as discursive competence because the professional community recognizes competence in debating and discussing the canons of correct ethical and aesthetic practices. What is negotiated and contested within a practice, and among practitioners, is not just the effectiveness or efficiency of the practice, but the vision of the world (ethical and aesthetic) that sustains a collective mode of doing. Practitioners have an emotional, aesthetic and ethical attachment to the practices that they support and reproduce. This attachment creates affiliations and celebrates 'community' within the community (Gherardi 2009).

In general, these professional norms, values and vocabularies are strongly institutionalized and adopted essentially through socialization processes, mainly pre-organizational and productive of a habitus or a system of dispositions, subconscious schemes of perceptions and appreciations that point the way to practising. We may say that the literature on organizational socialization is informed by especial attention to the internalization of norms, habit, and cultural adaptation of individuals to the profession and to the organization in which they will perform. On the other hand, the literature on communities of practice complements the literature on organizational socialization because it takes a similar point of view.

The work of Lave and Wenger (1991), introduced to an organizational audience by Brown and Duguid (1991), is focused on how learning at a collective level may occur as part of the lived day-to-day organizational activities. Under the label of

'social learning theory' the ideas of learning as participation, legitimate peripheral participation, and community of practice have been explored, developed and contested. If we circumscribe the birth of the idea of community of practice to its historical-cultural context, we note how it differs, on the one hand, from cognitive theories of learning and, on the other, from the conception of learning as individual learning. Hence, by means of this concept a shift was accomplished both with respect to where learning takes place (i.e. in the community, not in the head) and in respect to who learns (i.e. the community as a collective subject, not the individual). However, on adopting a perspective in which induction is viewed as an explicit and conscious activity by the organization which temporally follows the selection process and whose purpose is to facilitate socialization, we may, therefore, wonder how to describe (i.e. assuming that it exists) an organizational practice of induction. To this end, it is necessary to make explicit the theoretical premises of theories of practice compared with those of theories of action.

While theories of action assume a linear model of explanation which privileges the intentionality of actors, from which derives meaningful action, theories of praxis (Cohen 1996) assume an ecological model in which agency is distributed among humans and non-humans and in which the relationality between the social world and materiality reconfigures agency (Latour 2005) as a capacity realized through the associations of humans and materiality. Theories of practice are inscribed within conceptions that can be called 'post-humanist' in that they seek to decentre the human subject (Knorr Cetina 1997) and focus on relationships. A focus on social practice emphasises the relational thinking based on interdependencies between subject and object, person and world, networks and society. They develop their properties only in relation to other subjects, social groups, or networks (Østerlund and Carlile 2005).

Methodologically, an interpretative framework of induction as a social practice within an organization pays attention to the ecology of humans and non-humans involved in the production of induction as a social effect. The intentionality brought into being by the organization in making arrangements and planning organizational routines for induction purposes, therefore, amalgamates with the intentionality and the emotionalism of the subjects about to become practitioners (Gherardi and Perrotta 2010). In turn, the professional communities have a certain way of conceiving and undertaking working practices establish a relationship with newcomers. The effect of this ecology of actions may be a successful or unsuccessful induction, or even a hybrid negotiation of emergent intentionality in which all the relationships at play are modified by and during the process.

To illustrate who are the agents within the ecology of practices that compete in the process of induction and how their power generates the tensions that frame the process of becoming a professional, we shall present three different scenarios that can be taken as ideal types of organizational contexts. In fact, the concept of situatedness is central within a practice-based approach to becoming a professional since we cannot avoid consideration of the contingencies of the field of practices within a specific

organization and a specific community of practices. In other words, the becoming of a professional is necessarily the effect of a texture of situated practices, and every community of practices follows a situated curriculum on admitting a new member.

The concept of 'situated curriculum' (Gherardi et al. 1998) denotes the pattern of learning opportunities available to newcomers in their encounter with a specific community inside a specific organization. Whilst the learning curriculum focuses on the learning opportunities related to a specific occupation, the notion of the situated curriculum emphasizes that its content is closely related to the particular set of local material, economic, symbolic, and social characteristics of the system of practices and work activities. Most of the time, the situated curriculum is not fully known to the practitioners that enact it; or it may be part of a negotiated agreement and, therefore, bears many similarities with the hidden curriculum in that it is informal and non-canonical.

The theoretical framework that we have elaborated assumes that induction is produced within an ecology of practices at the moment when the newcomer is seduced by the ecology itself. We shall, therefore, analyse induction as a social practice within this ecology produced in the interaction among organizational induction routines, the emergence of a practitioner identity, and the working practices of the community to which the aspiring practitioner seeks entry. Moreover, we must consider also the professional associations that may exert an influence within that ecology and may take part in generating and solving the tensions and contradictions that pave the way to becoming a professional.

6.3 A Methodological Note

Three different centres for medically assisted reproduction were studied empirically using qualitative data collection and analysis techniques – specifically participant observation and interviews (Perrotta 2008; Gherardi and Perrotta 2010). In accordance with the logic of theoretical sampling (Glaser and Strauss 1967) the three centres were selected because of their different organizational characteristics, with particular regard to the size of the centre and its organizational form. The centres selected were the following: Sisma, a public university centre of medium size (around 300 infertility treatments a year); Beta, a private centre of small size (around 60 treatments a year); and Bioartlife, a network connecting a large centre with six satellite centres of medium and small size (for a total of 1,500 treatments a year, of which half at the main centre).

The next sections will be devoted, not to a detailed description of ordinary activities, but to descriptions of the different textures of induction practices in the three organizations studied. We intend to use the three cases as illustrations of three ideal typical models of induction practice. We, therefore, describe the respective situated practices in order to show the dynamics of interactions and the tensions between agents.

6.4 Sisma: When Socialization Precedes Selection

Sisma is a public assisted reproduction centre. It is part of a university hospital in which the personnel work in close contact with the adjoining gynaecology department. The Assisted Reproduction Technology (henceforth ART) centre has two chief consultants in reproductive medicine (each of them in charge of a team of doctors and trainee specialists); a head of the ART laboratory; a biologist; two anaesthetists in the operating theatre (who also supervise two trainee specialists); four nurses; and two ward attendants.

During the field observation, it was very difficult to determine the positions occupied in the organization. I (MP, the second author) was able to distinguish staff from patients by virtue of their nurse's uniforms or doctor's coats, but I did not have sufficient information to decide who did what. In fact, although some white uniforms had red (for doctors) and green (for nursing staff) badges, a large number of other subjects wore white coats without any type of marker, so that it was not possible to identify the positions of these people at the centre. The markings on white coats differed for a highly symbolic organizational reason: the centre provided white coats for nursing and medical staff; while trainees at the centre had to purchase their own coats regardless of their formal position. This artefact thus performed the function of a material symbol of induction, in that possessing it with a coloured badge signified membership of the organization. By contrast, its personal purchase symbolized the time to wait before being hired.

The white-coated students, in the two teams that I observed, all seemed to have the same position, but as I followed them in their activities and talked to them, I realized that there were differences. The student specialists describe the trajectory followed by novices as a process consisting of three stages:

- Undergraduate: Undergraduates come to the centre in the fourth or fifth year of medicine because they want to write a thesis in gynaecology. Their university supervisors assign the students a thesis topic, arranged for their attendance at the centre (in terms of days per week), and allocated them to an 'expert' trainee clinician (i.e. a fourth- or fifth-year student at postgraduate medical school), who decided what the student should do in the healthcare practice. In this period, the students do not take active part in the centre's activities.
- Intern: after graduation, attendance at the centre became more regular, given that participation in its activities was decisive for those seeking admission to postgraduate medical school. As one of the interns explained: an intern *is a transitory figure hopefully about to enter postgraduate medical school*. The period of time spent at the centre as an intern varied (from a few months to 4 or 5 years) and depended on the individual case: as *'an aspiring trainee specialist', you sit the entrance examination and wait for a grant for postgraduate medical school, and then you attend for five years*.
- Trainee clinicians: on passing the entrance examination for postgraduate medical school, the students attended the centre for 5 years and took part in its various activities (monitoring, pick-up, transfer, etc.). The trainee clinicians officially

joined the organization and had a well-defined role: they clocked on and off; attended the centre for 36 h a week, had to be on ward duty once a week, and received a bursary which paid for their work.

All three of these positions in the trajectory of becoming a member of the organization preceded the formal moment of selection, but they signalled a hierarchy of rules and competences among newcomers. It emerged from observation and interviews that tasks were assigned to new arrivals (i.e. the undergraduate medical students, the interns beginning attendance at the centre, and the trainee clinicians) according to a situated curriculum. The route followed by students wanting to enter the centre was well defined. While they were writing their theses, assiduity of attendance at the centre was relative, and they were more concerned to develop the topics of their theses. They followed a 'bottom up' training process whereby they gradually participated in the centre's work. When the student became an intern, the 'expert' trainee clinician to whom they had been assigned began giving them elementary tasks: for example making photocopies, or taking test tubes from the operating theatre to the laboratory. Through their participation, the interns began to receive slightly more demanding tasks: compiling the clinical records of patients, for example. When the interns passed the entrance examination to postgraduate medical school, they began to take active part in the centre's activities, but in this phase, too, tasks were assigned gradually. The status of the trainee clinician changed from peripheral participant to actual participant in the 5-year postgraduate medical course. Participation, it was explained to me, progressively increased: *It's gradual. At the beginning you do the* [clinical] *records, or not even the records because you don't know how to, you make photocopies… then as you get on, you do more professional things; it's not as if as soon as you arrive he* [the professor] *hands you a scalpel and says 'operate'. But yes, it's gradual, there are also things that you'll never do because they won't let you, but what he doesn't want to do because it's a drag, he lets you do*.

The three phases of the trajectory were pre-specified, but they could be of different durations. The position of undergraduate thesis-writers might last 1 or 2 years, while that of interns might vary from a few months to several years. The interns therefore followed different routes. There were a fixed number of places at postgraduate medical school. An entrance examination was held every year, and those who failed had to wait until the following year to take it again, and there was no guarantee that they would succeed on the second attempt. For this reason, there was fierce competition among the interns. Only postgraduate medical school was of fixed duration (5 years).

During my period of observation, I realized that the two 'expert' trainee specialists had a great deal of autonomy in all the centre's activities, not only the more central ones (for example, clinical work, oocyte extraction, or transfers) but also others (handling relations with medical representatives). Moreover, the 'expert' trainee specialists had the task of supervising the interns at the centre. The relationship between an intern and the supervising trainee specialist was hierarchical – as was that between the trainee practitioner and the chief consultant. The distribution of

power in the group was clearly vertical. Moreover, their relationship was negatively influenced by the competitive environment (at the end of the process only few trainee specialists would be hired by the centre) and characterized by the non-sharing of knowledge.

Summarizing the process by which novice gynaecologists were inducted into the centre, final-year students doing research for their theses cannot be considered members of the organization. On graduation, they spent varying periods of time waiting for admission to postgraduate medical school and attended the centre as 'interns'. Internship could last for even long periods of time, during which participation in the centre's activities grew increasingly intense. It is, therefore, difficult to determine exactly when the interns became full members of the organization.

Additionally, from a formal point of view, the trainee specialists were members of the organization. They clocked on and off, and they received bursaries for their work at the centre. Hence, they were effective members of the working unit, even though temporary ones (postgraduate medical school lasts for 5 years). However, although a sharp distinction between members and non-members can be made in formal terms, from the point of view of participation in the centre's activities it is less straightforward. Not all those who had completed medical school continued to attend the centre. Their decision on whether or not to do so depended on the availability of work at the centre or on contracts taken elsewhere. If they became a permanent member of staff, their change of status was largely formal. Whatever the case may be, they could not be described as newcomers.

This interpretation was confirmed when I asked the head of laboratory how newcomers were inducted. His reply was: *What newcomers? There's nobody new here. New intake has been frozen for years, and there are no new researchers. The last to arrive was, the biologist, and he's been here for years*. He did not believe that the medicine undergraduates, the interns, and the trainee specialists could be considered 'novices' in the organization.

From the medical team's point of view, undergraduates were not novices because they were not directly involved in the ART process and participated marginally in the group's activities. Their constant presence at the centre, first as undergraduates and then as interns, made their participation slow and gradual. These roles also served to enhance their novice status. Hence, when they became trainee specialists they were not regarded as novices because they had already been at the centre for years. The facets and contradictions within the category of novices were reflected in the fact that none of them was perceived as novices; rather they took part in the centre's activities as non-members.

The Sisma case shows how induction is the effect of an ecology in which organizational routines accompany a newcomer's entry are entirely lacking, because when the organization begins the selection process, the newcomer's socialization has already been accomplished. The professional community is instead the actor with complete autonomy in the management of socialization and which, informally, also manages the selection process. Finally, the community of practice, given the competitive nature of its relationships, is an ambivalent actor in a new member's

induction because it is responsible for both transmitting knowledge relative to the tasks that form the situated curriculum and implicitly selecting among the members themselves.

6.5 Beta: When the Profession Seduces

Beta is a private centre of very small size founded more than 20 years ago by Paolo, the gynaecologist who directs it, together with a group of friends and colleagues. These include: Alex, another gynecologist (who no longer works at the centre), Marco, a biologist, and Sara, an anesthetist. In recent years, Alex's place has been taken by Valeria, a young assistant gynecologist who worked with Paolo when she was specializing at university. The final member of the centre's medical staff is Ciro, a recent graduate in medicine waiting to enter a specialization school and Paolo's nephew.

The centre is located on the first floor of a private clinic, from which Paolo leases the premises (i.e. rooms for patients, laboratory, operating theatre, and so on), the personnel (i.e. nursing and administrative staff), and equipment for the laboratory and the operating theatre. All activities relative to the treatment (i.e. oocyte pick up, laboratory operations, sperm self-donation) take place within the centre, while during the initial phase (i.e. first examinations and monitoring) and the phase subsequent to the embryo transfer, patients are treated by Paolo at his private surgery.

Given the limited number of patients and treatments, to minimize costs, work at the centre is organized in "cycles": Paolo groups a certain number of patients (at least ten) and organizes all the interventions in periods of time ranging from a week to 10 days, with intervals of a couple of months between one cycle and the next. As the centre is so small and has developed on the basis of trust relations among the four friends/colleagues, it has no formalized practice of selection and induction; rather, these are the outcomes of an implicit process. This case study is significant because it epitomizes situations which are 'minor' from an organizational point of view but very common numerically and representative of the type of organizations which arise on the basis of trust relations among their members. One does not becomes a member of such organizations through formal selection, nor because of selection by the professional community, but by participating in a community of practice that is entered on the basis of the (relational and reputational) social capital (Coleman 1988) possessed by newcomers.

For the two most recent newcomers at the centre, Valeria and Ciro, in fact, access was made possible by personal relations which drew on social capital. Valeria, had met Paolo while she was at specialization school and he was working at the university where she was specializing. Their collaboration began externally to the centre and then stabilized and developed within it, when Alex, the second gynecologist, decided to leave the centre and a post fell vacant. Valeria was, therefore, not a novice in the profession when she joined the centre.

The only novice at the Beta centre was Ciro, who had been only sporadically present since he began working on his thesis 3 years previously. Ciro's position was distinctive, because he was present in the operating theatre as an intern, so that he actively participated in the practice. As Ciro specified: *"I am not an assistant. I collaborate with the operating theatre's work"*. This specification is important because it highlights Ciro's position as a novice with respect to the centre and to the profession. Ciro, in fact, was supervised in his learning process through constant explanations of activities and instructions on how to do the work. During the period of observation, Paolo – while working in the operating theatre – frequently directed Ciro's attention to the monitor on which uterus and endometrium could be seen, showing him their normal shapes and giving advice on how to recognize them.

Learning how to see images on the ecograph monitor, in fact, is one of the practices most difficult to acquire in both reproductive medicine and medicine in general. According to Ciro, he had difficulties in recognizing images on the ecograph screen because he only sporadically engaged in the activity: gaining experience in this field meant "getting an eye for it", developing visual skills.

A very similar account was also provided by Marco in relation to his experience of learning laboratory practices: *"There are no schools, books or handbooks; these things you only learn with practice. I spent a year and a half watching what they did; but if they don't make you do it, you don't learn"*. Marco then explained to me that at the beginning of his career he had gone to a centre in London to learn the techniques. However, the manager of the centre had commercial relations with an ART centre in the south of Italy and situated in the same city from where Marco came. For this reason, the manager was afraid that, once Marco had learned the techniques and returned to Italy, he would open his own centre in the same city and became a direct competitor of the centre with which the manager collaborated. Marco's learning process had, instead, been facilitated by his friendly relations with the two biologists at the centre: *"They were a Jamaican and an Australian girl. We made friends, we went out together, we went to the pub, and so on"*. In Marco's story, it was his personal relationship with the two biologists that enabled him to learn what to 'do': *"One of them suddenly asked me: 'have you have ever cleaned an oocyte? No. So clean one'"*.

This further episode shows how induction to the profession was closely tied to trust relations established both internally and externally to the centre. It took the form of 'seduction' into the profession by peers. This process of developing a passion for the profession, in fact, seems to be the factor that brings novices into its core (Gherardi et al. 2007).

The induction to the practice described (learning how to 'see' an ecograph or clean an oocyte) is situated in the specific context linked with the performance of the work, and well represented by the concept of situated curriculum. There is a body of practical knowledge required to become an 'expert'. This knowledge is eminently tacit and managed collectively by the community of practitioners where novices learn. Hence, induction to the practices of the gynaecological profession at the ART centre offered an opportunity to become expert in the area, depending on the difficulties inherent in the contingent situation and on the novice's ability to

grasp the learning opportunities offered to him. What novices learn depends on the actual practices where they are involved, and on the quality of their participation. Instructions and micro-explanations are dispensed wholly at random, in the sense that they depend entirely on situations as and when they occur.

6.6 Bioartlife: When the Organization Has a Vision

Bioartlife is a large, private ART centre. It consists of a main centre and six satellite (external) centres, whose work is organized in cycles. This means that while the main centre is always open (including weekends), the satellite centres concentrate the core part of their work (i.e. the surgical part, laboratory fertilization and the transfer) in a single week. The frequency of the cycles depends on the number of cases to be treated by each centre. The satellite centres are situated in private clinics staffed by gynecologists and biologists from Bioartlife (who travel between the clinics) and nurses and ward attendants provided by the host clinics. Bioartlife performs around 1,500 treatments per year, half of them at the main centre. It follows, therefore, that Bioartlife has a large staff (around 50 people). It comprises 15 gynaecologists (working internally and externally), 15 biologists (internal and external), 1 psychologist, andrologyst, anesthetist, president, storeperson and administrative director, 3 administrative workers, secretaries and nurses, 2 ward attendants, and 4 receptionists. All the gynecological staff were trained in the same university department and are directed by one of the best-known clinicians in the field, who is also the scientific advisor to the centre and has a private office at the Bioartlife centre.

The professionals who started to work in the satellite centres had acquired previous experience in the field of reproduction. The main part of their induction process was their integration with the internal team, which came about by standardizing ways certain procedures and administrative activities were performed. For instance, as the administrative manager said, at one of the last external centres to enter the network, the clinic concerned already had a team consisting of a doctor and a biologist: *"They were obviously professionals who had already worked in this field for a long time, and so the process was more rapid, but nonetheless they underwent an evaluation phase. In this case, they were only required to attend the centre in order to harmonize ways of doing things."*

During the observation period at the main centre, the sole newcomer (who had been hired only one month previously) was a person assigned to develop a new kind of network with gynecologists who had not previously worked in the specific field of fertility. The work of the new employee was to establish and maintain new relationships with external gynecologists, to increase the number of potential patients. These external gynecologists had a particular position, because they were not (and probably would never be) members of the organization, but they underwent a kind of induction process to work in partnership with the centre. The main activity required of an external gynecologist was the first phase of ovarian monitoring. The centre wanted to give its patients the opportunity to be supervised in the first part

of the process by their own gynecologist or one near where they lived. For this purpose, the external gynecologist, who did the material work, and the internal one, who decided on the therapy, had to collaborate. External gynecologists were not allowed to interfere with therapy management, because responsibility (and power in the relationship) pertained to the centre. For these reasons, the centre was trying to stabilize the relationship between the centre and internal gynecologists with the external gynecologists through a process whereby they monitored patients in a specific way required by the centre. They had to have some specific technologies; they had to follow the instructions given them by an internal gynecologist; and (possibly) they should have a day of induction into the centre when they were supported by the internal gynecologist who would be their referent.

To sum up, the organization established different kinds of routines for the induction of internal staff and external fixed partners in order to ensure control over desired behaviors and transmission of the organizational culture. For all these people, induction was both the process and outcome of a practice in which the organization, the various professional occupations and the peer group were involved, but the organization sought to exert formal control over both the selection process and socialization. For instance, the centre adhered strictly to the standards required by quality certification. According to the description given by the administrative manager, the certification quality rules converged with the organizational ones prior to them: *"The quality discourse has done nothing but induce us to formalize and better specify things that happened in substantially the same way before. The inception processes of both the doctor and the biologist took a very long time, at least one year. I mean, the specialist gynaecologist expert took around a year to familiarize himself with our work model, with our methods. During that year, he obviously passed through increasing levels of autonomy. However, this is a process that cannot simply be studied in a book; you have to acquire an experience and familiarity with these things, which necessarily take a long time."*

These standards were required not only of medical staff. A new non-medical member of staff shadowed a colleague for a week when they arrived so that they had time to adjust to the job. At the same time, participation was encouraged at social occasions (such as birthdays or other kinds of celebration), social dinners and parties organized by the centre. Induction to this centre involved a tacit dimension of what being a member of the centre meant: sharing professional behaviours and ethical assumptions embedded in working practices. In many interviews, workers at the centre used expressions such as "we do this…", "we don't do this…" to signify their involvement in, participation in, and (at least declared) agreement with the centre.

6.7 Three Models of Becoming a Professional

When the induction process is considered as a social practice – that is, in terms of how it usually takes place in a given organization. It assumes different patterns according to the type of organization, and, therefore, according to the ecology of power relations among the three principal agents of the process.

Table 6.1 A comparison between induction practices

Name of the centre	Type of organization	Size	Main agents in the induction practice	Model of induction
Sisma	Public university centre	Medium	The professional community	Socialization precedes selection
Beta	Private centre	Small	The community of practice	Professional seduction
Bioartlife	Private network organization	Big (network of six centers)	The organization	Organizational routines for specific competences

The three case studies that we have presented illustrate three different models of induction (Table 6.1):

- In the professional bureaucracy (Mintzberg 1979) of a university hospital, the professional community exercised almost complete control over the induction of newcomers, who entered the profession first and only, thereafter, the organization. In this case, socialization preceded selection, and the organization did not envisage a formal trajectory of accompaniment upon entry. Moreover, the community of practice constituted a 'recalcitrant' socialization agent because the competitive environment regulating access to selection made the sharing of knowledge more forced than freely available to newcomers.
- In the small private organization created by a professional or a group of professionals, the induction practice was almost exclusively managed by the community, and induction into the organization coincided with induction into the profession. In this type of simple bureaucracy, selection took place on the basis of trust relations, so that the type of social capital possessed by the newcomer was decisive for entry. The professionals also controlled the situated curriculum (as in the previous case) which produced the effect of induction/seduction. Passion for the profession and the professional vision were transmitted through participation in working practices because the work environment was collaborative and, in the absence of competitive power relations among peers, knowledge was freely shared.
- In the large network of organizations, the administrative area predominated over the professional one. In this case, the organization had devised formal routines to favour the induction of all competences (commercial, administrative, and professional) within the organization. These arrangements were deliberately created by the organization in order to transmit the organizational culture and to control the network's performance from a distance. These arrangements were flanked by induction to the profession, which was undertaken by the professionals, although they were subject to close control through the standardization of procedures via the quality control system. Finally, the community was the main agent of socialization as a tacit process. Organizational identity formation and cooperation among peers might or might not come about because the environment was not competitive. To be noted, however, is that, for the community, provenance from

the same university, and even the same department, meant mutual knowledge and development of a sense of belonging. But this access also signified the existence of an "old boys' network" and of an organization which had a tacit preference among its selection criteria.

We conclude by pointing out that the 'same' practice assumes very different situated features, and that a practice-based approach is able to bring out the ecology of actors that locally stabilize a situated practice and reciprocal power relations.

We now turn to how the tensions and the power games between all the actors in the ecology of professional practices may shape the becoming of a professional.

6.8 Becoming a Professional Within a Field of Tensions

The illustration of three empirical contexts allows us to stress the main limitation of both the organizational socialization and community of practice approaches. Both literatures conceive the learning process in a linear way, be it a trajectory in becoming a competent member, or be it a process of peripheral legitimate participation. The advantage of a practice-based approach, on the contrary, consists in giving primacy neither to the subject, nor to the negotiations that take place within the texture of situated working practices, nor to the tensions and contradictions that are generated in the interactions of all the humans and non-humans involved in the ecology.

The idea that tensions are important triggers for learning is put forward by Elkjaer and Huysman (2008: 171) when they note that 'learning as participation is oriented towards the inclusion of newcomers into communities of practice, rather than the disruptive and confusing elements of admitting membership to newcomers. This means that the gaze is directed towards processes of adoption and adaptation rather than the tensions that may arise from newcomers' (and others) participation in organizational life and work'. Similarly, within activity theory, the role of contradiction is central for expansive learning to occur (Engeström 1987; Miettinen and Virkunnen 2005). When contradictions generate disturbances, problems or breakdowns, practitioners elaborate some working hypothesis for a more advanced form of activity or a zone of proximal development that may solve the contradiction. Therefore, we can say that within both a pragmatist approach to learning and activity theory the active role of the subject who enters the organization and takes part in an activity system is acknowledged; and with it the idea of tensions, contradictions and power games is introduced. A practice-based approach looks at how the becoming of a professional is shaped following the resolution of tensions or their coexistence.

From the illustration of the previous three organizational contexts we can appreciate how the process of becoming a professional is accomplished, depending on the situated curriculum that the local community uses, and how the organizational context may vary according to who is the main agent of socialization for the newcomer.

In any case, we see how misleading is the image of a dyadic organization/individual relation that is traditionally portrayed in the organizational socialization literature. On the contrary, we have seen that at least three main agents are at work: (i) the organization, (ii) the community of practice and (iii) the profession. These do not include the individual as an active actor and the material world of artefacts and technologies. Finally, we should not forget that the becoming of a professional does not begin as these individuals enter an organization, because their educational training is already part of the same socialization process. Nor does that the process take place only within the organizational boundaries, because the social world of a profession is wider and it includes not only the professional associations and their power of control over the professionals and on the educational curriculum, but also the development of a professional ethics and aesthetics that contributes to the institutionalization of a professional power and network of political interests.

We do not have enough space here to fully develop the role of materiality in shaping power relations in intraprofessional networks, nor to illustrate how professions and professional practice change in relation to technological innovation. We have done this elsewhere (Gherardi and Perrotta 2011) for more detailed treatment in relation to assisted medical reproduction technological changes. Here, we discuss how the becoming of a professional takes place within a field of tensions and through the provisional and always unstable resolution of tensions.

We shall discuss the main tensions at the following levels: (i) within the individuals and their positioning in the field; (ii) within organizational control and professional control; (iii) within managerialism and professionalism. Our implicit assumption and our critique of the traditional literature on professionalism is that the process of becoming a professional is inherent to the entire working life of individuals and continues throughout their careers.

The focus on individuals allows us to recall that the concept of becoming has its roots in post-structuralism and Marxism (Carlsen 2006: 133), and to consider the constitutive nature of language and structures of meaning, in collective mobilization of beliefs and habits of action as a result of new experiences obtained through interactions.

In a study of the induction practice for becoming customer service officers in a bank, Bjørkeng and Clegg (2010) propose two concepts that illustrate the dynamics among the newcomers, the organization and the profession. The first is authoring acts – the inductees' processes of making sense of themselves as practitioners – and the second is performative acts, i.e. all acts constituting the object or process of which they are part.

Becoming a practitioner involves narrating self and practice, and narratives are not one-dimensional representations of a reality (Cunliffe 2001); rather, they are multi-voiced, contextually dependent, ambiguous, equivocal constructions of experience, always negotiated between the inductees, the work, and whatever they try to communicate to someone in a given context. In authoring the bank as a familiar place, and themselves as practitioners, the inductees recognise themselves as such, so that by the end of the induction course they have mastered the formal routines, tools, and methods of their working practices.

Another facet of the authoring act that is seldom addressed concerns becoming a gendered professional. Professions are also marked in terms of masculine/feminine cultures, and practicing gender at work (Martin 2006) means also knowing how to perform gender in appropriate ways, where 'appropriate' means in accordance with the professional culture and in accordance with the professional's gender identity. An example of how a young female consultant – Omega – entered a male-dominated profession and community of practice is reported in Bruni and Gherardi (2001). The tensions on her side and the rent position enjoyed by her (male) colleagues were part of Omega's becoming a professional and learning what is called 'gender switching', i.e. the unconscious choice of adhering to a masculinist gender language and resisting it at the same time through appropriate gender displays. Too often neglected in the discourse on becoming a professional are both the gender identity of the practitioner and the practicing of gender at work and in the professional culture. A profession is also structured along gendered lines and gendered activities that here we mention only in passing (Jones 1998).

What we can interpret through the concepts of authoring and performative acts is the interplay and the tensions between becoming a practitioner and constructing practices. In this process, the aspect of constructing professional practices is also linked with the capacity to imagine practices. By considering 'becoming' as the imagining of practice, Carlsen (2006: 135) places the authoring of identities within the lived experience of everyday work and its irreducible present-past and present-future temporality. Imagination of practice refers to:

> the manner by which an organizational collective assigns social weight to an act, an event, or a stream of acts and events within their living experience by selective attention, appropriation, extension, and amplification, in sum, the storied construction of shared fields of meaning and engagement. Participating in the imagination of practice is, therefore, a collective act in which the becoming of the professional and the performance of the practice co-evolve in the active reconstruction of the past in light of present circumstances and anticipations of the future. (Carlsen 2006: 135)

The second source of tensions in becoming a practitioner is located within the exercise of control in organizations. In the illustration given in the preceding sections we described how Sisma – a professional bureaucracy – relied mainly on professional control, while Bioartlife made use of control over behaviour.

Controls in organizations are necessary to ensure that organizational members direct their efforts towards organizational goals. A classic source of tension in organizations is the relation between administrative managers and professionals, and the inappropriate use of one form of control may lead to organizational ineffectiveness and conflict in interpersonal relations. The choice between behaviour control and professional control is emblematic of how the becoming of a professional is shaped in the relationship between superior/subordinate and, as we shall see next, in the tension between managerialism and professionalism.

Behaviour control consists in close monitoring and evaluation of subordinates' actions by superiors. Whilst this control has the advantage of being direct and immediate in giving feedback and correcting deviations, it has the disadvantage of being costly and limited to the superior's span of control. It may, therefore, become

inefficient, and may even reduce innovation and lead to risk-adverse behaviour (Snell 1992). In particular, if behaviour control is exercised over a long period of time when subordinates expect to be professionally controlled, they will perform at a lower level because controls are not aligned with their expectations (Rowe et al. 2012). Professional control has the following characteristics: (i) organizational reliance on self-enforced control, (ii) features like tacit in-group monitoring, and (iii) the symbolic or explicit social sanctions applied to those who do not respect norms. Professional control is more appropriate than behaviour or output control when intense socialization is present and organization-specific skills have been developed (Rowe et al. 2012: 64).

The becoming of a professional encounters the tensions and the gap in expectations between the different forms of control. In fact, the organizational use of behaviour control or output control when professional control is expected may lead to resentment, frustration, counterproductive behaviours and various forms of resistance. On the other hand, professional control is based on a socialization process rooted in long-term employment, rigorous selection and training. All these circumstances are now at risk because the increasing uncertainty, the severance of the employment relationship, and the rate of turnover induce a preference for behaviour control in organizations. Traditional professional control is also challenged by the tensions between managerialism and professionalism.

The conflict between organization and profession has been widely explored. Nevertheless, the terms of this tension are challenged by the changing organizational context of professional work (Farrell and Morris 2003). The reconfiguration of the two fields has been proposed under the label of 'organized professionalism' (Noordegraaf 2011: 1351), which represents professional practices that embody organizational logic. Professionals may take up organizing roles, and professional workers may develop organizational capacities, in order to deal with changing work circumstances. An emblematic example is provided by health organizations where managerial innovation tends to modify traditional professional practices, assigning them new goals and thus reducing professional autonomy. While some authors have seen a challenge to the decline of medical dominance, Freidson (2001) prefers to see a process of 'restratification' whereby an elite stratum of medical professionals is co-opted into management so that the profession can maintain its power. This dynamic also influences multi-professional teams, where health and social integration care generate conflict over the respective jurisdictions, and different professional cultures generate interprofessional tensions (Tousijn 2012). In multi-professional teams, many professionals carry out managerial work. Therefore, what can be deduced concerns not much the decline of medical dominance as the reconfiguration of the professions both internally and in relation to the changing context of other interrelated professions. The 'new' professionalism is constructed more from within than from above (Evetts 2009, 2011).

A final point to be made in regard to all the tensions reflected in the becoming of a practitioner is to acknowledge the professional associations that are external to the single organization in which the professional works but greatly influence the power that a profession may exert on the culture and the practices of that professional.

Regulative bargains between professional associations and the state have enabled professional groups to regulate their own work by establishing meaningful professional standards. Nevertheless, professional associations are just one actor in the institutionalisation process, and their power is challenged by changing employment relationships (Greenwood et al. 2002; Muzio and Kirkpatrick 2011).

When we consider the field of forces that keep together the individual professional, the organization, the community of practice, and the professional association, we see that the process of becoming a professional is not linear, is not harmoniously developmental, is not simply the effect of a socialization process, and does not end in becoming an expert. The concept of becoming includes the idea of an open-ended process in which tensions and contradictions are collectively elaborated and temporarily resolved within a field of struggles.

6.9 Conclusions

Whereas the lens of socialization focuses on the shared norms, values and standards that the professional newcomer internalises to become a competent member of a professional culture, the lens of the community of practice focuses on their peripheral legitimate participation, and both of them privilege the point of view of the individual in relation to the collective. The lens of induction is positioned instead on the eye of the organization and its mechanisms of selection, training and control. Finally, the lens of professional control makes it possible to consider how the professions may enjoy autonomy within the organization and how, through the regulative bargains of their professional associations with the state, they try to exert control on the educational system and maintain professional boundaries *vis-à-vis* interrelated professions. Different lenses not only represent distinct interpretative frameworks; they also express the points of view and the tensions that shape the field of professional practices.

As individuals become professionals throughout their working lives, their authoring and performing acts are accomplished within a field of practices marked by tensions and contradictions among the main agents just mentioned. The process begins before formal entry into an organization, and it continues with the induction into the organization. However, to author an identity as professionals, these individuals become seduced by the profession and author themselves as individuals who 'are' professionals and adjust to the gendering of the profession. In this process, becoming a practitioner and constructing practices is also linked with the capacity to imagine practices, since the authoring of identities emerges within the lived experience of everyday work and its irreducible present-past and present-future temporality.

Through three empirical examples from the medical field we have argued in favour of the situatedness of the becoming process and the difference that the organizational context exerts in shaping the path of the becoming. We have shown that, in a professional bureaucracy, professional socialization may anticipate the moment of becoming an organizational member, whilst in a small professional organization

it is the community that induces and seduces the newcomer, and that in a large managerially controlled organization, induction may be an explicit practice negotiated with the community of practice and the individual.

A final caveat is necessary in regard to the limits of a practice-based approach to induction. Whilst this approach proves its worth in the interpretation of the situatedness of becoming, it implies that any situated practice has to be described in relation to its context, so that we can generalize about it only through its modelling. On the one hand, we need further research to understand what is common across different organizations. On the other hand, we must further test the theoretical framework that we propose, because a practice-based approach to induction is an innovative contribution to the literature and it should be further confirmed, disconfirmed or refined.

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