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The personal dimension of allied health professional identity: A scoping review in health sciences literature

Die persönliche Dimension der beruflichen Identität von Gesundheitsfachkräften: ein Scoping-Review in der gesundheitswissenschaftlichen Literatur

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Abstract

Introduction: With a shift in healthcare from diagnosis-centered to human- and interprofessional-centered work, allied health professionals (AHPs) may encounter dilemmas in daily work because of discrepancies between values of learned professional protocols and their personal values, the latter being a component of the personal dimension. The personal dimension can be defined as a set of personal components that have a substantial impact on professional identity. In this study, we aim to improve the understanding of the role played by the personal dimension, by answering the following research question: *What is known about the personal dimension of the professional identity of AHPs in (allied) health literature?*
Methods: In the scoping review, databases, CINAHL, ERIC, Medline, PubMed, and PsychINFO were searched for studies focusing on what is regarded as 'the personal dimension of professional identity' of AHPs in the health literature; 81 out of 815 articles were included and analyzed in this scoping review. A varying degree of attention for the personal dimension within the various allied health professions was observed.
Result: After analysis, we introduce the concept of four aspects in the personal dimension of AHPs. We explain how these aspects overlap to some degree and feed into each other. The first aspect encompasses characteristics like gender, age, nationality, and ethnicity. The second aspect consists of the life experiences of the professional. The third involves character traits related to resilience and virtues. The fourth aspect, worldview, is formed by the first three aspects and consists of the core beliefs and values of AHPs, paired with personal norms.
Discussion: These four aspects are visualized in a conceptual model that aims to make AHPs more aware of their own personal dimension, as well as the personal dimension of their colleagues intra- and interprofessionally. It is recommended that more research be carried out to examine how the personal dimension affects allied health practice.

Abstract

Einleitung: Die berufliche Identität speist sich aus zwei Quellen: der Berufsausübung in einem konkreten Umfeld sowie einer Reihe von personenbezogenen, persönlichen Komponenten. In dieser Studie untersuchen wir, was in der Fachliteratur über die persönliche Dimension der beruflichen Identität von allied health professionals (AHP) bekannt ist.
Methoden: Im Rahmen des Scoping Review wurden die Datenbanken CINAHL, ERIC, Medline, PubMed und PsychINFO nach Studien durchsucht, die sich mit der persönlichen Dimension der beruflichen Identität von AHPs in der Gesundheitsliteratur befassen. 81 von 815 Artikeln wurden in dieses Scoping Review aufgenommen und analysiert.
Ergebnis: Vier Aspekte der persönlichen Dimension kristallisierten sich heraus. Der erste Aspekt umfasst soziodemographische Merkmale wie Geschlecht, Alter, Nationalität und ethnische Zugehörigkeit. Der zweite Aspekt besteht aus den Lebenserfahrungen der Fachkraft. Der dritte Aspekt umfasst Charaktereigenschaften, die mit Belastbarkeit und Tugenden zusammenhängen. Der vierte Aspekt, die Weltanschauung, setzt sich aus den ersten drei Aspekten zusammen und besteht aus den Grundüberzeugungen und Werten der AHP, gepaart mit persönlichen Normen.
Diskussion: Diese vier Aspekte werden in einem konzeptionellen Modell veranschaulicht, das darauf abzielt, AHPs ihre eigene persönliche Dimension sowie die persönliche Dimension ihrer Kollegen intra- und interprofessionell stärker bewusst zu machen. Es wird empfohlen, weitere Forschungsarbeiten durchzuführen, um zu untersuchen, wie sich die persönliche Dimension auf die Praxis der Gesundheitsberufe auswirkt.

Keywords
Personal dimension – professional identity – values – beliefs – dilemma – allied health professionals – interprofessional care – resilience

Keywords
Persönliche Dimension – berufliche Identität – Kernwerte – Kernüberzeugungen – Dilemma – Gesundheitsfachkräfte – Interprofessionalität – Widerstandsfähigkeit

INTRODUCTION

During an internship in an optometry practice, an optometry student is asked by a client, a young man of his age, to fill out a driver's license eye-test form. The optometry student is unfamiliar with such a form but wants to help the young man and measures his visual acuity. Unfortunately, the client's visual acuity is 0.4 instead of the threshold value of 0.5. The student informs the young man of the bad news, who, to his horror, becomes angry and tries to persuade the student to record 0.5 because 'it's almost the same.'

The student experiences moral distress: he knows the rules. He would be breaking the law by recording 0.5 instead of 0.4. He also thinks of the societal consequences – the traffic risks – an unjustified driving authorization might have; but he also feels, as a young man of the same age, the social effect of not being able to drive. His mentor helps him by deciding to record the real 0.4 visual acuity.

In hindsight, the student reflects that this incident changed him. He was raised to always tell the truth, but this young man did not tell the truth about his vision prior to the test. He must have known that he had poor visual acuity, and that the correct place to have the form filled out was not an optometry practice, but an ophthalmology office. Moreover, he seemed to deliberately take advantage of the student's age and greenness. The experience that clients, and also peers, are capable of not telling the whole truth to get what they want, made him more suspicious towards clients from that point on. Looking back, he is alarmed by his own doubts at that moment, that he almost committed fraud, and he wonders how this could have happened.

This situation illustrates the tensions allied health professionals (AHPs) might experience in complex situations in their daily practice. At the heart, these kinds of tensions seem to be the result of the inability of professionals to reconcile the value of learned professional protocols and their personal set of values (Helmich et al., 2017). To understand these tensions, we explore the concept in which AHPs attempt to unite both elements: their professional identity.

Professional identity is currently a frequently researched phenomenon (Cruess et al., 2019; Hendrikx, 2018; Monrouxe, 2010; Rees et al., 2019). At the turn of the century, medical training focused purely on professionalism. In the last decade, Cruess et al. (2014) have been advocating to make professional identity development a focal point in medical training, since the educational objective of professionalism turned out to be too narrow (Cruess et al., 2014). In nursing, for example, professional identity development is often a struggle, especially when nursing professionals work in nonstandard workplaces such as retirement facilities (Thompson et al., 2018). Research about the professional identity of teachers, in turn, shows that the person behind the teacher educator matters for both the teacher educator him/herself and for their teachers-in-training (Vanassche & Kelchtermans, 2016). Van Lankveld (2017) has shown that the development of medical teachers' professional identity is supported by the sharing of work experience stories in teacher communities and teacher-training courses. For students and teachers in medicine, nursing, and counselling/psychology, the clinical experience that they gather, the culture of their profession, and the norms and expectations that are central to their profession, are all important for professional identity formation – for both students and teachers, and also their wider environment (Volpe et al., 2019). In a scoping review of their own, however, Volpe et al. (2019) conclude that there seems to be a sociocultural bias within the reviewed studies: demographic data are collected but rarely included in qualitative results. Therefore, we conclude at this point that professional identity must be regarded as an important part of (inter)professional practice. In what follows, we look in more detail at what professional identity is, in order to learn more about the tensions AHPs experience in daily practice.

Professional identity

In spite of widespread research into professional identity (Burford et al., 2014; Feller & Berendonk, 2020; Fitzgerald, 2020; Goldie, 2012; Kwakman & Schilder, 2005; Monrouxe & Rees, 2017; Rees & Monrouxe, 2018; Ruijters, 2015), the multilayered and multidiscoursal nature of the subject makes it difficult to define professional identity in a straightforward way. According to Beijaard et al. (2004), Trede et al. (2012), and Fitzgerald (2020), a clear definition of professional identity is missing because of the multi-discoursal nature of the subject. Krueger (2008), upon considering some of the discussion-leading descriptions of professional identity, provides the following description of professional identity: *"Acquiring and demonstrating the knowledge, skills, and attitudes that characterize a profession, such as education, rights or medicine; recognition as a member of a particular profession"* (Krueger, 2008, p. 241). Schein, in his turn, describes it as the constellation of attributes, beliefs, values, motives, and experiences through which people define themselves in a professional role (Schein, 1999). In medical literature, professional identity is often described as 'thinking, acting and feeling as a doctor' or another healthcare professional (Cruess et al., 2014). Looking in greater detail at descriptions of professional identity in the literature, we find two recurring elements.

Firstly, professional identity seems to stand for the living-through of the individual's profession, which is like a red thread running through the actions, thoughts, and feelings belonging to the profession, in which the history of the development of the profession is still reflected on the present-day professional (Clouston & Whitcombe, 2008; Fitzgerald, 2020; Walsh, 2018). Secondly, in any description of professional identity, we always find a reference that it is not merely professional knowledge and actions that are important, but that the personal dimension plays a significant role as well (Fitzgerald, 2020; Monrouxe, 2010; Trede et al., 2012).

The personal dimension is not only described, but there are also suggestions that the personal dimension sometimes creates friction between different professional values (Fitzgerald, 2020). Helmich et al. (2017) describe this as the struggle between sensemaking through a personal set of values and beliefs, and sensemaking through the instrumental information of protocols. Such value conflicts lead to feelings of ambiguity in the personal dimension of healthcare professionals. Feelings of ambiguity in the professional context can be highly emotional and are caused by reflection on oneself from different dimensions of professional identity, that each have their own norms and rules (Helmich et al., 2017; Jarvis & Trodd, 2008). Conflicts between values in the personal dimension and professional values, can have the effect that AHPs experience internal tensions at critical moments in their professional activity (Fitzgerald, 2020; Helmich et al., 2017; Jarvis & Trodd, 2008).

Personal dimension

To understand the personal dimension, we will explore the concept in question. The personal dimension can be defined as a set of personal components that have a substantial impact on professional identity and frequently cause tensions in that role (Bushby et al., 2015; Fitzgerald, 2020; Lawson et al., 2017; McMahon et al., 2016; Nicholls & Gibson, 2010). Although much research has already been conducted on personal components, in-depth research into the personal dimension appears to be lacking, in spite of a clear need to deepen our understanding of this topic (Drolet & Sauvageau, 2016).

In the literature on education and teacher identity, in which much more research focused on the personal dimension has been performed, Beijaard (2009) describes the personal dimension as composed of a set of specific personal, sociodemographic characteristics, the personal biography and learning history of the professional, and the beliefs s/he holds about the profession. According to Kelchtermans (2009), teachers develop an interpretative framework that arises from personal values and beliefs, which is shaped and reshaped in the course of their career through interaction with teacher colleagues and the impact of the social, cultural, and structural conditions in their working environment. Ruijters (2015) emphasizes the interaction between social identity and the personal dimension as well. In order to understand the individual professional, one should start from her/his specific personal, sociodemographic characteristics. For example, a professional's perfectionism is something partly hereditary, but is also largely influenced by the range of experiences gained in the context of personal identity development. Where Beijaard (2009) and Ruijters (2015) state that the personal dimension is constructed by the combination of a set of specific personal, sociodemographic characteristics with the professional's personal biography and learning history, other scholars have emphasized different components and describe the personal dimension as composed of the personal, sociodemographic characteristics and the reflected set of values, beliefs and associated standards that originate from the professional's background (Fatoki, 2014; Lucieer, 2020; Matthys & Thijssen, 2013). In research on teaching, scholars who emphasize the personal dimension are particularly interested in how past personal life experiences interact with teachers' professional lives (Beijaard et al., 2000). Not every author uses the term personal dimension: some use the terminology 'personal interpretation framework' (Kelchtermans, 2009), while others frame the personal dimension in terms of Self Theory (Finn et al., 2010). Nevertheless, all these descriptions fit under what we understand as the 'personal dimension'. Although a large portion of the literature we refer to here comes from education research, the theory formation on personal dimension in this literature cannot simply be extrapolated to the allied health domain – although it must be pointed out that the professionalization processes of teachers, teacher educators, and AHPs are similar. As a summary of the insights in the personal dimension outlined above, we will be using the following definition in this scoping review:

> The personal dimension of the professional identity is composed of the set of specific personal, sociodemographic characteristics, the individual biography, personality-related subjects, and beliefs of the professional about profession-related subjects.

In this study, we aim to improve the understanding of the role played by the personal dimension by considering the following research question: What is known about the personal dimension of professional identity of AHPs in the (allied) health literature?

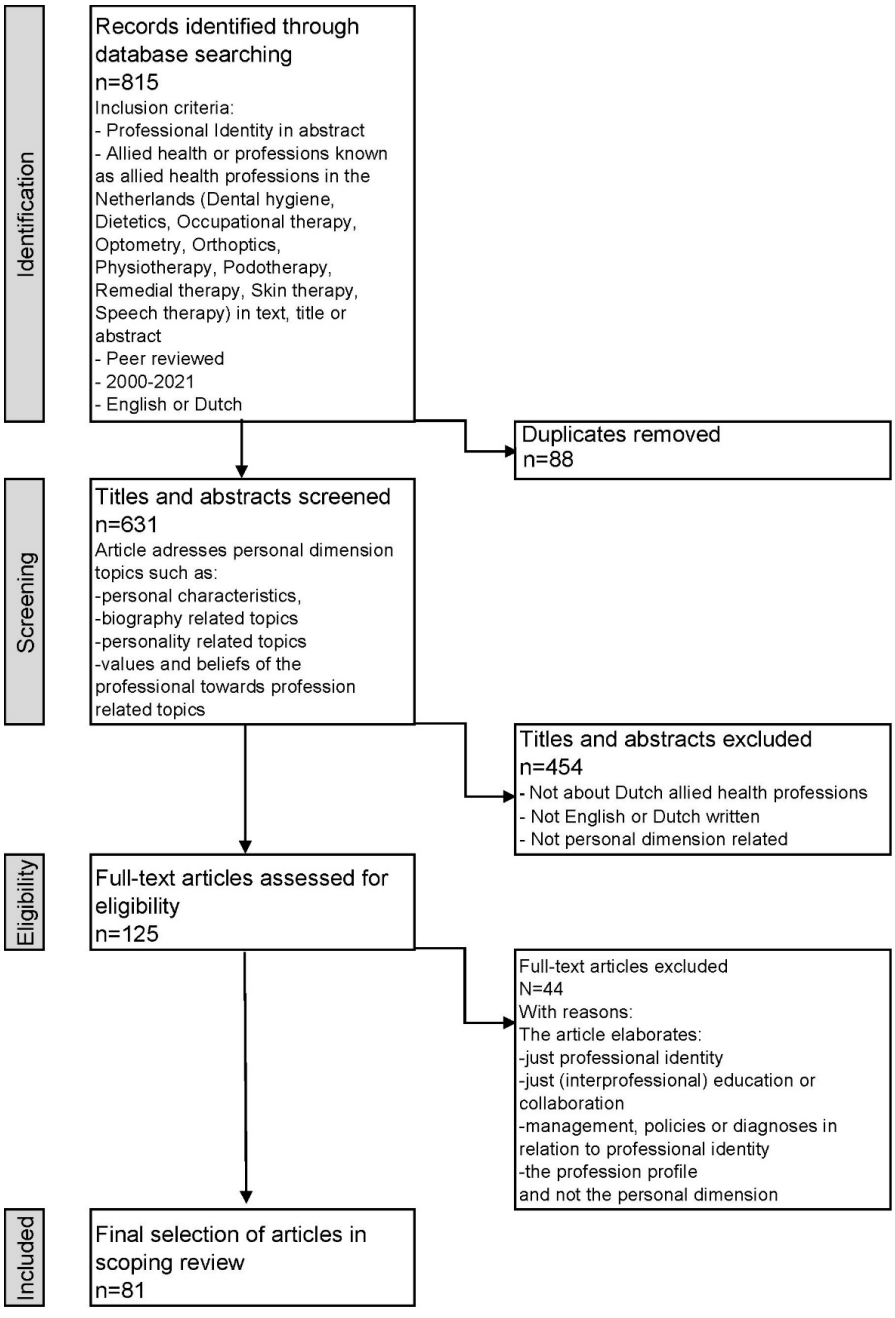

Figure 1: Flowchart of article selection process.

METHODS

To investigate how the personal dimension of AHPs is understood in (allied health) literature, a scoping literature study was conducted. Scoping reviews are used to clarify key concepts, key characteristics, definitions in literature, and to identify knowledge gaps (Munn et al., 2018). To select and analyze the literature, we used the five-stage methodological framework of Arksey and O'Malley (2005). These stages are: Stage 1: identifying the research question (in this article described in the introduction); Stage 2: identifying relevant studies; Stage 3: study selection; Stage 4: charting data; Stage 5: collating, summarizing, and reporting results. Stages 2-5 are shown in Figure 1.

Because of the allied health scope of the study, we conducted an electronic search in CINAHL, Medline, PubMed, PsycINFO, and ERIC. Keywords used were

'professional identity' in the abstract, and at least one name of a Dutch allied health profession or continuous use of the term 'allied health' in the text. In the Netherlands, allied health professions include dental hygiene, dietetics, occupational therapy, optometry, orthoptics, physiotherapy, podiatry, remedial therapy, skin therapy, and speech therapy. Unlike many other countries, nursing and social work are not allied health professions in the Netherlands and therefore were not included in the review. The PubMed search was conducted with the Medical Subject Heading (Mesh) term 'social identification', and at least one name of a Dutch allied health profession, or continuous use of the term 'allied health' in the text. This initial search resulted in 815 peer-reviewed articles published in the last 20 years, which were deduplicated for a total of 631 articles.

Screening of the articles was conducted based on title and abstract. Abstracts were selected when articles met the main inclusion criteria: 'person-in-the-professional' related matters in relation to professional identity, professional functioning, professional attitude, or professionalism, either as a main topic or subtopic. After a screening of the titles and abstracts, a total of 125 articles were included for full-text reviewing. All of these articles were read in full to determine eligibility and whether they fitted the inclusion criteria. Reasons for exclusion were: if the article merely brought up the term 'professional identity' (e.g., only mentioned it in a questionnaire), or merely elaborated about professional identity in relation to interprofessional education or collaboration, management, policies, or diagnosis – but did not link it with the personal dimension. As a result, 81 studies were included in the final analysis. The final 81 articles were analyzed and reviewed, and then summarized in outlines listing the title of the study, author(s), publication year, journal, database; methods, number of participants, discipline, type of population, main findings, and comments.[1]

First, the results were analyzed numerically according to the items in the outlines. Secondly, the results were analyzed thematically in order to map items related to the personal dimension. Development of themes was an iterative process. To start, the first author, EB, created a map of themes and subthemes that emerged from analysis of the data. Next, the first and second author, EB and RC, met on a weekly basis to discuss the emerging findings, refine mind maps, articulate themes and subthemes, integrate ideas, and to generate a thematic map of the findings. Finally, the four authors met quarterly to discuss the conceptual framework and evaluate the review process and the analysis.

1 These outline documents can be requested from the corresponding author, Eline Belgraver

FINDINGS

The findings of the scoping review are described numerically and in terms of their content. Over the last 20 years, what became visible was a huge increase in the literature about the personal dimension (Cruess et al., 2019): 39 out of 81 articles were published in the last six years (see Table 2 in Appendix). The numerical part reveals a paradigm shift in the last two decades from professionalism to professional identity development in the healthcare literature (Cruess et al., 2019). The numerical findings also reveal the varying degrees of attention directed towards the personal dimension within the various professions.

Descriptive numerical summary

The articles included in the scoping review were published over a period of 21 years (see Table 2 in Appendix). Not one of the articles studies the personal dimension in its entirety, and only one or a few aspects of the personal dimension are studied per article. The articles were published in 42 journals, which can be divided into multi-professional studies and uni-professional studies. Multi-professional studies that investigated the personal dimension were studies on interprofessional education (Clark, 2014; Conroy, 2019; Hertweck et al., 2012; Hind et al., 2003) and interprofessional care (Davis, 2006; Jakobsen et al., 2011; Kraft et al., 2014). Physiotherapy and occupational therapy are studied in a large number of these multi-professional studies. This can be explained by the fact that physiotherapists and occupational therapists often participate in interprofessional studies.

Occupational therapy is the profession with the most personal dimension-related studies; half of the studies are related to occupational therapy (see Table 1). This can be partly explained by the ongoing search for 'the' professional identity of occupational therapists, and the implications that a weak sense of professional identity has been the case for these professionals, which is a frequently recurring theme in occupational therapy literature (Ashby et al., 2016; Burley et al., 2018; Clouston & Whitcombe, 2008; Devery et al., 2018; Furness et al., 2019; Goh et al., 2019).

Furthermore, occupational therapy is holistic and more socially oriented (Burley et al., 2018; Drolet & Désormeaux-Moreau, 2016), whereas other allied health professions are more biomedically oriented and influenced by the medical model (Clouston & Whitcombe, 2008; Nicholls & Gibson, 2010; Whitcombe, 2013). This biomedical and biomechanical orientation can give rise to tensions for dieticians and physical therapists who are required to become more client-centered (McMahon et al., 2016; Nicholls & Gibson, 2010). In dietetics and

Table 1: Distribution of allied health professions in this scoping review.

Allied health professions in selected articles	Number	%
Occupational therapy	40	44%
Physiotherapy	22	24%
Health care (non-specified)	8	9%
Speech therapy	7	8%
Dietetics	6	7%
Dental hygiene	4	4%
Optometry	2	2%
Podiatry	2	2%
Remedial therapy	0	0%
Orthoptics	0	0%
Skin therapy	0	0%

dental hygiene research, some attention is given to the personal dimension, while in remedial therapy, orthoptics, optometry, and skin therapy the personal dimension is barely studied. This small quantity of personal dimension-related studies in some professions can be explained through a variety of reasons, ranging from organizational to occupational content factors. Remedial therapy and skin therapy are not practiced worldwide. Orthoptics is practiced worldwide but is a small profession. Optometry is practiced worldwide (WCO, World Council of Optometry, 2015), but in the optometric world barely any attention seems to be given to this subject. Optometry is an instrumentally and biomedically oriented profession (Long & Rosen, 2017), a profession taught through 'the official regulations and guidelines regarding optometry standards of practice' (Spafford et al., 2004, p. 802).
In conclusion, the findings for allied health professions reveal a substantial growth in attention given to subjects related to the personal dimension. In uni-professional research, the degree of attention given to these subjects varies, ranging from barely any studies in optometry and orthoptics; some uni-professional studies in speech therapy, dental hygiene, and dietetics; and a large quantity of studies in occupational therapy, with physiotherapy ending up in the middle range.
In the allied health professions studied in this scoping review, a variety of scientific approaches are employed, as illustrated in Table 1. In the articles studied for the review, the personal dimension figured mainly as a topic for a subsection. Most studies were qualitative studies, only 11 studies were quantitative studies. 25 out of 81 studies were multi-professional studies. Half of the quantitative survey studies are multi-professional studies (Cooper, Spencer-Dawe & McLean, 2005; Gendron et al., 2016; Hertweck et al., 2012; Hind et al., 2003; Jakobsen et al., 2011; Stull & Blue, 2016). In our review, many qualitative studies mentioned study limitations, such as small numbers of participants or regionally executed studies. Some studies (Drolet & Sauvageau, 2016; Guajardo et al., 2015; Helmich & de Carvalho-Filho, 2018; Khalili et al., 2014) specifically combine the findings and views of different authors and study them from a polyvocal and cross-cultural perspective.
Concluding the numerical side of the review, we can observe a large variation in the attention given to components of the personal dimension within a variety of allied health professions. The reviewed studies vary in sample size and research methods. Only seven out of 81 studies were review studies, which underlines the need for our scoping review.

The four interrelated aspects of the personal dimension

Viewed from diverse allied health discourses and cultures, the personal dimension appears to reveal itself as a multi-layered and multi-discoursal concept. Many components of the personal dimension can be unraveled from the multi-discoursal terms used to name single components. In order to do justice in our model to the fact that these components are not strictly demarcated, we introduce here the concept of four interrelated aspects of the personal dimension. The first aspect encompasses specific characteristics of the professional dimension and forms the foundation of the personal dimension. The second and third aspects consist of life experiences and specific character traits. Finally, the fourth aspect, the worldview of the professional, is formed by the interaction of the first three aspects (Figure 2).

Aspect 1: Characteristics

The professional's sociodemographic characteristics are factual properties of a single aspect within the personal dimension. These include characteristics like *age*, *gender*, *nationality*, *and ethnicity*. Each characteristic fulfills its own role in the personal dimension.
Information on the characteristic of *age* is frequently recorded, but not otherwise used as data in the studies included in our review. Given that age and time spent in the profession (seniority) are connected, and both are highly personal, some of the studies reviewed can be examined through the lens of the personal dimension. In their study about teaming, Gendron et al. (2016) state that age paired with time spent in the profession (seniority) is significantly associated with professional identity, and that teamwork adds both personal and professional value to occupational activity. Unfortunately, they do not further elaborate on their statement that the personal,

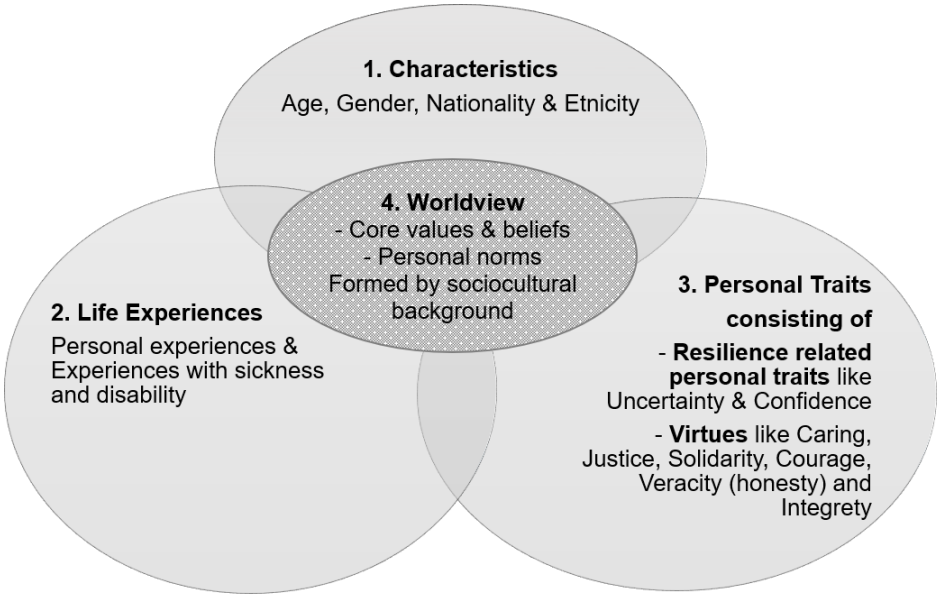

Figure 2: Interrelated aspects of the personal dimension of AHPs.

sociodemographic characteristics of age and professional experience are correlated with professional identity. Black et al. (2010) and Holland et al. (2013) do offer an explanation for this correlation. They state that age is related to professional seniority, and that being older is often associated with having increased professional experience, an asset that strengthens a professional's confidence. Moreover, being older is associated with experiencing other themes in ethical dilemmas (Kenny et al., 2009). Unfortunately, the studies reviewed that include experience as a factor do not take the characteristic of *age* into account, while in the research sample composed of students there is sometimes a large age difference (Atkins & Gingras, 2009). On the other hand, the professional identity of students and experienced professionals, and how both groups perceive their professional role, is frequently a topic of comparison in studies (Champine et al., 2018). This leads to the conclusion that researchers are not in a position to identify which part of the results are related to professional experience, and which part may also be related to age and corresponding life experience. Based on what is stated in the studies reviewed, more senior and experienced professionals tend to have more confidence in themselves and others. Confidence is related to resilience, which is part of the third aspect of the personal dimension.

Information on the second personal characteristic, *gender*, is also nearly always recorded: sometimes as a statistic, sometimes to indicate the distribution in the participants or the profession. Gender is very imbalanced in allied health: in most allied health professions the majority of professionals are female (McEntee-Atalianis & Litosseliti, 2017), an overrepresentation that is also reflected in the participants of the studies reviewed. In some studies, the fact that participants were male was a criterion for their selection (Gheller & Lordly, 2015; Holland et al., 2012; Lindquist et al., 2006). The so-called 'female monopolization' has several effects on men in allied health. First of all, it forms a barrier keeping men from entering female-gendered professions such as speech therapy, which is called 'an extreme sex-segregated occupation (an under-researched area)' by McEntee-Atalianis & Litosseliti, (2017, p.2). Female-dominated cultures sometimes feel unwelcoming to men. Men entering female-dominated professions experience feelings of difference, which is often seen as negative, but which can also be seen as an opportunity (McEntee-Atalianis & Litosseliti, 2017; Neiterman & Bourgeault, 2015). Furthermore, men in this position also experience professional differences due to a gendered approach to work, as men are more task-orientated and take less of a helicopter view (Gheller & Lordly, 2015). In practice, men are likely to look for male role models to support their professional identity development. In conclusion, men in female-dominated professions need to be passionate about the work field to 'survive' (Gheller & Lordly, 2015). Female-dominated professions face challenges in the male-dominated medical world, leading to being 'excluded' from professional legitimacy as a result of largely being populated by women and 'visible minorities', with negative effects on salary, status, and job opportunities (Khalili et al., 2014; McEntee-Atalianis

& Litosseliti, 2017). Finally, a female-dominated professional population is not always a negative factor according to Hertweck et al. (2012), since women are more positive about collaboration, teamwork, and interprofessional learning. Summarizing the role gender plays in the personal dimension, it can be concluded that male AHPs entering female-dominated allied health professions do indeed encounter barriers, which can create tensions. Female AHPs encounter barriers related to professional legitimacy, salary, status, and power, a negative factor which impacts their self-image.

The third characteristic, *nationality*, is not often mentioned in the studies we reviewed: it is mentioned once as specification of the research team (Rees et al., 2019), and twice as a characteristic in the table of participants (in both cases French-speaking Canadians) (Drolet & Désormeaux-Moreau, 2016; Drolet & Sauvageau, 2016a). It seems that nationality is implicitly linked to other characteristics of the participants' backgrounds. In case of the Drolet studies, nationality is linked to language. Language, as in mother tongue, is more frequently mentioned, and also linked by researchers to confidence (Holland et al., 2012). In the personal story of her professional identity development as an occupational therapist, Abreu (2006) reveals that being Puerto Rican in an American city was challenging and made her question who she was. Sometimes she felt Puerto Rican, at other times New Yorker/American, and this ambiguity affected her role as an occupational therapist, taking her time to adjust. Working in an environment in which colleagues speak a different mother tongue and have other nationalities affects one's professional self-image and decreases confidence.

The fourth characteristic, *ethnicity*, is mentioned in eight studies, primarily as an illustration of the target group, but the results do not list whether ethnicity is a significant factor. The reason that ethnicity is queried without further using these data may be due to an ingrained practice of researchers with a medical background, namely the standard consideration that ethnicity and diagnoses are epidemiologically intertwined (Whaley, 2003). Lawson et al. (2017) do mention in their study limitations that they would have liked more ethnic diversity in their research sample to create a better representation of their target group. It is to be expected that ethnicity influences the personal dimension, because ethnicity is connected with a specific culture, and also because of racist reactions that an ethnically 'different' professional or student may encounter. In their Facebook study, Ranz and Nuttman-Shwartz (2017) mention that they did encounter a tendency towards racism, but also an increased, positive awareness among students regarding their personal, professional, national, and global identities. According to Ranz and Nuttman-Shwartz, these findings are valuable because in regular academic settings students hesitate to give voice to personal, traditional, and cultural dimensions, which is precisely what is important for opening up to other worlds (Ranz & Nuttman-Shwartz, 2017). Being aware of the cultural (ethnic) background of habits and knowing how to cope with dilemmas arising from this kind of diversity is important for professionals who seek to provide appropriate responses in a practice visited by clients with a variety of cultural backgrounds (Mårtensson & Archenholtz, 2017).

To conclude, although these four characteristics – gender, age, nationality, and ethnicity – are rarely studied as main topics, they do influence the personal dimension of professionals to a greater or lesser extent. Gender, nationality, and ethnicity play a role in the background of all types of professionals, but their impact is greater for minority groups in allied health (Abreu, 2006; Gheller & Lordly, 2015; Neiterman & Bourgeault, 2015). Being part of a minority group affects the personal dimension of professionals and those professionals encounter barriers in study and work that challenge their confidence (Gheller & Lordly, 2015). It must be noted that this impact on minorities is not only relevant for the minority group itself. In multidisciplinary teams, it is important an individual professional will be able to understand that his perspective is one perspective and other professionals may look at a client, practice, or institution from a very different viewpoint (Jarvis & Trodd, 2008). Having an eye for the effect of personal characteristics can create awareness, and reduce tensions between the personal dimension on the one hand and professional beliefs that stem from the professional identity on the other (Jarvis & Trodd, 2008).

Aspect 2: Life experiences

To denote the impact of professionals' personal histories on the personal dimension, various terms are used. Hooper (2007) uses the term *biography*, while others speak of the effects *personal life experiences* and *family upbringing* have on the personal dimension (Atkins & Gingras, 2009; Drolet & Désormeaux-Moreau, 2016; Drolet & Sauvageau, 2016; Kenny et al., 2009; Plack, 2006). Hooper (2007) states that *biography, as an overview of life experiences*, has an impact on the thinking and acting of all types of professionals. We should not only consider the manner in which students' biographies are taken into account by educators, but also the biographies of educators themselves, since educators' biographies personify an implicit curriculum that informs their teaching (Hooper, 2007; Matthews et al., 2020; O'Shea & McGrath, 2019). In

their study about the development of professional values, Drolet and Sauvageau (2016) establish that personal experiences, family upbringing, and life experiences have a substantial impact. Their study shows that what constitutes impactful personal experiences and family factors varies with age. Younger professionals refer to childhood experiences such as practicing competitive sports, being part of a scouts group, or the influence of religious upbringing. Older professionals refer to their relationship and parenting experiences. As stated by one of the participants in the Drolet and Sauvageau study: 'Certainly, on a personal level, we grow from our life experiences, we react to them, we reflect upon on them, and that is what makes us who we are' (Drolet & Sauvageau, 2016 p. 291). Black et al. (2010) state that for physical therapists the first year of practice is an important transition period, because the full weight of professional responsibility weighs on novices along with the process of integration into the clinical community. This transition period from student to professional not only creates tensions but also brings growing confidence (Black et al., 2010). Personal life experiences such as having a disabled parent, grandparent, or sibling, and the resulting effects on family upbringing have been found to have lifelong impact on the personal dimension (Drolet & Sauvageau, 2016). A similar effect is shown by Lahav et al. (2018), who researched the effect that long-term relationships with persons with disabilities – and with their families and friends – have on occupational therapy students. Professionals with personal histories of illness do effectively connect these experiences to their work (Lawson et al., 2017). Kenny et al. (2009), in turn, point out that personal life experiences, as part of the personal dimension of speech therapists, play an important role in dealing with ethical dilemmas and challenges of the healthcare system in this profession.

All personal life experiences of being confronted with ethical doubt cause professionals to grow and to reflect on their professional values. Consequently, these personal experiences shape the professional practice of AHPs. Because of the demonstrated effects of personal dimension factors on healthcare practice and the limited research that has been done on these factors, Kenny et al. (2009) call for further investigation of the 'relationship between healthcare practitioners' personal and professional identity' (Kenny et al., 2009, p. 434).

Aspect 3: Personal traits

The third aspect of the personal dimension consists of personal traits. In the selected articles, many terms are used to identify traits related to the personal dimension. Some authors use categories like *character traits* (Kenny et al., 2009) or *personality and abilities* (Drolet & Sauvageau, 2016). Others study specific characteristics like *resilience, confidence, and virtues* (Ashby et al., 2016; Holland et al., 2012; Jakobsen et al., 2011). *Resilience* is the capacity to deal with adversity and traumatic events (Hendriks et al., 2018). Resilience-related character traits are the most studied, due to the phenomenon that resilience combined with career longevity supports professionals in facing challenges and preventing burnout (Ashby et al., 2016; Edwards & Dirette, 2010; Scanlan & Hazelton, 2019). *Character traits* interfere positively and negatively in the mental health of AHPs while working in a challenging healthcare system with high workloads (Lau et al., 2016). *Resilience-related personal traits and virtues* can be conceptualized as two sub-aspects in the personal dimension, which we will discuss here.

Resilience-related personal traits. Ashby et al. (2013) explore factors that influence the resilience of occupational therapists and establish that challenges requiring resilience often relate to (professional) values and identity. They distinguish between professional and personal resilience. Personal resilience can be supported through professional supervision when time is allowed for reflective practice and professional reasoning with a colleague with a shared philosophy. In the case of students, professional supervision is provided by clinical teachers, which supports the growth of personal resilience and professional robustness (Ashby et al., 2013). Clinical teachers should 'aim to build resilience in students that protects them from the corrupting influence of negative role models in the health system' (Rowe, 2015, p. 5), but need to take into account that they, too, have a personal dimension and will therefore experience dilemmas, notably due to their dual or triple identities as clinician-educator or clinician-educator-scientist (Kluijtmans et al., 2017; Matthews et al., 2020; Ong et al., 2019; Rees et al., 2019). Newly graduated AHPs feel more insecure and less confident about their decisions. This is supported by Holland et al. (2012) and O'Leary & Cantillon (2020), who describe professional confidence as a maturing, dynamic personal belief held by professionals or students. Feeling less confident has consequences for personal resilience. Professionals sometimes get overwhelmed by the emotional aspects of their job and by the workload they are confronted with (Jarvis & Trodd, 2008; Lau et al., 2016). Such feelings are related to their personal life experiences. Performing professional activities that are meaningful and hold personal value reduces the likelihood of burnout, increases job satisfaction, and generates a stronger sense of professional identity (Jakobsen et al., 2011; Scanlan & Hazelton, 2019). Resilience-related personal traits can be developed through (inter) professional socialization, which is often accompanied

by the virtue of solidarity, which will be explained in the next paragraph.

Virtues. Caring, justice, solidarity, courage, veracity (honesty), and integrity are virtues that are mentioned in various contexts in the articles reviewed. None of these articles have virtues as their main subject, but they are described as traits that influence professional practice.

The virtue of caring was often the reason for becoming an AHP: these professionals want to help and understand people (Drolet & Sauvageau, 2016). In practice, being caring causes tensions for professionals when working in the border area of caring and therapy, especially for students and young professionals. AHPs whose role it is to give therapy are sometimes regarded as caretakers. This brings with it the dilemma between wanting to help people but also needing to maintain professional and personal boundaries (Binyamin, 2018). Men in female-dominated health professions do effectively experience additional role strain because of the social prejudice that men are less caring than women, which can lead to feelings of inadequacy in caring (Gheller & Lordly, 2015).

Justice or fairness is a virtue that frequently causes dilemmas in allied healthcare. AHPs with a strong sense of justice face dilemmas when healthcare systems prioritize patient care differently than they do as professionals (Binyamin, 2018). Quality of care is another subject of dilemmas. In their human and professional hearts, AHPs want to do everything in their ability for a patient, but in economically managed healthcare systems, patients have limited rights to healthcare (Kenny et al., 2009). Particularly in occupational therapy, this is a common dilemma causing frustration for professionals. In Drolet and Sauvageau's study about occupational therapists in Quebec (2016), 81% of the participants spontaneously mentioned social justice and advocacy as values that were important to them. These values are linked with a core service provided by occupational therapists, helping patients to recover the occupations that are important to them (occupational justice). As a result, the confrontation with economic restrictions that prevent the recovery of these occupations leads to feelings of injustice among these AHPs. Moreover, since this is a field-specific service, dilemmas arise for occupational therapists in regard to interprofessional practice when their profession is not valued as important by other professions (Bushby et al., 2015; Dige, 2009; Hess-April et al., 2017; Wimpenny & Lewis, 2015).

In the stereotypical view of (allied) health professionals, *solidarity* is a shared virtue (Conroy, 2019) because these professionals are not only supposed to be caring towards their patients, but also towards each other. Ashby et al. (2013) describe feelings of solidarity within the occupational group when professionals work in a challenging work environment and find each other in informal social networks. These networks are part of professional self-care strategies that counter isolation and increase the resilience and identity of professionals (Ashby et al., 2013; Turner & Knight, 2015). In addition, increased personal resilience supports another virtue, courage.

The connection between courage and professionalism is elaborated by Zmetana (2013). She states that professionals have the conviction and the courage to do what is right and make the right choices, which goes beyond the capacity of merely knowing right from wrong. This fits with the findings of Rowe (2015) who refers to moral courage as 'a continuous commitment to and reflection upon personal values and moral behaviors that influence ethical decision making' (Rowe, 2015, p. 4). He states that a lack of moral courage and agency is frequently observed in health care professionals, which has a negative impact on their professional practice (Rowe, 2015). Moral courage, veracity (honesty), and integrity are connecting virtues between the personal traits in the third aspect and the core values in the fourth aspect of the personal dimension. This latter aspect is the worldview of the AHP, which is discussed in the next paragraph.

To conclude, the third aspect of the personal dimension, being personal traits, consists of two (sub)aspects: resilience-related personal traits and virtues. Character traits like resilience, self-assurance, and confidence, combined with the performing of professional activities that are meaningful and hold high personal value, reduce the likelihood of burnout and support professionals in meeting challenges. The development of positive traits and of character strengths, increases personal resilience. Virtues like caring, justice, and solidarity are positive personal traits that play an important role in human-centered care, but which can cause dilemmas when the quality of care desired by the professional cannot be realized due to cost-effective health care. In such situations, moral courage is required to balance the pressure between economy and good care.

Aspect 4: Worldview

The fourth aspect of the personal dimension, the worldview of the AHP, can be seen as the filter through which the professional views his or her professional practice. This filter is formed by the first three aspects of the personal dimension and consists of *core beliefs* (Burford et al., 2014; Hess-April et al., 2017) and *core values* of AHPs (Awlor, 2013; Hayward et al., 2013; Kenny et al., 2009), paired with personal norms which are, specifically, shaped by family upbringing and the AHP's socio-cultural background (Drolet & Sauvageau,

2016; O'Flynn et al., 2014; Wimpenny & Lewis, 2015).

In their study, Burford et al. (2014) see personal beliefs as part of the personal moral and ethical codes, or core beliefs, of individuals. These core beliefs are identified as underpinning the professionalism of individuals. In testing their theoretical findings with the participants of their study – students and educators of three health professions – Burford et al. observe that the participants saw professionalism as part of the identity of the professional that cannot be parceled off from the latter. In all the reviewed articles in which core beliefs are defined, core beliefs are seen as belonging to the personal dimension. The authors connect core beliefs with family upbringing and confirm that these are sometimes the underlying motivation for becoming a healthcare professional. One example of a core belief that is frequently mentioned in healthcare is consistency of approach; the belief that every patient has the same rights to good care, irrespective of origin or social status, and the right to be seen as a person, not as a patient (Burford et al., 2014).

This worldview filter, as outlined above, is formed by the first three aspects of the personal dimension. For instance, there is a relationship between the core values in the fourth aspect and the virtues in the third aspect. Two of the virtues, which are also values, that are important in the personal dimension are veracity (honesty) *and* integrity. Integrity is also one of the core values emphasized by the American Physical Therapy Association (Hayward et al., 2013). In addition, in the study of Kenny et al. (2009), integrity is the ethical principle at stake in ethical dilemmas of speech pathologists. These dilemmas arise from internal conflicts between personal and professional identity, conflicts primarily created on account of the professional code of ethics. Organizational and community-related dilemmas arise when professionals' personal values are not consistent with having to work 'cost-effective', 'outcome-driven', or when they experience that fair, equal access to care is not guaranteed for all patients (Hughes, 2001; Kenny et al., 2009). These feelings of unfairness usually arise from values that are shaped by the professional's family upbringing and sociocultural background (Drolet & Désormeaux-Moreau, 2016). The cultural background of the professional, with its different norms and values, is shaped by the context of regional cultures and countries, and impacts the development of professionalism and the professional identities of students according to Helmich and De Carvalho-Filho (2018) and Lecours et al. (2021). Many curricula are built on Western thinking about professional identity, but in this globalizing world we have to add non-Western insights, or as Guajardo et al. (2015) put it, bring together the '"developed" global north and "developing" south' (Guajardo et al., 2015, p. 4). This is exemplified in the research of Neiterman and Bourgeault (2015) on internationally educated healthcare professionals (IEHPs). These authors found that IEHPs who emigrated to Canada primarily had to adapt their cultural competency to the new context, by combining 'old' skills with new ones, and developing new communication patterns to transition to the new culture of the practices in which they were employed. The biggest challenge for IEHPs was to deal with the fact that their skillset and identity was questioned by Canadian colleagues. Canadian healthcare professionals view their Canadian identity and skill set as the norm, and emigrating IEHPs had to demonstrate that they met this norm, especially in terms of their ideas on gender and racial issues, due to stereotypes held by local professionals (Neiterman & Bourgeault, 2015). Conroy (2019) and Hind et al. (2003) argue that stereotyping about professions is a general problem in health care, which needs to receive attention in healthcare curricula as part of professional identity development and as a basic condition for interprofessional education and interprofessional healthcare (Conroy, 2019; Cooper et al., 2005; Hind et al., 2003).

These examples of the effects of worldview demonstrate that characteristics like nationality, ethnicity, and gender do influence the worldview of AHPs and, moreover, can cause moral dilemmas in allied healthcare. Life experiences, personal traits, and virtues do shape the core values and core beliefs of professionals, and the personal norms connected with these. Professionals are not always aware of their own worldview. The experience of an ambiguous situation, or talking about ethical dilemmas in peer-support groups or in response to new research findings, can create awareness of how the personal dimension interferes in clinical practice (Guendouzi & Williams, 2010). Hammond et al. (2016) argue that when professionals frequently participate in moral and ethical reasoning in peer-support groups, they develop a stronger sense of their personal dimension, which supports their individual agency.

CONCLUSION AND DISCUSSION

In the scoping review presented in this article, in which we included 81 studies, we explored the research question, *What is known about the personal dimension of professional identity of AHPs in (allied) health literature?* First of all, we observed that similar to the medical literature (Rees et al., 2019), there is a growing interest in allied health literature in professional identity (development), with a major rise in attention during the last 6 years. Another observation is the varying degree of attention for the personal dimension within the various allied health professions. Half of the studies are related

to occupational therapy whereas only two studies related to optometry addressed the personal dimension (Long & Rosen, 2017; Spafford et al., 2004). This varying degree of attention can be related to the different backgrounds of the professions; occupational therapy, for example, is a socially oriented allied health profession while optometry is biomedically oriented (Clark, 2014; Clouston & Whitcombe, 2008; Nicholls & Gibson, 2010). These different orientations also have an impact on practice, especially on interprofessional practice: 'The epistemological and ontological foundations of different professions ensure that they see things differently, even when they look at the same patient' (Clark, 2014, p. 36).

Our review demonstrates that how the young optometry student thinks and acts – as in the case presented at the beginning of this article – is entirely in line with findings in allied health literature on the personal dimension. To explain this, we will focus on the different aspects of the personal dimension. The personal dimension can be understood as a set of personal aspects that have a substantial impact on professional identity and frequently cause dilemmas. Students and new graduates experience different themes in ethical dilemmas than experienced professionals, or experience common dilemmas in a different way (Binyamin, 2018; Kenny et al., 2009). These reactions can be explained on the basis of the aspects of the personal dimension we presented in Figure 2.

The first aspect encompasses *characteristics* like gender, age, nationality, and ethnicity. Gender is the most researched characteristic. The second aspect consists of the life experiences of the professional, which include personal experiences in childhood and with family life, such as family upbringing, but also personal experiences with illness and disability and with illness and disability of family members. The third aspect involves personal traits relating to resilience and virtues. Resilience and other personal traits that relate to it are frequently studied in connection with burnout and professional identity education. Virtues are primarily studied in relation to moral dilemmas that professionals are faced with. The fourth and final aspect, the *worldview* of the professional, consists of core beliefs and core values of AHPs, paired with personal norms, which are, specifically, shaped by family upbringing and the AHP's sociocultural background.

In the case presented in the introduction, the optometry student is young and inexperienced. He was raised to always tell the truth and studies optometry to care for people's eyes. His education focuses on skills, knowledge, protocols, and law. The client is a young man of his optometrist's age, whom he expects to behave and think in the same way as himself. Because of his lack of experience, he is still insecure, lacking the resilience and moral courage to deal with the angry client. His mentor is an experienced optometrist who knows from experience that clients do not always tell the whole truth when they know that something important, like a driver's license, is at stake. His help, in taking the decision to record to real visual acuity, is an example of the supervision students need to gain confidence and resilience. This dilemma situation was a disconcerting life experience for the student, which brought about an adjustment in his worldview that served him in dealing with similar dilemmas in his later career.

Compared to general literature on the personal dimension, allied health literature shows similarities but also gaps. While in the educational literature, Beijaard (2009) describes the personal dimension as composed of a set of specific personal, sociodemographic characteristics, the personal biography and learning history, and the beliefs a professional has about the profession, the allied health literature does not define the personal dimension. Lieff et al. (2012) underline the need to be mindful of factors related to the personal dimension in the development and implementation of healthcare curricula. Professional identity research shows that teachers develop a personal interpretative framework that arises from personal values and beliefs, which is shaped and re-shaped in the course of their career through interaction with teacher colleagues and the impact of the social, cultural, and structural conditions in their working environment (Kelchtermans, 2009; Vanassche & Kelchtermans, 2016).

To conclude: in all the literature on allied health professional identity that we studied for our scoping review, not one of the articles studies the personal dimension in its entirety. Many articles researched or identified various (sub)aspects of the personal dimension, but this was never the core focus of the study. Only seven review studies were available for inclusion in our scoping review, compared to a large amount of small-sample qualitative studies. These qualitative studies were valuable but came with limitations for the generalizability of their findings, which was identified as the primary limitation of these studies by the authors. Many aspects of the personal dimension are mentioned in the articles reviewed, but these are not elaborated on. This is particularly the case for different personal, sociodemographic characteristics like gender, nationality, and ethnicity. In further research on the personal dimension, it would be interesting to combine several small studies.

Not all allied health professions are included in research about the personal dimension. In occupational therapy, aspects of the personal dimension are frequently studied, in optometry the personal dimension is barely studied. This demonstrates the need for further research into the personal dimension in all allied health professions. Lindquist et al. (2006) also call for further research into

how professional identities are formed and how the understanding of other professions is shaped. The lens through which the personal dimension is studied in this review will be checked in empirical research on four Dutch allied health professions, but perspectives from other disciplines or collaborations with other countries are also recommended.

Key messages

1. Being aware of the cultural (ethnic) background of habits and having an eye for the effect of personal, sociodemographic characteristics can create awareness for professionals to provide appropriate responses in a practice visited by clients with a variety of cultural backgrounds (Mårtensson & Archenholtz, 2017), and to know how to cope with dilemmas with this kind of background especially in interprofessional teams (Davis, 2006; Hertweck et al., 2012).
2. All personal life experiences of being confronted with ethical doubt cause professionals to grow and to reflect on their professional values and reduce tensions between the personal dimension on the one hand and professional beliefs that stem from the professional identity on the other.
3. Professionals are not always aware of their own worldview. The experience of an ambiguous situation, or talking about ethical dilemmas in (interprofessional) peer-support groups or in response to new research findings, can create awareness of how the personal dimension interferes in clinical practice (Guendouzi & Williams, 2010).

Strengths and limitations

The strengths of our scoping review are the systematic nature of our study, the quantity and range of the included articles, and the scoping review's potential contribution to future research, practice, and education.

A limitation is that the review is conducted on the basis of Dutch allied health professions, which includes some allied health professions that are not widely practiced internationally, but also omits some professions, such as nursing, which belong to allied health in other parts of the world such. It would be interesting to study the differences between the personal dimension as elaborated in the allied health professions of this scoping review and the personal dimension as elaborated in nursing.
Another limitation is that the search did not include a sociological database. Including a sociological database could have provided some relevant studies from a different perspective. Although there was a substantial overlap in the studied databases because many journals are included in both (allied) health and psychology databases.
This scoping review serves as an initiative to generate more attention for the personal dimension of professional identity.

Ethical approval

No ethical approval was necessary for the conduct of this review.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

Data availability statement

The authors confirm that the data supporting the findings of this study are available in original published papers used in this review and are available from the corresponding author, EB.

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APPENDIX

Table 2: Included articles in scoping review.

Year	Author	Journal	Research type	Profession(s)
2001-2005	Hughes, J.	Br J OT	literature study	OT
	Hind, M. et al	J Interprof Care	survey study	medicine, nursing, pharmacy, PT, diet
	Ikiugu, M.N.; Rosso, H.M.	OT intern	survey course evaluation analysis	OT
	Spafford, M.M. et al.	Optom Vis Sci	field observations interviews	Opt
	Cooper, H.; Spencer-Dawe, E.; Mclean, E.	J Interprof Care	survey study interviews	medicine, nursing, PT, OT
	Kathard, H.	Adv Sp-Lang Path	literature study	SLP
2006-2010	Abreu, B.C.	Am J OT	work journey literature study	OT
	Davis, J.	IJAHSP	interviews	OT
	Lindquist, I. et al.	Med Teach	Interviews	PT
	Plack, M.M.	J PT Educ	interviews	PT
	Clouston, T.J.; Whitcombe, S.W.	Br J OT	discussion paper	OT
	Hooper, B.	Am J OT	interviews, observations, narratives	OT
	Jarvis, J.; Trodd, L.	Child Lang Teach Ther	discussion paper	SLT Teachers
	Atkins, J.; Gingras, J.	Can J Diet Pract Res	interviews	Diet
	Dige, M.	Sc J OT	literature study	OT
	Kenny, B.J. et al.	Int J Lang Comm Dis	interviews	SLT
	Black, L.L. et al.	Phys Ther	interviews, reflective journals	PT
	Edwards, H.; Dirette, D.	OT Health Care	survey study	OT
	Guendouzi, J.; Williams, M.J.	Commun Med	interviews	SLT
	Nicholls, D.A.; Gibson, B.E.	PT Th Pract	literature study	PT
2011-2015	Jakobsen, F.; Hansen, T.B.; Eika, B.	J Interprof Care	survey study	OT, PT, nursing
	Hertweck, M.L. et al.	J PA Educ	survey study	psychology, OT, PT, PA
	Holland, K.E.; Middleton, L.; Uys, L.	SA J OT	literature review and focus groups	OT
	Holland, K.E.; Middleton, L.; Uys, L.	Sc J OT	literature study	OT
	Trede, F.; Macklin, R.; Bridges, D.	Stud Higher Educ	interviews written reflections	PT
	Ashby, S.E. et al.	Aus J OT	interviews	OT
	Awlor, S.L.	Can J Dent Hyg	history	DH
	Hayward, L.M. et al.	Phys Ther	interviews, reflective journals, observation	PT
	Holland, K.E.; Middleton, L.; Uys, L.	OT intern	interviews	OT
	Zmetana, K.	Can J Dent Hyg	literature study	DH
	Burford, B. et al.	Med Educ	focus groups	paramedic, OT, podiatry
	Clark, P.G.	J Interprof Care	narrative analysis of literature	health and social care
	Khalili, H.; Hall, J.; DeLuca, S.	J Interprof Care	literature study	health professionals
	Kraft, M.; Blomberg, K.; Hedman, A-M.R.	Intern J Older People Nurs	interviews	OT, PT, nursing

Continued *Table 2: Included articles in scoping review.*

Year	Author	Journal	Research type	Profession(s)
2011-2015	O'Flynn, S.; Kelly, M.A.; Bennett, D.	Med Educ	literature study	health care practitioners
	Bushby, K. et al.	Br J OT	literature review	OT
	Guajardo, A.; Kronenberg, F.; Ramugondo, E.L.	SA J OT	literature study	OT
	Martinez, J.; Leland, N.	OTJR	case study	OT
	Neiterman, E.; Bourgeault, I.L.	Soc Sci Med	interviews	int educ health care prof (IEHPs)
	Rowe, M.	SA J PT	nominal group technique (NGT)	PT, physician, surgeon, nursing
	Turner, A.; Knight, J.	Br J OT	literature review	OT
	Wimpenny, K.; Lewis, L.	SA J OT	Case study Interviews	OT
2016-2021	Ashby, S.E.; Adler, J.; Herbert, L.	Aus J OT	survey study	OT
	Drolet, M-J.; Désormeaux-Moreau, M.	Sc J OT	interviews	OT
	Drolet, M-J.; Sauvageau, A.	Sc J OT	interviews, literature study	OT
	Drolet, M-J.; Sauvageau, A.	Sc J OT	interviews, literature study	OT
	Gendron, T.L. et al.	Clin Gerontologist	survey study	Clin/Couns Psych, Geront, nursing, pharm, PT, OT, SW & management, administration
	Hammond R; Cross, V.; Moore, A.	Physiotherapy	group discussions	PT
	Lau, B. et al.	Phys Ther	systematic review	PT
	McMahon, A.T. et al.	J Human Nutr & Diet	literature search interviews	Diet
	Stull, C.L.; Blue, C.M.	J Interprof Care	survey study	OT, DH, DT, dentistry, clin lab sci, medicine, nursing, pharmacy, public health, vet med
	Hess-April, L. et al.	SA J OT	interviews	OT
	Kluijtmans, M. et al.	Med Educ	interviews	PT-sci, nurse-sci
	Lahav, O.; Yalon-Chamovitz, S.	Am J OT	survey study	OT
	Lawson, L. et al.	Am J Fam Ther	interviews	nursing, medicine, PT students
	Long, D.D.; Rosen, I.	Health Soc Work	reflection on work practices	Opt. SW
	Mårtensson, L.; Archenholtz B.	Sc J OT	focus groups	OT
	McEntee-Atalianis, L.; Litosseliti, L.	Narr Inq	small story analysis	SLT
	Ranz, R.; Nuttman-Shwartz, O.	Eur J Soc Work	25 Facebook posts (narratives)	SW
	Binyamin, G.	Adv Health Sci Educ	cases, personal reflections	OT
	Burley, S. et al.	Aus OT J	ethn study: obs, interviews, review progress notes	OT
	Champine, J.M. et al.	Int J Dent Hyg	survey study	DH
	Devery, H.; Scanlan, J.N.; Ross, J.	Aus OT J	surveys interviews	OT
	Gheller, B.J.F.; Joy, P.; Lordly, D.	Can J Diet Pract Res	interviews	Diet
	Helmich, E.; de Carvalho-Filho, M.A.	Med Educ	commentary to content analysis	medicine
	Hendriks, T. et al.	Int J Soc Psychiatry	interviews	Health care prof
	James, K. et al.	Br J OT	interviews	OT

Continued *Table 2: Included articles in scoping review.*

Year	Author	Journal	Research type	Profession(s)
2016-2021	Conroy, C.	IJAHSP	narrative literature review	nursing, OT, SW, biomed sci, medicine students
	Furness, L.; Tynan, A.; Ostini, J.	Aust J Rural Health	focus groups	PT, OT, Diet, ST, SW, Psych, Pod
	Goh, N.C.K. et al.	Aust OT J	interviews	OT
	Ong S.Y. et al.	BMJ Open	interviews, focus groups	OT PT
	O'Shea, J.; McGrath, S.	Br J OT	interviews	OT
	Rees, C.E; Kent, F.; Crampton, P.E.S.	Med Educ	interviews (group and individual)	medicine, midwifery, nursing, OT, param and PT
	Scanlan, J.N.; Hazelton, T.	Aust OT J	survey study	OT
	Volpe, R.L. et al.	Med Educ	scoping review	medicine, nursing, couns/ psych
	Feller, K.; Berendonk, C.	Med Educ	focus groups	physicians, AHPs
	Fitzgerald, A.	Nurs Forum	concept analysis	nursing, medicine, SW, OT, pharm
	Matthews, R.; Smith-Han, K.; Nicholson, H.	Adv Health Sci Educ	narrative inquiry	PT, medicine students, diet, psychology
	O'Leary, N.; Cantillon, P.	Adv Health Sci Educ	interviews	SLT
	Lecours, A.; Baril, N.; Drolet, M-J.	Can J OT	concept analysis	OT
	Sonday, A.	SA J OT	interviews focus groups	OT, PT