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# Choosing motherhood: The complexities of pregnancy decision-making among young black women ‘looked after’ by the State<sup>☆</sup>

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## ABSTRACT

**Objective:** this paper addresses the experiences of a group of young black teenage mothers looked after by the State, most of whom were also either migrants or asylum seekers. The paper explores the experience of discovery of pregnancy, attempts to seek professional help and the eventual decision to continue with the pregnancy.

**Design:** an interpretative study with in-depth interviews.

**Settings:** interviews were carried out in the participants' homes and focussed on their experiences of pregnancy decision-making.

**Participants:** 15 young women (aged 16–19), from black minority ethnic groups, with a history of care (past or present), currently pregnant or mothers of a child no older than two years of age.

**Findings:** all the pregnancies were unexpected: eight of the informants conceived as a result of rape and seven while in a relationship. All the young women chose motherhood over abortion despite their complex social and pregnancy background.

**Conclusions:** the importance of social positioning of migrants in terms of the cluster of negative aspects and environmental disadvantage generally experienced by most immigrants in the host country is raised in this paper. Care practices of pregnant women with complex social factors were little observant of woman-centred care approaches.

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## Introduction

This paper addresses the experiences of a group of young black teenage mothers looked after by the State, most of whom were also either migrants or asylum seekers. The paper explores the experience of discovery of pregnancy, attempts to seek professional help and the eventual decision to continue with the pregnancy.

In the UK, NICE guidelines on Pregnancy and Complex Social Factors (2010) recognised women who are migrants, asylum seekers or refugees as one group amongst four key areas, together with young women under 20, women who experienced domestic violence and those who misuse substances (alcohol and/or drugs).

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Bollini et al. (2009) have reviewed epidemiological studies that compared pregnancy outcomes for native and immigrant women in 12 European studies, concluding that, overall, migrant women experience poorer outcomes of pregnancy. Such disadvantage was reduced in countries that operate supportive integration; the UK was not amongst that group. A recent collaboration between *Maternity Action and the Refugee Council* (2013) has drawn attention to the additional stress suffered by pregnant women who are asylum seekers and are subject to practices of geographical dispersal, whereby asylum seekers are housed by the Home Office on a no choice basis in locations around the country.

The common public image of teenage pregnancy as a serious social problem (Winters and Winters, 2012) is underscored by its perceived destructive consequences believed to be the result of lower levels of education, welfare dependency, and low-paying jobs, as well as greater health troubles for these mothers and their children (Luker, 1996; Furstenberg, 2007). Alongside establishing teenage pregnancy as a deviant behaviour, British social policy has described it as a major public health problem to be prevented (see SEU, 1999). Scholarship on teenage pregnancy in Britain finds that social deprivation, poor attainment and disengagement at

school are the key underlying factors that affect conception rates (Hoggart, 2012).

In Britain racial–ethnic comparative perspective has received relatively less attention (Bonell, 2004). To date there has been no in-depth research in Britain to parallel US studies about ethnicity and early parenthood (Owen et al., 2008), partly due to the lack of comprehensive statistics on live births by ethnic groups (Phoenix, 1991). Higher-than-average rates of teenage pregnancy/parenthood among some minority ethnic communities, has been highlighted in British surveys (Berthoud, 2001), though these patterns have not been explored in depth. None of these studies have explored the pregnancy decision-making process of black minority young mothers with a history of care and displacement.

#### *'Looked after' teenage mothers*

'Looked after' young people undergo a high level of hardship and deprivation and suffer from a high level of emotional and behavioural disturbance (Roy et al., 2000; Cusick et al., 2003; Akister et al., 2010) and have worse health than that of the general population (Audit Commission, 1994). They have greater health needs than their peers but are less likely to receive adequate healthcare (Department of Health, 1998).

The family circumstances leading to being taken into care – material and emotional disadvantage – are contributory factors to the problems 'looked after' young people face (Chase et al., 2006; Knight et al., 2006). These experiences and sources of deprivation form clusters of 'risk factors' associated with vulnerability to early pregnancy and parenthood among young people in and leaving care (Barn et al., 2005; Chase et al., 2006). Despite experiencing a significant degree of risk or adversity in their lives, on becoming mothers, 'looked after' young women fashion resilience despite, and out of, the experiences which threatened to undermine it (Mantovani and Thomas, forthcoming).

#### *Pregnancy decision-making*

Conceptions that are terminated are usually not the result of intentional behavioural choices (Upchurch et al., 2002), and women vary considerably in the way they experience and respond to the possibility of an unintended pregnancy (Hoggart and Phillips, 2010). Research has examined decision-making in response to class, family values and local cultures (Lee et al., 2004; Hoggart et al., 2006), and cultural norms when examining decision-making among minority groups (French et al., 2005; Higginbottom et al., 2006). The complex range of conflicting values influencing decision-making is clearly illustrated in Hoggart's (2012) research.

A key factor affecting a young woman's decision whether to terminate a pregnancy is the nature of her relationship with her partner. Those feeling they are in a secure relationship and feel supported tend to opt for motherhood (Hoggart et al., 2006). Teenagers are also affected by the political, social and local discourses around teenage pregnancy (Greene, 2006), although there is no evidence that peers have influence on young people's behaviour (Arai, 2007).

## **Methods**

This study seeks to address two research questions: how interpersonal relationships affect the decision-making-process of an unexpected pregnancy among informants, and what is their experience of health professionals during decision-making?

The study took an interpretative approach to examine participants' interpretation and knowledge about their social world

(Denzin and Lincoln, 2003). In-depth unstructured interviews were undertaken with 15 young women by [first author] between 2005 and 2007. Informants were recruited in three London Local Authorities (LAS) selected for their geographical diversity, reported rates of teenage pregnancy and their high concentration of black minority groups. A purposive sampling method was employed and participants were selected according to: age (16–19); ethnicity (Black African, Black British, Black Caribbean, Mixed-Heritage); 'looked after' status (currently in care or left care); length in care ('looked after' for a minimum of one year); and motherhood status (a mother or currently pregnant).

The interview process was taken as a consultative process (Thompson, 1996) and a non-hierarchical relationship was adopted when interviewing respondents (Oakley, 1981). Both the University of London Committee and MREC governing body for ethics (N. 05/Q0801/168) approved the study. Key workers, who knew the young women and their levels of literacy, recruited participants. This method of recruitment was adopted so that key workers could explain the project and implications of participation in ways that participants could understand. Key workers offered their support to informants if they would become distressed as a result of revelations. Participants were informed that they could withdraw from the interview if they wished to do so at any time during the interview. At the outset informants were made aware that, as an acknowledgement of their help in the study, they would receive £10. The researcher received the informants' contact details only when they had given their consent to do so.

Interviews were carried out in the participants' own homes and were recorded with the consent of the interviewees. Transcribing the interviews verbatim ensured that there was an accurate account of the study interviews. To preserve anonymity the participants have been given names typical of each country of origin. Each interview transcript was coded individually with initial description codes. From a corpus of raw data a thematic organisation of the data emerged, including identification of similarity, contrast, and juxtaposition (Sim and Wright, 2000). To increase quality assurance of the qualitative work undertaken we applied Lincoln and Guba's (1985) idea of trustworthiness throughout the research process, by rigorously collecting data and synthesising it, and by conducting the research independently of the researchers' own perspectives. The interview material was carefully scrutinised by the researchers who took into account of the variations in responses.

## **The participants**

Fifteen participants were interviewed from 25 potential respondents who returned the participation form. There were difficulties in establishing first and/or further contacts with 10 women. Of the 15 women who took part nine were recruited through Social Services, one through peer education groups, four through family support groups, and one through snowballing.

At the time of interview three young mothers were aged 19; five were aged 18; five were aged 17; and two were aged 16. Of the 15 participants, 13 were from the African continent (three from South West Africa, five from West Africa, and five from East Africa) and two were British nationals. Of the 13 African born: 11 were unaccompanied minors when they arrived in Britain, and two had migrated at a young age with their families. Of these 11, two were educational migrants and nine were asylum seekers.

Informants in this study were under the local authority's (LA) legal responsibility for their care. Participants had been in care for an average of two years (range 1–4 years); two mothers entered care aged 14, five aged 15, six aged 16 and two aged 17.

Ten informants were in their first pregnancy and five were in their second or subsequent pregnancy. Eight conceived as a result of rape and seven conceived whilst in a relationship.

## Findings

In the following sections we highlight the unaccompanied minors' journeys to Britain. We describe the mothers' reproductive experiences and the informants' negotiations with their contextual reality (structural and social constraints, social organisation, interpersonal relationships). Next we examine the mothers' internal negotiations arising from a number of conflicting demands (their beliefs and the meaning of motherhood/parenthood) while deciding what to do with the pregnancy.

### Seeking protection in Britain

The 11 unaccompanied minors mentioned political, economic, persecution and violence as key reasons for leaving their countries. They were brought to safety in Britain by either a pastor, an 'auntie' or 'uncle', or by some family friend. Five of the informants who had been raped told a similar story about being subsequently abandoned on arrival. Limber explained:

I didn't know the person who brought me here. He was some friend of my dad. He brought me here and he left me somewhere, and he told me that he was coming back, but he never came back. Then, I asked people and they showed me a police station...and, they took me to the social services. (Limber)

The complexities of navigating the asylum system for children are known (Brownlees and Smith, 2011). At the time of the interview those unaccompanied minors who were seeking asylum were at different stages of their asylum applications. The fear, worry, and anxiety accompanying the asylum process (Maegusuku-Hewett et al., 2007) was coupled with the fear of being returned to the country from which they had fled and with the news of an unexpected pregnancy. This is illustrated here:

I didn't know what to do ...I didn't know what to think I didn't have a clue what goes on or what happens. (Shidah)

Limited English, lack of understanding of British cultural cues made it difficult to understand what was happening to many of them. This experience was also shared by the two educational migrants, whose status limited their entitlements.

### Reproductive experiences

The circumstances surrounding informants' conception were markedly different; eight participants conceived as a result of rape and seven conceived whilst in a relationship. None of the conceptions that occurred while in a relationship were planned. Of the women who were raped, seven were raped as a result of ethnic conflicts in their homeland and one was raped on arrival in Britain as a result of her homeless status. Accounts of rape were told within a context of destruction and human extermination:

It wasn't my fault I got pregnant, because where I come from is a war country. So, when the rebels invaded our area they capture so many young girls and I was a victim of that. You know, it doesn't go down well with me any way, but I have no choice. (Namuly)

None of the seven women who had been raped before migrating to the UK suspected being pregnant when they arrived in

Britain. Although some were 'sick all the time' and had no 'routine', they attributed this to stress or the fact that they were 'not used to the environment', or to the British weather:

I didn't know I was pregnant, you know? I was just sick and sick until I had blood tests. Because I had just come to this country and they said may be it is the weather. The weather has passed by but I wasn't well. It was when I had the blood test that they said I was pregnant. That's why I was sick! (Pemba) I was missing my periods cos' I didn't know I was pregnant, because when I came here, it was...I don't know (I thought) may be because I was not used to the environment – it was cold – and the tension that I didn't have money. Then I ended up being admitted in hospital for one and half weeks, that was when I realised I was pregnant cos' they'd...done everything and they told I was pregnant. I couldn't believe it! That is why I got a social worker because I really needed help. (Nakato)

In the next section we highlight the informants' personal and environmental context that influenced their actions when resolving their pregnancy.

### Personal and environmental context of decision-making

The context of the pregnancy resolution is the scenario within which informants played out their lives and highlights the structural constraints when resolving their pregnancy. Most informants were still looked after by the Local Authority on discovering their last pregnancy ( $n=12$ ) three were living independently and supported by the 'leaving care' team. Eleven participants were still in education, three had interrupted their studies because of the pregnancy and one had a part-time job. Thirteen participants were in receipt of benefits; nine reported they had experienced difficulties with lack of money.

The partnering context of the informants who conceived in a relationship was complex – re-partnering and repeat pregnancies had occurred in a number of instances. At the time of the interview 12 informants described themselves single, of whom two had visiting partners; three young women were cohabiting, of whom two were cohabiting with the father of their second child.

The majority of the respondents in this study were vulnerable when they arrived in the UK. They became separated from those who provided them with care and protection and they sought asylum in a country strange to them. They had to deal with the multiple losses while dealing with resettlement issues such as social, cultural and economic adjustments and cross-cultural clashes; their familial identity and their role within it was shattered. Loss of identity and multiple losses are important concepts in the context of the women's decisions.

Those respondents who were British born (Amy, Cherie), or had settled in Britain for a longer time (Abeo, Fola, Chicke, Malika), benefitted from a support network of family and friends. By contrast, those mothers who had recently resettled could not rely on support network in the area where they lived; nine said they did not know anyone in their neighbourhood they could count on receiving help, and four said they could rely only on one or two people. Not being inserted into networks or broader structures made pregnancy resolution very difficult for most of those informants who had been uprooted from their country:

No one was close to me when resolving my pregnancy, so it wasn't easy. It has not been easy not having anyone close to you. I can't just say that I got pregnant and I had my baby (it was much more complicated than this). (Isoke)

Lacking a durable network of social relationships led informants ( $n=8$ ) to experience a sense of isolation and loss at the time

of discovering and resolving their pregnancy. Many informants lacked the social capital to enable them to claim access to necessary resources and lacked trust which is an important conduit for networks to flourish (Putman, 1993):

It's been very hard for me. I didn't have anyone to talk to. The man who picked me from the street was a cabdriver. He was never (close to me)...and there is no way in any instance I could confide in him, because I never knew him. It was a very bad experience. (Twain)

The informants' social positioning limited their social contacts with the outside world, which in turn had an impact on their help seeking behaviour and the options that were made available to them. Their social positioning as asylum seeking young mothers reflects and expresses the women's inequalities, which consists of the intersections of the asylum seekers' capital (cultural, social, economic, and/or political capital).

### Interpersonal relationships and relations of power

Inter-personal relationships were very important during decision-making to the extent that informants were particularly susceptible to relationship of power with adults which influenced their decision about the pregnancy (Brady et al., 2008).

### Parental influence

Those respondents who had family and kinship in Britain were vulnerable to social disapproval from them. They were aware, before they were faced with a pregnancy, of the beliefs, values, responses and levels of support that they might expect from their families. These expectations were filled with fear and anxiety and being subsequently exposed to the shame that they had violated adult expectations about gendered sexuality and the cultural ethos about family formation. The anticipated parental reaction had a direct influence on the informants' decision-making:

When my dad would have found out, I would get into trouble. My dad would beat me, or he would kick me out of the house. That was my reason not to keep the baby; my dad's going to be disappointed of me. I was thinking a lot of negative things and feared the change in my home life. (Abeo)

Feeling she could not speak to her parents, Abeo, sought help from a pastor to resolve her conflicts. He applied cultural reasoning to dissuade her from having an abortion, and said to her: 'In religion we do not take out the baby because it's not nice'. Abeo subsequently decided to 'leave it' – to keep the baby. In contrast, Cherie's mother, who was 'the last person to know about the pregnancy' gave her ambivalent advice which made her revisit her initial decision:

She didn't want me to have it. She was saying I should get rid of it. She also said: 'Tell him if he marries you then you'll have the baby'. And I think *that* was one of the reasons why I was having second thoughts as well. (Cherie)

### Boyfriends' support

None of the young women had planned to be single mothers. Of the seven women who were in a relationship at the time of conception, two fathers started a new relationship during the pregnancy, one stopped contact as the pregnancy progressed, and two relinquished their ties with the mother soon after birth even if they had offered their support with parenthood. During

decision-making three fathers said they were supportive of the pregnancy, the remaining four fathers either showed non-committal attitudes – letting the partner decide the outcome of the pregnancy – or pressurised her to have an abortion. The disclosure of the pregnancy became a negotiation ground for Chicke, Amy and Cherie who withstood attempts from relations seeking to dissuade them from keeping the baby:

At the time when I was pregnant ... at the beginning of the pregnancy my boyfriend, my baby's father, was telling me to do an abortion. I say: 'No I can't do this' because ... he was insisting, he was saying: 'Oh you have to do it'. I say: 'No I'm not going to do that because ... I'm not going to do that'. He say you have to do it! ... and the first scan I did at the hospital, and everything was fine ... I went to his house and I showed him the pictures of the baby. He say: 'Wow you're going to have a baby!' He was happy, but soon he started a another relationship with another woman and I found out and I suffered at that time yeah, I really suffered, I cried a lot. (Chicke)

Amy, who was expecting her second child, recalled the attempts of her boyfriend to dissuade her from her resolution to keep the baby. He first denied she might be pregnant and then resorted to cast doubts on her ability to cope with another child. He then told her that if she 'did not want to get rid of it' she had 'another choice, adoption, and give (the baby) away to another family'.

Three informants said their boyfriends were fully supportive of the pregnancy. This meant they had never to consider how to resolve the impending pregnancy. Nevertheless, interview data indicates that only Fola's boyfriend supported her fully; economically, emotionally and practically. He had been very helpful and very understanding and very caring from the start.

### Professional responses

In encounters with health professionals, refugee mothers report being met with stereotyped judgements; this made them feel not in control of their birth (Strauss et al., 2009). Informants in our study revealed how professional practices had characterised them in terms of their age and economic situations. The professionals they consulted about resolving their pregnancy, discursively marked them out as different – as unable to cope – with concerns expressed about their ability to be 'good parents'. Five informants reported being advised by their foster mother and/or by health professionals to have an abortion on the basis of their young age:

My foster mother told me that getting pregnant was bad because at the time I was in school and that *I was too young to have a baby*. They didn't like it because I was still at school and they just told me if I could wait a little bit more, they said: 'You can take it off and continue your life'. (Malika) They booked an appointment with [abortion provider] and she was asking me if I was going to terminate. And she was talking like bad things, like making me terminate it. And I told her to make an appointment, 'cos I felt that she was making sense... They thought that it would not be easy. Although she was right but ... to her I don't know. She was trying to convince me. (Isoke)

In the next instance, Limber received contrasting advice by health professionals, both underscoring different normative values about the 'good mother':

The teenager midwife – those in the hospital – her advice was to terminate (because) she thought that I wouldn't cope. Yeah, I wouldn't cope to look after the baby. So, she was telling me to terminate...and another she told me that: 'If you have an

education here you can make it'...and I decided to give birth. (Limber)

A similar practice was adopted by a hospital nurse. Pemba said that her pregnancy had just been diagnosed and that whilst she was 'sitting in the waiting room at the maternity hospital waiting to be seeing by the doctor', a nurse 'was calling (her) asking' whether she was 'free'. Pemba continued:

They said they'd book me an emergency thing to remove the baby without me knowing, so, that's what upset me. They said: 'No but you can't have a baby you should go back to school'. (Pemba)

By contrast, two young women who were still within the term prescribed by the Abortion Law, were told they could not have an abortion because 'it was too late'. Abeo said:

When I found out I was four months pregnant and I wanted to take it out, but when I went to the hospital they were telling me it was too late that I can't take out the baby. (Abeo)

Lack of awareness, denial, or fear of the reactions of others prevents young women from seeking help, compared to older women (SEU, 1999). Three informants, who had sought advice from their GP on discovering the pregnancy were not offered information on access and entitlement to healthcare. Lack of access and information, isolation and unmet needs for social support among asylum seekers is highlighted in [McLeish's study \(2005\)](#). Limber, who told the doctor she wanted to 'keep it', was told 'to go and think about it and come back the next day with someone older'. Not being referred added another layer of difficulty:

My doctor asked me whether I wanted the pregnancy...I told him no. He talked to about his thoughts but we were not getting anywhere. So, he gave me two weeks to think about it, then he told me to come back. I had no one to talk about to then; I was **all** on my own. (Twain)

Nakato was taken for a counselling session before she 'made up the last decision' because she 'found it hard to make a decision'. She was carrying her father's baby – she was (having her sister). During the counselling session she was asked as to whether she had a boyfriend or not, and asked about what religion she was and whether her religion allowed her to have an abortion. This style of questioning was perceived as being neither welcome nor beneficial. Nakato said: 'When I came in I was sure about what to do, but now I'm not sure any more'.

To add to the complexity of already difficult circumstances, Nakato was 20 weeks pregnant when her pregnancy was diagnosed. She also experienced delays in having a social worker allocated which impacted on the time she was able to see a counsellor, and the subsequent options available to her. In addition, the staff seemed uncertain about government policy on late terminations:

By the time we went to the clinic I was about 23 to 24 weeks. When we went there they were not sure whether they could do it at 24 week. They told me we will have to do it today or leave it. They told me we will have to arrange today and when they were doing the arrangements they were saying they were not sure if they were going to do it from there. They didn't have space. They had to keep in me for two days. They phoned somewhere, they wanted to find out whether they could do it there. (Nakato)

## Personal values about abortion

Some informants either renounced or rejected having a termination by evoking the moral values imposed by their cultural/religious norms, or embraced a moral and fetus-centred stand:

I would feel like a murderer...I did not want to do it (abortion). It is better giving the baby out [for adoption] than killing the baby. I fell pregnant then I have to go and kill the baby? The baby is innocent, I don't kill it. (Isoke) I don't believe in abortion, that's why I kept it. I just don't think...it's not fair. I don't think it was the right time to have it, but I don't believe in abortion. (Malika)

## Choosing motherhood – imagining a new relational context

Understanding what parenthood/motherhood means to young women with a complex background is vital for professionals who support them in their decisions. Informants in this study felt that others definitions of their situation did not chime with their own assessment. They saw the value in having children and the support children would provide in the future (the sense of having a family). For all the unaccompanied minors, having a child meant ensuring they had a social support in the present and in the future, someone who would fulfil their otherwise emotionally empty lives and give them a focus:

I decided that since I don't have a family I can share a life with him. I will keep him *no matter how I got him*...and because I don't have a family at least I have someone to talk to. (Limber) A reason why I decided to leave her there (not to have an abortion), was because she would be the only biological person I would have. She would be my mum, she would be my family, she would be my sister, she would be my daughter. She is someone to smile at me...when I'm not feeling well and I smile back. And everything I am thinking about goes away; I concentrate on her. It gives hope in life, it gives you something to work for in the future something you know you're looking at. It's something you're working for it is something you're responsible for. These kids as they grow up they become our consolation. My baby is like consolation. If I had a hard day when it comes to pick her up she gives me a smile I forget everything, I just feel happy. And if I didn't have her, if I had aborted her, who would be there to give you that smile? So, it is not bad to make that decision to have that kid, it is not bad at all. (Nakato)

On the other hand, for other women motherhood gave them a chance to reassess their life; a moment to reflect on the past in order to undertake a new pathways and make changes in their life:

When I got pregnant it was like I saw things differently. It was like it wasn't just me, there was this little baby and I needed to grow up, I need to sort myself out. I think without him I don't think I'd be anywhere really. To be honest without him I just... wouldn't be doing anything. I just would be sitting here doing nothing. I think he's influenced me to go out and work. (Cherie)

The experience of motherhood provided a different pathway to maturity by serving as a powerful motive for *reforming* Cherie's life; it was a strong incentive for change ([Davies et al., 1999](#)). The theme of maturity emerged strongly in the women's accounts about their experience of motherhood/parenthood.

## Discussion

This paper has explored the experiences of black teenage mothers looked after by the State. In terms of the NICE (2010) guidelines on Pregnancy and Complex Social Factors, all were under 20, most were migrants or asylum seekers and more than half had experienced (domestic) violence, being pregnant as the result of rape. The combination of two or more complex social factors inevitably added to their distress. The health services did not always recognise this complexity, its origins and its implications for good care.

From the women's narratives there was very little evidence of a woman's-centred care approach adopted by health (and social) care professionals. On the contrary, informants were reminded by professionals that motherhood outside the confines of the social institution of motherhood and its socially prescribed conditions is deficient. The concerns of the professionals expressed regarding the young women's pregnancy revealed their assumptions of the inevitability of the cyclical view of teenage pregnancy. Becoming a mother at a young age would mean 'risking' their future life: it would curtail their education which would have an impact on their opportunities of having a skilled job. By having a child, they would be likely to remain welfare mothers with little education and, thus, be poor and inadequate mothers. An awareness of the difficulties encountered by the informants in this study due to the consequences of displacement may help health professional to understand and related to these service users better (Strauss et al., 2009).

Data from this study also highlight that there was little evidence of multi-agency working and needs assessment planning. This impacted on healthcare professionals' knowledge as to what other social problems the young women seeking their care might have. In the case of Nakato, for example, had the counsellor been informed of her complex background, s/he perhaps would have discussed Nakato's fears in a more sensitive and non-judgemental manner. In addition to this, the healthcare professionals 'helping' Nakato did not seem to have updated knowledge about government policies related to late abortions. NICE guidelines state that when dealing with migrants, asylum seekers and refugees healthcare staff should be given training on the most recent government policies on access and entitlement to care (NICE, 2010). In addition, it is important to note how powerful the individual professional can be in creating the caring environment, thus, developing cultural sensitivity in health practices should be promoted by leaders who envision changing environments where health professionals work (Briscoe, 2013).

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