

Learning During Internship

Patient Educator Interns' Experience of Transition to Workplace

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Dedication

This thesis is dedicated to the loving memory of my father; Abdulelah Almoayyad. He was and will always be my role model, he believed in me, encouraged me, provided me with endless love and support. He may not be here but his finger prints are all over who I am now.

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Abstract

New graduates' transition into the workplace is a critical period and workplace learning during this period is under-researched, particularly for people coming into newly emerging professions such as Patient Educators. The aim of this thesis was to explore Patient Educator Interns' (PEIs) experience of learning during internship.

In this case study from the Kingdom of Saudi Arabia, semi-structured interviews were conducted with 10 PEIs. Following a narrative analysis, case summaries were developed, compared and interpreted. The study's findings showed that being from a newly emerging profession can exacerbate the transition shock experienced by new graduates, as PEIs experienced additional challenges resulting from being new as a profession in the work force. The sociocultural element of transition shock was significant among those study participants who found it hard to settle in a workplace when they did not feel that they were formally recognised. The intellectual element of transition shock was evident in the rigid understanding which PEIs held about the role of patient educators. Finally, the concept of epistemological transition shock was introduced in this thesis to describe the challenge which PEIs experienced as a result of the shift from the formal learning given in educational institutions to learning which takes place in a working environment through engaging and participating in practice. This new understanding has implications for new graduates' making the transition to practice in a range of professions.

PEIs learning experiences were seen to be influenced by three factors; PEIs' understanding of their role, PEIs' relationships to others, and PEIs'

understandings of learning. These factors were distilled into two issues; professional identity and personal epistemologies. These issues should be taken into account when developing educational policy, particularly, when introducing a new professional discipline, and when enhancing learning in the workplace.

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List of Abbreviations

PEI.....	Patient Educator Intern
JCIA.....	Joint Commission International accreditation
WHO.....	World Health Organization
CBAHI.....	The Central Board of Accreditation for Healthcare Institutions
KSU.....	King Saud University
PNU.....	Princess Nourah bint Abdulrahman University
TCH.....	Tertiary Care Hospital
SHU.....	School Health Unit
SHC.....	Specialised Health Centres
NGO.....	Non-Governmental Organisation
GO.....	Governmental Organisation

Chapter 1 Introduction

This thesis explores patient educator interns' (PEIs) experience of learning during internship. A qualitative case study using semi-structured interviews was used to explore PEIs' views on their training experience. The findings of the study focus on the PEIs' experience and these were interpreted with reflection on both my own personal experience and with reference to the wider literature.

1.1 Structure of the thesis

The thesis starts with an introductory chapter where a background of the research is provided including the historical and contextual background in addition to my personal reflection on the context. Chapter 2 further elaborates on the relevant literature, namely workplace learning, internship, transition to the workplace, learning during transition and the introduction of new professions. Chapter 3 outlines the methodological considerations and the methods adopted for the research. The findings of the research are then described in Chapters 4 and 5 and discussed in Chapter 6. The final chapter discusses the implications of the research including the recommendations and conclusions.

1.2 Research background

Patient education is an important part of health care. The role of the patient educator is newly developed, not well established and poorly recognised in many instances. Although the literature emphasises the importance of

patient education, there is an identifiable lack of research, literature and standardised policy and practice. As a previous patient educator I am aware of the difficulties that face these professionals, especially during the first year of training. The struggle of being recognised as a health care practitioner can potentially be overwhelming, especially for new patient educators. In the literature, the importance of providing well-structured education during the early years of practice is emphasised. This is due to the critical nature of this period which may have a significant impact on the person's career. The possibility that this aspect of patient educators' training could be made more explicit and be further improved was an inspiration to start my doctoral research.

The main aim of the study was to explore PEIs' experience of learning during internship training in Saudi Arabia, with the intention of using this understanding to inform improvements in internship learning. My aim was addressed through an exploratory case study using semi-structured Interviews to explore the views of PEIs regarding their learning during their internship period. The case study provided a better understanding of the process of PEIs' training within its context, and the factors which influence that training Data was analysed using narrative analysis techniques which incorporated reflection on my experience as a patient educator. This combined understanding provided useful information that is directly related to the context, and therefore has the potential to improve internship training. The in-depth description of this case study can facilitate transferability of the outcomes, by allowing others to compare the findings to their own context.

1.2.1 Aim

To explore PEIs' experience of learning during internship.

1.2.2 Objectives

- To ascertain PEIs' views on the internship experience.
- To identify the factors that influence PEIs' learning.
- To develop a set of recommendations that can guide the improvement of PEIs' and other new graduates' training.

1.3 Patient education: historical background

Patient education provides medical care in a way which improves the knowledge, skills and health behaviours of individuals (Groene, Alonso and Klazinga 2010; Roter, Stashefsky-Margalit and Rudd 2001). This enables patients to become more involved in making decisions regarding their health (JCIA 2007). It allows them to manage their conditions better (Groene, Alonso and Klazinga 2010; Hartmann and Kochar 1994; Hawthorne *et al.* 2008; Rankin and Stallings 2001; Rueda *et al.* 2006) and ultimately has a positive impact on health outcomes (Lorig 2001).

In the last 50 years there has been increasing emphasis on promoting communication between health care professionals and patients (Hoving *et al.* 2010). Patient education and patient educators play an important part in this enhanced communication. Patient education interventions are directed towards individuals (Hoving *et al.* 2010) and involve practices which influence their health (Groene, Alonso and Klazinga 2010; Roter, Stashefsky-Margalit and Rudd 2001). The tasks of patient educators are

specific to disease management and treatment rather than forming part of general health promotion and prevention (Caraher 1998). The term 'patient education' is used to describe all aspects of education which involve patients as individuals rather than the population as a whole (Lorig 2001), and which enable patients to become more involved in making decisions regarding their health (JCIA 2007) and managing their conditions (Bartlett 1995; Deccache and Aujoulat 2001; Groene, Alonso and Klazinga 2010). In this research, the term 'patient educator' is used to describe any practitioner who is exclusively assigned to provide health education for patients in clinical settings.

The role of patient educators has been formalised by several international health policy organisations and is overseen by the Joint Commission International Accreditation (JCIA) standards (JCIA 2008; WHO 1998). These are based on a World Health Organisation (WHO) report on patient educators which refers to therapeutic patient education (WHO 1998) and sets out the roles and responsibilities of patient educators which include:

- Encouraging communication.
- Increasing the understanding of a person's health status, therapeutic plan options and the consequences of these options.
- Promoting decision making.
- Enhancing self-management and coping skills.
- Improving the likelihood of compliance to the health care plan and life style changes.
- Informing patients about the financial responsibilities of the health care plan.

Patient education has undergone several changes throughout its history. Until the 1960s, health care was mainly a reactive rather than preventative practice. Doctors held the full responsibility for patients' care, and providing patients with information was not a priority. However, due to society's growing emphasis on patients' rights, patient education started to be integrated into patient care. Some countries, such as the Netherlands and the United States, led the adoption of patient education within their health systems during the 1960s and 1970s (Hoving *et al.* 2010). However, it was not until the 1990s that the patient's right to be engaged in decision making was widely recognised when, due to increased participation by patients, it became very important to provide them with sufficient knowledge and skills to enable them to make decisions about their health care plans in addition to self-management of their diseases (Hoving *et al.* 2010).

In the United States the role of the health educator was delineated in the early eighties and has gone through several updates through the years (NCHEC 2015). In the 21st century, patient education began to be integrated into health care policy around the world (Hoving *et al.* 2010; Mis *et al.* 2015). This expansion in patient education challenged the education provided by health care practitioners and led to the development of a new field of practice; patient education, with its own specialist training (Hoving *et al.* 2010). Hospitals seeking to gain credentials, such as those provided by the JCI, had to integrate patient education into their programmes and resources and demonstrate that multi-disciplinary patient education was being implemented. They were also required to show evidence of patients' learning and document its direct impact on patients and families (JCI 2008; Rankin and Stallings 2001).

Considering the current situation of different health systems across the world, it is possible to identify some variation in the development of patient education services. While some countries have well established and extensive patient education services, others are still in the early stages of development, or provide limited education conditions (Deccache and Aujoulat 2001). In Switzerland, for example, the notion of patient education is well established, by the Division of Therapeutic Education for Chronic Diseases, which was founded to manage education activities within health institutions. This includes public, as well as patient, education; and the practice of patient education is not limited to specialist educators but is part of a multi-disciplinary healthcare team role (Assal and Golay 2001). The Swedish health care system has no separate service for patient education; Swedish health care practitioners provide education as part of their routine practice (Rosenqvist 2001). Similar systems exist in both Estonia and Iran, where family physicians and nurses are the main providers of education (Harm 2001; Ramezanli and Badiyepymaie Jahromi 2015). While patient education in Saudi Arabia shares some features with many countries, there remain differences which distinguish the practice from that seen elsewhere. The implementation of patient education in Saudi Arabia is described below.

1.4 Patient education in Saudi Arabia: contextual background

In Saudi Arabia, patient education started in the early 1980s. At that time, there were some health care professionals who were non-Arabic speakers and who required translators in order to carry out consultations with patients.

The translators' role changed over time as they began to provide patients with health information, initially in the presence of health care professionals and subsequently in their absence. However, because these translators were not trained, this led to inadequate patient education, which resulted in a negative impact on patients' health (Alabadi 2006). This was one factor which led to the formalisation of the patient educator role. The other significant influence was the drive for hospitals to seek JCIA credentials (Khan 2011). To receive this credential, hospitals were obligated to integrate patient education into their programmes, which required them to both train and employ specialist patient educators.

In addition to the JCIA accreditation, there is also a Saudi national accreditation, The Central Board of Accreditation for Healthcare Institutions (CBAHI), which includes family and patient education as one of the fundamental quality standards (CBAHI 2005). Thus, to be granted the CBAHI accreditation, hospitals are required to fulfil health education standards which include,

“PFE.1.5 According to the size of the hospital and its scope of services, the hospital assigns adequate health educators to cover the needs of patient/family education (e.g., diabetic educator, patient educator)” (CBAHI 2013)

Moreover, these standards describe the process of patient education and include the topics to be covered by these educators. Therefore, currently, patient education is implemented in most Saudi hospitals.

To understand the patient education status at an organizational level, I have reviewed a number of job descriptions, policies and guidelines for patient

education within the Ministry of Health and a number of hospitals in Saudi Arabia. From this review, it was clear to me that there were major commonalities among the job descriptions and policies reviewed. For example, hospitals require patient educators to assess patients' needs, develop an education plan and implement and evaluate patients' learning. However, there were differences in the level of clarity in policies and procedures. Where some hospitals provided detailed manuals, others did not offer any supporting guidance.

The practice of patient education in Saudi Arabia shares similarities with certain other countries, such as the United States, and these similarities exist when following the JCIA standards. However, there are also some differences, which make the practice of patient education different from that of other countries. For example, educators' roles in Saudi Arabia are not limited to chronic conditions, but extend to other health issues such as education in in-vitro fertilisation (IVF) clinics and for the carers of children with autism. In the context of Saudi Arabia, the term patient educator describes any health care professional whose job is exclusive to patient education in clinical settings. In addition, Saudi Arabia has its own system for preparing specialised patient educators, as discussed below.

1.5 Preparing patient educators

Despite the emergence of patient education around the world, there is still a need to place greater emphasis on preparing health care practitioners to become patient educators (Hoving *et al.* 2010). The training provided for

patient educators is considered to be insufficient in many countries, such as France (Fournier *et al.* 2001) and Estonia (Harm 2001).

Currently, patient education training is provided using a variety of approaches. In countries such as France (Fournier *et al.* 2001) and Estonia (Harm 2001), patient education is included in initial medical and nursing training. However, in other countries such as Sweden (Rosenqvist 2001) and the Netherlands (Albada, Elbers and Visser 2007), courses are provided for health care professionals in the workplace. Finally, in some countries, health education is provided as a bachelor's or master's degree to prepare specialized educators, such as in the United States (Livingood and Auld 2001) and Saudi Arabia (KSU 2011; PNU 2015).

In Saudi Arabia, two approaches are used to prepare specialised patient educators. First, there are courses provided for health care professionals who wish to work as specialised educators. For example, diabetes education courses are provided by several health institutions to prepare health care professionals to work as diabetes educators (KSAU-HS 2012). Second, a number of universities such as King Saud University (KSU) (KSU 2011) and Princess Nourah bint Abdulrahman University (PNU) (PNU 2015) provide an undergraduate health education degree. By the time I started my research, the programme of health education was only provided by KSU, which became the case in my study.

1.5.1 KSU Health education programme:

The programme of Bachelor of Health Education provided by KSU comprises 136 hours of study divided into nine terms, over a 5 year period, plus a required internship year. To my knowledge, this programme has

recently recommenced after a period of not being offered (it does not have a sustained history of delivery).

The programme is taught in English in an all-female section at the university. Entry requirements for the programme include having a general secondary certificate or an equivalent that is not more than five years old (KSU 2009). Most of the students enter the programme straight from an all-female secondary school. Acceptance in this programme is competitive as students need to pass an examination and an interview.

The modules within the Bachelor of Health Education can be divided into two categories. First there are the modules that focus on public and health education such as Principles of Health Education, Fundamentals of Health Education The Social Concept of Health Education, Methodology in Health Education and Health Education in Health Care Services. Second, there are health modules such as Human Anatomy and Physiology, [Infectious Disease](#), Growth and Development, Family Planning, and Maternity and Child Care. This programme aims to prepare individuals to work as specialised health educators in different sectors, becoming for example patient educators, school health educators and community health educators (KSU 2011). When I reviewed the course description, I found that it included different health educator responsibilities. However, when I contacted University staff to clarify to what extent different roles are defined and explained to students, I was told that there are variations on the implementation and it all depends on the individual lecturer's focus. Some of the modules include practical training, but experience in the workplace is limited. In the Health Education in Health Services module for example,

students are required to show their ability to practice some of the patient educators' skills such as assessment of patients' needs. This training usually takes place in the workplace but under the supervision of staff from the university.

Graduates from this programme must complete a mandatory year-long internship programme before qualifying to work as independent practitioners. During this year, interns are expected to work under supervision in a health institute which provides health education services. There are no specific requirements for training except that the workplace should complete the university assessment form upon the completion of training. This year of training in the workplace is important to support the education which students receive. During the year of internship PEIs receive a monthly allowance as is the custom for all students in public universities in Saudi Arabia.

1.6 Personal reflection on patient education training during internship

My initial interest in this area arose out of reflections on my own experience as a patient educator. After my graduation from a health education department, I worked as patient educator for four years in Saudi Arabia. Before graduating with a health education degree, I was required to complete a year of internship training. During my internship, I worked at three different hospitals. Training approaches varied from one hospital to another and had different impacts on my learning. For example, I started work in a hospital which had a health education department but had no

patient educators working in it. The department was responsible for issuing educational materials and organizing educational events, but had no previous experience of training patient educators and only a limited understanding of their role. I therefore felt this experience was lacking and as a result my colleagues and I had to define our own role and to work independently. This was very stressful and a difficult situation, and I felt that I required more guidance. Then, some months into this job, I was assigned to work under the nursing department in a diabetes education clinic. This involved a planned approach to my work. I began working alongside more experienced staff in tasks such as helping patients to monitor their blood sugar, and in time I was gradually assigned more tasks until, finally, I was practising independently with minimal or no supervision. The positive influence of this experience was not limited to improving my knowledge and skills; it also made me more confident in socializing with others and being part of a work team. In fact, the placement within this hospital was the most significant period during my internship.

After this hospital I worked in one with a well-structured department which had clear guidelines and a training plan. This hospital did not offer many opportunities to practise independently, but I learned how clear guidelines improved the service provided. In the final stage of my internship, I worked in another diabetes education clinic. This was a very different experience from my previous experience in the diabetes education clinic and at the time I did not feel that I benefited to a great extent from this training. This could have been due to several reasons, but the main significant reason was that there was less coordination between the doctors and the educators. As a result, it was difficult to be totally clear about the needs and education plan for each

patient. These examples from my training highlight three completely different learning experiences. Each of these has influenced my learning in a different way. In my experience at the time I felt that having a clear training plan, practice and guidance were the most significant factors which improved my learning.

In reflecting on my own experiences, and by talking to and observing other qualified patient educators and PEIs, it became clear that my experience was not unique and that other newly graduated patient educators in Saudi Arabia faced a similar series of challenges. Consequently, I became interested in exploring the period of transition from student to independent practitioner. Therefore I researched the literature to see what had been written about professional training during this transition period. This reading confirmed my interest in the importance of the first year of practice (Seah, Mackenzie and Gamble 2011; Spouse 2001). Of particular interest was the work of Duchscher (2009), who identified the concept of transition shock. Research in this area focuses on the transition into work and the way in which this influences the creation of competent practitioners (Seah, Mackenzie and Gamble 2011).

In deciding on an area of focus for my doctoral studies, I wished to choose a topic that would be of practical value to patient educators. My interest in learning during transition was confirmed as important by a preliminary review of the literature. I was curious to learn whether it would be possible to improve patient educators' training in Saudi Arabia and whether there was something I could contribute to improve this training. In developing the scope of the research, I therefore decided that I would focus on learning during the

period of internship of patient educators in Saudi Arabia, with the intention of using the findings of the research to improve training and at the same time inform improvements in internship learning.

1.7 Rationale

The proposed research aims to provide in-depth understanding of the experience of PEIs internship training in Saudi Arabia, with the intention of using the findings to inform improvements in internship learning. This area has been chosen because of the great need to develop and improve patient education training programmes; especially in the first year of practice. More specifically, while there is an international emphasis on the importance of improving the training of patient educators, the lack of sufficient training has been considered an obstacle to improving patient education services (Fournier *et al.* 2001; Keller and Basler 2001; KSU 2011; Skelton 2001). The literature reviewed for the purpose of this research showed deficiency in the studies concerned with the training of new graduates entering new professions and no studies at all studying patient educator graduates. It is expected that findings from the research will provide an understanding of how PEIs experienced their one-year internship, and the factors which influence their learning during that period. It is hoped that the findings will not only help in improving the development and implementation of patient education training programmes, but also help in broadening the understanding of the experience of graduates entering new professions.

1.8 Conclusion

Patient education is an important part of health care. In Saudi Arabia, patient education has a unique system of practice and training. In this system, patient education is provided by specialized educators who are specifically trained to provide this service. The training of patient educators in Saudi Arabia is conducted through many different approaches. Internship training is one of the main approaches to training new graduates and the first year of transition from student to professional is recognised as a critical period. In my experience, PEIs may experience transition shock and this may have a negative impact on the learning experience. Due to the importance of providing adequate patient education and the problems associated with its training, the proposed research project was conducted with the intention of providing useful information, to help improve internship learning.

Chapter 2 Literature review

This chapter examines the literature related to my research aim. My research concentrates on PEIs' experience during internship, with a focus on learning. Therefore, the literature reviewed will provide a background on five related areas which are workplace learning, internship, transition to the workplace, learning during transition and introduction of new professions. First, I will present a review of workplace learning and the common theories underpinning it. Second, I will introduce the concept of internship and the different ways in which people understand it. Considering that the internship period is the period in which graduates make their transition into the workplace I will provide a discussion about transition to the workplace. I will then bring evidence from literature on factors which influence learning during that period. Finally, considering that the patient educators' role is new to the health care system, I will discuss the literature relevant to introduction of new professions in the health care system. Each of these areas are outlined and elaborated in relation to PEIs' training.

To find literature relevant to the topic, I searched electronic databases, including; MEDLINE, PsycINFO, CINAHAL, Embase, BEI (British Education Index), Australian Education Index, ERIC (Educational Resources Information Centre), and Social Services Abstracts. Examples of the terms used for the search are; "workplace learning", "practice based learning", "transition", "new graduate*", "new profession" and "new role" (See Appendix A for an example of an electronic search). A range of text books about workplace learning and transition were also searched. Reference lists from

key articles helped me to identify further studies. In addition, a number of new articles and related theses were suggested by my supervisors.

2.1 Workplace learning

Workplace learning is an important aspect of PEIs' experience. Once PEIs complete their academic requirements at the university they move to a hospital or related health administration institution to complete a year of practical training (KSU 2015). Many authors have argued that formal learning which occurs in universities can provide baseline knowledge and skills for entry level, but it cannot be considered sufficient for producing professional practitioners (Billett 2001; Hager 2011; Morris and Balney 2014; Sullivan and McIntosh 1996). Learning in the workplace is considered an important part of developing competent practitioners (Williams 2010). Many authors emphasise that well-organized and structured training is crucial for developing competent professionals capable of independent performance (Billett 2001; Hager 2011; Illeris 2011; Spouse 2001; Sullivan and McIntosh 1996). In this section, I will provide an overview of the way in which workplace learning is conceptualised and the main theories underpinning it. When reading about workplace learning, I found that it has attracted the interest of researchers in many disciplines over the last two decades (Fenwick 2008). In this section, I focus on workplace learning as understood in the field of education, as the studies about workplace learning in health care are mostly focused on clinical teaching rather than learning and often tied to specific contexts (Dornan et al. 2007). In the literature, different classifications have been applied to understand workplace learning, these

classifications depend on the school of thought which the researchers follow. Morris and Balney (2014) described three ways in which people classify workplace learning. First is the distinction between theories that focus on individuals, such as those concerning individuals' behaviour and cognitive conception, and those that focus on shared learning, such as social-contextual conceptions of learning. Second is the distinction in theoretical orientation i.e. psychological, sociological or socio cultural theories. Finally, there is a metaphoric distinction which was introduced by Sfard (1998), where she differentiated between understanding learning as skill acquisition and learning as participation. When I started my research, I was thinking of learning in the workplace in terms of skills acquisition for learners. As the research progressed however, and with the guidance of my supervisors, I realised that a more social understanding of learning was necessary. The development of my understanding of learning is described in detail in section 6.2. Below I will discuss relevant theories based on their individual or social-contextual focus, with reference to the metaphors of learning and their relation to that understanding.

2.1.1 Individual focused view

In reviewing the literature, I realised that theories which focus on the individual are commonly used to understand professionals' learning. These theories are mainly influenced by psychological and behavioural theories (Hager 2011; Morris and Balney 2014). A widely used example of this view is the experiential learning theory, which considers the learning outcome as a combination of grasping and transforming experience (Kolb and Kolb 2009). Another commonly used concept is learning by reflection, which was

suggested by Schön (1995). This concept focuses on the learners' engagement and reflection in order to learn. Schön (1995) introduced two types of reflection. These are reflection-in-action (during practice) and reflection-on-action (after practice). This theory mainly relies on the ability of the learner to notice, identify and consequently correct features of his/her own actions (Hager 2011). The five stage model of skill acquisition (Dreyfus and Dreyfus 1980) is also used to describe and predict the development of individual workers' skills (Benner 2004; Dreyfus 2004). According to this model, workers go through five stages to achieve expertise; novice, advanced beginner, competent practitioner, proficient, and expert (Dreyfus and Dreyfus 1980). The progression of the worker through these levels is expected to be associated with the learners' engagement at work (Dreyfus 2004), where individuals learn by reflecting on their practice and the consequences of this practice (Hager 2011). The focus on the individual learner seems to be associated with using the term "acquisition" to describe learning. Numerous scholars argue that using this metaphor has several weaknesses. According to Hager and Hodkinson (2009) and Sfard (1998), using the acquisition metaphor objectifies knowledge and/or skills. As a consequence, it implies that knowledge and skills can be acquired, possessed and transferred. This assumption implies that what is being learned is separate from the learner and the context (Hager and Hodkinson 2009).

Theories that focus on the individual expect learners to reflect on their actions in the same way and consequently gain the same knowledge despite any differences in their backgrounds and capabilities (Hager 2011). Additionally, learning is considered to be isolated from the context in which

learning is occurring, thereby underestimating the influences of the social, cultural and organizational factors at work (Hager 2011). Identification of these weaknesses of focussing on the individual has encouraged other researchers to develop a wider view of learning. In this work, researchers examine the cultural and social context influences as well as individual influences on learning. This work is described in the next section.

2.1.2 Social-contextual view

Theories which fall under the social-contextual view recognise learning as a complex process which is influenced by a range of cultural, social and organisational factors (Hager 2011; Morris and Balney 2014). According to this view, learning is visualised as an on-going process that involves active engagement of learners at work (Hager 2011; Lee *et al.* 2004). In addition, this view rejects the isolation of learning from the context and viewing it as independent from learner; instead learning is viewed as developed by the individual and shaped by the context (Hager 2011). Therefore, the metaphor of acquisition is rejected and different metaphors are used, such as participation (Hager and Hodkinson 2009; Sfard 1998), transformation and reconstruction (Hager and Hodkinson 2009).

A widely used example of this approach is the concept of “*communities of practice*” (Lave and Wenger 2003; Wenger 1998). This approach describes learning as an on-going process that is not limited to gaining knowledge and skills. Instead it also includes social relationships and co-participation of the learner as the source of learning (Lave and Chaiklin 1993; Wenger 1998).

Lave and Wenger (2003) define communities of practice as:

“A set of relations among persons, activity and world, over time and in relation with other tangential and overlapping communities of practice” (p.98)

As with other social learning theories; the concept of communities of practice rejects the focus on the individual and emphasises the influence of social relations. As Wenger (2010) stated;

“It is a perspective that locates learning, not in the head or outside it, but in the relationship between the person and the world, which for human beings is a social person in a social world. In this relation of participation, the social and the individual constitute each other”.

Lave and Wenger (2003) use the participation metaphor for learning, as they call learning that occurs within communities of practice *“legitimate peripheral participation”*. According to this concept, learning is viewed as a situated activity in which newcomers master the knowledge and skills and become part of the communities by moving toward full participation in sociocultural practice. Learning in communities of practice does not only involve learning knowledge and skills, but also learning values, identities and the culture of the community. Although communities of practice theory is highly regarded within workplace learning research (Hager 2011), this notion has been criticised for directing attention exclusively into the social aspect of learning and missing the influence of the individual (Hager 2011; Morris and Balney 2014).

To provide a broader understanding, a number of scholars' work encompasses both social and individual influence. Billett's (2001; 2006) work appears to be influenced by communities of practice, as mainly shown in his

description of the way in which the novice worker starts by being involved in simple, peripheral and less accountable activities and moves towards full participation by being gradually involved in more complex and accountable tasks. However, he also emphasises the individual's role, as he highlights the importance of personal influences such as cognitive abilities and emotions (Billett 2001).

To summarise, workplace learning is theorised in different ways. Theorists who focus on the individual are influenced by the fields of psychology and behavioural science. These theorists focus on the individual's ability to learn and consider learning as a process of knowledge and skill acquisition with little or no consideration of the social and contextual impact on learning. The work of social-contextual theorists gives more attention to cultural, social and organisational factors. These theorists reject the concept of acquisition and believe that learning is developed by participation and the engagement of the learner with the context. The work of Billett (2001; 2006) expands the socio-contextual understanding of workplace learning to encompass the individual influence and impact.

In my research I adopted a socio-contextual view of learning, which also considered individual influence, as this seemed to provide the broadest understanding of learning. This broad understanding of learning allowed me to analyse the data considering all possible influences on PEIs' learning. In the next section, I will discuss literature which talks about the period of internship and the learning during that period.

2.2 Internship

This section will introduce the concept of internship and the different ways in which people understand it. According to Cantillon and Macdermott (2008), the concept of internship was initially introduced in the early nineteen-forties as an educational year to provide a vast amount of supervision and personal study. However, over the years, interns became part of the workforce and hospitals depended on their support. With this change, the view of internship has changed to become not only an educational opportunity but also necessary for service delivery and an opportunity for learners to take various responsibilities (Bearman, Lawson and Jones 2011).

Internship training has become an essential part of preparing new graduates in a range of different industries (Baker *et al.* 2009; Beecroft, Kunzman and Krozek 2001; D'Abate, Youndt and Wenzel 2009; Goode *et al.* 2009; Kendall 1980; Lam and Ching 2007). Internship programmes are developed to facilitate new graduates' transition to the workplace and to fill the gap between their academic studies and workplace's demands (Altier and Krsek 2006; D'Abate, Youndt and Wenzel 2009; Edwards *et al.* 2015; Lam and Ching 2007; McKenna and Green 2004; Owens *et al.* 2001). In the health care field, clinical placement within internship has been considered an essential component of health care practitioners' education (Deketelaere *et al.* 2006), it is usually a prerequisite for further career development (Baker *et al.* 2009; Beecroft, Kunzman and Krozek 2001) and in some areas is mandatory for graduation, as is the case with patient educators in Saudi Arabia. When PEIs complete their university courses, they are required to

complete one year of internship as stated in the college graduation requirements web page:

“After completing the academic requirements, students have to complete a training period (internship) for one calendar year in hospitals or related health administration institution following a training program approved by their departments, with mutual supervision between the college and training institution. After successfully completing the internship period, the students receive certificates which entitle them to practice their profession” (KSU 2015)

As mentioned earlier, one of the main purposes of an internship programme is facilitating the transition of students to workplace. Below, I will elaborate on the transition period and the difficulties associated with it.

2.3 Transition to workplace

As this research focuses on training patient educator interns during their transition from the university to the workplace, it is important to recognize the importance of this period. Being faced by reality during transition into and within work for new graduates causes the development of mixed feelings which can include shock, anger, fear, confusion, and happiness (Brennan *et al.* 2010; O'Shea and Kelly 2007; Tryssenaar and Perkins 2001; Waite 2004) During this transition period, new practitioners encounter a number of challenges that may hinder them, make them vulnerable to stress, instil a lack of confidence and may even cause them to leave work in search of another career (Duchscher and Cowin 2004; Edwards *et al.* 2015; Owens *et*

al. 2001). Transition is therefore an important and critical stage of a person's career (Beyea, von Reyn and Slattery 2007; Seah, Mackenzie and Gamble 2011; Spouse 2001), which may be associated with a number of difficulties which influence the person's professional and personal life (Levine *et al.* 2006; Seah, Mackenzie and Gamble 2011; Spouse 2001).

The transition to health care practice has been referred to as a "shock". "Reality shock" was initially described by Kramer (1974) as the social, emotional and physical responses to the conflicts between the education and work environment. Duchscher (2009) specifically focused on "transition shock" in relation to graduate nurses' experience. According to Duchscher (2009) transition shock consists of four elements which are; emotional, physical, intellectual and sociocultural and developmental shock. Emotional shock includes the feeling of inadequacy in taking decisions and in performing tasks. Anxiety and lack of confidence may come about as a result of having to deal with complex cases such as patients with co-morbidities, in addition to dealing with difficult situations for which the students feel they are not prepared, such as the death of a patient (Duchscher 2009; Levine *et al.* 2006; Morley 2009; Newton and McKenna 2007; Turner and Goudreau 2011). Physical shock occurs when new graduates are overwhelmed with a heavy workload or long working hours. It can also occur when a new worker struggles to prioritize between different job responsibilities (Duchscher 2009; Levine *et al.* 2006; McKenna and Green 2004; Morley 2009). Intellectual shock includes deficiencies in knowledge or understanding (Duchscher 2009), such as a lack of understanding of workplace systems or a lack of a clear understanding of one's own role. Finally, sociocultural and developmental shock is

experienced when new graduates try to find a connection between what they were prepared for and their role in reality (Duchscher 2009; Morley 2009; Williams 2010). This is demonstrated in several ways, such as their need to distinguish themselves from other and the effort they put to be accepted (Duchscher 2009). These shortcomings are attributed to the lack of, or minimal, chances to put into practice what the graduates learned during their formal learning period (Billett 2001). Owens *et al.* (2001) state that when new nurses start working they often find themselves expected to practise at a professional level which exceeds their abilities.

Transition shock continues to be an issue, as recent research demonstrates (Duchscher 2009; Edwards *et al.* 2015; Stacey and Hardy 2011). Reported negative impacts of transition include depression (Levine *et al.* 2006) and fear (McKenna and Green 2004; Morley 2009). In extreme cases, transition can be traumatic (Newton and McKenna 2007), leading to personal problems such as marital problems or drug abuse (Levine *et al.* 2006) or professional problems like leaving work and searching for another career (Duchscher 2009; Edwards *et al.* 2015; Levine *et al.* 2006; Newton and McKenna 2007; Owens *et al.* 2001).

To some scholars, unpreparedness for work is considered as an obstacle which is faced during training (Buddeberg-Fischer *et al.* 2006; Clare and Loon 2003; McKenna and Green 2004; Newton and McKenna 2007; O'Shea and Kelly 2007; Waite 2004). In these studies, learners have complained of the gap between what had been studied before graduation and the tasks assigned to them afterwards. Unpreparedness is not limited to knowledge. Emotional unpreparedness is another obstacle which new graduates face.

For example, this appears to be an issue which faces new doctors when experiencing a patient's death (Brennan *et al.* 2010; Delaney 2003). Another form of emotional unpreparedness is the lack of confidence in taking on responsibilities and working alone (Berridge *et al.* 2007; Brennan *et al.* 2010), which is considered as an inhibitor to learning (Berridge *et al.* 2007). Kilminster *et al.* (2011) disagreed with the high level of emphasis placed upon the concept of preparedness. These authors disputed whether preparedness is the sole responsibility of medical school education, and argued that this understanding of education minimises the focus on the social and contextual influence on learning and the challenges associated with this period. Therefore they proposed recognising workplace transitions as critically intensive learning periods (CILPs) which are influenced by workplace settings.

McKenna and Green (2004) and Newton and McKenna (2007) found that 'facing reality' and moving into work can help new nurses to overcome their 'unpreparedness' for understanding the work and where they fit within it. Kilminster *et al.* (2011) and Newton and McKenna (2007), who seem to adopt a sociological view of learning in their work, related the influence of transition on the trainees, the setting and the 'organisational culture' in which training occurs.

Some studies have suggested that transition support programmes can ease graduates' integration into the workplace. Levine *et al.* (2006) stated that the stress associated with this period can increase self-awareness and promote personal growth if accompanied with emotional support and reflection.

Sheehan, Wilkinson and Billett (2005) have also emphasised the importance

of supporting students during the transition to becoming competent practitioners. Making the best use of this period and easing this transition plays an important part in creating competent practitioners (Seah, Mackenzie and Gamble 2011). This has implications for the individual and the profession as successful transition allows the practitioner to participate in work and become part of the working community by enabling them to follow their professional and social norms (Sfard 1998). This enhances practice and, in turn, service delivery (Davies *et al.* 2011).

In summary, studies in health care have indicated that the transition from the university setting to the workplace setting is a critical period. Researchers in the field of nursing have suggested that new graduates experience a “shock” when facing the reality of work (Duchscher 2009; Kramer 1974). The role of the universities is contested, as some authors relate the difficulty of this period to the poor preparedness of graduates, while others argue that preparedness is not the only problem with transition and that the impact of the workplace environment should also be considered. My socio-contextual view of learning makes me lean more toward the latter view. The importance of the learning that occurs after moving to the workplace will be emphasised in the next section.

2.4 Learning during transition

Despite the importance of learning in the workplace and the critical nature of the learning during this period, there is a clear deficit of published literature about experiences of learning during the first year of practice. When I searched the literature I found that the majority of studies focused mainly on

doctors (Bearman, Lawson and Jones 2011; Berridge *et al.* 2007; Brennan *et al.* 2010; Brown, Chapman and Graham 2007; Buddeberg-Fischer *et al.* 2006; Cantillon and Macdermott 2008; Deketelaere *et al.* 2006; Kilminster *et al.* 2010; Kilminster *et al.* 2011; Levine *et al.* 2006; Sheehan, Wilkinson and Billett 2005) or nurses (Altier and Krsek 2006; Cameron, Clubb and McBeath 2000; Clare and Loon 2003; Daley 1999; Delaney 2003; Duchscher 2009; McKenna and Green 2004; Newton and McKenna 2007; O'Shea and Kelly 2007; Saghafi, Hardy and Hillege 2012; Schoessler and Waldo 2006; Thomka 2001; Turner and Goudreau 2011; Waite 2004), and less research has focused on other health professionals, such as occupational and physiotherapists (Morley 2009; Spalding 2000; Tryssenaar and Perkins 2001) and Multidisciplinary Allied Health Professionals (Smith and Pilling 2007). No research has been found which explores the learning of patient educators, which is the focus of my study.

In the studies reviewed for this research, some authors seemed to adopt a clear learning theory while others did not. A number of authors adopted individual focused theories, such as Daley (1999) and Spalding (2000), who adopted Dreyfus and Dreyfus' theory of skill acquisition. Schoessler and Waldo (2006) also seemed to adopt the individual-focused view when they developed The Transition Process Model (Figure 2.1) which is intended to explain development of newly graduated nurses. This model was developed based on three theories, which were the novice to expert skill acquisition model (Benner cited in Schoessler and Waldo 2006), Bridges' transition management ideas (1980 cited in Schoessler and Waldo 2006), and Kolb's experiential learning cycle (1984 cited in Schoessler and Waldo 2006).

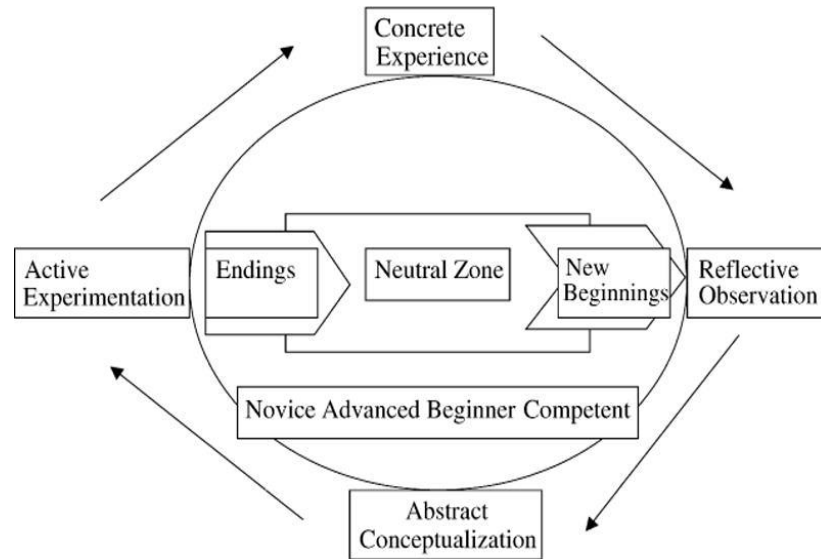


Figure 2.1 The Transition Process Model

(Schoessler and Waldo 2006)

This model suggested that a novice nurse starts at a neutral zone and goes through the experiential learning cycle of reflection, conceptualisation, experimentation and then the practicing and building of experience to reach competency in a period that takes approximately 12-18 months. Schoessler and Waldo (2006) emphasised the importance of learner's emotions during that process, as they stated that learners go through tumultuous emotions that start with fear and concerns and end with the feeling of accomplishment. They assumed that this is a normal process that all newly graduated nurses go through and that understanding this process is the only way to help them through that difficult period.

From my wider reading, this seems to provide a narrow understanding of learning, which ignores the influence of the workplace setting and relationships in the workplace.

Other authors have adopted a social-contextual view, including Bearman, Lawson and Jones (2011), who adopted the concept of communities of practice to understand new medical graduates' progression when entering the medical practice. Deketelaere *et al.* (2006) also showed a similar understanding of learning when they developed a model that explains the components of doctors' internship experience (Figure 2.2).

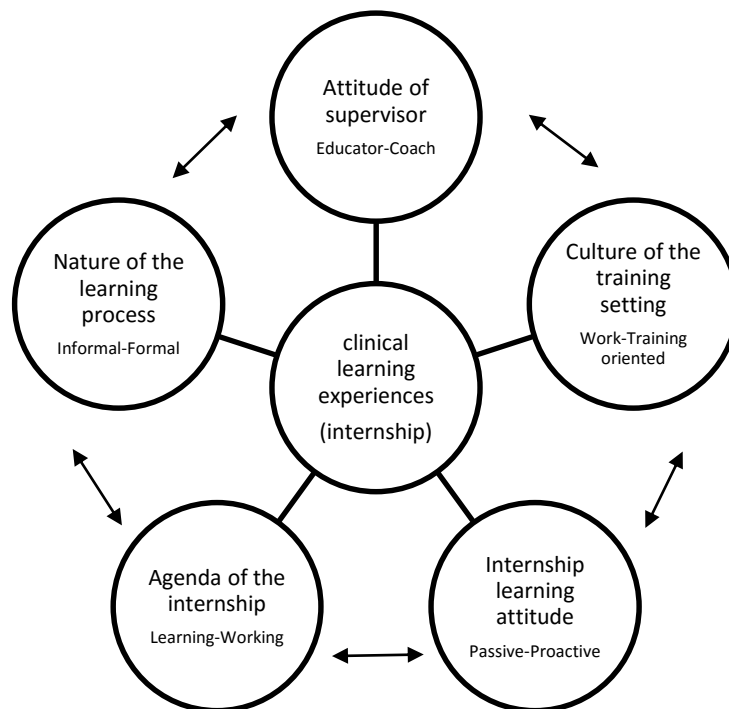


Figure 2.2 Internship Components and Tensions framework
(Deketelaere *et al.* 2006)

This model seems to recognise the complexity of the learning during this period and considers both individual and socio-cultural influences. To be explicit, Deketelaere *et al.* (2006) suggested that learning during internship consists of five components. First, the agenda of the internship which is represented in the tension between learning and working. Second, the supervisors' attitude and to what extent they provide feedback to interns.

Third, is the culture of the training setting which differentiates work oriented environments from learning oriented environments. Fourth, is the interns' characteristics and specifically their attitude toward learning. Deketelaere *et al.* (2006) suggested that some interns have a proactive attitude towards learning and tend to take initiative, others however have a passive attitude which is described as a "wait-and-see" attitude. The final component in this model is the nature of learning which the authors see as the tension between formal and informal forms of learning.

However, not all authors have a rigid stance. For example, while Morley (2009) states that she adopted situational learning theory, she still considered learning as competency acquisition.

From my initial literature search, I have identified five factors which are reported to influence new graduates' learning. These are the work environment, participation, structured learning, social environment and individual related factors. These factors are described next.

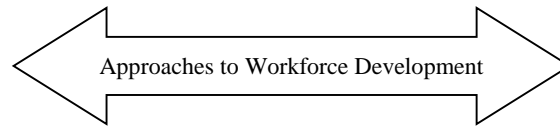
2.4.1 Work environment

Deketelaere *et al.* (2006) highlighted the importance of the work environment on learning. In their paper, they differentiated between work-oriented and learning-oriented environments. A work-oriented environment is one in which new graduates become part of the work, but no attention is given to their learning or progression. In this situation, they are expected to develop naturally. Work-oriented training is usually due to a lack of sufficient staff.

By contrast, a learning-oriented environment is one in which new graduates work to learn (Deketelaere *et al.* 2006), and work undertaken is supported by formal and/or informal learning opportunities. This approach is seen to

provide good learning prospects. For example, this kind of work environment was appreciated by new psychology nurses in a study by Waite in (2004). Nevertheless, Buddeberg-Fischer *et al.* (2006) pointed out that the quality of teaching may influence the learning outcome. Cameron, Clubb and McBeath (2000) reported that nurses stated that high quality teaching improved their ability to learn.

Fuller and Unwin (2006) whose work is highly influenced by Communities of Practice, introduced a framework to explain the features of a work environment which influence learning opportunities, which they describe as an “expansive – restrictive continuum” (Figure 2.3). When analysing the apprenticeship programmes in a number of companies, they found that learning was promoted in companies that exhibited more expansive features such as; recognising that learning occurs in the workplace, adopting mechanisms that facilitate knowledge and skill sharing and applying workforce development policies (Fuller and Unwin 2006; Unwin *et al.* 2007).



Expansive	Restrictive
Participation in multiple communities of practice inside and outside the workplace	Restricted participation in multiple communities of practice
Primary community of practice has shared 'participative memory'	Primary community of practice has little or no 'participative memory'
Breadth: access to learning fostered by cross-company experiences	Narrow: access to learning restricted in terms of tasks/knowledge/location
Access to range of qualifications including knowledge-based vocational qualifications	Little or no access to qualifications
Planned time off-the-job including for knowledge-based courses, and for reflection	Virtually all-on-job: limited opportunities for reflection
Gradual transition to full, rounded participation	Fast – transition as quick as possible
Vision of workplace learning: progression for career	Vision of workplace learning: static for job
Organisational recognition of, and support for employees as learners	Lack of organisational recognition of, and support for employees as learners
Workforce development is used as a vehicle for aligning the goals of developing the individual and organisational capability	Workforce development is used to tailor individual capability to organisational need
Workforce development fosters opportunities to extend identity through boundary crossing	Workforce development limits opportunities to extend identity: little boundary crossing experienced
Reification of 'workplace curriculum' highly developed	Limited reification of 'workplace curriculum' patchy access to reificatory aspects of practice
Widely distributed skills	Polarised distribution of skills
Technical skills valued	Technical skills taken for granted
Knowledge and skills of whole workforce developed and valued	Knowledge and skills of key workers/groups developed and valued
Team work valued	Rigid specialist roles
Cross-boundary communication encouraged	Bounded communication
Managers as facilitators of workforce and individual development	Managers as controllers of workforce and individual development
Chances to learn new skills/jobs	Barriers to learning new skills/jobs
Innovation important	Innovation not important
Multi-dimensional view of expertise	Uni-dimensional top-down view of expertise

Figure 2.3 Expansive/restrictive continuum

(Fuller and Unwin 2006, p.40)

2.4.2 Participation

Regardless of the authors' view of learning, there seems to be a general agreement that participation in practice is fundamental to new graduates' learning processes.

A number of studies reported that novice practitioners value the opportunities arising from independent practice to enhance their skills, increase their confidence (Bearman, Lawson and Jones 2011; Berridge *et al.* 2007; Cameron, Clubb and McBeath 2000; Cantillon and Macdermott 2008; Kilminster *et al.* 2010; Levine *et al.* 2006; McKenna and Green 2004; Morley 2009; Newton and McKenna 2007; Sheehan, Wilkinson and Billett 2005; Turner and Goudreau 2011), recognize their limitations (O'Shea and Kelly 2007) and develop their own way of practising (Morley 2009). Cantillon and Macdermott (2008) and Clare and Loon (2003) found that interns from medicine and nursing preferred working in places that gave them more chance to practise, as this gave them more learning opportunities. However, while independent practice is mostly considered as a useful motivation for learning, it was perceived as a barrier to learning in two situations. The first one is where learners felt that they were assigned to carry out tasks with little perceived educational value (Buddeberg-Fischer *et al.* 2006; Deketelaere *et al.* 2006), such as doing paper work instead of clinical practice. In several studies in health care, trainees complained of being involved in managerial tasks which minimized the time they spent with patients and subsequently gave them less opportunity to learn (Clare and

Loon 2003; Daley 1999; O'Shea and Kelly 2007; Tryssenaar and Perkins 2001).

The second is the high workload (Brennan *et al.* 2010; Buddeberg-Fischer *et al.* 2006; Clare and Loon 2003; Delaney 2003) that was sometimes the result of delegating work to trainees (Deketelaere *et al.* 2006; Levine *et al.* 2006; Morley 2009).

Besides independent practice, teamwork has also been reported to have an influence on learning. Several studies suggested that working with a multidisciplinary team improves learning, as it facilitates interaction and observation from seniors and professionals from other disciplines (Brennan *et al.* 2010; Brown, Chapman and Graham 2007; Cameron, Clubb and McBeath 2000; Kilminster *et al.* 2010; Kilminster *et al.* 2011; Levine *et al.* 2006; Saghafi, Hardy and Hillege 2012; Smith and Pilling 2007; Waite 2004). Furthermore, Levine *et al.* (2006) reported that some interns learned from observing the unprofessional behaviours of others. This may be because interns witness the negative influence that such behaviours have on the workplace. However, this can only happen if the interns are able to identify these behaviours as negative. While team work is generally valued it is also reported to have pitfalls and can have a negative influence on learning. Levine *et al.* (2006) reported that newly graduated doctors did not appreciate working with a team, as they found that the presence of too many staff can limit their chances for interaction with others, and as a consequence, their chance to learn. In Brennan *et al.*'s (2010) study, junior doctors did not appreciate team work as they did not feel confident enough to perform in the presence of seniors.

In several studies, participants appreciated working with peers and considered it a useful opportunity to share experiences, learn from each other, and decrease feelings of loneliness (Buddeberg-Fischer *et al.* 2006; Clare and Loon 2003; Saghafi, Hardy and Hillege 2012; Spalding 2000; Turner and Goudreau 2011; Waite 2004).

Finally, working under supervision was greatly appreciated by new practitioners in many disciplines; including doctors (Bearman, Lawson and Jones 2011; Brennan *et al.* 2010; Buddeberg-Fischer *et al.* 2006; Cantillon and Macdermott 2008; Deketelaere *et al.* 2006; Sheehan, Wilkinson and Billett 2005), nurses (Clare and Loon 2003; Newton and McKenna 2007; Saghafi, Hardy and Hillege 2012; Thomka 2001; Turner and Goudreau 2011; Waite 2004) as well as graduates from other health professions (Smith and Pilling 2007; Spalding 2000; Tryssenaar and Perkins 2001).

To gain the best outcome from supervision, trainees stated that they needed to have sufficient time with supervisors to learn (Daley 1999; Deketelaere *et al.* 2006; Delaney 2003; Levine *et al.* 2006; Sheehan, Wilkinson and Billett 2005; Thomka 2001) and they needed the supervisor to have a realistic understanding of their knowledge, skills and limitations (Clare and Loon 2003).

Furthermore, new graduates seem to place importance on the characteristics of the supervisors (Clare and Loon 2003; Delaney 2003; Waite 2004). In Waite's (2004) study, new psychological nurses raised two issues. The first was the need to have supervisors who are experts in the same field, as they felt that having a supervisor from a different discipline limited their chances to practice and learn their role. The second point raised

concerns about the attitude of the supervisors towards learning. More precisely, the respondents indicated that the supervisor's lack of interest in training had a negative influence on their learning.

Participation was found to be affected by the amount of practice undertaken. Cantillon and Macdermott (2008) and Clare and Loon (2003) indicated that continuous practice helps new graduates to master skills. Similarly, McKenna and Green (2004) described how new nurses' performance improved after repeated practice. According to Spalding (2000), routine tasks provide a good chance for learning as they become easier and quicker with time, unlike non-routine, rare incidents that do not offer sufficient practice for learning. Conversely, a number of studies offer a different point of view about non-routine tasks, as they found that unusual and challenging situations can trigger the new practitioner's desire to learn how to deal with such situations (Levine *et al.* 2006; Newton and McKenna 2007; O'Shea and Kelly 2007).

2.4.3 Structured training

Structured training has different forms, and in the reviewed literature, a number of studies reported structured training programmes integrated to train new graduates. In Clare and Loon's (2003) study, graduates appreciated having an orientation period which allowed them to understand the environment prior to starting practice. Cameron, Clubb and McBeath (2000) reported the use of in-service sessions, study groups and portfolios to support new nurses' training in emergency room practices. Turner and Goudreau (2011) described the use of seminars to train nurses in emergency room practices. During these seminars, nurses were encouraged

to share experiences and to discuss work-related events such as challenging or successful situations. In addition, participants reflected on their own experiences, discussed cases and listened to formal presentations. Morley (2009) reported the use of workshops in a preceptorship programme to ease the transition experience of newly graduated occupational therapists. An interdisciplinary allied health graduate training programme introduced conferences to engage new graduates in interactive sessions where they received support from the programme coordinators and each other, by being able to discuss, ask questions and share experiences (Smith and Pilling 2007). Finally, courses and formal tutorials were introduced to new graduate doctors in a two-week post-graduate training programme (Berridge *et al.* 2007). Besides these programmes, several other places did not depend exclusively on practice, but instead were supported by assessment and feedback (Berridge *et al.* 2007; Buddeberg-Fischer *et al.* 2006; Levine *et al.* 2006; Morley 2009; Smith and Pilling 2007; Spalding 2000; Turner and Goudreau 2011), and rewards such as continuing professional development (CPD) evidence or financial incentives (Buddeberg-Fischer *et al.* 2006; Morley 2009). Finally, various studies reported that new graduates chose to support their learning by some sort of formal learning such as; attending conferences (Daley 1999), seminars (Deketelaere *et al.* 2006), and courses (Bearman, Lawson and Jones 2011; Thomka 2001).

In their review of the literature regarding the effectiveness of strategies to improve nurses' transitions, Edwards *et al.* (2015) emphasised the importance of training programmes on facilitating these transitions. In my review of the literature I found that having structured programmes was

mostly considered helpful. As discussed earlier, working under supervision was found by many authors to be a helpful learning approach. This was particularly true where trainees were assessed and received constructive feedback to help them to improve their skills (Buddeberg-Fischer *et al.* 2006; Clare and Loon 2003; Levine *et al.* 2006; Saghafi, Hardy and Hillege 2012; Smith and Pilling 2007; Spalding 2000; Turner and Goudreau 2011). Useful feedback is not only provided by seniors; patient and peer feedback has also been valued for learning (Saghafi, Hardy and Hillege 2012). However, Morley (2009) reported that although new-graduate occupational therapists stated that positive feedback improved their learning, they preferred not to be assessed in order to feel more relaxed and confident. Clare and Loon (2003) and Thomka (2001) found this particularly true when new graduates were criticized in front of colleagues and patients.

The same point applies to incentives and rewards for achievement, as some consider them motivating while others feel that they limit their choices (Buddeberg-Fischer *et al.* 2006; Morley 2009).

The use of formal learning approaches has been found to impact trainees in different ways. Several studies reported that new graduates preferred learning from reading books, journals and protocols (Daley 1999; Kilminster *et al.* 2011; Spalding 2000). Bearman, Lawson and Jones (2011) and Deketelaere *et al.* (2006) considered this form of learning to be a complementary approach that helps in refreshing information and to support learning. A number of authors reported that courses, seminars, conferences and workshops were also valued as useful sources for learning (Clare and Loon 2003; Daley 1999; McKenna and Green 2004; Morley 2009; Sheehan,

Wilkinson and Billett 2005; Spalding 2000; Tryssenaar and Perkins 2001). According to Spalding (2000), these methods are considered helpful when they are followed by the immediate application of knowledge and skills. Furthermore, portfolios are reported as a useful support for learning as they are used by trainees to set individual goals, reflect on practice and monitor self-progression (Cameron, Clubb and McBeath 2000).

However, Berridge *et al.* (2007) reported different views of the influence of courses. On one hand, some participants considered the courses to be a good way to refresh and improve their knowledge. Furthermore, some participants appreciated the influence that courses had in improving their feeling of preparedness, by offering the chance to get to know each other and become familiar with the environment prior to commencing practice. On the other hand, some considered it a waste of time and a repetition of what had been studied before. A similar view was described by Cameron, Clubb and McBeath (2000): in their study, new nurses stated that they did not favour attending in-service learning sessions or writing logs. This may be because the more time they spend doing these activities, the less time they spend in practice.

2.4.4 Social environment

The importance of the social environment has been emphasised by trainees in several studies, and particularly its influence on new workers' feelings. Being recognized by colleagues and seniors as part of the team increased trainees' self-confidence and enhanced their learning (Brown, Chapman and Graham 2007; Buddeberg-Fischer *et al.* 2006; Cantillon and Macdermott 2008; Clare and Loon 2003; Delaney 2003; Morley 2009; Saghafi, Hardy

and Hillege 2012; Thomka 2001). In addition, new graduates found it encouraging when they were treated by patients as professionals and not students (Cantillon and Macdermott 2008; Morley 2009). In Saghafi, Hardy and Hillege's (2012) study, new nurses indicated that they hid their lack of experience from patients. In a number of studies (Bearman, Lawson and Jones 2011; Brennan *et al.* 2010; Cantillon and Macdermott 2008; O'Shea and Kelly 2007; Saghafi, Hardy and Hillege 2012; Thomka 2001; Tryssenaar and Perkins 2001), trainees stated that feeling bottom of the hierarchy was disappointing, stressful and in some situations hindered learning. One explanation for this is others' lack of understanding of new graduates' level of knowledge and skills, which influenced the way in which they treated them. However in two studies some new graduates preferred to be at the bottom of the hierarchy to hide under the 'student' label, as it made them feel safe to make mistakes and learn (McKenna and Green 2004; Newton and McKenna 2007).

Poor communication (Buddeberg-Fischer *et al.* 2006), conflicts and verbal abuse (Bearman, Lawson and Jones 2011) from colleagues, seniors or professionals from other disciplines, are considered barriers to learning. Thomka (2001) reported that there was a tendency among some new graduate nurses to quit because of the way they were treated at work.

Networking with other new workers from different disciplines was found to be helpful for learning (Saghafi, Hardy and Hillege 2012), as this provided opportunities for emotional support and for reducing feelings of loneliness. It also helped new graduates to share experiences and reflect on each other's practice (Smith and Pilling 2007). In addition to this, having access to

managers (McKenna and Green 2004; Turner and Goudreau 2011) and receiving their support was found to be extremely useful for encouragement and guidance (Buddeberg-Fischer *et al.* 2006; Clare and Loon 2003; Daley 1999; Morley 2009; Smith and Pilling 2007) and gave new graduates the chance to make complaints (Clare and Loon 2003).

2.4.5 Individual related factors

The final theme identified from the literature was that of personal influence and professional development. Deketelaere *et al.* (2006) suggested that individuals either have a proactive or a passive attitude toward learning; the former is seen when learners take the initiative to participate and practice, while the latter is seen where learners prefer to learn from observation. Deketelaere *et al.* (2006) argued that while trainers appreciate trainees with proactive attitudes more, neither of these attitudes should be considered right or wrong, because individuals have different ways of learning. As reported by Tryssenaar and Perkins (2001), a desire to learn and determination helped new graduates in developing their own strategies to adapt and progress. One possible motivation for learning was found to be valuing the work and feeling able to make a difference in patients' lives (Clare and Loon 2003; Delaney 2003).

Finally, learning was found to be influenced by the individual's progression in work and increased experience. This includes; the development of knowledge, skills (Berridge *et al.* 2007; Brennan *et al.* 2010; Daley 1999; Kilminster *et al.* 2010; O'Shea and Kelly 2007; Spalding 2000; Tryssenaar and Perkins 2001; Turner and Goudreau 2011) and identity development (McKenna and Green 2004; Newton and McKenna 2007). Progression was

associated with increased ability to recall knowledge and skills and recognise where a person fits into the team. Schoessler and Waldo (2006) considered this progress to be a natural process that all new graduates go through. Similar opinions were expressed by some supervisors in the study by Bearman, Lawson and Jones (2011) as they considered learning to be a natural progression caused by the trainees engagement in work. Delaney (2003) reports that once new graduate nurses develop a personal style for practice they become more confident.

In summary, new graduate learning during the period of transition to workplace is a complex process which is reported to be influenced by a number of factors including; the work environment, participation in work, structured training, social and individual factors. Published literature focuses on well-established health care professions and that there is a significant gap in the literature concerned with the learning of new graduates who come from new developing professions such as patient educators. The lack of literature for new graduates from new professions made me wonder how their experience would be different from those published. I wondered whether PEIs learning is influenced by other factors related to them being from a new emergent profession. This led me to look at the literature concerned with new professions and the challenges facing them which will be described in the next section.

2.5 New professions

Recent changes in health care have led to the development of new professions and specialities as well as shifting responsibilities of existing

professions. These roles have developed in response to a number of factors, including; the aging population, complexity of needs, and shortage of staff (Bridges and Meyer 2007; Merkle *et al.* 2011; Monach 2013; Ross *et al.* 2012). Recent evidence suggests that these new roles can help in providing better health services by reducing the workload of existing professionals (Lindblad *et al.* 2010; Merkle *et al.* 2011; Ross *et al.* 2012) and increasing the collaboration between health professionals (Ledger 2010). Examples of new roles include physician assistant (Merkle *et al.* 2011; Ross *et al.* 2012), infertility counsellor (Monach 2013), creative arts therapists (Ledger, Edwards and Morley 2013), interprofessional care co-ordinator (Bridges and Meyer 2007), rehabilitation assistant (Stanmore, Ormrod and Waterman 2006) and advanced practice nurse (Lindblad *et al.* 2010). The patient educator role is also a relatively new role though it has been formally recognised by the WHO (1998), the National Commission for Health Education Credentialing (NCHEC 2015) and the Joint Commission International (JCIA 2008).

When I searched for literature about the patient educator's role, I found that there was no literature describing health or patient educators' experiences. Evashwick, Begun and Finnegan (2013), who discussed public health professionals in general, pointed out that despite the fact that public health meets the criteria to be recognized as a profession, which includes having a unique body of knowledge that can be differentiated from other disciplines and having an accredited educational framework, it is still not a well-established profession widely accepted by employers.

Several authors have reported challenges which face people in other new professions. These challenges are described in detail in the following section.

2.5.1 Challenges facing new roles

2.5.1.1 Formal Recognition

Previous research findings indicate that professionals with new roles face difficulty in being recognized in the workplace (Bridges and Meyer 2007; Ledger 2010; Merkle *et al.* 2011; Monach 2013). In their review of the literature which compared the situation of physician assistants in different countries, Merkle *et al.* (2011) found that in the case of the Netherlands, where the profession was officially recognised, practitioners found better opportunities for training and development and had authority for practice. In comparison, in the UK, where the profession was not officially recognised, practitioners found that their authority in work was limited. In the case of infertility counsellors, Monach (2013) indicated that accreditation can help improve practice by allowing counsellors to participate in more sophisticated practices.

In a study of interprofessional care coordinators, Bridges and Meyer (2007) found that practitioners faced a similar problem, where although their contribution in work was appreciated by colleagues and managers, there was no formal recognition, which led to a lack of policies regulating the role. In Ledger's (2010) study about music therapists, it was found that practitioners felt that their role was misunderstood in the workplace, which often led them to avoid interaction with other workers.

2.5.1.2 Role blurring and ambiguity

Role ambiguity is a common challenge that faces new professions across different disciplines. Lindblad *et al.* (2010) stated that both advanced practice nurses and their colleagues lacked understanding of their role as there was no clear conceptualisation of what advanced practice nursing included. Similarly, dual diagnosis workers were reported to have concerns about taking on their new role because of the lack of “*base line*”, because they were the first to practise that role (McLaughlin, Sines and Long 2008). Ledger (2010) reported similar findings about music therapists, who took on a role where there was no previous music therapist to go on. In those conditions, practitioners were not confident of their scope of practice, despite reading literature to explain it. According to Ledger (2010), this role ambiguity could be the result of diverse possibilities for the role. This opinion is in line with Bridges and Meyer’s (2007) findings of the experience of interprofessional care co-ordinator. This role seemed to have high flexibility as although it was initially planned to be clerical, it informally shifted over time to include patient care.

With the lack of understanding of the role, comes the issue of “role blurring” which may arise from overlapping competencies and responsibilities and extending the scope of practice to include the practice of other professionals (Brown, Crawford and Darongkamas 2000; Hall 2005). In the studies by Ledger (2010) and Cummings, Fraser and Tarlier (2003) it was found that blurred roles can be associated with a feeling of competition and conflict between practitioners.

2.5.1.3 Seeking acceptance

Finally, the seeking of acceptance was highlighted by two studies: by (Ledger 2010; McLaughlin, Sines and Long 2008). In the former study, Ledger (2010) reported that most of the music therapists in the study felt loneliness in the workplace, where they received minimal guidance and had to develop their own way of working. Both studies indicated that practitioners felt the pressure to work hard to convey the worth of their work and gain acceptance from others.

From the review of the literature available about new professions, I have identified a number of difficulties that are commonly experienced in the workplace including; the lack of formal recognition, role ambiguity and blurring and the need to seek acceptance. Considering that PEIs come from a new profession and go through the critical period of transition made me wonder how the experience of transition would be for them and whether these challenges make their experience different from what has been described in nursing.

2.6 Summary

From reviewing the literature, it is evident that workplace learning is a complex process, which is approached in different ways and is influenced by a number of factors. The transition to the workplace may be a critical learning period which may have consequences on the learner. The literature concerned with learning during that period largely focuses on doctors and nurses, and little attention is given to other health professions. In addition,

there is no literature focusing on the learning of patient educators or of professionals holding new roles.

Patient education is a new profession which is under-researched and there is a significant lack of literature about PEIs' learning and experiences. By conducting this research I am hoping to reveal more about experience of PEIs' transition to the workplace and increase the understanding of factors which influence learning during that period. This will not only be of value to the profession of patient education but it will also increase the understanding of how practitioners of new professions in general learn during this critical period.

Chapter 3 Research methodology

This chapter discusses the methodology utilised in the study. It starts with a reminder of the aim and objectives of the research. Then, a discussion of the underlying philosophy for this research is presented, including the reasons for selection of a constructivist paradigm. This is followed by an explanation of the rationale for choosing a qualitative, case study approach. The chapter also provides a detailed presentation of the research processes involved in the research including recruitment of subjects, data collection and analysis. The pilot study is also described, and insight given into the way in which the methodology evolved based on this. Lastly, the quality of the research and ethical issues are considered.

3.1 Research aim and objectives

3.1.1 Aim

To explore PEIs' experiences of learning during internship.

3.1.2 Objectives

1. To ascertain PEIs' views on the internship experience.
2. To identify the factors that influence PEIs' learning during internship.
3. To develop a set of recommendations that can guide the improvement of PEIs and other new graduates' training.

3.2 Philosophical background

Research may be underpinned by a variety of philosophical standpoints.

According to Guba and Lincoln (1994), these include positivist, post-positivist and constructivist paradigms as well as critical theory. When comparing these paradigms, I decided that the most suitable approach for exploring PEIs' experiences of learning was constructivism. In the constructivist view, people develop a unique view of the world around them according to the interactions and the context and experience in which they are situated. This viewpoint therefore rejects the notion of absolute truth, and acknowledge that multiple realities are possible (Guba and Lincoln 1994).

I chose to use a constructivist paradigm based on various considerations. First, this approach was likely to yield detailed information with which to understand the perceptions and experiences of the PEIs, what influences these perceptions and the meanings assigned by subjects to their experience. Further, any learning is bound up with the learner and as such it is vital to investigate the perceptions of these learners, which are by their nature unique (Guba and Lincoln 1994). An additional consideration in favour of constructivism in this case is that I had no intention to generalise outwards from the findings, and nor had I any intention to make judgements regarding PEIs' perceptions. In addition, from my own experience as a patient educator, it was clear that my own experience was also relevant to the research process and inseparable from it, and that therefore this should be utilised in reflecting on the study's findings. This practice is in line with a research philosophy of constructivism, which contends that the observer cannot stand separately from the research process, but the researcher's

own experience may be utilised in reflection and assist understanding (Guba and Lincoln 1994; Patton 2002).

3.3 Design

The study was designed as a single embedded case study concerning PEIs' training experiences while interns, and investigating factors which influenced learning in this context. This section will describe and justify the research methods and design followed in the study.

3.3.1 Qualitative research methods

Qualitative research methods include a variety of techniques and approaches, such as interviews and observations, which are used to gain information and understanding regarding the subject of the investigation (Denzin and Lincoln 2008). In comparison with quantitative approaches, the qualitative approach involves viewing the subject within its natural context and does not seek to make predictions or create particular conditions (Patton 2002). Qualitative methods rarely involve generalisation of findings, nor do they look for causality, instead they aim to explore the subject in rich detail and understand it within its particular setting (Patton 2002). For the current study, I considered that a qualitative approach would offer appropriate methods of gaining a rich understanding of the complexities of PEIs' internship learning experience, while situating this within the environment where it is naturally found.

3.3.2 Case study

In approaching the question of which design to choose for the research, it was necessary to consider literature and available information regarding the

training, practice and policy of patient education around the world. From this, it emerged that there are significant differences in the training for and practice of patient education within Saudi Arabia as compared with other countries. It is noted in Chapter 1 that although parallels exist in the Saudi system and that of other states, it is markedly different in many ways. This highly individual context suggested, in line with Yin (2009), that a case study approach may be suitable to allow me to explore this context in depth.

When I read about case studies; I found that they can be employed in either qualitative or quantitative research. Stake (2008) argued that a case study represents not a method as such but rather a means of selecting the subject of the study. Case studies have been categorized in different ways.

According to Stake (2008) a case of a study can be simple, focusing on a single individual, or complex, including multiple individuals within a certain context. He identified three types of case studies; the first of these is the intrinsic case study, in which the focus is on the case itself. Secondly, instrumental case studies investigate a particular phenomenon with the intention of theory construction or to reconsider generalisation. The third type of case study is collective, and in this approach, more than one case study is conducted and in sum these contribute to the picture of a subject in general (Stake 2008).

Yin (2009), presented a different, design-based typology. He described four types of case studies; single-case holistic case studies, which focus on one case taken inside its natural context; single embedded case study, in which several occurrences of a case are selected in the given context; multiple holistic case studies, which incorporate several cases, each of which is set

within its own individual context; and multiple-case embedded case studies, in which different contexts are looked at by focusing on several cases in each context (Figure 3.1)

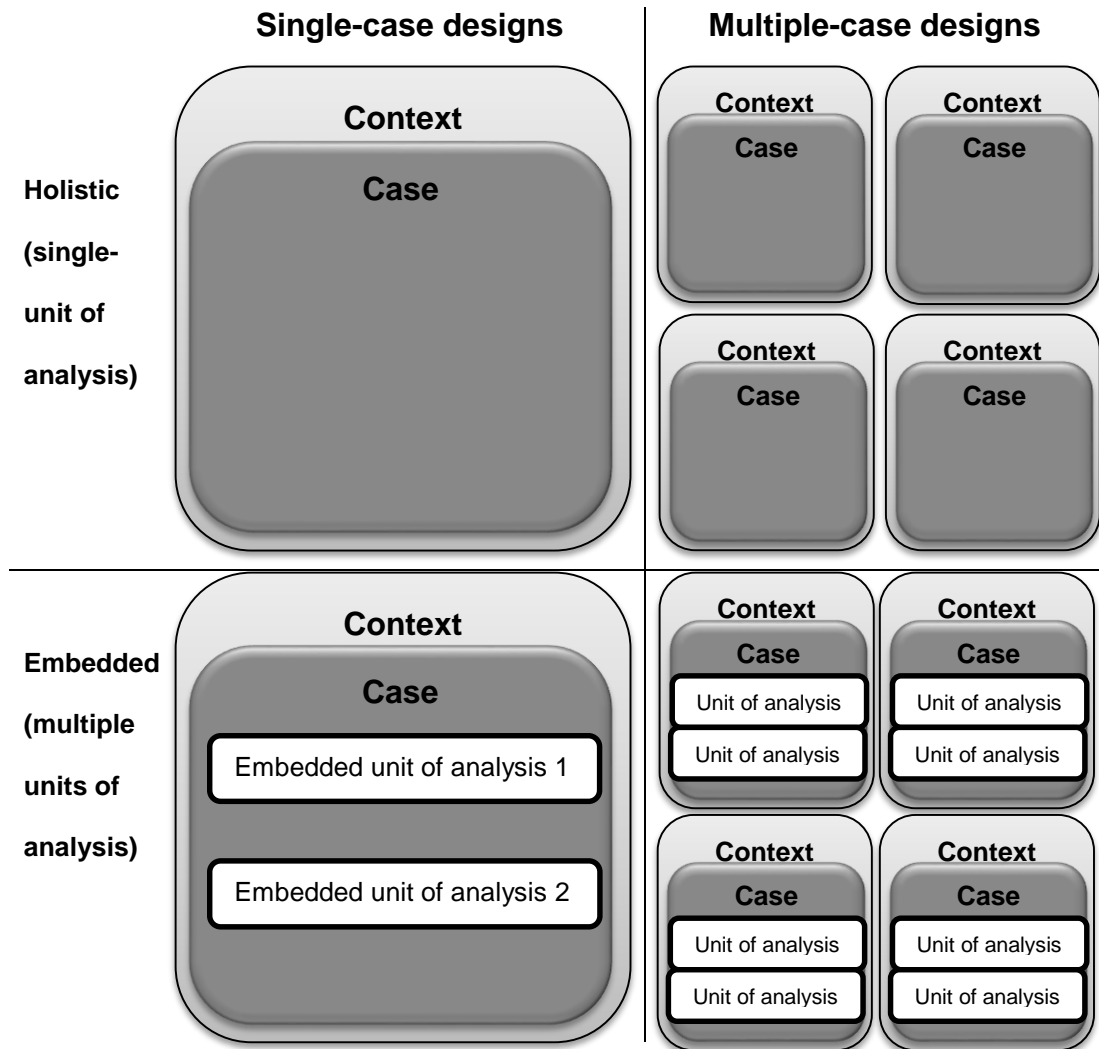


Figure 3.1 Basic types of designs for case studies

(Yin 2009, p.46)

My present research project takes an intrinsic approach and is conducted via a single embedded case. The case under study is the experience of PEIs within the context of Saudi Arabia, the embedded units for analysis are individual PEIs. The embedded case study design presents the potential for error in that subunits may become the main focus as opposed to being used to reach an understanding of the main analytical unit (Yin 2009). During the

process of my research I was aware that the individual participants are examples representing the case under study and took that into consideration all through my analysis and interpretation.

3.4 Procedure

3.4.1 Participants

In the case study approach the sample is selected in a different way to other study methods, in that sampling is considered as case selection. For the intrinsic case study, the research question informs the choice of the case, which is the central focus of the research (Patton 2002; Stake 1995).

In the present study, the case under investigation is that of PEIs' learning and the embedded units of analysis comprise individual PEIs in Saudi Arabia. At the stage of my data collection only one university had graduates in the internship period as the course of health education was not yet established or still new in other universities. Therefore, as only a small number of PEIs undertook this stage of training, I decided to contact all PEIs who graduated in the year of data collection, 31 in total, with the intention of recruiting at least 8 subjects with which to undertake the study.

My initial recruitment plan was to contact participants through KSU, However, these PEIs were spread across various hospitals, and therefore were difficult to access from the university. To circumvent this problem, I made contact with health education professionals who were previously my colleagues, providing a description of the study and requesting that they pass a request for contact on to those interns with whom they worked. As a result of this, a patient education intern invited me to contact her, and

through this contact it was established that from a pool of 25 interns identified, eighteen had sufficient internship experience to take part in the research (a minimum of 6 months' experience of internship was set as the requirement, with the aim of targeting only those interns with a reasonable level of experience regarding their learning during the internship period). A request was relayed to the eighteen interns identified to have their telephone contact details and permission to call: this was granted in all cases, and after calling each intern to describe the study and its goals, all of them stated that they were happy to take part in the study. The only requirement in selecting participants was 6 months' training, as mentioned above, but the group also had the feature of being entirely female, due to the fact that health education was only available as a subject of study within an all-female university department. From the sample of eighteen interns, it was only possible to arrange interviews with ten individuals, due to time and travel constraints within my field trips to Saudi Arabia. Each of the ten participants had at least nine months' experience, and the longest training period already undergone was one year.

The ten participating PEIs were each provided with an information leaflet and consent form 24 hours or more prior to the interview taking place. In addition, PEIs were each offered an opportunity to raise any questions regarding the research and their participation before signing the consent form. The questions asked by the PEIs mainly concerned reassurances of confidentiality, the specific interests of the research, and the reasons for conducting the study in terms of its possible effects. Regarding confidentiality, participants were reassured of the anonymity, with all names and locations concealed and access to transcripts of interviews only by me

and my supervisors. Quotations from the interviews would be anonymised within the research work itself and any future publications of the research. In terms of the research purpose, I informed the participants that this mainly related to experiences and perceptions regarding the internship period, including any and all aspects of that experience, and that the eventual aim of the study was to contribute to continued improvement in patient educator training programmes, enhancing learning and ultimately improving practice. I also explained that the findings of the research could also affect professional training in other subject areas. A large number of the participants requested that they be informed of the findings of the research.

3.4.2 Data collection

My initial intention when planning the study was to gather data through focus groups, in order to create a safe environment within which PEIs could openly discuss their training experience and offer their views on this (Morgan 1998), which is a rare opportunity for this group. I also felt that interaction with peers might facilitate the exchange of and reflection upon views and ideas, and that this might help in gathering more detail than in a single-participant interview (Morgan 1998). In practice however, these group meetings were not possible to arrange because of the spread of patient education interns across different hospitals and geographical spaces. There was also a concern of a possible lack of in-depth reflection from all participants in comparison with individual interviews (Morgan 1998).

I settled on semi-structured individual interviews for data collection, on the basis that interviews were both practical in the circumstances and allowed me to gather a reasonable depth of information concerning interns'

perceptions regarding the learning taking place as part of their training, and the meanings which they assigned to their experiences (Bowling 2009; Fontana and Frey 2005). The choice of a semi-structured approach to interviews was made as it allowed more control over the direction of the interview than the unstructured approach, while being more flexible than the structured interview (Bryman 2008; Holloway and Wheeler 2010). To strengthen my data I considered triangulating observations with interviews. This might have offered a greater depth of information about learning processes at work during training and allowed any issues missed during interviews to emerge or be identified (Patton 2002). However due to the time constraints and my position in the UK, I was unable to carry out observations.

In line with the recommendations of Teijlingen and Hundley (2001) I carried out a pilot study before conducting the main interviews for the research.

This step was taken due to the need to assess the efficacy of the interview questions in obtaining the data required to address the research question, and also to allow an evaluation of the planned method of analysing the obtained data. From the pilot study, it was also possible to check for authenticity issues by reviewing the findings with participants. The pilot study was also invaluable in providing practice in the art of interviewing and in gaining supervisor feedback prior to continuing with the main study.

3.4.2.1 Pilot study

The sample selected for the pilot study consisted of four patient education professionals who had qualified in health education and completed a period as a patient education intern within Saudi Arabia. Thus, the pilot participants

bore strong similarities to the group selected for the actual study, with the exception of the fact that these were individuals who had already completed their training.

The pilot study participants were all female and had each undergone training within a clinical context for at least 9 months of the internship programme undertaken. Beyond this however, participants had a range of experience and fields, with two of the sample going on to work in academia rather than as patient educators, and two entering the patient educator field and working for two and four years in this field respectively. Thus half of the sample had also performed the role of intern supervisor, while half the group were involved in the tutoring and general preparation of PEIs. Thus, it was probable that data gathered from the pilot sample would not only reflect their period of internship but also their subsequent professional experience. Further, there was variation in the time elapsed since subjects had graduated, with the most recent being six years and the longest being fourteen years, and this meant that the internship experience was a comparatively distant one for these individuals. All of the subjects were currently studying at postgraduate level and therefore not working as patient educators at the time of the study.

The pilot study consisted of a semi-structured interview carried out in English on a face-to-face basis and voice-recorded. Prior to each interview, a consent form and information sheet were provided, time allowed for reading and questions related to these, and the consent forms signed and returned. The interviews ranged from 20 to 40 minutes in duration, with transcripts between four and six sheets of single-spaced text on A4 paper.

Transcription of each interview occurred directly afterwards, and then checked against the recording once more, for corrections to be made to allow for mishearing and omission.

The first pilot interview revealed the presence of leading follow-up questions, and this issue was addressed and eliminated in subsequent interviews. The second person to be interviewed had difficulty in recalling her experiences as an intern, and this problem was addressed in the remaining interviews by prompting for examples in order to obtain greater depth of information and to jog the memory of participants. Further, as the pilot study progressed, I learned to give greater time to participants for thinking, remembering and response, and thus more detailed information was gained from the later interviews. In addition, questions left unanswered were returned to using different wording. Thus, where asking “what is missing from the programme?” did not yield findings, this was then changed to, “if you were responsible for the programme, what would you add to it?”

Data analysis was then undertaken on the initial two pilot interviews. In line with Wolcott (1994), transcription of the interviews was followed by careful rereading to allow key terms to be identified and highlighted using Microsoft Word tools, and these terms were used to develop codes. The highlighted terms were each written down on a separate post-it note and placed on individual sheets of paper, each relating to a separate code. Any similar items were grouped into codes and through a process of review and regrouping, 28 codes emerged and were grouped into 7 groups and 14 subgroups, with the help of further analysis of the transcripts. The 7 groups

represented the themes of training programme, preparedness, support, observation, practice, supervision, and feelings and motivations.

Following this process, analysis of the third and fourth interviews was conducted and the codes arising were mainly placed within the themes already established. For those which did not, a further key group was created, the theme of which was workplace environment.

I then re-examined these themes thoroughly and the terms and phrases placed in each theme were revisited in the transcripts and reviewed, with changes made as necessary. A further step was to reconsider the themes established by identifying similarity, overlap and connections; by doing this I identified five key themes: preparedness; training programme; recognition and clarity of role; practice; and personal influence.

Based on the recommendation of Gibbs (2007), I took notes continuously throughout the interviews and analysis, and this proved valuable in the eventual development and linking of codes. For example, it was noticed that greater detail was obtained regarding training where interviewees were recalling training in a location where they went on to work after qualifying, suggesting that in these cases, participant views may be influenced by subsequent experience. Following analysis, the authenticity of the pilot study was checked by providing interview transcripts and findings in summary form for interviewees to suggest changes as necessary. No alterations arose as a result of this process however. Transcripts for the interviews were anonymised, password protected and placed on the secure M drive at the University of Leeds, while printed consent forms and interview transcripts were kept in a secure filing cabinet within the University.

The experience of conducting the pilot study drove various choices regarding the main study. First, I decided not to include the pilot findings with the main study findings, as participants' experience subsequent to their patient education internship might interfere with their recollections, and their involvement in the internship process of others might lead to the mixing of personal and second hand experience. Further, the time elapsed since training may impact upon the clarity of recollections, and also mean that the pilot participants experience may not be similar to that of current interns in terms of the training provided. It was confirmed that the main study could encompass only those engaged in their internship or having just completed it at the time of data collection.

A further issue emerging from the pilot interviews was the description of learning experiences as progressing and evolving over the internship period, and this consideration led to the decision only to seek information from PEIs who had already undertaken a minimum of 6 months of their internship programme. In addition, I made small changes to the interview schedule based on the pilot, in that rephrasing of one item was necessary. For that I changed the negative question "what does the programme lack? What needs to be improved" to a more constructive question asking; "if you were in charge of the training programme what changes would you make?" I also decided to ask participants to give examples.

3.4.3 PEIs' interviews

The data obtained in this research towards exploring the training experience of PEIs was taken from the narratives of PEIs themselves, in conjunction with my reflections as a patient education professional.

Ten patient educator interns participated in the study. All were females with a health education degree and living in Riyadh city. The length of training completed ranged from nine months to one year, and the number of rotations ranged from two to four. All of the PEIs had completed at least one rotation in a tertiary care hospital (TCH), while two went to school health units (SHU), six went to specialised health centres (SHC), two went to non-governmental organisations (NGO) and four to governmental organisations (GO). Their training took place in a variety of departments, including medical departments such as paediatrics and oncology, as well as non-medical departments such as the media department. The rotations of the participants are summarized in Table 3-1.

Table 3-1 Rotations of participants

<i>Participant</i>	<i>Rotation (3 months)</i>			
Sophia	TCH	TCH	SHC	
Linda	TCH	TCH	SHU	TCH
Ruby	TCH	TCH	SHC	
Emma	GO	SHC	TCH	SHC
Sara	GO	SHC	TCH	SHC
Jane	GO	SHC	TCH	SHC
Brooke	TCH	NGO	TCH	
Katey	NGO	TCH		
Anna	TCH	TCH	SHU	TCH
Amber	GO	TCH	TCH	SHC

TCH: tertiary care hospital, SHU: school health unit, SHC: specialised health centres, NGO: non-governmental organisation GO: governmental organisation.

All interviews were conducted face to face and were audio recorded. The interviews ranged from 35 to 70 minutes in length. The interviewees were told that the interview could be conducted in Arabic or English, depending on their preference. All of the subjects chose to speak Arabic: however they

mixed both languages during the conversation. At the beginning of the interviews I asked the participants to tell me about their internship experience and gave them the freedom to discuss what they considered important for them. The PEIs told their stories in chronological order. Most of them started by describing how they chose their training places. They all then described the rotations, focusing on the aspects which they considered most important. On many occasions the interviewees gave examples of situations which were of significance to them. To enhance my understanding of their experience, there were occasions when I asked for further clarification and examples. At the end of the interviews I asked the interviewees their opinion of the training and how they would improve it if they were in charge. This gave me an idea concerning the most important issues for each participant (see appendix B for Interview Topic Guide). Many PEIs in my study asked about my internship experience in order to compare it with their own. This was mostly when they wanted to criticise a certain place and/or people, and it occurred to me that through knowing that my experience was not so different from their own, the interviewees felt safer in sharing their experience. In dealing with this situation, I had three issues to consider. Firstly, I wanted the PEIs to feel comfortable in sharing their experience. Secondly, I wanted to be honest and not simply tell them what they wanted to hear. Lastly, I did not want to influence the responses of the PEIs. I therefore encouraged them to tell their stories before sharing a brief part of mine and then listening to their reflection and how this had influenced them. It was interesting to see that PEIs were open and were happy to talk about their experience, and some even used the interview as a chance to complain. This reflected a feeling of trust. When analysing the data, I found

that this feeling was common toward health education graduates, which reflects a feeling of belonging. Their openness was useful for my research as it provided me with rich data and a great deal of information about the difficulties which faced the interns.

3.4.4 Data Analysis

My analytic approach was not fully developed until a later stage of the research. My original choice for data analysis was that of data coding to allow the emergence of themes, which would follow Riessman's (2008) conception of thematic analysis, Polkinghorne's (1995) paradigmatic analysis and Mishler's (1995) categorical analysis cited by Elliot (2005).

Later in the research, my understanding of the data developed.

Consequently my analytic approach evolved over time and I adopted several approaches before settling on using Polkinghorne's (1995) approach of narrative analysis.

When reading about different analytic approaches I noted that narrative analysis might be the most appropriate approach for my research. By using narrative analysis, I could explore PEIs' views and at the same time consider the context and my personal experience (Chase 2011; Holloway and Wheeler 2010; Riessman 2008).

3.4.4.1 Analytic Process

As suggested by various scholars (Corbin, Strauss and Strauss 2008; Holloway and Wheeler 2010; Maxwell 2013; Silverman 2010) I was planning to commence analysis at the same time as the data gathering process. My initial plan involved transcription of interviews immediately following each one, with an external, qualified translator experienced in working with the

dialects used in the interviews to provide a translation, as suggested by Bryman (2008) and Lopez *et al.* (2008). This was initially planned in order to maintain a high level of transparency within the research process by avoiding any loss of meaning in terms of idiomatic language and implications of speech which might not find easy translation into English for the inexperienced translator. A problem arose however when conducting interviews, in that the interviewees made extensive use of specific professional terminology used with the field of patient education, which raised difficulty in the prospect of identifying a suitably experienced translator, and I subsequently decided that the translation would be best achieved by myself. I also hoped to treat interview data consistently. The time needed for this approach meant that translation was delayed until after the interview period, but I immediately transcribed in Arabic as recommended in the literature (Gibbs 2007; Holloway and Wheeler 2010; Maxwell 2013; Miles and Huberman 1994; Patton 2002). I kept writing memos throughout the interviews and immediately post-interview and I developed and completed an individual interview sheet during each interview so that I could record my observations including non-verbal cues and other impressions. I added to these notes while transcribing the interviews with the intention of reviewing these notes at the analysis stage to assist with the process and highlight any gaps, with this process forming an "*iteration*" as explained by Holloway and Wheeler (2010) (p.284). The notes kept were beneficial in understanding similar and different features between the experiences and views of the various participants, as well as gaining information related to the emotional reactions of interviewees and alterations with time. Further, these notes helped me in identifying the lacks and gaps in

analysis, and consequently informed changes in the analytic approaches used.

Once I completed the Arabic transcriptions, I started the translation to English, after which I carefully scrutinised the translated scripts to identify terms and create codes. I began an open, line-by-line approach to coding for the first three transcripts. However, although key elements were identified in this process, including PEIs' identity, working environment, individual related factors, social relationships and increased participation in practice, many elements from the notes were not included in the developed categories, including time-sequencing of events described, the gap between the expectations and experience related by the PEIs, and their reaction to this, and the consequences for learning.

Breaking the text into small segments was taking it out of the context, made it lose the meaning given by participants and made it hard for me to relate it to the rest of the text. As I progressed in coding I felt that I was losing my grasp on the data. In my notes I was noticing that the data was complex and that many aspects were linked together. However, as the coding process separated them I felt that the meaning was being lost and the complexity of the data was being ignored. Consequently, after completing three transcripts, I decided to step back from coding, kept on reflecting and considered a different holistic approach.

The act of dividing the narrative transcripts into small chunks broke the contextual linking of the data and did not capture the entire meaning which the participants had expressed, as well as causing difficulties for me in forming new meaning links with the data chunks. The coding process

seemed to build barriers to interpretation of the data overall, and felt overly simplistic. Thus, work on the coding was halted to allow a period of increased reflection and the consideration of alternative approaches. After discussing these difficulties with my supervisors, we agreed that narrative analysis could potentially be more suitable to the data and research aims.

3.4.4.2 Narrative analysis

The role of narrative analysis within the constructivist research paradigm is seen as having great utility, offering rich, dense and context-specific data which is highly appropriate when seeking to understand respondents' perceptions of their experiences and the meanings which they assign to them (Elliott 2005). Narrative analysis is a broad term that includes several techniques and approaches (Elliott 2005). Different authors have classified these analytic methods in different ways. Polkinghorne's (1995) conception includes two categories, namely narrative and paradigmatic analysis. Paradigmatic analysis is termed the "analysis of narratives", in which the gathered data is coded to assist in the development of themes. Meanwhile, narrative analysis allows for the creation of stories out of the research data collected. Polkinghorne (1995) summarises the difference in the two techniques as that "*analysis of narratives moves from stories to common elements, and narrative analysis moves from elements to stories*" (p.12). Elliott (2005), in "using narrative in social research" offers two frameworks through which to classify data analysis techniques. Firstly, Mishler's framework of analysis (1995, cited in Elliot, 2005) builds upon linguistic function, i.e. through meaning, structure and interactional context. Within this, the meaning approach is described by Elliot (2005) as being focused on

content, and facilitates stories to be elaborated, with previous occurrences set down sequentially in time and attention given to the meanings which participants imbue their narratives with. In comparison, a focus on structure entails analysis of the way in which narratives are related by respondents, while the third approach is based in assessment of the performance and the context of the story creation.

An alternative framework was developed by Lieblich (1998, cited in Elliot, 2005), and this framework addresses two dimensions. Firstly, approaches are categorised by the research focus on either form or content in analysing narratives, and is somewhat analogous to the division made by Mishler (1995, cited in Elliot, 2005) between meaning and structure analysis. However, the second dimension also makes a distinction between holistic and categorical analysis, in which the holistic approach considers the narrative in its entirety, while categorical analysis segments the narrative and organises the material as a part of the analysis (Elliott 2005) through the use of codes as with researchers following a grounded theory (Strauss and Corbin 1990). From the two dimensions given by Mishler, analysis may be categorised as: holistic-form, holistic-content, categorical-form and categorical-content (Elliott 2005).

According to Riessman (2008), narrative research may take a thematic, structural, dialogue/performance or visual analytical form. Within this, the thematic approach includes the use of coding as in the paradigmatic analysis of Polkinghorne (1995) and the categorical analysis of Mishler (1995, cited in Elliot, 2005), in seeking to extract themes from narrative data. Reissman's (2008) structural analysis is based upon that described by

Labov and Waletzky (1967), in which clause function is of key importance and six elements are identified within the narrative; abstract, orientation, complicating action, resolution, evaluation, and coda (Elliott 2005; Riessman 2008), with each element playing a different role (see Table 3-2). This model holds benefits for investigating the perceptions and views of participants (Elliott 2005).

Table 3-2 Labov and Waletzky's structural model

<i>Component</i>	<i>Function</i>
Abstract	Summary of the subject matter
Orientation	Information about the setting, time, place, situation, participants
Complicating action	What actually happened, what happened next
Evaluation	What the events mean to the narrator
Resolution	How it all ended
Coda	Returns the perspective to the present

(Elliott 2005, p.42)

Meanwhile, a wider approach to analysis is presented by dialogue/performance analysis (Riessman 2008), in which the context, listener and relater of the story is emphasised (Victor 2009). The final approach given, visual analysis, is used in analysing photographs, paintings, and other objects produced through visual media (Riessman 2008).

As following a coding process seemed be inappropriate for addressing the aim of the research, I therefore decided to adopt more holistic techniques which might give greater scope for addressing the research aims.

Consequently, I adopted the narrative type of analysis identified by Polkinghorne (1995) which includes a process of synthesizing the data into a coherent account rather than breaking up the story.

Since the elements of PEIs' narratives were arranged sequentially as stories, maintaining the chronological integrity of the data was vital in understanding the way in which responses followed events and the participants' casual links (Polkinghorne 1995). To gain a better understanding of the transcripts, I created case summaries for each of the transcripts, and these proved a more manageable way of understanding the data and key occurrences within the timeline of the story. The summaries were produced by rereading the transcript and highlighting words and phrases which appeared to be important. Stories were then written in first person and utilising participants' own words, with up to a paragraph quotation being used unabridged in some instances.

As a means of checking the quality of this approach, completed summaries were given to one of my supervisors for comparison with the original transcripts, and she confirmed that the summaries had succeeded in presenting the key elements of the stories. Thereafter, with the encouragement of my supervisors, summaries were written based on the pre-translation Arabic transcripts (see Appendix C for case summaries).

The process of writing the summaries allowed me to notice that the participating PEIs had harboured expectations from their programme which did not relate closely to their actual experience of the training provided, and further, that their reaction to this disconnect impacted upon their perceived learning. Based on this observation, and in light of Labov and Waletzky's

(1967) approach to the identification of structural elements of a narrative, the PEIs' narratives were then divided into five elements, namely; expectations, experiences, emotional responses and actions. This facilitated analysis and enabled me to understand each case in depth, and to draw comparisons between participants' experiences. This was achieved based on a grid developed for this purpose (see Table 3-3) which was applied in analysing each case (see Appendix D for an example of this analysis).

Table 3-3 Analysis Grid

Place	Expectations	Experience	Emotional responses	Personal Action	Comments

After identifying these components in each of the summaries, I was able to notice similarities and differences between different cases and identify the main issues experienced by my study participants. In developing the first chapter of my Findings (which describes the PEIs' internship experiences), I structured it in a time-sequence of events following the way it was presented in the grid i.e. emotions and expectations, challenges, responses. This method helped me to identify the shock that PEIs experienced as a result of the mismatch between their expectations and reality. When presenting these findings I found it helpful to write illustrative scenarios to highlight critical incidents in PEIs' experiences. Illustrative critical scenarios were written by combining similar experiences of several respondents into a composite story. The grid was also helpful in the second chapter of the findings which is concerned about factors influencing PEIs' learning. Looking at the participants' expectations and responses helped me to understand how their

understanding of themselves, professional role and learning reflected on their learning.

3.5 Ethical issues

When designing my research I was aware of several ethical dilemmas including various potential problems of confidentiality. Within this, use of external translating services would have endangered data confidentiality, and for this reason, the data was intended to be anonymised by removing any identifying details before being passed to a translator. Further, the necessity of passing data to the translator was detailed on the interviewee information sheet. However, this issue became less of concern when it was later decided that I would be responsible for translation of the transcripts.

A further confidentiality issue concerned the limited numbers of participants in the sample, which led to the possibility that respondents may be identifiable based on quotations used in the thesis. This issue was a primary consideration during the preparation of the data presentation, so that meaning and richness could be preserved while minimising any chance of recognition. With this in mind, as well as altering names and locations, small details regarding staff and workplaces were altered where it could be assumed that these were not influential in the experience of the interns. To preserve total anonymity I have selected Anglo-Saxon names for the participants instead of Arabic names to avoid the chance of using other interns' real names.

To assure confidentiality, all transcripts were stored under pseudonyms. In addition, all recordings and transcripts were stored on the secure University

of Leeds M drive and password protected. All written transcripts and consent forms were stored in a locked cabinet at the University of Leeds.

A further ethical issue arose as a result of my position as an 'insider' within the context of the study (Mercer 2007). Graduating from the same university, and being trained in various health care settings, made me recognise many of the people that were mentioned by the participants. Possible ethical issues emerging from this were avoided in the following ways: I maintained strict confidentiality concerning the content of the interviews with staff and trainers whom I already knew. It should be added here that while I worked in patient education in the past, there is no current conflict present in my role as researcher, as I am not involved in any way with the present intake of patient education interns.

3.6 Obtaining ethical approval

It was necessary to obtain ethical approval prior to conducting the pilot and main studies. Information letters (Appendix E and G) and consent forms for participating individuals (Appendix F and H) followed guidelines issued by the University of Leeds Research Ethics Committee (UREC). I submitted the study proposal to the Medicine and Dentistry Educational Research Ethics Committee (EdREC) in the University of Leeds, and their letter of approval (Appendix I) was issued in August 2013. Upon getting the approval from the University of Leeds, I started the pilot study. For the main study, it was necessary to forward the letter of approval from the University of Leeds to the Vice Rectorate for Graduate Studies and Scientific Research at King

Saud University, where the patient education interns pursued their studies, and approval to proceed was issued in December 2013 (Appendix J).

Once I agreed with my supervisors to carry out translation of the interview transcripts by myself, and due to alterations in the team of supervisors for the project, it was necessary to apply for an amendment to the original proposal, and this was granted in January 2014 (Appendix K).

3.7 Quality of the research

Considerable debate exists concerning the quality criteria of qualitative research (Hammersley 2007; Mays and Pope 2000). The criteria of reliability and validity which are used in judging the rigour of quantitative research may not be applied to qualitative research, as qualitative research does not seek an ultimate truth or to create findings which can be generalised. As I took a constructivist perspective in my research, I have selected the criteria suggested by Yardley (2000) as most useful to assess the quality of the study. These criteria are; sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. The application of these criteria for quality assessment will be discussed in the next section.

3.7.1 Sensitivity to context

Yardley (2000) presented a discussion of various aspects of context sensitivity which should be considered. The first is sensitivity regarding the theoretical context, including previous work on similar topics and/or research using similar approaches. Developing awareness of the various studies and perspectives linked to the topic being studied helps a researcher to create deeper analysis (Yardley 2000). The context of my study is described in

depth in the introduction chapter. In addition to this, a detailed description of previous work is given in the literature review chapter and is further considered in relation to my findings in the current study within the discussion chapter.

The second aspect of context sensitivity relates to the data itself. Yardley (2000) suggested developing data sensitivity through presentation of and accounting for findings which are conflicting. A similar concept, that of identifying a deviant case, is highly emphasised by various researchers as a way of increasing credibility and strengthening research findings (Creswell 1998; Lincoln and Guba 1985; Miles and Huberman 1994; Patton 2002). In my study, while I did not explicitly seek a deviant case during the sampling process, one of the PEIs interviewed for the study presented a picture which differed from the others and appeared to show an atypical learning experience. More specifically, while all other PEIs in this study started their training with certain expectations, this PEI had no specific expectations, and went on to show appreciation of all sorts of work and educational experiences.

The third facet of context sensitivity is socio-cultural sensitivity, which includes but is not limited to consideration of the influence of both the participants' and the researcher's normative model, as well as the history and ideology represented in the expectations, objectives, beliefs, and speech of these participants (Yardley 2000).

A further aspect of context sensitivity is seen in the need for sensitivity to the given social context, and specifically to researcher-participant relations.

Considering the relationship between my research participants and I was

crucial for this research. Both social and socio-cultural sensitivity exerted an influence on my research, and are discussed in detail under *reflexivity* in section 3.8.

3.7.2 Commitment, Rigour, Transparency and Coherence

Commitment, rigour, transparency and coherence relate to how far data collection and analysis can be said to be thorough (Yardley 2000). In my research, I have provided a detailed description of the research process and given an explicit trail for the analysis conducted in order to provide the reader with an understanding of how research conclusions were reached. Working with my supervisors was also helpful in strengthening my research. During the course of the research process, I was able to discuss my research design, analysis and findings with them. One supervisor audited my analysis by comparing some of the case summaries with the translated transcript to confirm that these summaries captured important aspects of the data.

As recommended by Yardley (2000), a possible approach to transparency is through ensuring clarity of description and argument. For the current study, this entails explicitly describing each step taken in the research process, clarifying my position from the research and taking a reflexive approach (see Section 3.8). Coherence is described by Yardley (2000) as adoption of a philosophical perspective and research methodology which is most suitable in order to answer the research question. As described in Section 3.2, a constructivist perspective was a suitable approach for understanding the perceptions and experiences of PEIs, as well as the influences informing these perceptions and the meanings assigned by subjects to this

experience. This perspective accepts the diversity of perceptions expressed by different individuals, and their standpoints regarding the context and experiences which they encounter (Guba and Lincoln 1994). In addition, my position regarding the research and my intention to use my personal experience to inform and reflect on the findings of the study was also in line with the constructivist perspective (Guba and Lincoln 1994; Patton 2002). In addition to this philosophical perspective, a case study seemed to be the most appropriate method to fulfil my research aim (see Section 3.3.1), due to the uniqueness of the context in this research (Stake 1995; Yin 2009). Use of semi-structured interviews for data collection provided in-depth understandings of PEIs' perceptions as related to their learning, and the meanings which they assigned to their experiences (Bowling 2009). Finally, the choice of a narrative type of analysis seemed the most appropriate approach in terms of its ability to preserve the essence of each story, maintain a chronological order and explore the participants' causal explanations (Polkinghorne 1995) (see Section 3.4.4).

3.7.3 Impact and Importance

Yardley (2000) indicated that in order to achieve a high degree of quality, research undertaken should be useful, with practical impact in its own context in addition to its contribution to the existing body of knowledge for the research area. My initial aim in this research was to develop in-depth understanding of the experience of PEIs' internship training in Saudi Arabia, with the potential to significantly influence training and practice within patient educator training, both in Saudi Arabia and elsewhere. This is particularly important because problems with training are considered an obstacle to

improving patient education services (Fournier *et al.* 2001; Keller and Basler 2001; KSU 2011; Skelton 2001). Furthermore, this research aimed to inform first year training for other professions, and especially for those which are newly established. In order to create findings which are as useful as possible, a detailed description of the context of the research, the findings reached and my position as an internal researcher is presented, in order that interested parties can make informed decisions as to how far the findings can be applied to their own contexts (Bryman 2008; Lincoln and Guba 1985).

3.8 Reflexivity

My interest in this research topic was driven by my previous experience as a patient educator. During the period of my training and work I faced many difficulties and also encountered disappointments in regard to the way patient educators are marginalised and not well recognised. When I started planning my research, I was concerned that my position in relation to the research topic might influence the objectivity of the study and cause bias in the findings. When I shared my concerns with my supervisors however, they pointed out that subjectivity is a quality which is a feature of most qualitative research, and that my previous experience might enrich my study. I then attended a course entitled "*The Impact of Research Perspectives: The Importance of Metatheory, Research Methodology and Reflexivity in Crafting Qualitative Research*" to broaden my understanding of the area of reflexivity. On further reading, I learned that in constructivist research, the role of the researcher is often considered to have a significant positive impact on the

research participants, interpretation and findings (Guba and Lincoln 1994; Patton 2002; Watt 2007; Wolcott 1994).

Reflexivity is an approach which emphasises the importance of the researcher's own perspective, consciousness of the research context and self-awareness (Patton 2002). Patton (2002) stated that reflexivity demands that a researcher pay attention to his or her own perspective and surroundings, in addition to those of the research participants and audience. Following Patton's (2002) recommendations in terms of a reflexive approach, I decided to write my research in the active first person voice in order to communicate awareness of my role in the research. To further facilitate reflexivity, I have used a number of tools, as described below.

At an early stage of my research, I wrote an autobiographical account of my personal internship experience in order to introduce the research problem (see Section 1.6). When I wrote my story, I was aware that it would be read by an audience who were not familiar with the role of patient educators. My awareness of this lack of understanding led to my decision to describe the role in a way which defined patient educators as health professionals. When conducting my analysis, I noticed that my desire to ensure recognition for patient educators was not different from that of my participants. My attention was particularly drawn to the issue of the feeling of being underestimated and the desire to belong to the health professional community.

Autobiography was similarly used by Gallais (2008) to increase her awareness of her own influence on the research.

Following guidance drawn from other researchers (Gallais 2008; Maxwell 2013; Watt 2007) throughout the course of the research, I kept a reflective

diary and shared an on-going journal with my supervisors which recorded my thoughts about the research process, consisting largely of reflections on the data collection and analysis. As described earlier in the chapter, documenting the research process helped me in shaping my research method and reaching findings. Using my reflections in the diary, as well as the memos on the individual interview sheets which I kept during the data collection process, increased my understanding of how my identity as a patient educator influenced my interaction with the participants, as well as my interpretation of the findings. As described in section 3.4.3 PEIs were not only sharing their stories but they were also interested in knowing about my internship experience. I was therefore aware that it was inevitable that I would have an influence on what subjects share, and considered that in my analysis.

The participants opened up and shared sensitive information, which reflects a feeling of trust. This may be because I shared the same background, as this was considered an important issue by many participants. I also gained the impression that the PEIs felt that the research was important and that they were happy that someone was interested in improving the internship training. Finally, I sensed that the PEIs appreciated the sense that their opinion was valued and would be used to improve training.

3.9 Summary of the method

The research presented here takes the form of a qualitative single embedded case study investigating Saudi Arabian PEIs' experiences of training while serving as interns, and focusing especially on influential

factors for learning within this context. The source of the data used for the study was semi-structured interviews conducted with patient education interns. The analytic approach taken altered during the course of research from an initial thematic analysis approach to an eventual approach of narrative analysis, with further input from structural analysis as well as my experiences and reflections as a patient educator. The chapter which follows will present the findings of my research process.

Chapter 4 Findings: experiencing internship

The findings of the research are presented in two chapters. In the current chapter, I address the first research objective which is to ascertain PEIs' views on the internship experience; by revealing the essence of PEIs' training experience, while in Chapter 5 I outline factors which seemed to influence PEIs' learning which answers the second research question

In Chapter 3, I described an analysis grid which was used to identify the narratives' elements (expectations, experiences, emotional responses and actions). The outline of this chapter will be similar to the categories used in that analysis, as the PEIs' experience is revealed as a time-sequence of events, starting with PEIs' emotions and expectations upon starting, the challenges they faced and how they responded to this experience. As the methods chapter indicated, I have used illustrative scenarios to reflect on the PEIs' experience. In addition, the findings are supported with extracts from the interviews transcripts.

4.1 Overview of internship

The interviews revealed that the internship experience was a journey in which interns encountered challenges and difficulties as well as rewarding moments. The internship period was one year long, and was commonly divided to four 3-month rotations. PEIs had the freedom to choose between a number of training places which provided a health education service, including tertiary care hospitals, school health units, specialised health centres, governmental and non-governmental organisations. Training which took place in large institutions usually consisted of rotations to different

departments such as diabetes and oncology. The study participants gained their training in fourteen places overall, and these are described in Table 4-1

Table 4-1 Training places

Training place	Type	Patient education Department	Existing patient/health educator position
A	TCH	Yes	Yes
B	TCH	No	Yes
C	TCH	No	Yes
D	TCH	Yes	Yes
E	SHC	Yes	Yes
F	TCH	Yes	Yes
G	TCH	Yes	Yes
H	TCH	Yes	Yes
I	TCH	Yes	Yes
J	NGO	No	No
K	TCH	Yes	Yes
L	TCH	Yes	Yes
M	SHC	Yes	Yes
O	GO	Yes	Yes

TCH: tertiary care hospital,

SHU: school health unit,

SHC: specialised health centre,

NGO: non-governmental organisation, GO: governmental organisation.

4.2 Emotions and expectations

To the majority of the PEIs in the study, patient education was not just a career but a passion. For some PEIs, their passion toward health education had developed prior to studying and had driven them to choose this area as a career;

"I love health education and I studied it because I want to, unlike others who enrolled because of their low GPA. It was my desire to enrol in the applied medical sciences college and my desire to study health education, I love my specialty and I will hopefully continue and do postgrad degrees" Katey

These feelings were also associated with a devotion and desire to improve the health education profession;

"I love my speciality and I want the health education department to be one of the biggest departments in hospitals" Amber

Just as the previous statements reflect the strong feelings that some PEIs held toward their profession, they also showed a degree of personal investment.

These feelings seemed to be associated with understanding the value of their own role;

"We are very important, we make a difference, doctors don't spend enough time with--- the educator's role is to sit with chronic patients, talk with them, discuss the disease, the treatment, the complications and advise them on what to do" Amber

"I love paediatrics so much, I love working with them I feel that their families need more support, I feel that they really need the education" Katey

PEIs who expressed passion about their profession seemed to start their internship with enthusiasm and excitement, and this passion also created certain expectations;

“When we started our health education degree we were very passionate and excited about it. We knew that there were negatives because people are not aware of the role of health educators: however, we thought after the few years we spent at college the situation would have improved” Emma

Participants' expectations were based on three sources. Firstly, there were promises from training places;

“A representative visited our university and promised us that we'd have a good training programme” Jane

Secondly came the opinions and experiences of other people, as Sara described;

“We asked previous interns, we also asked demonstrators from the university, some people told us ‘you won't get any benefit', some told us ‘if supervisor so-and-so is there, you will learn: if not you won't' ”.

“Many people were against training there: ‘there is nothing to do, you will end up having naps in the prayer room', this was also the demonstrator's exact words ‘you will be sleeping in the prayer room, there is no work at all' ”

Thirdly, the good reputation of the patient education programme;

“I arranged for my second rotation training in hospital A, which is known to have the best health education programme in Saudi Arabia” Katey

“I started in hospital G which was recommended for us because of the strong programme they have” Brooke

The expectations that PEIs had about different institutions and/or people seemed to influence the choices they made in regard to training places;

“Although hospital G has bad reputation and that it is very bad and horrible and that they treat people badly and etc. I still wanted to go...50% because of teacher Diana, this what actually made me excited” Sophia

“We chose to go to institute O because it is different, we thought it would be useful to try something other than hospitals, we expected to gain a different experience there, you know health educators’ work is not limited to hospitals, we can also work in schools, governmental organisations etc.” Emma

However, the reality of the training did not always match expectations and PEIs did not necessarily gain the internship experience which they expected or hoped for. The PEIs’ experience and its relation to their expectations are described in more detail in the next section.

4.3 Challenges

A number of challenges faced the study participants. These included the mismatch between reality and expectations, as well as difficulties related to their roles as interns and patient educators.

The following scenario illustrates how an excited and motivated intern may be faced with a reality which is not in accordance with their hopes and expectations. This scenario is based on an incident which faced Jane and is also inspired by other PEIs' emotions and reflections;

The five years are over, I am not a student anymore, I can finally say I am a patient educator. I am so excited, I could not sleep the whole night waiting to look different. I am not one of the public, I am one of "them". As I walked into the hospital, I went to the information desk asking about the health education department. The person on the desk looked at me and said there is no department with this name. Well, maybe it is called health promotion department? No. I know there is, I have been accepted for training here. I went around the wards and clinics looking for patient educators. I was finally told that there is no specific department and I will work with nurses, social workers, and media personnel. I was shocked, disappointed and devastated.

Figure 4.1 Critical scenario 1

4.3.1 Mismatch between reality and expectations

While respondents reported starting their training with certain feelings and expectations, upon commencing training they were confronted by a reality which did not meet these expectations. This mismatch was considered by many interns as a shock (صدمة);

*"When we started it was a **shock**; the place wasn't prepared, it was messy and dusty, they had not planned a training programme and we didn't go on different rotations as promised, before our graduation she visited us and said that she would do this, that and the other, and that she had a training programme for us, but in*

reality she had nothing: she just took us and placed us in the mall”

Jane

*“The second period of my training in hospital A was a **shock** for me; I was hoping that my training in this hospital would compensate for the time I had wasted in the first rotation. I believed that this hospital would provide the best training”* Katey

*“I started in hospital G which was recommended for us because of the strong programme they had, we were interviewed and thank God, I was accepted to their programme, but when I actually started I was **shocked** that no work was given to us for the first one or two weeks, they just seated us in a room and gave us hospital policies to read, I mean nothing for us to do”* Brooke

*“We were excited to start in institute O, we expected that there we would not be dealing with a patient but with a community, so we had certain expectations, nothing like the reality, that is why we were **shocked**, this and the negligence of course, when we didn’t feel that we got any attention from our supervisors”* Emma

I have noted that the feeling of shock was expressed among participants with high expectations of training. Sara for example expected to receive “*intensive training*”, and described training which did not meet this expectation as “*the biggest failure in my life*”. She stated however that she would have accepted the realities of training if she had been prepared for it;

“We were not ready, they did not tell us that in advance, I mean because--- I mean you are prepared for something and then you are

surprised with another thing, if we'd been told from the beginning it would have been fine”.

Sophia also recalled an incident she had encountered with the head of the health education department in one of the hospitals;

“Once we were in an annoying situation, all the interns were sitting in a hall, like a library or something, I mean just waiting, but it was not our place, not ours but we were waiting for a specialist to take us on a tour. We usually use the residence, so... while we were waiting for the specialist to come, the head of the department came to check on the place, the employees and etc. we--- I didn't know her at that time, I mean not personally, she didn't even know we were health educator interns, I had just met her once, that was before the internship, before the graduation... she was the one who inspired me... she told us ‘we have so and so for interns, we have a good training programme’ and--- I mean special treatment, but I saw the opposite when I came, there is no--- imagine she asked ‘who are you’ we said we--- I am telling you that while her words are still ringing in my ears--- I was thinking that I was going to meet Jennifer, the one who has a good training programme and special treatment for interns, OK? but I swear to God since we started there I didn't meet her once, I mean I didn't see her, of course I was frustrated, I mean she has a good reputation, I was frustrated because I didn't meet her at all, and then she came in and asked ‘who are these?’ we said, ‘patient educator interns’ so she said ‘excuse me girls can you please go to the residence’ After this

incident we shrunk away, I mean what about the things you said before, she just said 'go to the residence', she said nothing else, no greetings, nothing at all you know, what she meant was 'there is nothing for you to do here'..... so we were shocked, I mean you should sit with us, we should sit together this is based on her promises when she visited us at the university, I didn't know what she really does... but she promised us a lot in the meeting"

From her story it was evident that Sophia had developed high expectations based on the promises given to her in advance. Finding that the reality was different from her expectation was frustrating and shocking for her.

Participants responded positively when the internship exceeded their expectations. In the following statement, Sophia describes an experience which was better than her expectations, and she as a result seemed to appreciate the experience more;

"I benefitted and I was beneficial, I felt good; because based on what I had heard from others I was scared about training here... I was really scared that I would regret choosing that hospital, but overall--- it was different, I mean really, really different, they were very courteous with us, although I had heard that they were not like that with interns"

Another intern presented her low expectations as being realistic, which helped in coping with the reality. She stated;

"When we studied health education we were aware of the negatives, we were aware that it was not well recognised, so we were not shocked" Emma

However, low expectations may not necessarily have a good influence on trainees, as holding such expectations may lead them to feel daunted. When Emma described an experience which was not beneficial, she stated that she had been told by one of the instructors in the workplace beforehand about the low value of the training. She recalled;

“The preceptor was a health education graduate so she knew what we needed to learn but she shocked us by saying that we would not be gaining any benefit during training, and that was true, we did not gain any benefit from the three months we spent with them”

This statement raised questions as to whether Emma’s experience of internship was influenced by her preceptor’s opinion, which in this context would have seemed to be a valuable opinion, as it came from a professional whom she trusted.

In summary, expectations seemed to have a significant influence on PEIs’ experience. The mismatch between expectations and reality is a common issue for new interns. PEIs who had high expectations of training described the mismatch with reality as a shock. Poorer expectations seemed to help in coping, but such expectations could carry the risk of making the experience daunting or discouraging.

4.3.2 The challenges of being an intern

Being an intern seemed to be associated with a number of expectations, including the existence of a training plan, specific arrangements for interns and the assignment of tasks which are of high educational value. A number of interns perceived that arrangements for interns were lacking. One intern stated that workplaces should be aware of the identity of interns;

“They should understand that interns have an identity, they should have their own arrangements” Sophia

Another intern explained how not being recognised as interns influenced the quality of training received, stating that;

“In hospital C they treated us like employees not trainees, there was no training plan, they asked us to go to departments with no plan; for example ‘go to the paediatrics’ well, how can we go, what should we do, you did not even give us a background to your work, and what you do... anyway, they do nothing at all” Emma

In particular it was important for PEIs to have a designated workplace;

“In hospital F--- Although it was a small room... I mean with a partition and everything... but at least we had a place... a place to stay... you know we need a place where we can talk, prepare for events, feel comfortable, make brochures, we also need a place with a computer, it is easier you know, but the--- in hospital G we had a computer, but it was annoying, I have told you that, with everything going around... I mean sometimes they even give patient education in the room... so you can imagine... we never, ever felt comfortable there... not at all--- hospital E was not too bad... it was good, we felt comfortable, it even had computers and everything... but the bad thing about it was the nurses, the smell of their food and everything... I mean this was annoying” Sophia

“In hospital C we had no place to stay, we were just lucky that an employee went on maternity leave and we used her office” Jane

Although PEIs wanted to be recognised as interns, they also cited disadvantages to being an intern, such as being exploited by staff members;

“Sometimes they take advantage of us as interns, I mean there are jobs that we should not do, but as long as they have interns they delegate, I am talking about their responsibilities, things that they should do and which don't have any educational value for us, but they still give it to us, it is kind of exploitation” Ruby

“In hospital C we used to be given tasks that were not related to us, they even made us write names on wedding invitation cards, this is a shocking story, I actually figured that out by chance because my auntie's name was on the list, that was really upsetting, because they gave us a lot of work that was not actually ours, they just have girls that can do anything, I felt they announced in the hospital that they have interns if anyone needs help, for example they had a conference once and they made us work on the registration, you know what I mean don't you... we sat there, registering attendance, why is that? Why is that happening to us? We don't get any benefit from these tasks but the point is that they made interns do everything, everybody told us that, as long as they have interns they give them all the work, they delegate their work, this is how things work anyway” Jane

“In this hospital I have given more than what I have taken, or maybe it was 50% give and 50% take. They were supposed to teach us and give us knowledge and experience, instead they took the breath out of us, they exhausted us just because we were interns”. Sophia

4.3.3 The challenges of being a patient educator

Beside the challenges that participants faced as interns, they also faced challenges associated with their role as patient educators. These challenges were mainly related to the uncertainty about role, a lack of formal status and not being distinguished from other professionals.

4.3.3.1 Role ambiguity

A difficulty which was brought to my attention during the interviews was the lack of understanding of patient educators' role. This was seen with patients as well as staff members. When describing the uncertainty which patients had regarding her role, one PEI said that;

“For them you are the person that can do everything, they ask you do the work of the social worker like asking you to get them a blood pressure monitor or so, and this is not my work, it is not my specialty at all, so I start telling them that there are certain people for that, anyway I have noticed that a lot of people here don't know what health promotion is” Sara

“A patient once devastated us, I think he was psycho or something, I mean he was not a maniac or something no he was... what do they call it...megalomaniac... so he sees you as nothing... so dealing with him was something, it is not just us, it is all departments, but for us it was more, he asked, ‘What is your job? We know who psychologists are, we know social workers, doctors and nurses, but what are you, what do you do, explain to me.’ so I said, ‘we are part of the health care team, we all complete each other’, I explained, but his questions sometimes make you doubt

yourself, it gives you a feeling that he is right, 'who are you?' our role is preventive, I mean I do things for you, for prevention, to prevent you from getting diseases, and if you get a disease, how to live with it and stuff, how to deal with it' this is our job, people sometimes say: 'so what the doctor can do this, it is just a few words and doctors can say them, you are not necessary'. So this is a problem we struggle with, there are people who are like, 'I have never heard about this, what does it mean?' and when we explain they are like 'oh wow that's amazing' ” Sara

The uncertainty was not limited to patients; Sara also described situations when staff did not fully understand her role;

“Even staff members ask, 'what do you do here? Do you just explain to patients? Doctors already do that'... you know, this is kind of degrading--- nurses of course don't accept us at all, we are on their blacklist, I sometimes hear them talking among themselves 'what do health educators do?' and one may reply 'they monitor blood pressure, blood sugar and stuff and if there is a referral for excessive weight gain, they talk to patients, to convince them, they also talk patients into transplants or whatever' so they accept that. When I hear that I feel devastated and disappointed and I feel tempted to explain but I can't because they haven't asked me directly”

When describing her experience with staff members, it was noticeable that the problem for Sara was not limited to uncertainty, but extended to reveal conflicts between educators and other health professionals. From my

experience, I recall facing a similar problem with nurses, who generally did not welcome patient educators into the health care team. My explanation for this issue relates to the potential threatened overlap in the tasks of patient educators and nurses, particularly when the educators' role is poorly defined.

The magnitude of the issue of ambiguity became clearer during my interview with another intern, who said that;

"I told the girls that we had wasted five years in college, I wished I had studied something that people knew, like radiology or laboratories, at least we would have a clear job in any hospital. It is really upsetting, people sometimes ask about our role--- we actually do a lot of things; we engage in patient education, we participate in public events, we provide education to employees, there is no precise answer" Jane

This statement was made by Jane as a reflection on her experience of practice, in which she was not sure whether what she was engaged in was part of her role or not. She also stated that she found it difficult to answer questions related to the nature of her work and the nature of her role.

4.3.3.2 Lack of formal recognition

The health education service in Saudi Arabia is still in a process of development, and areas remain in which this service has not established itself firmly. Poor recognition was not only limited to individuals; there were several occasions when patient educators found no formal recognition for their role.

“My problem is not with the individuals, it is with a community, the health care community underestimate patient educators, our department is oppressed, it is not being given any importance”

Amber

“Health education is very oppressed, they have just heard that there are patient educators and they include them, but there are no standards or anything, I feel that they are overlooked” Amber

The lack of formal recognition manifested itself in the absence of a department and defined role and in patient educators not being distinguished from other health professionals.

One participant expressed a feeling of devastation when she found that there was no special department for health educators in one of the hospitals.

She said that;

“Of course one of the most upsetting things is that our department does not have a name, I mean when we asked the security about the health education, health promotion department, he said ‘I don’t know’... then we found it under the media department, that was devastating, you know you study and study and then when you start in the hospital you find no clear name, this is very upsetting”. Jane

When listening to her story, I was reminded of my own experience in the same place. I fully understood her feelings as I had felt similarly. I understood how important it is for PEIs to see that their studies count and that they have a recognisable place in the health service. Other interns also expressed disappointment at the poor recognition of the role and the fact that the patient educator identity was not shown to the public;

“My first rotation was in institute O and it was one of the worst experiences ever, it was a literally awful experience, although we worked for the institute, we did not feel that we were working for it, it was not good because we had no place, I mean we had a small corner that didn’t even show who we were, other organisations had their logos on” Amber

“When interns from other specialities start training, people know what work they should be given, but our department is different, some hospitals don’t really recognise us, we have no status there, the department doesn’t have a status, so when you go there they don’t even know who you are, that does not necessarily influence your learning but it definitely influences you psychologically, you feel worthless” Jane

Another intern also indicated that patient education was not well recognised in hospitals, and demonstrated that the situation within the profession mismatched her previous expectations;

“It was a new experience, starting the internship, not knowing what to expect, the work in the hospitals was nothing like our expectations, there was not much done, frankly patient education was the least of the hospitals’ priorities” Emma

One respondent explained poor recognition as a result of limited understanding of the value of the role of educators:

“They know they need diabetes educators so they value them but no attention is given to the others” Amber

According to Amber, patient educators are only valued when staff or patients need them, which is only seen to be the case in diabetes care/prevention.

Amber's explanation of this issue made sense to me as it is noticeable that the diabetes educator is a role which exists in all hospitals regardless of the existence of a patient education department or otherwise.

A poor understanding of the value of the educator was not seen among the participants themselves. As described earlier in the chapter, PEIs showed an understanding of the importance of their role as patient educators;

"Patient educators should have a bigger role in hospitals" Emma

Consequently, it was noticeable that the majority of PEIs did not appreciate being grouped with other professionals with different training: particularly when not distinguished from non-health care staff.

"I was very, very devastated, it is devastating, it doesn't matter whether you have a Masters, a PhD, a Bachelor's, a diploma, it is all the same, all under the name of health education, on what basis did you--- I mean health education is also a health care department, we have studied health related topics, how come a social sciences graduate who, her studies were in Arabic and her course was only three years long, became a health promotion specialist, and this is what was really frustrating" Sara

"When I hear that a nurse became a health educator in two years or something, to be honest I feel hatred, I mean why is our department the only one that allows people to take a year or two course and become patient educators?" Sara

“Honestly, there I was unbelievably devastated, I mean we were like everybody else, we were all under the name of health promotion specialists” Jane

These two interns reflected a common feeling among PEIs when workers from other backgrounds are hired as or treated like patient educators. In reflecting on my own experience, I recall having the desire to be distinct from other professionals. I had a feeling that patient education was our territory and should be protected from invaders. I felt that having people from different backgrounds practising patient education undermined the importance of studying a bachelor's degree in health education. I perceived nurses as a threat: especially when they considered themselves more qualified for the job. In addition, I felt that giving the title of patient educator to people with a diploma and not a bachelor's degree, or to those with a non-medical related degree such as social studies or translation, belittled the value of the profession.

Upon discussing my work with other academics in the field, they expected PEIs to find the transition between an all-female university environment and a mixed workplace challenging. It should therefore be noted that gender was not brought up by any of the participants as an issue in their internship experience, nor did I consider this as something significant in the PEIs' transition. This may be because women in Saudi Arabia are experienced in moving between single-gender and mixed environments in other aspects of their lives.

4.4 Responses

PEIs responded to the internship experience in a variety of ways. Emotional responses were commonly expressed in reflection on their experience; furthermore there were some occasions when people acted upon these emotions. Emotions expressed varied from negative feelings such as disappointment, frustration and shock to positive feelings such as excitement and motivation. Respondents' reactions were on some occasions proactive, such as taking the initiative to work or filing complaints, while on other occasions, respondents conveyed passive reactions such as withdrawing and being absent from work. It was noticeable that during the period of internship, an intern can respond differently to similar situations. This could be the result of progression and the experience they had built up, as well as the surrounding environment.

The following scenario shows the kinds of dilemmas PEIs experienced, and shows an example of the thoughts which may go through a PEI's mind when responding. This scenario is based on different reactions that participants described and the factors that they took into consideration when they made choices.

This is not how the training should be and definitely not how patient educators should work, did I choose the wrong profession? Should I report the training to the university or should I complain to the hospital? Would they help me if I did or would that affect my evaluation? Should I just put up with things until it's over or should I leave and go somewhere else?

Figure 4.2 Critical scenario 2

4.4.1 Emotional responses

Respondents expressed different feelings in regard to their experience. I noticed that positive feelings were mainly reported in relation to the value of the health education role. As described earlier in the chapter, some PEIs showed passion toward health education, and those PEIs described the satisfaction of experiencing recognition of their profession. One PEI described feeling happy and proud when seeing the department recognised;

“I actually love my department and I am planning to resume this career, when I walk along corridors and see the health promotion department name hanging up, I feel happy, I mean if there are any ads or stuff I feel so proud” Sara

Another intern revealed that the happiness she experienced was not just for the recognition she received but also because of her understanding of the value of her role. She stated that;

“No one can imagine how much I enjoyed school visits. After each visit head teachers gave me certificates or gifts, this made me really, really happy, not because of what I got, but because of the feeling, I felt really important and beneficial” Anna

Positive feelings were also notable among participants when being given responsibilities;

“He used to sometimes call me and tell me to open the clinic and start seeing patients, I was given the authority and that was really nice, it was nice to feel that someone depends on you and gives you responsibilities” Amber

This was particularly true when the nature of work met the interns' preferences and/or expectations;

“Working in diabetes was really nice because there was direct contact with patients. I specifically like working with patients more than working with the community” Amber

“Here you see the patients, talk to them, have your papers, you know who you are... this is why you have spent years studying, you are doing what you are meant to do and that feels good” Jane

However, when the work did not meet their expectations, interns tended to express their dissatisfaction. In the following example, Anna described how she was influenced by the nature of work;

“I was very happy during the times when I helped the public. I love working with the community; specifically I like to see healthy people. I hate it about myself that when I enter a patient's room I end up crying: seeing sick patients is really difficult, it really affects me, sometimes I get in the room to greet the patient and then tell him/her that I just want to be sure that everything is ok and that I will come again, and I then leave to cry and come back in two days or something, it weighs very heavily on me” Anna

As mentioned earlier in the chapter, the mismatch between the reality and PEIs' expectations was one of the main reasons for these feelings. For example, four interns started a rotation in one institute based on promises given from that institute. However, the reality of training was nothing like what they had expected and all four expressed strong feelings of dissatisfaction. To be explicit, Sara described the training as “*failure*”, Amber

stated that it was “*the worst experience*” and both Jane and Emma said that they were “*shocked*”.

Negative feelings were also caused by other issues which were described earlier, including a lack of arrangements for interns such as no physical space in which to work, described as “*annoying*” by Sophia. Second, a feeling of being exploited by employees was highlighted by Sophia, Jane and Ruby. Third was the role ambiguity that Sara considered as “*devastating*” and which even led Jane to regret studying health education. Finally, the lack of formal recognition in the workplace was repeatedly highlighted as a reason for dissatisfaction. As shown in the previous examples, Jane described not having a department as one of the worst experiences and stated that this made her feel “*worthless*”.

4.4.2 Actions

Negative emotional responses did not necessarily result in negative reactions. Instead, it was noticeable that the difficulties which faced participants were in the majority of cases motivational and an incentive for hard work. In the following example, Amber explains that although she experienced depression after a mismatch between reality and practice, this did not hold her back. Instead, it led her to explore other contexts as she sought training in another city;

“After my unsuccessful experience in institute O I had depression. I got depressed because prior to starting, I was excited by the department, I was excited by the internship, so I thought that I needed a change and as a result went to another city” Amber

A similar scenario occurred with Jane, who was also annoyed with the poor recognition in hospital C and institute O and she responded by withdrawing and seeking training elsewhere where she felt more appreciated;

A number of PEIs suggested that poor recognition could be seen as daunting and discouraging. However, there was a mixture of responses to this situation, and the majority seemed to be challenged and motivated to overcome being devalued. In the following statement, one PEI pointed out that poor recognition can affect PEIs' interest and motivation to work;

"The lack of interest in patient education makes you frustrated, it does not encourage you to work, you then barely drag yourself to work because you know what is awaiting you there.... the discouragement you see from the surrounding community hinders your ambitions" Amber

However, although she anticipated that the lack of recognition would have a significant negative influence on interns, she stated that this was not the case in her experience because she fully understood her role;

"The lack of interest in teaching interns may influence the quality of training, but it does not affect me because I know my role, I know my department and I know my work" Amber

A similar view was expressed by another PEI, who was also upset by the lack of recognition but did not consider it to be a hindering factor;

"Sometimes they shock you, I mean you feel ignored, I became devastated, but that did not influence my learning. It actually did the opposite, it made me more--- it gave me the desire to uplift the

name of health educators, I mean to show what health promotion is”

Sara

Alongside these two PEIs, who articulated that they were not hindered by the lack of acknowledgment, I noted similar situations with other participants. For example, Katey was faced by marginalisation during one of her rotations. She described a situation in which she was not welcomed in clinical consultations and was given marginal tasks. However, this did not hold her back and she asked for more involvement, took the initiative in practice and contacted the university to complain.

Determination was also seen in Brooke’s story, who reflected on her experience by saying;

“We used to organise the rooms and do stuff, we actually created work for ourselves, because we were expecting that hospital to be one of the best. The problem is that their manager left at the time we started and it obviously depends on an individual, I mean it was not well established so we of course--- we did not like the situation and we started asking for work” Brooke

In that hospital she complained of not being given work to do, and she related this issue to not having a well-established department and relying on one individual. However, as with the previous example, she did not resign herself to the situation, and she sought work.

In my experience as a patient educator, there were many times when I felt that the profession was underestimated and was not given the value it should have been. For me, this feeling was the motivation for conducting this research, in the hope that this work might represent a way of improving

learning and practice. Therefore, I was not surprised by the resilience and determination that I noted among participants. My interpretation of their reaction is that they were driven by a need for belonging and a passion toward the profession, as described earlier in the chapter.

As with Brooke, another intern recalled an experience in which she was not satisfied with the amount, nature and quality of work given to her and consequently went to where she believed good training would be provided;

“We went to the departments a few times and then we found that we were not benefitting, so we stopped going there and we started going to Hope’s clinic” Emma

In the interviews I also noted that being in a tense situation was motivational for a number of participants. In the following statement, a PEI recalled an incident which, although it seemed unpleasant and humiliating, she still found useful as it taught her a lesson and was reflected in her future work;

“A clash happened between me and Diana when I was five minutes late, she shouted at me, rebuked me and wiped the floor with me [an expression that means being humiliated]. However, from that situation I learned punctuality: I have really changed. In my current place the manager is very relaxed and is not bothered about the time I arrive, but I can’t, I get insane if I don’t get to work on time. I think she created a psychological issue for me but a positive one I guess” Anna

Another PEI began by arguing that criticism hurt her feelings and did not motivate her. However as she went through the discussion she also

expressed a view which conflicted with this, stating that there was a good side to criticism, which was working to avoid that criticism;

“Criticism does not motivate me, it actually hurts, except for one thing: maybe if I wasn’t criticised I would not do things. You know when you feel that a person is picking on you, she wasn’t really picking, but if someone is judging you, you then do your best to avoid being criticised, that was the good side of it” Ruby

The desire to work hard and do their best was also seen when participants felt that they were dealing with complicated work or areas that were difficult to learn. One intern for example recalled how she was constantly challenged by work, as she was asked to give lectures to other health staff including nurses and doctors, and she reflected on that experience by saying;

“Challenges are scary at the beginning, but once you believe that you can, you will, and nothing feels better” Brooke

Another intern stated that being worried about not being able to answer questions led her to read in order to increase her knowledge in the area she was covering;

“Students used to ask a lot of questions, so I had to read daily, everyday reading was a must, because I was afraid of being asked a question that I couldn’t answer” Anna

Amber also described a technique which she used to record and revise information when working in diabetes education, as she believed that it was a big area to learn. She stated that;

“Diabetes is a big topic--- my colleagues used to make fun of me because I carry a notebook all the time, wherever I go I take my notebook and record everything on it, even clinics’ abbreviations: I didn’t know what they meant so I recorded them in my notes to google them later and learn what they refer to” Amber

Finally, Anna recalled an experience in which she failed an exam. She described how this experience was very disappointing to her, yet motivated her to work hard;

“Honestly when I did not pass the exam I cried so hard, because I am not used to failure and I was sure that I would pass that exam, but anyway, failing made me re-study again, I was going for a break at the weekend and took the booklet and other hand-outs with me to study, have you ever seen someone studying on a weekend trip, but honestly it was a good motivation” Anna

Beside the difficulties and challenges, PEIs were encouraged by good experiences. Feeling the value of the work and achieving goals were highlighted as a motivation to work by one participant;

“Helping people and seeing your accomplishments gives you motivation to do more and more, that’s really nice” Jane

Emma, Sara and Jane who had each had a good experience in hospital E, decided to get back to that hospital to avoid further disappointments;

“I came back to that hospital because I felt this is where I worked the most, I was not sure if other places would give me work and I did not want to go through the same shock again going to a new place and wasting my time doing nothing, so that was a good place

where I felt comfortable and I liked the work here so I came back”

Emma

“We came back to hospital E because they gave us attention; they even gave us a room, a decorated room” Jane

While these interns considered returning to hospital E to be a way to maintain their good training, it is possible that this could be a disadvantage as it limited interns' exposure to different work environments.

Determination was not always in evidence, and there were conditions under which PEIs seemed to accept their situations when things became difficult for them. When Sophia felt that the head of the department made her feel unwelcome (see Section 4.3.1), I noticed that, regardless of her feelings of being hurt, she still found an excuse for the manager's behaviour, stating that;

“I said to myself; yes, maybe she is right”

It was also notable that as this incident happened during the first week of her rotation, she stated that the rest of the period was not as good as she had hoped, but that she did nothing about it and waited for it to finish;

“There was nothing interesting there, no events, nothing... I did nothing and the three months passed quickly”

As this incident occurred in a hospital which three other interns i.e. Emma, Sara and Jane considered a very good training place, I wonder whether this incident had an effect on Sophia's later training.

Another intern also showed a passive reaction to being neglected. When this intern did not receive the training which she desired, she responded by being absent and not being trained at all. She recalled her experience;

“I spent 4 months in hospital H, which felt like four years, four years of being lost; I did not gain any benefit from there, in the first week they asked me to sign and wait--- no, no, no, on my first day I waited until 3 pm, but I saw no one. I wanted someone to tell what I was supposed to do there, where should I sign? I did not know where the department was, I had no phone numbers. I was told to go to hospital H and look for the department, this distressed me for a while, and I therefore did not go for two days” Anna

“I used to come in the morning, sign in and leave, at that time I had no preceptor in my schedule. They told me, ‘the one assigned for training you is on annual leave and we did not find a replacement, deal with it’ so what should I have done, should I have just sat there staring at them? they should have given me work, once they told me ‘we will assign you with an educator, so and so, go and look for her’ and so I did but I did not find her so I said to myself, why bother chasing her? I should take a break, and that was it. I ignored them for a month and a half and then came at the end of the rotation, submitted my papers and said farewell to the whole internship”

Anna

I was surprised to see this reaction from this intern in particular, as on several occasions she showed enthusiasm and resilience when faced with difficulties. However the difficulties which motivated her seemed to be of a

challenging nature, such as being criticised or failing an exam, while in this situation she was lost and neglected. When reflecting on the time wasted in that hospital, she expressed a feeling of regret and frustration;

“Honestly, between you and me, when I received my graduation certificate I cried out of frustration because I did not benefit from what is supposed to be the most beneficial place, it was an educational hospital but I did not gain any benefit” Anna

This intern shows the complexity in the ways interns responded to their experiences and demonstrates that they can combine both passive and active reactions. This complexity was also seen in other interns' stories. In the following interview excerpt, an intern explained how being with peers influenced the way in which she reacted to criticism;

“In the first and second rotations I had my friends with me so I did not really care about what was going around me. There were annoying things that were happening, but I am the kind of person who does not care if there is someone with me. I mean there were times when one of the educators said something or something happened but I did not care much. However, now in hospital M, I am all alone, so criticism has become an issue. I honestly get hurt, I am not saying that I should not be criticised but I think it is about the way it is delivered, which makes it hard, I mean when my preceptor criticises my education or anything else I get really hurt” Ruby

Another participant also described two different ways in which she reacted to not receiving the training which she desired. In the first instance, she sought the university's support: however, as she did not get the support which she

had hoped for, she felt that she could not make any changes as an intern and that reacting could be harmful to her, and as a consequence she decided to accept the dissatisfaction and delay appropriate actions until she became an employee;

“In institute O, we complained to the university, we called our supervisor and she said that that this shouldn’t happen to us and we felt that they were going to do something about it, but then nothing happened and no one actually cared: that is why we did not complain here in hospital C, we did not complain to anyone in the hospital because the department does our evaluation, they may say that we refuse to do the work given to us. Complaining was not for our good, so we did whatever they asked us to do until the rotation was over. The best thing to do is keep a low profile until you finish and get your certificate and then do what is right” Jane

4.5 Summary

This chapter has addressed the first research objective which is to ascertain the PEIs’ experience of internship. The experience was presented by highlighting the emotions and expectations which participants had prior to starting their internship. Then, the main challenges which faced the interns were described, including the mismatch between the expectations and reality and the challenges related to being an intern and/or patient educator. Finally the ways in which participants responded to that experience, including proactive and passive responses were presented. The next

chapter will present the main factors which influenced participants' learning during their internship.

Chapter 5 Findings: factors influencing PEIs' learning

This chapter address the second objective of the research which is to explore the factors which were found to influence participants' learning. Three categories of factors were found to influence PEIs' learning; PEIs' understanding of their role, PEI's relationships to others, and PEI's understandings of learning, the findings are supported with quotes from participants.

5.1 Understanding of role

The first factor which was identified in the data was the PEIs' perception of themselves. Participants revealed that they view themselves in different ways, as a student, employee and health educator. The way PEIs viewed themselves influenced their learning preferences and made them selective in terms of what and how they learn. Their perceptions of themselves were also found to influence the value they gave to the work and their commitment towards learning.

5.1.1 Influence of perceived role on perception of tasks

The way participants viewed themselves appeared to influence the choices they made in regard to working and learning. The first perception which was noted among participants was the feeling of being an intern. To be explicit, some participants presented themselves as interns or students rather than staff members; others did not show this perception about themselves and considered themselves part of the team. PEIs who considered themselves as interns differentiated between the work of the employees and the work of

the interns. An example of this was Ruby, who complained of having to work a full day as an employee. She said;

“There was a lot of free time; we used to work from eight to four. I don’t think as an intern I should work all these hours. For me there was a lot of free time, long hours spent on nothing”

When describing the work assigned to her, Ruby stated that she was given work which should have been done by staff rather than interns. On reflection on her work in a health promotion campaign she said;

“Although they were supposed to do the work, they gave it all to us, the interns”. Ruby

Later in the interview she explained her disapproval by saying;

“It is their job to hand out brochures and stuff, but they made me do it and that is fine but I am not benefitting”.

Her statement shows that she separated herself from the work team and this influenced whether aspects of work were seen as beneficial or not. As a consequence, she did not understand the educational value of some of the activities performed, such as time management and working with people.

This perception was seen among other participants who differentiated between the work of interns and the work of staff. One intern differentiated between tasks by describing them as “give” and “take”. She recalled that;

“In this hospital I have given more than I have taken, or maybe it was 50% give and 50% take. They were supposed to teach us and give us knowledge and experience, instead they took the breath out of us, they exhausted us just because we were interns”. Sophia

The way participants judged the educational value of the work is described further in Section 5.3.

The sense of being an intern was not universally expressed by respondents, as there were some interns who considered themselves members of the work team. These individuals did not question the educational value of the jobs assigned to them. I first noticed this with Katey, who, like the others, expressed her passion and her desire to learn. However, the way she communicated with me was very different; as she talked to me as a colleague rather than a senior. Unlike others, she felt comfortable using my first name. I did not need to start the conversation: she actually asked if I was willing to listen to the whole story and from there she went on. She had high expectations of the training period, wanted to be treated like an employee, and was hoping to be hired after the training. I detected differences in her expectations of the training and also in the way she perceived herself as an employee rather than a student/intern. She revealed this perception when she was not happy about marginal work that was not usually practised by staff members;

“The work they gave us...it was volunteers’ work”

As doing peripheral jobs was not satisfactory to her, she insisted on being involved in practice and attending clinics and even contacted the university to complain. She also took the initiative to do other jobs which she felt were important for the work, such as updating the department database.

“We started looking for anything to do- is this what you want to know? [Interviewer: yes, sure keep on] so we started looking for anything to do, so I updated their database. Their database hadn’t

been updated since 2008. I updated--- I called families telling them 'send us emails to update your records' because a lot of families were annoyed with them [pause] aaaah. Anyway, it took me a month and a half and then I couldn't take it anymore so I called the university and I told them 'please I want to get out of here by any means' " Katey

This discussion revealed the respondent's persistence, resilience and determination to achieve her goals.

The other perception seen in participants was the feeling of being a patient educator. As with the intern identity, the patient educator identity seemed to lead PEIs to be selective regarding the value they awarded to work, training and preceptors.

The interviews showed that the majority of participants had a fixed idea about the role of patient educators, that they had a defined role in their minds and did not want to step out of the boundaries which they had set for themselves. As a consequence they did not recognise the benefit they gained from work which was not related to their fixed idea of the role. Emma, for example, participated in a health promotion campaign, which is one of the main responsibilities for patient educators. However, the image she had of her role did not include this job, and as a result she described being there as being in "*the wrong place*". Later in the interview she said of this experience;

"I don't see it as beneficial, we didn't learn anything, I was hoping that we could gain some knowledge but we didn't".

Her perception reflects the downside of being inflexible about one's professional role. As she did not value the activity, she did not appreciate the experience and what could be learned from it.

Another intern presented a similar opinion in regard to public events, and she stated that she did not find them beneficial because they did not provide her with medical information;

"I personally don't like events, the preparations and everything, I like building my medical information so I like seeing patients more, this is where I feel the benefit is" Ruby

Selectivity with regard to the nature of the job was also seen when another intern did not approve of the kind of education provided to patients;

"One of the team members came to us, she was the type who is willing to--- I mean enthusiastic and interested in us, and she said 'come and start educating patients', but anyway the topic is--- I mean they--- I don't blame it on them, but in general patient education [in that topic] is a bit dull, it was like basic instructions for all patients, they had other areas they could have worked on if just the old manager was still there, which is public health for example, they could have dug more to find work for us, but we were not under work stress and we did not even feel that we were benefitting"
Brooke

In the following quotation, an intern stated that she did not benefit from training which did not include working with patients. She said;

“I stayed 5 months there and I learned nothing at all: nothing clinical, nothing related to the patients or whatsoever, basically we were not allowed to talk to patients” Katey.

One intern justified her disapproval of certain types of work as a result of the lack of relevance to the practice of patient education, stating that;

“In hospital G we watched surgery on TV and we also attended some, she also showed us new technology in surgery and it was horrifying, I honestly don’t like watching surgery, although it was to explain how they do it but I really don’t like that, they meant it to be educational, but it was of no benefit to me because I am not going to explain to the patient how the surgery was performed, it is just for me to understand, it is beneficial for me as a medical professional but not for patient education, it would be of no use to tell a patient they inserted so and so inside you that would just scare him” Anna

In addition to the educational value PEIs assigned to work, personal preferences seemed to also play a role in the judgements they made. Most PEIs tended to value experiences where they were working with patients;

“I spent three months in school units and I really regret doing that rotation, it is true I gave lectures but I felt that I belonged more to hospitals, I wanted to be in a hospital and I wanted patients, schools may be good for girls who like to give lectures or deal with teenagers” Linda

“Working with the patients on your own is very useful because, you learn by experience, you learn how to talk to old women, to little

girls, to men, some people shock you, some yell at you and you learn from being in different situations, I also learned some information, like different types of--- I mean medical details” Jane

“I like to go into patients’ rooms , you feel that--- it is not only you being there and they get in and you keep talking and talking, this what happens in the outpatient clinics, you talk to patients, you give them the education they need--- but I didn’t like that, maybe when I work there, this is a comfortable job because you sit in your clinic and patients come to you, but I didn’t like it, because I felt that the same thing is repeated over and over again, and this is what I am doing now because my preceptor is on an emergency leave, so it is all the same, that is why she (the temporary preceptor) allowed me to come here now, she said ‘ you have been here with me for a week, you have seen all cases so no need for you...’--- I liked working with inpatients more, you feel that you are an effective member of the health staff” Katey

While the majority expressed a preference for clinical environments, Anna was the exception and preferred schools over hospitals;

“In schools I gave students as well as teachers lectures, and that was really something, I really felt good after giving school lectures”

The unique opinion she presented can be understood when looking at her statement in section 4.4.1, in which she described the feelings she encountered when seeing sick people and how this “weighs very heavily” on her.

Being assigned work that is not considered part of the role seemed to carry the risk of driving interns away from work, as described in the following quotation;

“Sara: If she tells you to do bizarre things that are not even your job.

Interviewer: Like what?

Sara: Things like, ‘print this, write that’ which is not related to work, of course in hospital C they asked us to write papers, wait, search for the causes of divorce... this was a research project for the daughter of Mrs Eva ... not their work at all, not their work, they even asked us to do secretarial jobs... so sometimes when people give you such work, you try to avoid them because it is not your work” Sara

Just as PEIs did not appreciate tasks which they did not consider related to their role, they valued work which matched their image of the role of the patient educator. In one instance, a participant described the work assigned to her as a “*real health educators’ work*”, as she recalled;

“You see patients by yourself, you fill in papers by yourself, you go by yourself, you do this and that, I felt alive again, I started to feel that yes this is really education, I am really an educator”. Sara

While inflexibility was widely seen among participants, there were some exceptions. In the following example, a participant explains how the reality of work did not match the right work as she understood it. However, although she considered this an obstacle, she coped with it and adapted her practice.

“The problem in the in-patient wards is that you find the patients sleeping, so there is an issue with the readiness to learn, so that was an obstacle that faced me, which is finding a time, sometimes I visit patients’ rooms and I don’t find them or I find sleeping so I can’t talk to them, although some specialists wake them up, but I think that is very wrong, how can they understand, I am not a nurse giving a medicine, the education needs the patients’ to understand, and that was the challenge because I remember visiting some patients who were always sleeping and I needed to do the education, I was required to have the education documented within three days of admission, so I had to [wake patients up]” Ruby

In another instance, the same participant was not convinced that the work she was given matched her role, and yet she had to do it and she eventually seemed to learn skills which were useful for a later rotation;

“When we were in hospital G they had a campaign, and the educators were responsible about that campaign but it was us, the interns who did everything, the work was mainly about making materials, which were posters, rollups and other educational materials, I actually started learning Photoshop in hospital F, I and other girls worked on designing there, so when we came to hospital G we found that they had a very bad designer so we did all the materials by ourselves and it was really tiring. It may not be our speciality nor our field but we did the designing, that was a lot of work and we spent more than a month working on it, we prepared all the educational materials for the whole campaign” Ruby

While Ruby presented a rigid understanding in regard to her role, she seemed to become more flexible in accepting what was offered to her.

Flexibility with regard to the role was also seen in other PEIs. One participant recalled being introduced to work which she had not anticipated as part of the patient educators' role. However as this work matched her personal preferences, she accepted it;

"I went to the school education unit, where I participated in giving lectures for schoolchildren. I was surprised because I didn't know that that was part of the educator's role. However it was a nice experience because I like dealing with people and answering their questions, especially those who are eager to learn" Amber

Another example was Linda, who appreciated being engaged in different kinds of activities, even when she perceived that they were not part of the patient educator's role;

"I managed to get to the OR, I told my preceptor that I wanted to see how the bone marrow biopsy was performed and she let me, I know it is not my job, but it is exciting, I like to learn new things and they were very supportive".

This intern did not seem to differentiate between the work of employees and interns and did not separate learning from practice, and as a result she felt that she benefitted from all work given to her. This was particularly apparent when she explained how being involved in different activities –which were not considered valuable by others- was beneficial for learning, stating that;

"I feel that interns should learn clinical work, they should observe and practice, they should also be involved in managerial tasks and

research so they won't lose their skills, these are the three important elements of training" Linda

The flexibility which these PEIs showed seemed to expand their learning opportunities, and made them utilise every opportunity to learn regardless of the nature of work.

Some PEIs seemed to have certain ideas about the role of patient educators which led them to be selective in terms of what work they do. In addition, some PEIs expressed preferences in terms of who was qualified to train them, as is discussed in detail in Section 5.2.3. These beliefs seemed to limit their learning as PEIs avoided tasks and/or people who did not fall under their predetermined criteria. Interviewing PEIs with more flexible ideas helped me to realise the vast number of learning opportunities which had been missed by more inflexible PEIs.

5.1.2 Commitment to learning

PEIs' perceptions of themselves were found to influence their commitment to learning and work. Among the study participants, it seemed that the feeling of being an intern led to an obligation to learn and seek good training; as one of the PEIs put it;

"I am an intern, I am here to learn, and it is your responsibility to teach me, when I get hired I am on my own" Brooke

However, the feeling of being an intern was not necessarily motivating. Instead, some interns found it to be a source of protection and comfort. One PEI considered that being an intern made her less accountable, and as a result she felt more relaxed in making mistakes:

“If I do it right I feel great, but if not, what can I do about it, I am an intern after all” Sophia.

In contrast, the feeling of being a patient educator seemed to be a motivation to work and learn. As described in Chapter 4, participants expressed passion and devotion toward their profession as well as a desire to improve themselves and the department. An example of this was Sara’s desire to *“uplift the name of health educators”* (see Section 4.4.2).

A feeling of belonging to the patient education profession was associated with loyalty and pride, as seen in Sara’s statement in section 4.4.1, and appeared to increase PEIs’ desire to work hard as revealed in Katey’s intention to *“do postgrad degrees”*

In conclusion, the image which PEIs have about themselves seemed to influence their choices and enthusiasm to learn. The feeling of being an intern seemed to provide a feeling of affirmation, comfort and protection for some PEIs. It also seemed to help some in setting goals, and motivated them to learn and seek learning opportunities. However, its downside was that on many occasions, interns missed learning opportunities. It also restricted some PEIs from benefitting from tasks where they did not understand their educational value. The feeling of being a patient educator was mainly a motivating factor. However, as indicated in section 5.1.1, it was evident that it also influenced PEIs’ judgements about the value of their work and as a result led some to miss valuable learning opportunities.

5.2 PEIs in relation to others

The second factor derived from the data is the PEIs' perception of themselves in relation to others. This factor does not stand alone as it is related to their perceptions of themselves. PEIs described a number of aspects which revealed the influence their relationship to others had on their learning and practice. These aspects included; being recognised and distinguished, role clarity, and working and learning from others.

5.2.1 Being recognized

The way PEIs were perceived by others in the workplace seemed to be an important aspect to many participants. This was expressed by one participant who appreciated being noticed. She said;

"I was the only one coming from my city, I was alone, so I had the privilege of having everybody's eyes on me" Amber

The same intern showed the need to feel valued when working with people and considered this to be a rewarding experience;

"Working with students was really nice, because they wanted to know, they asked questions, they don't even give you a chance, the minute you finish they raise their hands to ask. I benefitted because I like direct contact with people, I like people who give and take, I like people who ask and are interested to find the right information"
Amber

PEIs revealed different ways that they wanted others to view them. First, a number of PEIs highlighted the importance of being recognised as interns. In several interviews, I found that PEIs believed that being recognised as

interns guaranteed access to proper training. This was evident in the following statement from a PEI;

“In hospital C they treated us like employees not trainees, there was no training plan, they asked us to go to departments with no plan; for example ‘go to the paediatrics’ well, how can we go, what should we do, you did not even give us a background to your work”. Emma

In her statement, Emma related insufficient training to being treated like employees. Another participant presented a similar view when she expressed her dissatisfaction with the poor arrangements for interns, seen mainly in not having an assigned room. She related these unpleasant conditions to the lack of understanding of interns’ identity, stating that;

“They were supposed to give us a room, they should understand that interns have an identity, they should have their own arrangements”. Sophia

She also recalled an incident when she felt that the staff should have recognised her as an outsider, saying that;

“One day something awful happened, two of them [employees] came into our office yelling at each other. They should give us some dignity, I mean, not dignity; dignity has nothing to do with this, yes? They should give themselves dignity, at least in front of us, give us some respect, you know, I mean we should not see their negatives, you know. If you want to fight, do it in your own room:... why do you come here?... In our room, you know, I mean she really shouted at him in a really, really bad way, we shouldn’t hear that. Of course it was the person in charge shouting at a specialist, this is not

appropriate, but this was her only problem, other than that she was very, very, very, very nice and courteous and very---aside from a little bad temper with--- we are not supposed to see that, you know... it should be between the staff...At the end of the day, we are just interns, we are not employees. ... Yes, we will keep your secret, but still, that wasn't good" Sophia

The previous examples show the belief that being recognised by the workplace as interns can help in promoting respect and avoiding mistreatment, neglect and/or marginalisation.

Sophia did not only want to be recognised but she believed that she contributed to the team as new blood, and she felt that this was appreciated in one of her rotations, recalling that;

"Everyone there... they have been there for a long time, so they need fresh blood, you know, new ideas. I mean they always come to us, I mean talk to us and everything" Sophia

In addition, she stated that a lack of recognition of her intern status led to her being given work that she was not supposed to do;

"We should not have done it, but they gave it to us, and for what? They wanted to use us because we had free time, between brackets you know. What else [pause], sometimes we participated in an event and unfortunately they made us prepare the gifts, I mean like cleaned. This is also worth mentioning, I mean there was no recognition that we were interns, by the way we are also specialists like yourselves, Ok, but what can you do about it... you can't say anything" Sophia

In the previous example, it was noted that the preference which this PEI had in regard to her role had influenced her judgement. This was also seen in other interns who presented a different point of view in regard to the value of being recognised as interns. This position was described earlier, in section 4.3.2, where Jane and Ruby believed that being viewed as an intern led them to being exploited in workplace and being delegated tasks which were not appropriate for interns. As with Sophia's statement, both of these interns seemed to be influenced by the preference they had in regard to their responsibilities as interns.

Ruby preferred to be treated as an employee rather than an intern. She explained that being recognised as an employee was helpful for her learning;

"I personally was very tired, I was under pressure and I worked really hard, but at the end of the day it was all for my own good, I was the one benefitting, from the beginning she [the preceptor] treated me like an employee and not as a trainee" Ruby

It was interesting to see how Ruby held different opinions in regard to working hard, these opinions seemed to be influenced by the way in which she viewed herself as well as the way others viewed her. To be explicit, when Ruby felt that she was being treated as an intern, she felt exploited: however, when she felt that she was being treated as an employee, she did not mind the hard work and valued the benefit she gained from this. The PEIs' different beliefs may reflect their views about learning, which will be described further in Section 5.3.

In contrast to participants who thought of others' views as a way to improve learning, some responded by avoiding work. For example, one intern stated that being identifiable as an intern protected her from being placed in difficult situations;

"We wear specific lab coats, green ones, they are just for the trainees... they (the patients) can identify us and as a result they don't ask many questions". Sara

While hiding under the intern label seemed to help Sara in avoiding work challenges, it seemed to cause her to miss out on some learning opportunities. This was surprising to me, as during my internship I preferred to appear as an employee not an intern, as I felt this made me appear more credible and professional.

In one of the interviews I noted that the importance PEIs placed on being recognised as an intern was supported by their supervisors, as one said;

"Some educators told patients that we are interns and some told us not to say that we were interns so patients won't feel that we don't have the right information and underestimate us" Linda

This example shows how there maybe advantages and disadvantages to presenting one's self as an intern.

In addition to being recognised as interns, participants placed importance on the need to be recognised as a patient educator. A number of PEIs appreciated it when people were aware of their role and sought their help in patient care. In the following example, an intern stated that she felt that she had an identity when she was asked to practice her role as a patient educator. She said;

“They ask ‘who is this? Oh, health educator, would you come please we need you here, this patient needs a blood pressure monitor or whatever’ so I feel that I have an identity” Sara

This was also noted in another interview in that when an intern described how beneficial her training in one of the hospitals had been, she emphasised the value of being recognised;

“It was really nice in hospital E, it was very good and I felt satisfied, we saw patients, so we have learned a lot about the conditions, on the top of that here we have a department, there is a section in patients’ files for patient educators’ notes, we follow up with patients, in short we have a name here”. Emma

The need for recognition was also expressed as the need to be distinguished from other health professionals by having a clear a distinct role, which is described further in the next section.

5.2.2 Role clarity

PEIs also highlighted the importance of understanding the scope of their own as well as others’ roles and responsibilities. The majority of the respondents considered the ambiguity of the role of patient educators as a problem which faced them, and valued having a clearer understanding of it. Sophia for example appreciated training when she was well informed of her role and the work she was involved in, recalling that;

“Before going on rounds, we sat with the specialists, and they explained everything to us; things that we should do and also

everything about the disease, common problems, the education provided and the procedures taken, I really benefitted from that”.

Another PEI supported this viewpoint, and considered this preparation to form an important aspect of training. She said;

“I think it is very good to know what we will be doing, when we start in a new place we should know everything, I feel comfortable when I work knowing my tasks and other professionals’ tasks” Emma

Her statement revealed not only the importance of understanding the scope of her own role, but also of understanding other professionals’ roles and responsibilities. By referring to Section 4.3.3.1, it can be seen that the ambiguity of the role of patient educator seemed to be a difficulty for PEIs. Sara, who described the difficulty she faced with patients as well as staff members who lacked an understanding of her role, recalled experiences in other places when her role was clear and described to her;

“When we started, the supervisor explained to us.... The health educator explained everything about the conditions we were covering as well as our role, everything, and that was really, really helpful” Sara

The importance of clarity for learning can also be seen in Amber’ s interview (see Section 4.2.2), when she stated that she was not affected by the lack of interest in training PEIs because she was clear about her role.

One of the interns explained that eliminating ambiguity for interns is the responsibility of different parties. First, she stated that hospitals were responsible for clarifying role responsibilities as well as limits for interns;

“They should clarify our responsibilities and our limits, like ‘you can talk to patients but you are not authorised to open the files’. If the work is related to other people we should know, for example ‘that is the social workers’ job, you are not allowed to do so and so’. This keeps me clear, and there will be no conflict between me and the doctors, for example, if doctors come I will know that I should wait for them to finish and then my role starts” Jane

She also indicated that the university should play a role in minimising ambiguity, suggesting that;

“I think the training should be more rigorous, I mean they should follow up, they should not just set us free [an expression which means having no supervision or follow up], the university should provide a training programme to the training places, specify the things they want the students to learn. I mean, ‘the students should be able to do so and so when they complete the training’, we shouldn’t be left on the blind, keep it to luck, if it is a good place you gain benefit if it is not you won’t, when you send the training letter from the university to the hospitals, include the goals or a training programme. I mean say what you want the girls to learn during the training, this will minimise chaos and the arguments about what is the educators’ work and what is not, so whatever happens there--- I mean we would be able to complain and if we were derelict in our duties they can say something” Jane

Unlike the rest of the PEIs, one participant considered the ambiguity of the role of patient educators as an advantage. She stated;

“Doctors treated us like medical students, they showed us patients’ cases and taught us about complicated ones. There were times when they went too far, for example asking us about the medications, and when we told them that this was not our job and not what we had studied, they wanted to teach us and they thought we were like medical students, they did not know our limits. They know what health education is, they refer patients to the educators, but they don’t know how much information we have and to what extent we can teach patients, honestly, I liked that, I like to watch and learn and it strengthens my medical information. Understanding what the doctors want helps me when educating patients” Linda

I have noted that this view, unique in the study, regarding the value of role ambiguity came from a PEI who also conveyed flexibility in other aspects of training such as the kind of work assigned to her, as described in Section 5.1.1. Linda seemed to have developed her understanding of roles through attending an orientation course about various team member responsibilities;

“When we started the rotation there was an orientation programme and we also attended courses. One of them is called [whose job is it to care?] the idea of this course is answering patients’ potential question [whose job is it to care?], We care, we provide the needed service, so one of the things they emphasised strongly is if you don’t know say I don’t know, look for an answer and don’t give the wrong answer” Linda

In conclusion, role clarity seemed to be an important issue for PEIs. The ambiguity of the role was evident in the reported reactions of staff members,

patients and in some instances the PEIs themselves. Most PEIs appreciated workplaces which provided them with a clear description of their role, but Linda's experience indicated that there may be some benefits to having an ambiguous role.

5.2.3 Perceptions of responsibilities for training

An important aspect of the PEIs' position in relation to others is their preference in terms of who was best placed to train them. As mentioned in Section 5.1.1, participants' perceptions of themselves seemed to play a role in the choices they made about their training. This notion was further seen in cases where PEIs devalued the training they had received from people with non-health education backgrounds.

A number of the PEIs in the study highlighted the importance of being trained by fully qualified patient educators. An example of this was Amber, who, when asked if there was anyone who was helpful in the hospital, said;

"No, because most of them were social workers not patient educators, they had experience but being an educator is different, they knew how to deal with people but they didn't have medical information"

When describing her training at another place, she said;

"They were all patient educators, they were not nurses, nor social workers, it was really good experience".

In her first statement she related the poor training to a lack of medical information among social workers. However, in her second statement she

included nurses, which revealed that her concern was not necessarily about her trainers' knowledge have as much as their educational background.

Katey also indicated that it is important to have a preceptor from the same educational background. This was particularly apparent when she mentioned every preceptor's degree. An example of this was that when she described the rotations, she stated;

"The health educator there--- she is a health education graduate, she never left me without work, she is very, very good"

When describing poor training she had received during one of her rotations she also pointed out the preceptor's background;

"My other preceptor holds a nursing degree"

For Katey, the degree was not only an indication of competence, it was also a reason for trust. While there were several occasions when she relied on the opinions of the health educator graduates, she doubted the intentions of those who were not;

"They don't want anyone to take their places, because they're not qualified to be in this position, they just have experience but they didn't study health education".

Sophia expressed a similar opinion as she related the good treatment she received to preceptors' educational backgrounds, and according to her, preceptors who shared a similar background were more able to understand the interns' needs;

"They treated us in a very, very, very courteous manner, I mean maybe because... They were applied medical sciences graduates

so they were more considerate, they give and take and understood us more, I think they gave to us because they understood our needs”

Besides patient educators, I have noted that a number of PEIs trusted doctors and considered them a valuable source of information. One of the PEIs said;

“When I was not sure about the medical information, I used to ask doctors, most of the information I got was from doctors. I did not want the educator to know because I did not want to upset her, it was not that I doubted her knowledge but she did not give me direct information or explicit medical explanations of what we advise patients to do, so I used to always return to doctors” Amber

Another intern expressed a similar opinion;

“I liked working with the doctors, I think it increases my information, with them I see different cases and when I observe how they deal with them, I understand what I need to teach”. Linda

However unlike the others, Linda was exceptionally flexible in her understanding of the qualified trainer. Although like many other PEIs she highlighted the importance of having good preceptors, her focus was not on the identity of those preceptors. She appreciated being trained by knowledgeable, competent and enthusiastic professionals, regardless of their speciality. There were several occasions when she appreciated the training which she had obtained from other health professionals. When recalling her work with the diabetes educator, she said;

“My training in the diabetes educator clinic was very beneficial, because the educator was enthusiastic, she was not a health educator by profession, she was maybe a nurse with a health education diploma or something”

She made a similar statement in regard to her work with midwives;

“The workers were not educators, they were midwives, I liked working there because they give from their heart”

Linda’s flexibility was not limited to working with health care professionals, as she was also willing to work with whoever could be beneficial to her. She, for example, described working with the media department;

“I really liked working in the media department, I learned how to use public media for education, how to prepare educational messages, I was engaged in translating and editing videos, in summary I have learned many things”

5.2.4 Working with others

This section focuses on the ways in which participants perceived their work with others and how this appeared to influence their learning. Working with others has two facets; working with other health professionals and working with peers. In general, PEIs seemed to appreciate working with other health professionals and considered it a good opportunity for learning. The following example shows how a PEI appreciated working with doctors and nurses. To her, communicating with such professionals was helpful to understand patients’ cases, but more importantly she felt that her work with them added value. She said;

“Besides working with patients, we were able to communicate with doctors, say for example if they have left you a note in a patient’s file and you did not get what they want from you, you were able to get back to them to understand, we were also able to communicate and discuss things with nurses, that was really nice because you feel that you are doing something real and not just fooling around”

Jane

Another intern also conveyed a similar view. Sophia, who provided an in-service programme to hospital staff, highly appreciated the presence of other members of the team and considered that a rewarding experience;

“I gave lectures and in-service and all the staff attended, nurses, doctors, administrators.

I: and how did that influence you, doing the in-service and...

P: It was WOW, WOW... even at the beginning, people attending, yes that's the point, this is what helped me the most in hospital E, even more than the presentations because, even in hospital F I did in-service at the end but it was in Arabic, it is a must, plus--- no the slides were written in English, presented in English but I explained it in Arabic for the team, just the health education department team in which all were specialists, but in hospital E it was wow: really, really wow, I mean the in-service was in English and then explained and presented in Arabic, so it would be 50/50, I mean some people don't speak Arabic: those can read the slides, and some don't speak English, because some are social workers or something and they don't speak English so they listen to the Arabic, but no it ended up

with me saying every sentence in Arabic and then translating it to English, so this experience was really a WOW, it was the first time in my life in which I had given a lecture in English and Arabic at the same time [laugh], in addition doctors attended, I mean you lecture in the presence of doctors, nurses and administrators, I mean men-- the first time, honestly, it was a WOW. I mean, thank God, that was fantastic” Sophia

By referring to Linda’s opinion in section 5.2.4, it can also be seen that she valued working with different professionals for her education.

The value perceived in working with others was most apparent when PEIs talked about their interaction with doctors. This seemed to be the result of them considering doctors a trusted source of learning. In the following quotation, an intern provided an example of how working with doctors help patient educators’ practice;

“In the urology department, doctors used to examine patients and sometimes give them new medical devices or something, the educator will come then and teach the patient how to use that device because she already knows what doctors want, I think a rotation that includes doctors’ rounds and clinics is good for training”
Linda

Anna also appreciated the presence of doctors and explained how that was useful to her;

“We attended a course that was designed for patients, but being there with doctors allowed us to ask questions and discuss medical things after they finished with the patients, then we attended

courses made for staff and it had updates about diabetes and anything you can think of” Anna

Anna further revealed that being with doctors was valuable even as an observer;

“Thank God, I had so much benefit from her, I mean I truly benefitted, she used to take us to doctors’ clinics, and there would be us the educators, an intern doctor and a consultant, and then when a patient comes, the consultant examines the patient and discusses his disease and treatment with him and once the patient leaves he explains everything to us, we have never been asked to provide education during these consultations: we were just observers” Anna

The other aspect of working with others is working with peers. A number of PEIs stated that the presence of a colleague was an advantage. In Section 4.4.2, Ruby described how being among peers can influence an intern. In that example she stated that being among other interns gave her the strength and ability to cope with criticism, while being on her own made it harder for her to cope with the preceptors’ criticism.

Another intern described how interns helped each other when providing patient education. She recalled;

*“I was not alone, we were four girls, so you know when you are in a group you share experience, for example; can you explain more, can you continue the education, let’s ask the other specialist... etc.”
Amber*

I have noted that several PEIs expressed their encouragement in and excitement about tasks in which they were in a group. One example was provided by Brooke;

“They asked us to work on a campaign and we agreed, and then we got excited about it, me and my colleague there were two of us, and we worked together, we collected things and worked on educational materials and blah blah blah” Brooke

Another advantage of having peers was evident in the data in which PEIs compared themselves to others. In the following example, Katey explains how she assessed her preceptor’s work by comparing it to her colleagues’ preceptors. She said;

“Katey: I mean she had never attended rounds...she doesn’t attend doctors’ rounds, maybe during the two whole months that I have spent with her, I have attended twice.

Interviewer: Is attendance a must? Do the rules require her to attend?

Katey: honestly I don’t know whether it is a requirement or not, but in my first two weeks I used to attend and I’m comparing myself to my colleagues who are getting their training here, they do attend [pause] anyway that is not important now” Katey

As a consequence of this comparison, Katey decided to file a complaint and seek training with another preceptor.

However, being with peers was not always appreciated. Amber for example felt that being the only PEI in one rotation was an advantage as staff gave

her special attention (see Section 5.2.4). In another example, an intern related the limited benefit she gained in one of her rotations to the presence of another intern who was given the responsibility of training her. She said:

“There is something noteworthy here, I think maybe because the intern who was already there is brilliant... she’d been there for six months already, so she became perfect and when I started she was still there, so they told me you will go with her instead of a specialist, that’s a point, I mean I was frustrated but I said nothing, I mean maybe they are busy” Sophia

A possible explanation of Sophia’s dissatisfaction is that she felt that being trained by another intern was unsatisfactory and she wanted more qualified trainers to be involved.

5.3 Perceptions of learning

Participants’ learning was clearly influenced by the way in which they understood learning. In this section, I describe aspects of the intern experience which participants valued as learning opportunities.

5.3.1 Organised training

Many PEIs saw the existence of a structured training programme as an integral part of learning. Examples of their opinions are demonstrated by the following quotations;

“They almost have the best training programme, the truth is that they have developed a programme, and I feel that this is the right way, I mean we cannot ask for anything more” Jane

“I started in that hospital, which was really amazing, a very well established programme, it started with rotations, this how their system works” Brooke

In line with PEIs' appreciation of structured training programmes, some PEIs criticised work in which the learning was not made explicit. For example, Sophia stated that staff were supposed to teach interns and give them knowledge and experience (see Section 5.1). Therefore, when learning was obvious, she identified this as “*taking*” and considered it as valuable aspect of training. In contrast, she considered her engagement in practice that did not explicitly entail learning as “*giving*”, she considered herself giving to the workplace rather than receiving and did not value the learning that was inherent to the experience.

This understanding was also evident in the interview with an intern who criticised the fact that she was given work with no structured plan or previous education. She said;

“They sent me all alone, this is how they did it, they said ‘we have no plan, we will not come with you to tell you what to do... you just go, and see by yourself’ as if we knew what we were doing and what must be done, what did they expect, was I supposed to have information about everything before starting in their department? In the previous hospital they gave us two weeks where they explained everything to us, starting from the diseases, every detail about the conditions that we will cover and what our work will be and then the they took us to patients and taught us practice” Emma

According to Sophia, a structured training plan can make the experience less boring and minimise free hours, which she considered a waste of time.

“To maximise the benefit... and not to make it boring for them, the training programme should be well structured and interns shouldn't feel bored, I mean I come here from eight and I am an intern, I have nothing to do, and I am not authorised to do anything... and I come from eight to four, I go on a tour with a specialist from eight to ten, and that's it, I sit there doing nothing [pause] until four, so what--- interns get bored, tired and everything... no... I should cut down their working hours and keep them busy... or give her more work through the day”

However, while the previous respondent understood free time as a waste, the following quote shows a different view, wherein an intern valued having free time and considered it as a learning opportunity. She said;

“The first week was a bit calm, the preceptor asked me to read for most of the time and then he made me attend some doctors' clinics and that was when I started getting excited, because his clinic was once a week and we had nothing else to do for the rest of the week, so I either attended doctors' clinics or did some kind of project, because of all the free time I had there by the end of the rotation I had a booklet and three brochures made, also because of the free time I managed to attend surgeries, I actually went to the OR” Linda

Another intern showed a similar perception about free time as she described how she used it to learn about patient conditions which her preceptor did not explain;

“I started opening patients’ files and reading them by myself, looking at the diagnosis and if I find something that I don’t know... I go and search about it online in my free time” Katey

The different views about free time further illustrate how PEIs’ understandings can impact on their learning. When PEIs expected others to teach them, free time was considered as a waste, but when PEIs took responsibility for their own learning, they invested their free time in learning.

5.3.2 Guidance

While PEIs valued having a structured training programme, they also valued the guidance of the senior professionals on the training. The benefit of an experienced preceptor was highlighted by a participant, who said;

“ I went to this--- the health educator, the one who’s very good---, so in that week I swear to God I learned things that I hadn’t learnt in a whole month [pause] [Interviewer: OK]. She sat with me and asked ‘what did you learn today? What do you know about this? What don’t you know about this?’ to know if I--- it was like an assessment at the beginning, you know, to know what I know and what I don’t, and when she finds something that I don’t know she says ‘read and write an article about it’ and the next day she reviews the article, even if we are on the doctors’ round, she sits whenever it’s not our role, she sits and reviews the article, she corrects me ‘correct this, do...’ and everything, I mean honestly she teaches with passion”

Katey

Anna expressed a firmer view that learning does not occur unless the preceptor pushes the intern to learn and work as one intern said;

“We spent two weeks with each preceptor, so it depends in which clinic you were in, I mean if you want to teach me you will pull me by my hair [drag me to work], I wasn’t pulled by my hair except for one month, that was the only person who actually pulled me by my hair; she used to call me at half past eight saying ‘Anna where are you? Can you rush to the clinic?’ and then she would not let me leave until four she really, really, taught me, she pressured me into working, asked me to read and make brochures, I learned about diseases that I have never heard about, I really had a great benefit”

Anna

This attitude towards learning seemed to be problematic as not all training places were similar. In the following quotation, an intern that explained the reason why she developed in one rotation was that she did not rely solely on preceptors to guide her learning. She stated that those who did not benefit were those who wanted to be pushed and evaluated, which was not what happened in that rotation. She said;

“I feel that maybe they want someone pushing them into doing things... and this is not the case in hospital C, I mean you have probably seen that yourself, so the girls wanted someone to tell them ‘go there and you will be evaluated, go there or the supervisor will...’ you know” Sara

In the following example, an intern related her dissatisfaction of working without supervision to a lack of confidence in her knowledge, and as a result in the service she provided;

“I worked with no supervision, I used to explain things to patients but I did not feel that I was explaining things well, I was telling them what I have learned but I was not confident of what I was saying, and that was not good, feeling that you are not...” Jane

A similar opinion was expressed by another intern, who considered guidance and monitoring as a way to identify gaps in her knowledge and help her to learn;

“They should have been with me from the beginning, that would have made me able to go, I mean no one even asked if we had gone or not, there was some negligence, they should have at least showed some interest, I mean if I did not do the work, they should know and ask so I can tell them what I don’t know and what I need to learn, they could have helped, I think monitoring is important at that stage” Emma

For one intern, monitoring was particularly useful when combined with feedback about her performance. She said;

“When I was done with the education, the preceptor commented on me and told me that I was talking fast, he told me to try and slow down a bit, these comments are really useful, this is just an example because I speak fast and many commented on that and told me to pay attention to that issue” Ruby

The role of the preceptor seemed to change over time and the more experienced PEIs needed less guidance from preceptors. However, the preceptor was still needed in difficult situations, as demonstrated in the following quote;

“She [the preceptor] started by doing things by herself and then when a task was repeated she asked us to do it... so we did, we learned you know... and then when she was sure that we had learned, she left us to do the work by ourselves, so we started opening files and documenting, but we were always able to seek her help, for example when educating patients there were times when I faced stubborn patients who didn’t want to listen or anything”
Jane

While guidance was important to the majority of participants, one PEI revealed that learning could still occur in its absence. The following quotation shows how a PEI acted without guidance. Linda, who often showed initiative, was not hindered by the lack of guidance. Instead, she retrieved her previous knowledge and used other resources to learn and practice;

“No one gave me anything, I looked on trusted websites for medical information: I then translated the information to simple Arabic, and then prepared the PowerPoint presentations, for the children I have tried to include pictures more than writing, of course I have learned about that in the university, that children don’t concentrate for long, so I prepared simple, short and brief lectures for them” Linda

I wondered whether this was related to the proactive attitude that I had already noticed in Linda and her tendency to take initiatives in learning, or whether the lack of guidance would force other interns to help themselves.

5.3.3 Engagement in work

The majority of the study participants emphasised the importance of being engaged in work to learn, as in the following quote from Sophia;

“Hospital G was beneficial because--- the good thing was that I felt, I used my talents, the designing, the Photoshop and everything, all my ideas--- the most beneficial thing in hospital G was an event, there was a big event--- I mean we prepared all the flyers and brochures, we also did a presentation, everything about the event”

Sophia

Many PEIs saw that they benefited the most from taking on responsibilities, as evidenced by one participant who described her experience of covering a clinic on her own;

“It was really nice, it is nice to have someone depending on you and to take the responsibility” Amber

This example suggested that PEIs appreciated the feeling of trust that is implied when given full responsibility. This was apparent in another quotation when an intern was disturbed by being marginalised and not given a chance to become fully engaged in practice. She said;

“The most annoying thing was when you feel that your supervisor does not give you all authority and does not trust your work, like, ‘I am always right and you are a student,’ because yes we are here to learn but provide the learning we need, you’re telling me that I am still learning then give me what I need, or for example when they did not give us patients and we were just observing, I liked when they gave me something to say. It helped me to develop” Linda

This quote illustrates that this intern believed that when she was viewed as an intern, she was not trusted with as many responsibilities as when she was seen as a member of the team (see Section 5.2.1).

Engagement in work was most appreciated by participants when the work matched their personal preferences. This is demonstrated in the following statement;

“I can say that the most beneficial thing to me was working with patients; I dealt with patients all by myself, I visited them, talked to them and wrote to them. I was all alone, not with the supervisor or anything, that really gives you confidence. When a supervisor is present you feel that you depend on him, I mean if you make a mistake or anything he corrects you, but being alone makes you hold the responsibility by yourself. I myself have already built enough experience and I can do that, but you shouldn't start like that of course” Emma

As this quote suggests, PEIs mostly appreciated working with patients and considered this most valuable for their learning. This further highlights the importance of PEIs' judgement on the nature of their work, as was discussed in Section 5.1.1.

While engagement in work seemed to be highly valuable to participants, it was noted that some interns took the initiative to involve themselves in work, while others waited for work to be given to them. The following example is of an intern who did not wait for learning opportunities, but instead seemed to hunt for opportunities for practice. She recalled;

“There was a phone in the clinic and whenever it rings the girls avoid it, I used to tell them that we should answer but they were worried that it might be a patient calling for a consultation or something, so I became the only one answering, and once a doctor

called and asked who I was, and I told him I am Amber so he asked if I was an educator and I said yes so he asked if I am authorised to educate patients and I said yes go ahead and send me the patient you have, and that was really good because this doctor memorised my name and for him, it was Amber, the one who will teach, Amber, the one who will do this and that. I advised the girls to answer, I told them 'you might be lucky and talk to a doctor that will then know you and be there for you when you need', but they did not listen.

Sometimes it is small things you do that give you great benefits"

Amber

The previous quotation further shows the value which PEIs placed on working with doctors, as was described in Section 5.2.4.

Brooke presented a different attitude toward learning. For her, learning seemed to be associated with being given tasks rather than taking initiative. She complained of being held accountable for being late to work when there were no particular learning activities scheduled. She said;

"They used to file a lot of complaints against us because there were times when we were 10 or 15 minutes late, but you know, these things are negligible if you were good enough, it is negligible don't you agree? I mean even they were late at times and we used to tell them if we were late we are willing to make it up at another time, that is how responsible we were. There was some sort of incitement against us, they called the hospital administration and asked them to issue a letter of admonition, so the admin called us and asked us about the negligence and about us being late. So we told them that

we actually were not being given work and as a result we were not motivated to wake up and come early. I told them, don't ask me to wake up early and come here for seven or eight hours and give me nothing, and then question me about the 10 or 15 minutes that I was late by in the morning. That is not fair treatment and something is actually wrong with this whole matter" Brooke

Although Brooke showed a lack of interest in practice in this section of the interview, there were other occasions when she described more active participation. However, it is notable that in those occasions she was encouraged by staff;

*"A good thing in my training was that in hospital A, whatever I want to learn they **give** me. I was also lucky at hospital A in that I got to write two articles in a newspaper. My writing skills are OK so they told me to write an article, they read it, liked it and sent it for publishing. It is very good to reach the public, it is part of public health"*

The previous quote suggests that this intern only perceived benefits when staff took an active role in promoting her learning.

5.3.4 Learning challenges

As described in Section 4.2.2 participants were motivated by work and learning challenges. In the following example Brooke was challenged by being asked to provide education to medical staff;

"They asked me to give lectures for nurses, and I said 'how can I teach nurses' but they told me that these are the nurses in the

surgical area and they are not familiar with your work, they have probably studied it once but they are not up to date. So I went last week and gave them full education. It was stressful, more stress than dealing with the patients of course, because they are nurses with a medical background, they are exactly like me, but then they told me: you have accepted the challenge of the nurses, next week we want you to go to doctors, and I said 'no, no, no, not doctors, that is too much'. But they told me that these doctors actually asked to have this in-service, they were not specialised in that area, they are from other areas and they are not familiar with all the details you deal with, so I agreed and next week I will give a lecture to doctors, it is a new challenge and I am actually taking on a new challenge every week" Brooke

From Brooke's story, I have noted that although PEIs generally liked to be considered as health professionals, Brooke seemed to view herself as lower in rank to others and found it challenging to provide education to those who she viewed as higher in the hierarchy. However, this challenge seemed to have a positive impact on her learning, as evident in the quote relating to this experience in Section 4.4.2.

Anna was also motivated by learning challenges, as mentioned in Section 4.2.2. During her interview, Anna recalled several incidents which were useful learning experiences. The first was when she learned punctuality after being yelled at for being late. The second incident was when she failed an exam for the first time in her life; this experience encouraged her to study hard. Finally she recalled how she was worried about not being able to

answer patients' queries and thus she used to read about the topics she was covering.

5.3.5 The development over time

Another important theme was the PEIs' understanding of learning as a gradual process of knowledge accumulation and increased experience over time. All participants described how they improved over time with gradual exposure to work. This process started with an introduction to work, followed by observation of a professional's practice and then gradual involvement in work (initially under supervision but becoming more independent). This understanding of progressive development is demonstrated in the following quotations;

“They start by explaining everything to the girls, explain the work basics, what rules they are going to follow and then explain the topic, if it is diabetes for example, educate, like school, start with the pancreas function and what happens with percentages and everything... it is not just about the education. I mean, I was not happy when I was in the university and asked to memorise, because that keeps you in the blind, what I meant is you start by learning and then applying, they should apply in front of you and then you work under their supervision before they leave you to work on your own. Another example is when they ask you to do a report of what you have accomplished or even ask for a presentation or assignment” Jane

“When I started in the elective area I observed for a while of course, I did not practice from day one. I told them I want to observe until I

feel that I can educate in that area, and when I felt ready they started sending me patients or I take part in their session” Brooke

“In the four months you spend here, you start with two months of rotations to visit all the areas the patient educators cover, and then they locate you in an area for the other two months, in each rotation, we see patients, we first observe and then we educate. Of course we start by observing how the work is done, we see how they produce the materials, we actually help in the materials production. I really feel that I am benefitting, I am seeing new things. You don’t just observe, no, you observe for a while and then they give you a case study, a simple one but I still feel that I have to search for information. I also see patients, I look for the new cases, things that I have never heard about before. I am also seeing the compassion, in oncology clinics, the educators came down to patients’ level: if for example the patient cannot speak or for example his language level is simple then you learn how to give the patient the information and how you convince the patient even if he was from a different background” Brooke

“Anna: we used to spend full days with our preceptor, writing notes and asking about things that needed clarification, then after two weeks, she asked us to start calling patients. She said, ‘you talk to the patients and I will be monitoring how you work, I will see how you deal with patients’. She taught us for two weeks and then gave us the green light to deal with patients, that was really nice and gave us confidence, it was my first rotation and it was the best,

honestly it made me really, really confident, it was a very nice experience,

Interviewer: so you gained confidence?

Anna: Yes, because when I started working with patients on my own, I was confident of the information which I'd gained from their course" Anna

Many PEIs considered this gradual involvement as a way to promote confidence, as noted in the last quotation. Another PEI described how her confidence improved over time. She said;

"At the start I was scared of how I am going to walk into patients' rooms, how I am going to handle them, how I am going to talk to them by myself, this was actually after three months of training because in the first three months I did not see any patients, so I did not get used to them or feel that it is something I have seen and done before. It was a new experience and it was really good. I felt that I had so much benefit, I benefited from walking into patients' rooms, seeing them, talking to them with confidence. I was able to do it: I think that was a really good experience and that I had great benefit from it because during our four years at college we have never seen or worked with patients" Emma

"We attended the clinic, observed the educator's work and then we started to see patients by ourselves, now I have a room to work in, I see patients there and if there are any new cases I call the supervisor to see the patient and then she explains it to me. I feel that I've got the hang of it, and I don't need her by my side all the

time. I think they gave us this confidence, I mean how would we know what to do when we start, if it is my first time in a hospital or a department and then I go to a patient's room, what should I do? What should I say? Am I authorised to write in patients' files or not? We have no idea about any of these details" Emma

Progression over time was also noted in other interns' stories, as described in the following examples;

"Ruby: At the beginning of the training, I felt that it was all about memorising and reciting. I memorised what the educators taught me and then repeated it as it was to the patients, regardless of their differences. Now that I am at the end of my internship, I have changed: I listen to patients and weigh what I am planning to say to find out what suits them.

Interviewer: and how did that happen? How did you progress from a person who memorises and recites to a person who understands? What changed you?

Ruby: I feel that maybe seeing a lot of patients helped me the most. It could be the beginner's fear, the fear of making mistakes or forgetting something which made me memorise and recite, especially when being observed. I mean when someone is observing me I get nervous and cannot be giving as when I am on my own, I tried that. Now that I am in the last rotation, I am more fluent, it is so different from having someone on your head [being under close observation]. Because I keep thinking about the observer, their presence influences my practice: that is the thing.

Maybe also that when I feel confident of my information I give and take with the patient to see what they need, but at the beginning I didn't have enough knowledge so I had to memorise and recite"

Ruby

"Then she started involving me by giving me tasks that didn't include teaching patients. I printed patients' name sheets, I checked new admissions and I checked lab results. I did all of that by myself because I had done it with other preceptors before. I have also done some work under observation. That was helpful because you feel that you are now doing the work of health educators" Katey

Another PEI described how this gradual involvement, together with the guidance of a preceptor, not only taught her what to do but also made her feel as if she was making a contribution to the team. She recalled;

"In the first two weeks, she would explain things to us, she explained things to patients and us at the same time, she answered all our questions. She was extremely helpful, more than you can imagine. She taught us about insulin injections, how to draw and inject, how to use insulin pens and how to check blood sugar: we observed her and then she asked us to start practising, and with time she started leaving us alone in the clinic, and we did the work exactly as she wanted. We really enjoyed that, we felt that we have a status and that we are being beneficial: we are not just coming and leaving with no goal" Jane

In the following statement, Linda describes how, after a period of training and gradual involvement, she managed to hold a clinic by herself. She recalled;

“I had my own clinic, I let the patients in and closed the door. It was all mine, no one was observing me or anything. I even used to do my own rounds: I had my own patients, I was authorised to get their files, read them and write documentation of everything, doing all of that on my own. The clinic the round and everything was really beneficial, because I had no one with me I took the responsibility, I used earlier experience, I also used the notes that I had been writing during the training. At the start I used to read from the notes but with time I started to understand, so I began to ask patients, chat with them and then gave them the knowledge. Step by step, it was gradual because I had to depend on myself, I felt that I am an educator and I had to run the clinic” Linda

One participant stated that this gradual involvement was helpful, but that it was not the only way of learning. In the following quotation, Sophia compared starting with observation to immediate work with patients. She said;

“In hospital G we used to attend tours with specialists. We didn’t deal with patients directly until we completed a month and a half, half the training period. I mean we were trained for 3 months, but we were only allowed to deal with patients and talk to them after a month and a half, I mean a month and two weeks ... In hospital F it was different... We went on rounds and talked to patients from the

beginning. Honestly, each way has an upside, in hospital F we had to face it, the second one no: we felt that the job is not a piece of cake, I mean seriously you should take experience and then start dealing with patients, it is not just like you go and do it, this is what we felt” Sophia

5.4 Summary

In this chapter, I have presented the factors which were found to influence participants' learning during internship, thereby addressing the second objective of the research. These factors fall into three categories. First, the way in which PEIs viewed themselves was found to influence their preferences in terms of the work they became involved in and their commitment to learn. Second, participants' learning was also influenced by the way they viewed themselves in relation to others. This was mainly seen in being recognised, having a clear role, their views on the backgrounds of their preceptors and working with other professionals and peers. The final category is PEIs' understandings of learning. PEIs understood an experience as learning when there was a structured training programme, guidance from preceptors, when they took on responsibilities, faced learning challenges and gradually became more involved in work.

Chapter 6 Discussion

This chapter provides a discussion of the research findings in relation to the existing literature and the contribution made regarding PEIs' experience of learning during internship. To address the first research objective, which is to ascertain PEIs' views on the internship experience, I present the findings concerned with PEIs' internship experience drawing on literature from the health care field. Then, I address the second objective of the research, which is to identify factors that influence PEIs' learning. I discuss the factors which influenced PEIs' learning as identified through the study in relation to the literature. Following this, I discuss how my personal understanding of learning has developed over the period of the research. Finally, I present the strengths and limitations of the research and the contribution of the study.

6.1 PEIs' internship experience

Although new graduates' experience has been covered in numerous studies, these studies were mainly concerned with graduates from the well-established professions of doctors and nurses, and limited literature covered other newer health professionals. This is the first research project studying the experience of newly graduated patient educators. Therefore, this research adds an understanding of how students of a 'new profession', in this case PEIs, experience their transition to the workplace. This knowledge is particularly important for understanding how graduates in new roles can best be supported in transition. Although studies of new graduates in established professions have described the transition to practice as challenging, my study suggested that this transition may be even more

'shocking' for graduates in new professions. In the next section, I summarise the findings emerging through the research which highlighted the transition shock experienced by PEIs.

6.1.1 Transition shock

Participants in the study were found to be challenged by the mismatch between their expectations and reality of work. PEIs in my study expressed passion and appreciation toward their profession. Many of them showed an understanding of the value of their role and had some expectation of what the training and/or work was going to be like.

Once PEIs moved to the workplace, their expectations and hopes were not necessarily met. A number of these participants described this as "صدمة" which is translated by the Oxford Arabic Dictionary (2014) as "*shock, impact, blow, thrust, jolt*" and when describing an emotion, as "*trauma*", "*to be traumatized*", "*to get a shock*", "*to be in a shock*" and "*to be in a state of shock*". When translating the transcripts I have used the term shock, which to me as a native Arabic speaker felt most appropriate and represents the meaning of what people said, rather than trauma, which is more severe.

Several authors describe new graduates' transition to the workplace as a shock. In the early work of Kramer (1974), she referred to nurses' transition as "*reality shock*" and defined it as "*The total social, physical, and emotional response of a person to the unexpected, unwanted, or undesired and in most severe degrees intolerable*" (p.3). Further studies on this shock followed and "*transition shock*" was then defined by Bennett (1998) as "*a state of loss and disorientation precipitated by a change in one's familiar environment that requires adjustment*" (p.215). Finally, transition shock in

nursing was described by Duchscher (2009) as “*the experience of moving from the known role of a student to the relatively less familiar role of professionally practising nurse*”. She conceptualised the transition to work for nurses in terms of a transition shock, which includes emotional, physical, intellectual and sociocultural and developmental elements. Duchscher’s conceptualisation was helpful when thinking about the experiences of the participants in my study for whom these elements were present. However, being from a new emerging profession seemed to magnify the intellectual and social elements of transition shock in particular. A new element of shock was apparent which I referred to as the epistemological element of transition shock.

In my study, the term “*shock*” was mainly used in the interviews by PEIs who had high expectations and found that the reality of the workplace did not match their hopes and/or expectations. These PEIs expressed their dissatisfaction, frustration and disappointment when facing the reality of the workplace. Previous studies on transition have similarly highlighted the notion that facing reality can be associated with different feelings that include shock, fear, frustration and anger (Brennan *et al.* 2010; Chang and Daly 2012; Duchscher 2009; Kramer 1974; O’Shea and Kelly 2007; Tryssenaar and Perkins 2001; Waite 2004).

However, not all respondents showed high expectations: instead, some did not expect as much and were aware of and prepared for some of the difficulties they faced. Those PEIs showed better ability to cope with the reality and appreciated the training period more than those with high expectations. Having realistic expectations was found by McElhinney (2008)

and Lingard *et al.* (2002) to be crucial in the identity formation process. However, Emma, a PEI who did not expect much from the training, ended her interview by saying that she had not really benefitted from that training (see section 4.3.1). In Emma's case I have noted that the source of her low expectations was a particular supervisor, who told her not to expect to benefit from the training period. This brought to my attention the importance of having realistic and not low expectations.

PEIs used several expressions to convey their dissatisfaction with the internship experience. These include describing the training period as a "*failure*" and "*the worst experience*". For the study participants, I found three elements of shock to be significant in their transition experience. The first was sociocultural shock, which although found in studies of nurses, was magnified in PEIs who were entering a new profession. Second was intellectual shock, which is mostly described in the literature as the gap between theory and practice. Finally, I have identified a new element of shock facing new graduates which I will refer to as epistemological shock, and which is the result of being in a new, unfamiliar form of learning. Each of these aspects is described in detail below.

6.1.1.1 Sociocultural element of transition shock

The sociocultural element –which was described by Duchscher (2009) as the difficulty of finding a connection between the role new graduates feel that they have been prepared for and their actual role in the workplace- was exacerbated in PEIs' experience, and a main issue that contributed to this shock was a lack of formal recognition. When PEIs started their training, they found that some training places lacked a patient education department,

did not have a defined role for patient educators and/or did not distinguish patient educators from other health professionals in the workplace (see Section 4.3.3.2)

A number of participants described their disappointment and even “*devastation*” when they started their training in places which did not formally recognise patient education. The stories which these PEIs told reminded me of my own experience as a patient educator intern. As one of my rotations was in a place that did not have a department for patient educators, I could appreciate the feeling they encountered. As some participants described, I understood how important it is for PEIs to see that their studies count and that they have a recognisable place in the health service. This situation is not limited to PEIs; in the literature I found this to be a common problem among new professions such as interprofessional care co-ordinators (Bridges and Meyer 2007), music therapists (Ledger 2010), infertility counsellors (Monach 2013) and physician assistants (Merkle *et al.* 2011).

As PEIs in the study expressed the need for formal recognition, I found that literature suggests that formal recognition and accreditation can improve training and practice (Merkle *et al.* 2011; Monach 2013). When looking at the Saudi context, I found that although PEIs experienced a lack of formal recognition, many hospitals are obligated to incorporate patient education into their practice, because of JCI and/or CBAHI accreditation, in which patient education is a fundamental quality standard.

Different hospitals interpreted these standards in different ways with some hospitals providing clear policies and procedures for patient educators while others had no guidelines, or guidelines limited to a brief description.

An important issue raised by Amber in section 4.3.3.2 was that the poor recognition of the role was associated with poor understanding of the value of the role. This intern gave an example of diabetes educators whose role was the only one valued by organizations, health professionals and patients and as a result always had an established role regardless of the existence of a department or otherwise.

Along with the lack of formal recognition, participants found that the role was poorly understood by people in the workplace, including both staff and patients. Role ambiguity, which is defined as “*the lack of clear, consistent information about the behaviour expected in the role*” (Chang and Daly 2012, p6) was reported by several authors as an issue facing workers in new professions such as advanced practice nurses (Lindblad *et al.* 2010), dual diagnosis workers (McLaughlin, Sines and Long 2008) and music therapists (Ledger 2010). This seems to be problematic for new graduates as they struggle to decide their responsibilities and boundaries: especially when there have been no previous workers in the place. Chang and Daly (2012) report that role ambiguity in nursing had negative implications on new graduates including low job satisfaction, stress and turnover. In my study, I was able to identify a similar problem when Jane stated that she regretted choosing patient education as a profession and wished that she had become a professional with a role that other people knew about (see Section 4.3.3.1).

Another challenge that faced PEIs in my study was their relationship with other health professionals. It was noted in the interviews that some PEIs felt they had experienced interprofessional conflict in the workplace. In the

example of Sara in Section 4.3.3, this conflict was associated with poor understanding of her role. When recalling my own experience, I remember that the feeling of conflict between patient educators and nurses in particular was always present: especially when the responsibilities were not clear and the work of the two groups overlapped. My personal explanation was that both nurses and patient educators were concerned about others taking over their roles. Conflict between people from new professions and others from well-established professions has been previously found in new professions such as music therapy (Ledger 2010) and advanced practice nursing (Lindblad *et al.* 2010).

Just as some professionals did not appreciate having patient educators as co-workers, PEIs themselves did not want to be grouped with others and wanted to be seen as distinct professionals. This was particularly true when they were grouped with people who were not considered to be health professionals. In section 4.3.3.2 Jane and Sara described the feeling associated with the experience of being grouped with professionals from other disciplines and backgrounds as “*hatred*” and “*devastation*”.

6.1.1.2 Intellectual element of transition shock

The intellectual element of transition shock is another issue which was significant among the study participants. PEIs started their training with certain expectations which were not met in reality. The first intellectual shock for the participants was the gap between what they had been prepared to do and what they understood as their role and what was really needed in practice.

To start with, a number of PEIs felt that they were not ready for practice upon starting their training. An example of this was provided by Emma in Section 4.3.2 when she was asked to start practising without being told what the work included. As PEIs felt that they lacked the knowledge needed for practice, they demanded to have someone teaching them before being involved in practice. This feeling of unpreparedness is not uncommon among new graduates and several studies in health care report that new graduates feel a gap between their studies and practice and thus consider themselves unprepared for work (Buddeberg-Fischer *et al.* 2006; Clare and Loon 2003; McKenna and Green 2004; Newton and McKenna 2007; O'Shea and Kelly 2007; Waite 2004). Duchscher (2009) and Owens *et al.* (2001) for example, reported that new nurses in their studies found the work requirements and expectations to exceed their abilities. Chang and Daly (2012) however point out an important issue in regard to this matter, which concerns the need to realise that the education received prior to graduation is not intended to produce expert professionals but acceptable entry level graduates who are capable of learning and coping with different work environments. This seems to be in line with what Kilminster *et al.* (2011) argue, which is that preparing graduates cannot be the sole responsibility of undergraduate schools and that therefore it is important to recognise the period of transition to the workplace as a critically intensive learning period which should be supported on site.

Another issue within intellectual shock was the rigid understanding of the role that new graduates had upon starting their training. A significant number of participants had a fixed image about their role in the training place. The reality of the practice did not always match the interns' ideas, and seemed to

contribute to the shock and even influenced their ideas about the benefit they gained from that training. To be explicit, PEIs frequently described being involved in tasks that they did not consider part of the educators' role and described being involved in such activities as being in the "*wrong place*", "*bizarre*", a "*waste of time*" or "*not beneficial*" and which even led some interns to avoid work. In general, most interns participating in the study favoured tasks which involved working with patients and considered these more beneficial for their training. This selectivity in regard to tasks is seen in many studies in health care, whereby students and new graduates consider that they only benefit when they spend time with patients and that being distracted by managerial work minimises learning opportunities (Clare and Loon 2003; Daley 1999; O'Shea and Kelly 2007; Tryssenaar and Perkins 2001). Ledger and Kilminster (2015) reflected on the use of competency lists on placements and observed that medical and nursing students did not consider work outside their lists as "learning".

While I found that the ambiguity of the role carries the risk of driving new graduates away from the profession, it seems also that having a rigidly fixed idea about the role carries similar risks. Therefore, it may be worth considering the balance between being very specific about the role and being flexible about it. The tension between role flexibility and clarity was raised by Bridges and Meyer (2007) and they conclude that although a certain level of clarity is needed, flexibility is also important to promote individualised patient care and fill the gaps in the workforce. In their studies of new graduate nurses, Chang and Daly (2012) state that universities need to prepare students to be flexible, critical thinkers who are able to function in different environments. This is an important aspect to raise here in the case

of patient educators. Just as there is clearly a need to have an agreement on what the role of a patient educator encompasses, there is also a need for new graduates to understand that there is a level of flexibility and that the role can adjust to the needs of the workplace.

6.1.1.3 Epistemological element of transition shock

Before discussing the interpretation of the concept of epistemological shock, I will start by explaining my understanding of the term. Epistemology is a branch of philosophy which is concerned with investigating human knowledge, and how people arrive at this knowledge (Hofer and Pintrich 1997). In the area of education, researchers have argued that an individual's epistemological belief influences their learning (Chan and Elliott 2004; Hofer and Pintrich 1997; Schommer 1994). Billett (2006) focuses in particular on learners' personal epistemologies and considers that a person's capacities, previous experiences and negotiations drive their ways of knowing and acting.

In my study, I have found that new graduates start their internship with a certain understanding about learning, which is mainly centred on the need to be formally taught. However, as they move into the workplace, they face a new form of learning that they do not appreciate or understand, which is learning by participation and through engagement in practice.

Using the definitions of transition shock provided earlier in the chapter, the term **epistemological shock** is used here to describe the challenge which newly graduated professionals experience as a result of the shift from the formal learning given in educational institutions to learning which takes place in a working environment through engaging and participating in practice.

Epistemological shock was previously used by Bateson cited by Bloom (2013) to describe situations where people's epistemologies do not support their assumptions but I am not aware of the term being used in workplace learning literature before.

I began to think about this aspect of shock amongst the study participants when I identified challenges related to being interns. I noted that PEIs' perception of themselves as interns was associated with a number of expectations in relation to the way they should be learning, including having a structured training programme and the assigning of tasks which are of high educational value (see Section 4.3.2). I also found that this perception influenced the way in which they judged the work with which they were involved (see Section 5.1.1). The significance of how participants' viewed learning became clearer when I was looking at the factors influencing the participants' learning and most particularly when I realised the extent to which the way they understood learning influenced the learning itself (see Section 5.3).

Upon starting their internship, most of the PEIs showed an understanding of their identity as interns in which their main role in the workplace was learning. In the example of Brooke in Section 5.1.2, she showed a clear differentiation between her current role as an intern who is there to learn and her future role when she will be hired as an employee. In that particular example, the intern made it clear that as long as she was in that role she was expecting others to teach her. Brooke was not alone in that opinion; other interns such as Emma and Sophia (see Section 4.3.2) showed not only that they identified themselves as interns but that they also want others to

identify and consequently treat them as learners. Along with that perception about their role as learners came several issues which had implications for their learning. These included the differentiation between learning and working, the belief that learning only happens when the teaching aspect is explicit, and the assigning of educational value to tasks and judging their value to learning accordingly. This section explores how these PEIs' perceptions of learning did not match how learning occurred in the workplace. Implications for their learner "identity" are described further in Section 6.1.2.1.

PEIs' expectations of learning were not always met and the majority complained about the quality of training received. The complaints made were mainly in regard to the idea that training places were not prepared for training, there was little or no understanding of interns' needs and they did not receive a training plan or formal teaching activities. Looking at the examples given in section 4.3.2 it became clear to me that these interns did not understand the value of many activities and interactions which they encountered.

Billett (2006, 2009, cevetPaderborn 2012) has explained how in the modern world where people are immersed in school led societies, individuals find it hard to understand and accept learning through practice. His writings and presentations made me realise how it is difficult for new graduates who are embedded in the education discourse to understand and appreciate the terms and potentials of learning through practice. It would be interesting to conduct further research to explore the existence of epistemological shock in

other professions and to more deeply explore ways to help overcome this shock and help new graduates to understand the value and practicalities of learning in a different way.

To summarise, PEIs face transition shock upon their transition to the workplace. Accounts of similar shock are found in the literature of medical and nursing graduates. However, my research shows that being from a new profession can exacerbate the sociocultural and intellectual aspects of this shock. In addition, I propose a new element of shock not noted in earlier studies, which is the **epistemological shock** which results from lack of understanding of how learning occurs through practice. In the next section, I will discuss factors which influence PEIs' learning in further detail.

6.1.2 PEIs' learning

In Chapter 5, I found that participants' learning was influenced by three main factors, which were; their understanding of their role, their relationships with others, and their understanding of the nature of learning. Looking at the wider literature, I found that these findings fit under two main areas in the learning literature, which are; professional identity and personal epistemologies. These two areas are not independent from each other, but rather are interrelated, and each of them has an impact on the learning process.

6.1.2.1 Professional identity

Professional identity refers to the range of attitudes, beliefs and understandings present about a role and interactions within the context of the workplace (Adams *et al.* 2006; Lingard *et al.* 2002). It encompasses the individual's relationship with others as well as the feeling of belonging to a

group (Cardoso, Batista and Graça 2014). In this section, I will discuss the identities that PEIs developed and how these influenced their learning. First I will describe how PEIs understood their role as “intern” and “patient educator” and how these understandings influenced the way in which they judged the work assigned to them. Second, I will discuss the feeling of belonging and the way it affected PEIs’ loyalty and interactions in the workplace.

Understanding of the role

In my study, participants presented two forms of identities which were evident in influencing their learning. First is the identity of the intern, which was mainly characterised as a learner. Second is the identity of the patient educator, in which each PEI seemed to have a fixed understanding of the role and the responsibilities assigned to it. These identities were not contradictory, and they coexisted, i.e. some interns held both identities at the same time. Below, I discuss both identities which PEIs presented and then I discuss identity in relation to others in the workplace.

As pointed out earlier in the chapter, the intern identity was evident among several participants. These PEIs viewed their role in the workplace as that of learners and expected to be treated in that way, as for example being taught, guided and receiving feedback. This feeling is understandable considering the status of these graduates, who are expected by the university to undertake a practical training period before becoming certified qualified practitioners.

The first issue related to the intern identity was the differentiation between learning and working. PEIs who saw learning as separate from work were

selective in terms of the tasks with which they wanted to be involved in. They differentiated between the work which should be done by them as “interns” and that which should be done by staff. The justification offered by PEIs was that they were not benefitting from some of the tasks. Those PEIs appeared to have perceptions about the educational value of tasks and therefore they evaluated them accordingly. Buddeberg-Fischer *et al.* (2006) and Deketelaere *et al.* (2006) reported similar findings among new doctors, who stated that they did not benefit from certain tasks which they perceived to have low educational value.

In my study, Sophia expressed the distinction in a very interesting way as she summarised her experience in each rotation through a percentage of give and take (see Section 5.1.1). She described being engaged in activities that she considered educational as taking, and engaging in activities with no perceived educational value as giving. As a result of this distinction, some PEIs felt that they were being exploited by staff members when asked to do work which was perceived as a staff job and with low educational value. Ledger and Kilminster (2015) also found this distinction present among students in different health professions and considered it unhelpful for their learning. The distinction between learning and work was evident in my study, as there were several instances when a PEI undervalued the learning that occurred from different aspects of practice. A significant example of that was seen with Ruby (see Section 5.2.1) where she presented two working experiences; one of which she considered as being exploited by staff members and the other where she considered the hard work to be for her own good. The difference between these two experiences as she described them is that in the former she was seen as a “*trainee*” while in the latter she

was seen as an “*employee*”. A similar feeling is reported by several authors wherein new graduates feel that they are not benefiting from the work which has been delegated to them (Deketelaere *et al.* 2006; Levine *et al.* 2006; Morley 2009). Numerous studies in health care report that new graduates feel encouraged, are more confident and experience enhanced learning when being treated as professionals by staff (Brown, Chapman and Graham 2007; Buddeberg-Fischer *et al.* 2006; Cantillon and Macdermott 2008; Clare and Loon 2003; Delaney 2003; Morley 2009; Saghafi, Hardy and Hillege 2012; Thomka 2001) as well as patients (Cantillon and Macdermott 2008; Morley 2009).

Another issue that appeared in the study was that being an intern provided some PEIs with protection from hard work and responsibilities and made mistakes more acceptable to them. This was shown in the example of Sara (see Section 5.2.1) where she felt that wearing the interns’ green lab coat protected her from patients’ questions, and the example of Sophia (see Section 5.1.2) where she stated that she makes mistakes because she is “*an intern after all*”. This is similar to the findings of McElhinney (2008), who stated that being a trainee was considered as a shield and protection from the responsibilities of qualified practitioners. In addition, in studies about nurse transition, McKenna and Green (2004) and Newton and McKenna (2007) found that some new graduates appreciated the feeling of safety in making mistakes which resulted from being identified as students. While Newton and McKenna (2007) considered that “sheltering under the umbrella” is helpful in the times of uncertainty, I sensed that it inhibited some PEIs from engaging in complex work and therefore reduced the learning that could have come with it.

The intern identity was not always a disadvantage. PEIs' understanding of their role as learners appeared to be mostly associated with a feeling of commitment and obligation to learning. Duchscher (2009) similarly found that when new nurses held the feeling of being in a learning role, they presented high levels of energy, enthusiasm and excitement.

It is important to note that the learner identity is temporary and that individuals develop a professional identity through interactions and exposure to professional behaviours upon moving to the workplace in a process referred to as "socialisation" (Adams *et al.* 2006; Lortie 1966). As identity formation was not the focus of this research, I have not explored this area in depth. However, as it appeared in the findings to be a critical issue influencing the learning process, it may be worth exploring in further detail in to understand how the change in the PEIs' identity from learner to professional influences learning.

The second form of identity which was evident among participants and showed an impact on their learning was the identity of the patient educator. The majority of the PEIs in my study showed that they had started their training with fixed perceptions about the role of patient educator and they were determined to stick to the boundaries which they had set for that role. Having this fixed idea about the role made PEIs selective about the tasks they wanted to be involved in, which in this case was not necessarily about educational value but about whether they perceived these tasks as the responsibility of patient educators or not. From my previous work as a patient educator and my review of the existing job descriptions and guidelines, I have noted that some of the tasks which the PEIs did not

perceive as part of their role were basic patient educators' responsibilities such as participating in community awareness campaigns and preparing health promotion materials. Aside from one intern for whom working with sick people seemed to be emotionally overwhelming, all PEIs favoured work with a clinical aspect and which included dealing with patients. Reflecting on my personal experience, I understand this preference as a desire to be further up the medical hierarchy in comparison with being involved in tasks which are less clinical in nature. Therefore, having what appears to be a rigid idea about the role of a patient educator seemed to create inflexibility in accepting different sorts of tasks. This inflexibility seemed to cause PEIs to avoid taking some responsibilities which might offer good chances for learning. This was demonstrated by PEIs who had more flexible ideas about the role and/or were willing to take on any responsibilities offered by the workplace. Those PEIs were engaged in a wider range of work activities and interactions and, as a consequence, learning opportunities. These findings are consistent with those of Ledger and Kilminster (2015) who found that students prioritised technical aspects of work such as wound dressing and medication dispensing over what is considered basic care such as feeding and bathing patients. The final aspect of professional identity is the feeling of belonging, which is described further below.

Belonging

PEIs in my study conveyed the feeling of belonging to a professional group. A number of PEIs described the role and criteria of that group and wanted to be distinguished on that basis. In the work of Wenger (1998), there is emphasis on the importance of the feeling of belonging to a community

which helps the learner to be able to act competently, be treated by others in the community as competent and to know how to interact with others.

In the examples given in Section 4.3.3.2, interns described how they are different from others, through the value of the role and their educational background. As a consequence, these PEIs felt disadvantaged by not having a clear professional title. They had a desire to be distinct and clearly identified in relation to their specialised educational background. This led PEIs to resent both people working as patient educators without specialist training and other health professionals who did not distinguish between these staff and PEIs. Hobman and Bordia (2006) report that feeling a difference in professional background and work values can create work conflict. This conflict was repeatedly reported by the study participants, and mainly existed between them and the professionals with whom their work overlapped: particularly when the role was not clearly understood, such as in the example of Sara (see Section 4.3.3.1). Overlap and shared responsibilities, elsewhere described as “blurred roles”, has been considered by some authors as a cause of conflict between health professionals (Brown, Crawford and Darongkamas 2000; Hall 2005). Workplace conflicts carry the risk of being learning inhibitors for new graduates (Bearman, Lawson and Jones 2011) and have been found to increase the inclination to quit in newly graduated nurses (Thomka 2001).

The conflict created by having a different educational background was clearly evident in my study when PEIs devalued working with and/or being trained by people who held degrees in subjects other than health education. The examples given in Section 5.2.3 show how a number of PEIs had strong

opinions about who provided good training. They explained their views in several ways, including the idea that people from other educational backgrounds do not have enough medical information, do not understand the needs of PEIs and/or even are not trustworthy. Similar results were found by Waite (2004), where new nurses indicated that they only learned from seniors who are experts in the same field.

However, it was notable in my study that doctors were exempted from this feeling, as PEIs appreciated interacting with them during their training and considered such encounters as valuable training opportunities. I wonder if this exemption arises because of the perceived higher professional status which doctors usually have (Carpenter 1995). Ledger and Kilminster (2015) describe this as the hierarchy of interactions, where in their study they found that many students considered themselves learning only when interacting with more senior staff.

While the majority of the PEIs showed a rigid understanding about who should be responsible for their training, one participant, Linda, indicated that her interactions with different people –with both medical and non-medical backgrounds- provided her with excellent training opportunities (see Sections 5.1.1 and 5.2.3). This again brings to attention the importance of promoting flexibility among new graduates to enable them to benefit from all interactions which occur in the workplace.

It was interesting to note that the sense of belonging seemed important to some participants despite the non-existence of that group in reality. That is to say that while PEIs were able to articulate the criteria for patient educator professionals, there was not necessarily such a community and in many

instances this was based on assumptions which they had made in regard to their profession. Wenger (2004) refers to this as an imagination mode of belonging, which is defined as “*constructing an image of ourselves, of our communities, and of the world, in order to orient ourselves, to reflect on our situation, and to explore possibilities*” (p78).

However, the feeling of belonging has an upside. PEIs who expressed a strong feeling of belonging usually described their pride in being part of that community and happiness at seeing their profession recognised, and expressed enthusiasm, passion and personal investment. This reminded me of the findings of Ledger (2010), who reported that music therapists showed high levels of energy and enthusiasm, which she considered a way of conveying the importance of their role to other professionals in the field. Looking at the stories of my study participants, many state that their role as patient educator is valuable and important but that their profession is underestimated and not given the value which it should be given. These PEIs felt that they needed to work hard “*to uplift the name of health educators*”, as one of the participants described it. Coming from the same profession and being motivated by similar reasons to conduct my doctoral research, I tend to believe that PEIs were motivated by the lack of understanding of their role.

Finally, the last aspect of belonging was working with peers. PEIs seemed to mostly appreciate being and working with peers and found it encouraging and a source of support. Several PEIs showed that being in a group of peers made them more excited to work. One PEI also described how being among other colleagues made supervisors’ criticism less personal and more

tolerable. I also noted that working with peers helped PEIs to share their stories, compare their experiences which in some cases led them to seek better training. Working with peers was also considered valuable by nursing and medical graduates in several studies as it helped in decreasing the feeling of loneliness and also presented a way to share and learn from each other (Buddeberg-Fischer *et al.* 2006; Clare and Loon 2003; Saghafi, Hardy and Hillege 2012; Spalding 2000; Turner and Goudreau 2011; Waite 2004).

This section explored the advantages and disadvantages of the identities which PEIs hold during their period of training. The PEIs' identity manifested itself in the way they understood their role and their feeling of belonging to a community. The main advantage of these identities was being enthusiastic and dedicated to learning and practice. However, a disadvantage was shown in the inflexibility which PEIs presented toward activities and interactions, which may limit learning opportunities.

6.1.2.2 Personal epistemologies

PEIs' beliefs about learning seem to play a significant role in the learning process. In section 5.3, I discussed what PEIs considered as valuable learning opportunities. The most obvious perception seen was participants' belief that learning only comes from explicit educational activities, which had been planned specifically for training and supported by guidance and feedback. PEIs appreciated being trained in places which “*give*” medical information and which have someone “*teaching*” them knowledge and skills. The way in which most of the PEIs understood learning seemed to be related to what I have described in Section 2.1.1 as an individual-focused view of learning which focuses on knowledge and skills acquisition. As

pointed out earlier in the chapter, PEIs' understanding of the nature of and approaches to learning (personal epistemologies) influenced their judgement of the activities and interactions, and consequently the way in which they engage, act and learn. The example of Anna, who stated she did not learn except when she was with a preceptor who dragged her to work, shows how this understanding can influence learning (see section 5.3.2). Anna appeared to me as a passive learner who did not learn unless there was someone driving her learning. Another example was seen in Section 5.3.3, where Brooke did not value her engagement in work unless staff members took an active teaching role. This understanding of learning seemed to be particularly problematic when it influenced the way in which learners responded. PEIs described not having explicit education as being ignored and that it reflected staff's lack of interest in teaching. In Section 4.4.2, several examples showed how several PIEs avoided places where they felt teaching was not taking place and look for training alternatives. In the extreme case of Anna, her feeling that she was not receiving proper training led her to avoid work for almost a whole rotation.

Other than this view of learning, some PEIs presented a more social understanding of learning in which they saw their role as more active and influenced by the tasks and interactions available in the particular setting. The most powerful example of that epistemological position was seen in Linda (see Sections 5.1.1 and 5.2.3), who seemed to appreciate different aspects of training and found herself benefitting from all interactions.

I have noticed that PEIs' personal epistemologies were linked to their developing identity. To be explicit, PEIs who conveyed an intern/learner

identity seemed to have a concrete understanding of knowledge and were looking for training which gave them that knowledge. PEIs who did not emphasise their role as learners seemed to be less concerned about the teaching aspect of training and more appreciative of the social aspects of activities and interactions.

The views which Billett discussed in his papers (2006, 2009) and presentation "Learning through practice" (civetPaderborn 2012) seem to align with these findings. Billett places great emphasis on the importance of personal epistemologies of learning and argues that most learning comes through the actions of the learners' themselves, considering these actions to form the basis of their engagement in knowing. Billett describes personal epistemologies as more than just beliefs but rather a way of knowing, engaging and understanding through sensory processes. According to Billett, personal epistemologies are also about the sense of self, the way in which an individual views themselves, the way they look at the world and the way they feel the world is looking at them, which shapes their professional identity. He considers all of this to be important to the quality of their learning and to influence what he calls epistemological acts; which are the way in which individuals observe, imitate, and engage in practice.

However, it is important to note that PEIs' understanding of learning was complex, as some PEIs seemed to represent two different ways of understanding learning within the interview. The findings in Section 5.3.5 show that many PEIs wanted to be formally taught at the beginning of their internship and then leaned toward a more social means of learning as they progressed. In the examples given in that section, PEIs described their

preferred mode of training, which starts with being taught and then includes being involved gradually into practice, initially under supervision and subsequently independently. PEIs reported that going through these stages helped them to gain confidence and develop their own practice approaches. These findings may suggest that discussing stages in learning may help new graduates to understand the social aspects of workplace learning. Billett (2001) suggested a training approach which seemed similar to that which PEIs described. He proposed that a novice worker starts by being involved in simple, peripheral and less accountable activities and moves towards full participation by being gradually involved in more complex and accountable tasks. During the development process, the level of guidance decreases over time as the learner shows readiness to take further responsibilities. While this process is intended to help workers to gain the most from the learning opportunities available in the workplace by making full use of the workplace environment and coworkers, I wonder also whether it can help new graduates in overcoming epistemological shock, and facilitate the transition in understanding the nature of learning in the workplace. For future research, it would be useful to explore this area further to understand how the change in personal epistemologies affects new graduates and how changes occur.

6.2 Personal reflection on learning

As described in Chapter 2, I started my research with an individual-focused understanding of learning. As a result, I was thinking of learning in the workplace in terms of skills acquisition, which led me to look at the literature focusing on the learner, such as the five stage model of skill acquisition

(Dreyfus and Dreyfus 1980) and outcomes of learning such as competency-based education (Sullivan and McIntosh 1996). Reading through the literature and with the advice of my supervisors, I was introduced to the social-contextual view, starting with the work of Lave and Wenger (2003) on situated learning and communities of practice (Wenger 1998). The work of Billett (2001) then broadened my understanding, with the view that considering both aspects is important in order to understand learning.

My social understanding of learning was strengthened as I started my analysis, as I realised how PEIs were influenced by context, interactions and activities. However, when I started looking at the personal epistemologies aspect, I wondered whether that would shift my view from having a social understanding of learning to a more individual-focused one. Then, reading the paper by Billett (2009) entitled “personal epistemologies, work and learning” clarified to me that the concept of personal epistemologies is socially grounded, as it not only encompasses the personal aspect of how individuals view the world but also how these views affect engagement and interactions with social and brute worlds. This resonated with the findings of my study, wherein PEIs’ personal epistemologies affected their interactions with other people and environments and consequently their learning.

6.3 Strengths and limitations of the study

Although I was able to address the research aim and objectives there were a number of unavoidable limitations. First, because of the time limitation, and my position in the UK, interviews were conducted at one point during the PEIs’ internship period. The study could have been stronger if a longitudinal

design had been applied, which would have allowed me to explore the changes in professional identity and personal epistemologies occurring over the period of training and how that influenced the participants' learning.

Second, when planning the research, my intention was to conduct focus groups, hoping that the interactions and exchange of ideas between group members may tease out data that may not appear in a one to one interview. However, this was not possible because the PEIs were spread across distant locations. It was decided that individual interviews were more practical. However, due to my position as an insider researcher where I shared a similar educational background and identity as the participants (Dwyer and Buckle 2009), seemed to give them a feeling of confidence and they provided me with rich, deep information. My previous role as a patient educator helped me in understanding the context and experience of the PEIs and in attending rigorously to reflexivity issues by maintaining transparency and considering of my role and the research context. This allows the readers of my research to assess my interpretation of the findings. My position an insider researcher also facilitated my access to the participants which helped me during the recruitment process. It is possible that my status as a qualified patient educator meant that participants were reluctant to be critical of their university course and internship experience. However, the honesty of their accounts led me to believe that their responses were uncensored.

Third, a potential weakness of the research could be caused by being a first time researcher analysing data in a language that is not spoken by my supervisors. However to enable my supervisor to check the quality of the analysis three transcripts were translated to English and the analysis

process was reviewed with them. When summarising the interviews one of the supervisors compared the translated transcripts to the case summaries and confirmed that the transcripts managed to capture key elements.

To improve the research quality; I have applied a number of quality criteria that were proposed by Yardley (2000) which are; sensitivity to context, commitment, rigour, transparency and coherence, and impact and importance (see Section 3.7) . Sensitivity to the research context was addressed by providing detailed description of; the case under study in Chapter 1 and the previous work and its relation to my research in chapters 2 and 6. In addition showing the complexity and conflict opinions within the data improved the data sensitivity. Social context sensitivity was addressed by maintaining reflexivity and considering my own position from the research and participants. Commitment, rigour, transparency and coherence, were addressed by providing clear descriptions of my philosophical position and the research process in chapter 3, by discussing my decisions with my supervisors and continually documenting my decisions, Finally the impact and importance of the research was considered to not only have an impact on PEIs training in Saudi Arabia but to also inform the wider policy and practice of educational institutions, particularly when introducing a new professional discipline, and also ways to enhance learning in the workplace.

An additional strength in my study was the use of narrative analysis techniques. When conducting the interviews I asked my participants to tell me about their internship experience and gave them the freedom of covering the topics that felt most important to them. I have noted then that PEIs were telling me a story in a chronological order. Therefore when I developed my

analytical approach I was not satisfied with using an approach that broke up these stories and disrupted their flow and I was drawn into using holistic approach that keep the stories intact. Using case summaries helped me to keep the flow of the stories intact and highlighted PEIs different feelings such as their enthusiasm, excitement and disappointments.

Through writing the case summaries it became clear to me that PEIs passion toward their profession and their desire to learn created certain expectations which were not necessarily met. This led me to develop an analysis grid (see Table 3-3) to identify the main aspects of the stories which are PEIs' expectations, experience, emotional responses and personal Actions. Developing this grid was a turning point in my analysis as I was then able to compare PEIs' experiences, and the key issues in each and overall became easier to pinpoint. I would recommend the use of a similar grid in studies where exploring expectations and outcomes is critical.

Keeping a reflective diary and sharing a weekly journal with my supervisors was a very helpful approach during my research. The diary and journal contained my thoughts about the research process as well as my reflection, about the data collection and analysis. The continuous reflection during and after the interviews helped me to realise my influence on the research and how I reached certain interpretations of the data. When I started using coding for analysis the notes helped me to identify the areas that I started to lose in that process which helped me to consider a different analytic approach. In addition, by keeping a record of the progress of my thoughts I was easily able to document and communicate my research process to the readers of this thesis.

Positivist researchers may consider my insider position as a weakness, on the grounds that I was unable to remain objective and this may introduce an element of bias (Merriam *et al.* 2001). However, as I adopted a constructivist paradigm, my position in relation to the research and my awareness of the context were considered as advantages which added richness to the data (Guba and Lincoln 1994; Patton 2002). My insider position provided me with better access to participants and helped in building a feeling of trust, leading to greater openness among participants which enabled me to gain an in depth understanding of their experience. In the research I did not claim objectivity, instead I was inseparable from the research from the beginning, when my experience shaped my research question.

Insider researchers are also criticised for being too close and unable to see the bigger picture (Unluer 2012). To avoid overlooking important aspects of the research, one of my supervisors compared the case summaries to the translated transcripts and confirmed that the summaries managed to capture important aspects of the interviews. Continuous reading and discussions with the supervisory team also helped in broadening my views and understanding the data.

While coming from a similar background may still have led me to overlook some aspects that could be significant to other researchers, I have made it clear to the reader that the findings are based on my interpretations which were explained all through the findings and discussion chapters. Giving a detailed description of the context, my personal perspective and background and providing lengthy quotes and access to the case summaries gives

readers a chance to interpret the findings in their own way. It is also worth noting that my findings were supported by literature and the discussion chapter shows how the findings fit within the wider literature.

6.4 Contribution to research knowledge

This research mainly aimed to explore PEIs' experience of learning during internship with the intention of informing improvements in internship learning. As discussed in Chapter 2, most of the existing literature on newly graduated health practitioner training focuses on graduates from well-established professions, and mainly on doctors and nurses. What is significant about this research is that it is the first to explore the experience of newly graduated patient educators, providing in depth understanding of their learning experience.

The insights derived from my research are helpful for not only understanding the experience for patient educators, but also for understanding the experience of others from newly emergent professions and new graduates' transition to the workplace in general.

The findings of the study suggest that there are similarities between the experience of graduates from new professions and well established ones. However, the study suggests that the experience of transition shock can be exacerbated among graduates from new professions, and particularly the sociocultural element of the shock, which results from a lack of formal recognition, role ambiguity, and not being distinguished from other professions.

An important contribution of the study is the introduction of the concept of epistemological shock, which may face new graduates when their learning changes from being provided through formal education to learning through participation and engagement in the workplace. The next chapter will summarise the research findings, discuss the possible implications of the research and provide ideas for future research.

Chapter 7 Conclusion and Implications

This research aimed to explore PEIs' experience of learning during internship by addressing three objectives. The first section of this chapter will outline the main findings of the study and how they address the first two objectives of the research which were; to ascertain PEIs' views on the internship experience and to identify the factors that influence PEIs' learning. The second section of the chapter will provide a set of recommendations which can guide the improvement of PEIs' and other new graduates' training, which was the third objective of this research. The last section of the chapter will provide suggestions for future research in the area.

7.1 Summary of findings

7.1.1 PEIs' internship experience

The first objective of this research was to ascertain the views of PEIs regarding their internship experience. The literature reviewed as part of this research suggests that the period of transition from a university based setting to the workplace environment is a difficult period. The concept of shock introduced by Kramer (1974) and the further work of Duchscher (2009) was useful in understanding the of shock that PEIs experienced. However, being from a newly emerging profession seemed to make the transition shock more evident for PEIs, as they not only faced the usual difficulties which new graduates face but experienced additional challenges resulting from belonging to a new profession in the work force. To be explicit, the sociocultural element of transition shock was significant among those

study participants who found it hard to settle in a workplace when they did not feel that they were formally recognised. This was seen mainly when there was no department for patient education services, no clear description of the patient educator's role and/or no distinction between patient educators and other professionals. Moreover, PEIs experienced an intellectual element of transition shock when they held rigid understandings about the role of patient educators in practice.

Finally, the last issue that was identified as part of transition shock is the epistemological element of the shock, which was related to PEIs' understanding of learning and the challenge they faced when learning in the workplace was different to their former experience of learning in the university. PEIs expected to be "taught" in formal sense rather than learning through practice.

7.1.2 Factors that influence PEIs' learning

The second objective of this research is to identify the factors which influence PEIs' learning. The factors influencing PEIs' learning in this study were categorised as; PEIs' understanding of their role, PEIs' relationships to others, and PEIs' understandings of learning. These findings were later condensed to two key areas of professional identity and personal epistemologies. Participants of the study conveyed two forms of identities which seemed to have an impact on learning, which are the intern/learner and the patient educator. These identities were revealed in their understanding of the role and their feeling of belonging to a community. PEIs who held an intern identity seemed to understand that they were in a learning role and therefore showed enthusiasm and a desire to learn.

However, there was a tendency for PEIs who held an intern identity to be judgemental in terms of the educational value of the work and to avoid work with low perceived educational value. Furthermore, the intern identity seemed to be used by some interns as a shield from challenging and complicated work. At the same time, the feeling of belonging to a group of interns encouraged many PEIs and provided them with a support group.

Most of the PEIs who conveyed the patient educator identity seemed to have a rigid understanding about the role of a patient educator and as a result showed inflexibility in accepting the work assigned to them and in interacting with their co-workers. However, the feeling of belonging to that community seemed to motivate PEIs to work hard and convey the importance of their profession.

Personal epistemologies or individual beliefs about learning were also identified as having an influence on PEIs' learning. As PEIs leave university they look for similar training approaches in the workplace, which means having someone who can provide them with a formal style of training. At an early stage, PEIs indicated that they were as less appreciative of the learning which came from their involvement in practice and of the interactions which happened in the workplace. However, over time, PEIs started to appreciate the social aspect of learning and value their engagement in work more than the formal education provided.

The two factors identified in the study, i.e. professional identity and personal epistemology, seemed to be linked together. That is to say that the development from holding a learner to a professional identity may be accompanied by a change in the personal epistemology.

7.2 Implications and recommendation

The final objective of my research was to provide a set of recommendations which can guide the improvement of PEIs' and other new graduates' training. This section will show how the insights derived from my research could be helpful for educational institutions, workplaces and new graduates.

7.2.1 Understanding Learning

My research showed that the way learning is understood affects how people engage in work, interact with people and learn. Therefore, the first recommendation of my study is in regard to understanding learning.

Educational institutions as well as working/training places play a significant role in helping new graduates to understand learning. Educational institutions need to prepare flexible graduates who are aware that the learning in the work environment will not be as explicit as it is in the university environment and to provide greater exposure to workplace environments and interactions during undergraduate training. The workplace should be mindful that new graduates are used to being "taught" and that they need to be supported in their transition to understand the reality of learning in the workplace. In their systematic review of the literature regarding the effectiveness of strategies to improve newly graduated nurses' transition, Edwards *et al.* (2015) found that as long as the workplace provides a support system to ease the transition, there are always positive outcomes regardless of the approach used. Therefore, workplaces need to understand that new graduates need to feel supported when starting their training and a gradual change to independence can help them in their transition. I also recommend promotion of the awareness of the possibility of

epistemological shock when new graduates enter the workplace.

Workplaces can support new graduates by explaining that the way they learn and practise will change overtime and that most of the learning happens through participation.

7.2.2 Promoting the patient educator's role

Poor recognition of the patient educator role was seen as an obstacle facing new graduates in this research. This poor recognition was a result of the lack of understanding of the role and/or its value, and contributed to the shock which new graduates experienced upon transition as well as to interprofessional conflict. Promoting the patient educator's role is the responsibility of both educational institutions and workplaces. Universities which provide a health education degree should communicate to the public and health care professionals who patient educators are, what their role involves, how their work contributes to the health care team and what it adds to patients' care. In addition, they should make this information available to health care professionals. Workplaces which have already implemented the patient educator role should clarify the responsibilities of patient educators and their role in the multidisciplinary team, to avoid the ambiguity and blurred roles which often lead to conflict. Promoting new roles may also be a need for workplaces introducing any new role.

7.2.3 Maintaining flexibility

Although I have recommended clarifying the patient educator role to minimise transition shock and interprofessional conflict, I also recommend that patient educators and PEIs maintain a degree of flexibility about their roles. My study showed that PEIs who were inflexible with regard to the role

resisted full engagement in practice and did not welcome learning which came from many health professionals. Therefore, it is important that new graduates understand that their role as patient educators is still in a developing phase and that it can be adjustable to the needs of the patients and the workplace. The university's role here is important in preparing students for this flexibility and explaining that the role is broad and changeable and depends on the workplace. In addition it should also collaborate closely with workplaces to ascertain possibilities for practice. This recommendation is likely to be applicable to any emergent profession, and universities preparing students for entering new professions should collaborate with workplaces and at the same time consider full range of possibilities in practice.

7.2.4 Summary of recommendations:

7.2.4.1 Lessons for the university:

- 1- Prepare graduates for different forms of learning and clarifying that training in workplaces is not limited to acquiring knowledge and skills but has a wider implication of becoming a professional.
- 2- Familiarise students with workplace environments by integrating more workplace training during the course of the study.
- 3- Provide graduates with clear definitions of possible roles in practice (i.e. health promotor, patient educator, health educator, community health educator).
- 4- Prepare students to be flexible in regard to the role and in accepting different possibilities of practice.
- 5- Collaborate with workplaces to ascertain possibilities for practice.

7.2.4.2 Lessons for workplaces:

- 1- Prepare transition support programmes for new graduates which consist of orientation and active education followed by gradual involvement in practice.
- 2- Define and promote the role and responsibilities of patient educators to other workers

7.3 Future research directions

Based on my research and the gap identified in the literature search, I have identified several areas for future research. My search of the literature identified a significant gap in studies focusing on the transition of individuals from new, emergent professions to the workplace. My research adds a significant contribution to this area, indicating that the transition shock of those from new professions can be magnified and exacerbated. Further studies on other new professions would be useful to test whether these findings are applicable to graduates entering new professions in general.

In my study, I have identified a new element of transition shock facing new graduates when moving to a new place. Further studies to explore the element of epistemological shock are needed to investigate whether this shock appears in other professions and how it manifests.

As this study has suggested, for the element of epistemological shock, it remains important to further explore how it occurs and how to help students cope with and/or overcome this shock, as well as how to help new graduates to understand the value and practicalities of learning in a different way.

Finally, in my research, I have found that the PEIs' personal epistemologies influenced their learning and that the gradual change from being a dependent learner to an independent practitioner helped their learning and self-confidence. It would be interesting to explore this to understand whether the change in personal epistemologies affects new graduates' learning and to understand how these changes occur. It would be interesting also to explore whether a change in personal epistemology is linked to the development of professional identity. I therefore recommend conducting a longitudinal study which observes changes in personal epistemology over time, and examines how this happens, and how this impacts learning and identity development.

References

- ADAMS, K., S. HEAN, P. STURGIS and J. M. CLARK. 2006. Investigating the factors influencing professional identity of first-year health and social care students. *Learning in Health and Social Care*, **5**(2), pp.55-68.
- ALABADI, F. 2006. *Development of clinical health education center at King Faisal Specialist Hospital and Research Center*. PhD thesis, American University of London.
- ALBADA, A., E. ELBERS and A. VISSER. 2007. Patient education in Western European hospitals: a comparison of the Netherlands, Flanders and England. *Patient Educ Couns*, **66**(1), pp.4-10.
- ALTIER, M. E. and C. A. KRSEK. 2006. Effects of a 1-year residency program on job satisfaction and retention of new graduate nurses. *J Nurses Staff Dev*, **22**(2), pp.70-7.
- ASSAL, J. P. and A. GOLAY. 2001. Patient education in Switzerland: from diabetes to chronic diseases. *Patient Educ Couns*, **44**(1), pp.65-9.
- BAKER, S. R., M. J. ROMERO, C. GEANNETTE and A. PATEL. 2009. The value of the internship for radiation oncology training: results of a survey of current and recent trainees. *Int J Radiat Oncol Biol Phys*, **74**(4), pp.1203-6.
- BARTLETT, E. E. 1995. Cost-benefit analysis of patient education. *Patient Educ Couns*, **26**(1-3), pp.87-91.
- BEARMAN, M., M. LAWSON and A. JONES. 2011. Participation and progression: new medical graduates entering professional practice. *Adv Health Sci Educ Theory Pract*, **16**(5), pp.627-42.
- BEECROFT, P. C., L. KUNZMAN and C. KROZEK. 2001. RN internship: outcomes of a one-year pilot program. *J Nurs Adm*, **31**(12), pp.575-82.
- BENNER, P. 2004. Using the Dreyfus Model of Skill Acquisition to Describe and Interpret Skill Acquisition and Clinical Judgment in Nursing Practice and Education *Bulletin of Science Technology Society* **24**(3), pp.188-199
- BENNETT, M. J. 1998. Transition Shock: Putting Culture Shock in Perspective. In: M. J. BENNETT, ed. *Basic concepts of intercultural communication : selected readings*. Yarmouth, Me.: Intercultural Press, pp.215-224.
- BERRIDGE, E. J., D. FREETH, J. SHARPE and C. M. ROBERTS. 2007. Bridging the gap: supporting the transition from medical student to practising doctor--a two-week preparation programme after graduation. *Med Teach*, **29**(2-3), pp.119-27.
- BEYEA, S. C., L. K. VON REYN and M. J. SLATTERY. 2007. A nurse residency program for competency development using human patient simulation. *J Nurses Staff Dev*, **23**(2), pp.77-82.
- BILLET, S. 2001. *Learning in the workplace : strategies for effective practice*. Crows Nest, NSW: Allen & Unwin.
- BILLET, S. 2006. Relational Interdependence Between Social and Individual Agency in Work and Working Life. *Mind, Culture, and Activity*, **13**(1), pp.53-69.

- BILLET, S. 2009. Personal epistemologies, work and learning. *Educational Research Review*, **4**(3), pp.210-219.
- BLOOM, J. 2013. An ecology of mind: teaching – learning complex systems. *Kybernetes*, **42**(9/10), pp.1346-1353.
- BOWLING, A. 2009. *Research methods in health : investigating health and health services*. 3rd ed. ed. Maidenhead: Open University Press.
- BRENNAN, N., O. CORRIGAN, J. ALLARD, J. ARCHER, R. BARNES, A. BLEAKLEY, T. COLLETT and S. R. DE BERE. 2010. The transition from medical student to junior doctor: today's experiences of Tomorrow's Doctors. *Med Educ*, **44**(5), pp.449-58.
- BRIDGES, J. and J. MEYER. 2007. Policy on new workforce roles: a discussion paper. *Int J Nurs Stud*, **44**(4), pp.635-44.
- BROWN, B., P. CRAWFORD and J. DARONGKAMAS. 2000. Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health Soc Care Community*, **8**(6), pp.425-435.
- BROWN, J., T. CHAPMAN and D. GRAHAM. 2007. Becoming a new doctor: a learning or survival exercise? *Med Educ*, **41**(7), pp.653-60.
- BRYMAN, A. 2008. *Social research methods*. 3rd ed. ed. Oxford: Oxford University Press.
- BUDDEBERG-FISCHER, B., R. KLAGHOFER, I. ZIVANOVIC, E. VETSCH and C. BUDDEBERG. 2006. Institutional conditions and individual experiences in the career-entry period of Swiss medical residents--a qualitative study. *Swiss Med Wkly*, **136**(1-2), pp.26-32.
- CAMERON, S., M. CLUBB and C. MCBEATH. 2000. Training to become a general practice nurse. *Community Nurse*, **6**(1), pp.15-6.
- CANTILLON, P. and M. MACDERMOTT. 2008. Does responsibility drive learning? Lessons from intern rotations in general practice. *Medical Teacher*, **30**(3), pp.254-259.
- CARAHER, M. 1998. Patient education and health promotion: clinical health promotion--the conceptual link. *Patient Educ Couns*, **33**(1), pp.49-58.
- CARDOSO, I., P. BATISTA and A. GRAÇA. 2014. Professional Identity in Analysis: A Systematic Review of the Literature. *The Open Sports Science Journal*, **7**, pp.83-97.
- CARPENTER, J. 1995. Doctors and nurses: stereotypes and stereotype change in interprofessional education. *Journal of interprofessional care*, **9**(2), pp.151-161.
- CBAHI. 2005. *National hospitals' standards* Riyadh: Central Board of Accreditation for Healthcare Institutions.
- CBAHI. 2013. *CBAHI Standards Field Review: Patient and Family Rights (PFR)* [online]. [Accessed 14/07/2015]. Available from: <http://www.cbahi.org/newfieldreview/ReViewStandard.aspx?titleSerial=14&titleText=New+CBAHI+Hospital+Standards&GuestSerial=>.
- CEVETPADERBORN. 2012. *Keynote Prof. Dr. Stephen Billett - Griffith University Australia - Learning through practice* [online]. [Accessed 25 July 2015]. Available from: <https://www.youtube.com/watch?v=dh7F11oJpuo>.
- CHAN, K. W. and R. G. ELLIOTT. 2004. Relational analysis of personal epistemology and conceptions about teaching and learning. *Teaching and Teacher Education*, **20**(8), pp.817-831.

- CHANG, E. and J. DALY. 2012. Managing the transition from student to graduate nurse. *In: E. CHANG and J. DALY, eds. Transitions in Nursing: Preparing for Professional Practice*. 3 ed. Australia: Libby Houston.
- CHASE, S. E. 2011. Narrative inquiry: still a field in the making. *In: N. K. DENZIN and Y. S. LINCOLN, eds. The Sage handbook of qualitative research*. 4th ed. ed. Thousand Oaks: Sage.
- CLARE, J. and A. V. LOON. 2003. Best practice principles for the transition from student to registered nurse. *Collegian*, **10**(4), pp.25-31.
- CORBIN, J. M., A. L. STRAUSS and A. L. B. O. Q. R. STRAUSS. 2008. *Basics of qualitative research : techniques and procedures for developing grounded theory*. 3rd ed. ed. Thousand Oaks, Calif.: Sage Publications, Inc.
- CRESWELL, J. W. 1998. *Qualitative inquiry and research design : choosing among five traditions*. Thousand Oaks, Calif. ; London: Sage Publications.
- CUMMINGS, G. G., K. FRASER and D. S. TARLIER. 2003. Implementing advanced nurse practitioner roles in acute care - An evaluation of organizational change. *Journal of Nursing Administration*, **33**(3), pp.139-145.
- D'ABATE, C. P., M. A. YOUNDT and K. E. WENZEL. 2009. Making the Most of an Internship: An Empirical Study of Internship Satisfaction. *Academy of Management Learning & Education*, **8**(4), pp.527-539.
- DALEY, B. J. 1999. Novice to expert: An exploration of how professionals learn. *Adult Education Quarterly*, **49**(4), pp.133-147.
- DAVIES, K., K. HARRISON, D. L. CLOUDER, M. GILCHRIST, L. MCFARLAND and J. EARLAND. 2011. Making the transition from physiotherapy student to interprofessional team member. *Physiotherapy*, **97**(2), pp.139-44.
- DECCACHE, A. and I. AUJOULAT. 2001. A European perspective: common developments, differences and challenges in patient education. *Patient Education and Counseling*, **44**(1), pp.7-14.
- DEKETELAERE, A., G. KELCHTERMANS, E. STRUYF and P. DE LEYN. 2006. Disentangling clinical learning experiences: an exploratory study on the dynamic tensions in internship. *Med Educ*, **40**(9), pp.908-15.
- DELANEY, C. 2003. Walking a fine line: graduate nurses' transition experiences during orientation. *J Nurs Educ*, **42**(10), pp.437-43.
- DENZIN, N. K. and Y. S. LINCOLN. 2008. *The landscape of qualitative research*. 3rd ed. ed. London: SAGE.
- DORNAN, T., H. BOSHUIZEN, N. KING and A. SCHERPBIER. 2007. Experience-based learning: a model linking the processes and outcomes of medical students' workplace learning. *Medical Education*, **41**(1), pp.84-91.
- DREYFUS, S. E. 2004. The Five-Stage Model of Adult Skill Acquisition. *Bulletin of Science Technology & Society*, **24**(3), pp.177-181.
- DREYFUS, S. E. and H. L. DREYFUS. 1980. *A Five-Stage Model of the Mental Activities Involved in Direct Skill Acquisition*. (ORC-80-2). Berkley: Operations Research Center, University of California.

- DUCHSCHER, J. E. 2009. Transition shock: the initial stage of role adaptation for newly graduated registered nurses. *J Adv Nurs*, **65**(5), pp.1103-13.
- DUCHSCHER, J. E. and L. S. COWIN. 2004. The experience of marginalization in new nursing graduates. *Nurs Outlook*, **52**(6), pp.289-96.
- DWYER, S. C. and J. L. BUCKLE. 2009. The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, **8**(1), pp.54-63.
- EDWARDS, D., C. HAWKER, J. CARRIER and C. REES. 2015. A systematic review of the effectiveness of strategies and interventions to improve the transition from student to newly qualified nurse. *Int J Nurs Stud*.
- ELLIOTT, J. 2005. *Using narrative in social research : qualitative and quantitative approaches*. London ; Thousand Oaks: SAGE.
- EVASHWICK, C. J., J. W. BEGUN and J. R. FINNEGAN. 2013. Public Health as a Distinct Profession: Has It Arrived? *Journal of Public Health Management and Practice*, **19**(5), pp.412-419.
- FENWICK, T. 2008. Understanding relations of individual collective learning in work: A review of research. *Management Learning*, **39**(3), pp.227-243.
- FONTANA, A. and J. H. FREY. 2005. The interview: from neutral stance to political involvement. In: N. K. DENZIN and Y. S. LINCOLN, eds. *The SAGE handbook of qualitative research*. 3rd ed. ed. Thousand Oaks ; London: Sage Publications.
- FOURNIER, C., D. MISCHLICH, J. F. D'IVERNOS, B. SANDRIN-BERTHON and J. MENARD. 2001. *Towards promotion, structuring and acknowledgement of patient education activities in France*. Patient Education and Counseling. 44 (1) (pp 29-34), 2001. Date of Publication: 2001.
- FULLER, A. and L. UNWIN. 2006. Expansive and restrictive learning environments. In: K. EVANS, P. HODKINSON, H. RAINBIRD and L. UNWIN, eds. *Improving workplace learning*. London: Routledge.
- GALLAIS, T. L. 2008. Wherever I go there I am: reflections on reflexivity and the research stance. *CREP*, **9**(2), pp.145-155.
- GIBBS, G. 2007. Analyzing qualitative data. *The Sage qualitative research kit*. London: SAGE.
- GOODE, C. J., M. R. LYNN, C. KRSEK and G. D. BEDNASH. 2009. Nurse residency programs: an essential requirement for nursing. *Nurs Econ*, **27**(3), pp.142-7, 159; quiz 148.
- GROENE, O., J. ALONSO and N. KLAZINGA. 2010. Development and validation of the WHO self-assessment tool for health promotion in hospitals: results of a study in 38 hospitals in eight countries. *Health Promotion International*, **25**(2), pp.221-229.
- GUBA, E. and Y. LINCOLN. 1994. competing paradigms in qualitative research. In: N. K. DENZIN and Y. S. LINCOLN, eds. *The handbook of qualitative research*. Thousand Oaks, Calif. ; London: Sage.
- HAGER, P. 2011. Theories of Workplace Learning. In: M. MALLOCH, L. CAIRNS, K. EVANS and B. N. O'CONNOR, eds. *The SAGE Handbook of Workplace Learning*. London: SAGE, p.17.

- HAGER, P. and P. HODKINSON. 2009. Moving beyond the metaphor of transfer of learning. *British Educational Research Journal*, **35**(4), pp.619-638.
- HALL, P. 2005. Interprofessional teamwork: professional cultures as barriers. *J Interprof Care*, **19 Suppl 1**, pp.188-96.
- HAMMERSLEY, M. 2007. The issue of quality in qualitative research. *International Journal of Research & Method in Education*, **30**(3), pp.287-305.
- HARM, T. 2001. Patient education in Estonia. *Patient Educ Couns*, **44**(1), pp.75-8.
- HARTMANN, R. A. and M. S. KOCHAR. 1994. The provision of patient and family education. *Patient Educ Couns*, **24**(2), pp.101-8.
- HAWTHORNE, K., Y. ROBLES, R. CANNINGS-JOHN and A. G. EDWARDS. 2008. Culturally appropriate health education for type 2 diabetes mellitus in ethnic minority groups. *Cochrane Database Syst Rev*, (3), pCD006424.
- HOBMAN, E. V. and P. BORDIA. 2006. The role of team identification in the dissimilarity-conflict relationship. *Group Processes & Intergroup Relations*, **9**(4), pp.483-507.
- HOFER, B. K. and P. R. PINTRICH. 1997. The development of epistemological theories: Beliefs about knowledge and knowing and their relation to learning. *Review of Educational Research*, **67**(1), pp.88-140.
- HOLLOWAY, I. and S. WHEELER. 2010. *Qualitative research in nursing and healthcare*. 3rd ed. Oxford: Wiley-Blackwell.
- HOVING, C., A. VISSER, P. D. MULLEN and B. VAN DEN BORNE. 2010. A history of patient education by health professionals in Europe and North America: from authority to shared decision making education. *Patient Educ Couns*, **78**(3), pp.275-81.
- ILLERIS, K. 2011. Workplaces and Learning *In*: M. MALLOCH, L. CARINS, K. EVANS and B. N. O'CONNOR, eds. *The Sage Handbook of Workplace Learning* Los Angeles, London, New Delhi, Singapore, Washington: Sage.
- JCIA. 2007. *Joint Commission International Accreditation Standards for Hospitals 3rd Edition: Patient and Family Rights (PFR)*. Joint Commission International.
- JCIA. 2008. *Millennium and JCI Patient and Family Education Accreditation Standards*. Joint Commission International.
- KELLER, S. and H. BASLER. 2001. Implications of structural deficits for patient education in Germany. *Patient Educ Couns*, **44**(1), pp.35-41.
- KENDALL, R. 1980. Internship Practices in Public-Relations. *Public Relations Review*, **6**(2), pp.30-37.
- KHAN, F. 2011. King Fahd Hospital seeks international accreditation *The Saudi Gazette*
- KILMINSTER, S., M. ZUKAS, N. QUINTON and T. ROBERTS. 2010. Learning practice? Exploring the links between transitions and medical performance. *J Health Organ Manag*, **24**(6), pp.556-70.
- KILMINSTER, S., M. ZUKAS, N. QUINTON and T. ROBERTS. 2011. Preparedness is not enough: understanding transitions as critically intensive learning periods. *Med Educ*, **45**(10), pp.1006-15.

- KOLB, A. and D. A. KOLB. 2009. Experiential Learning Theory: A Dynamic, Holistic Approach to Management Learning, Education and Development. In: S. ARMSTRONG and C. FUKAMI, eds. *The SAGE handbook of management learning, education and development*. London: SAGE.
- KRAMER, M. 1974. *Reality shock; why nurses leave nursing*. Saint Louis,: C. V. Mosby Co.
- KSAU-HS. 2012. *Diabetes Educators Course* [online]. [Accessed 10-01-2012]. Available from: <http://www.ksau-hs.edu.sa/English/Media/Events/Pages/DiabetesEducatorsCourse.aspx>.
- KSU. 2009. *New Student Guide Book Regulations, Instructions, Activities and Services 1430/1431 H*. Riyadh: King Saud University.
- KSU. 2011. *College of Applied Medical Sciences : BSc in Health Education* [online]. [Accessed 06-02-2011]. Available from: <http://colleges.ksu.edu.sa/AppliedMedicalSciences/CommunityHealthSciences/default.aspx>.
- KSU. 2015. *College of Applied Medical Sciences: Graduation Requirements* [online]. [Accessed 14/5/2015]. Available from: <https://cams.ksu.edu.sa/en/students/graduation-requirements>.
- LABOV, W. and J. WALETZKY. 1967. Narrative analysis: oral versions of personal experience. *Essays on the verbal and visual arts* Seattle University of Washington Press
- LAM, T. and L. CHING. 2007. An exploratory study of an internship program: The case of Hong Kong students. *International Journal of Hospitality Management*, **26**(2), pp.336-351.
- LAVE, J. and S. CHAIKLIN. 1993. *Understanding practice : perspectives on activity and context*. Learning in doing. Cambridge ; New York, N.Y.: Cambridge University Press.
- LAVE, J. and E. WENGER. 2003. *Situated learning : legitimate peripheral participation*. Cambridge: Cambridge University Press (Original work published 1991).
- LEDGER, A., J. EDWARDS and M. MORLEY. 2013. A change management perspective on the introduction of music therapy to interprofessional teams. *J Health Organ Manag*, **27**(6), pp.714-32.
- LEDGER, A. and S. KILMINSTER. 2015. Developing understandings of clinical placement learning in three professions: work that is critical to care. *Med Teach*, **37**(4), pp.360-5.
- LEDGER, A. J. 2010. *Am I a founder or am I a fraud? Music therapists' experiences of developing services in healthcare organizations*. PhD thesis, University of Limerick.
- LEE, T., A. FULLER, D. ASHTON, P. BUTLER, A. FELSTEAD, L. UNWIN and S. WALTERS. 2004. Workplace learning: Main themes & perspectives. *Learning as work research paper*, (2).
- LEVINE, R. B., P. HAIDET, D. E. KERN, B. W. BEASLEY, L. BENSINGER, D. W. BRADY, T. GRESS, J. HUGHES, A. MARWAHA, J. NELSON and S. M. WRIGHT. 2006. Personal growth during internship: a qualitative analysis of interns' responses to key questions. *J Gen Intern Med*, **21**(6), pp.564-9.
- LINCOLN, Y. S. and E. G. GUBA. 1985. *Naturalistic inquiry*. Beverly Hills, Calif.: Sage Publications.

- LINDBLAD, E., E. B. HALLMAN, C. GILLSJO, U. LINDBLAD and L. FAGERSTROM. 2010. Experiences of the new role of advanced practice nurses in Swedish primary health care--a qualitative study. *Int J Nurs Pract*, **16**(1), pp.69-74.
- LINGARD, L., R. REZNICK, I. DEVITO and S. ESPIN. 2002. Forming professional identities on the health care team: discursive constructions of the 'other' in the operating room. *Med Educ*, **36**(8), pp.728-34.
- LIVINGOOD, W. C. and M. E. AULD. 2001. The credentialing of a population-based health profession: lessons learned from health education certification. *J Public Health Manag Pract*, **7**(4), pp.38-45.
- LOPEZ, G. I., M. FIGUEROA, S. E. CONNOR and S. L. MALISKI. 2008. Translation barriers in conducting qualitative research with Spanish speakers. *Qual Health Res*, **18**(12), pp.1729-37.
- LORIG, K. 2001. *Patient education : a practical approach*. 3rd ed. Thousand Oaks, Calif. ; London: Sage Publications.
- LORTIE, D. C. 1966. Professional socialisation. In: H. M. VOLLMER and D. L. MILLS, eds. *Professionalization*. Englewood Cliffs: Prentice-Hall, pp.98-101.
- MAXWELL, J. A. 2013. *Qualitative research design : an interactive approach*. Applied social research methods. 3rd ed. Thousand Oaks, Calif. ; London: SAGE Publications.
- MAYS, N. and C. POPE. 2000. Qualitative research in health care. Assessing quality in qualitative research. *BMJ*, **320**(7226), pp.50-2.
- MCELHINNEY, R. 2008. *Professional identity development : a grounded theory study of clinical psychology trainees*. thesis, University of Edinburgh.
- MCKENNA, L. G. and C. GREEN. 2004. Experiences and learning during a graduate nurse program: an examination using a focus group approach. *Nurse Educ Pract*, **4**(4), pp.258-63.
- MCLAUGHLIN, D. F., D. SINES and A. LONG. 2008. An investigation into the aspirations and experiences of newly appointed dual diagnosis workers. *Journal of Psychiatric and Mental Health Nursing*, **15**(4), pp.296-305.
- MERCER, J. 2007. The challenges of insider research in educational institutions: wielding a double-edged sword and resolving delicate dilemmas. *Oxford Review of Education*, **33**(1), pp.1-17.
- MERKLE, F., T. S. RITSEMA, S. BAUER and L. KUILMAN. 2011. The physician assistant: Shifting the Paradigm of European medical practice? *HSR Proc Intensive Care Cardiovasc Anesth*, **3**(4), pp.255-62.
- MERRIAM, S. B., J. JOHNSON-BAILEY, M.-Y. LEE, Y. KEE, G. NTSEANE and M. MUHAMAD. 2001. Power and positionality: negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education*, **20**(5), pp.405-416.
- MILES, M. B. and A. M. HUBERMAN. 1994. *Qualitative data analysis : an expanded sourcebook*. 2nd ed. ed. Thousand Oaks, Calif. ; London: Sage.
- MIS, C. C., I. TRUCCOLO, V. RAVAIOLI, S. COCCHI, L. GANGERI, P. MOSCONI, C. DRACE, L. POMICINO, A. PARADISO and P. DE PAOLI. 2015. Making patient centered care a reality: a survey of

- patient educational programs in Italian Cancer Research and Care Institutes. *Bmc Health Services Research*, **15**.
- MONACH, J. 2013. Developments in infertility counselling and its accreditation. *Hum Fertil (Camb)*, **16**(1), pp.68-72.
- MORGAN, D. L. 1998. *The focus group guidebook*. Thousand Oaks, Calif. ; London: SAGE.
- MORLEY, M. 2009. An evaluation of a preceptorship programme for newly qualified occupational therapists. *British Journal of Occupational Therapy*, **72**(9), pp.384-392.
- MORRIS, C. and D. BALNEY. 2014. Work-based learning. In: T. SWANWICK, ed. *Understanding medical education : evidence, theory and practice*. Oxford: Wiley-Blackwell.
- NCHEC. 2015. *Health Education Profession* [online]. [Accessed 12 June 2015]. Available from: <http://www.nchec.org/profession>.
- NEWTON, J. M. and L. MCKENNA. 2007. The transitional journey through the graduate year: A focus group study. *International Journal of Nursing Studies*, **44**(7), pp.1231-1237.
- O'SHEA, M. and B. KELLY. 2007. The lived experiences of newly qualified nurses on clinical placement during the first six months following registration in the Republic of Ireland. *J Clin Nurs*, **16**(8), pp.1534-42.
- OWENS, D. L., M. A. TURJANICA, M. W. SCANION, A. E. SANDHUSEN, M. WILLIAMSON, C. HEBERT and L. FACTEAU. 2001. New graduate RN internship program: a collaborative approach for system-wide integration. *J Nurses Staff Dev*, **17**(3), pp.144-50.
- Oxford Arabic dictionary*. 2014. Oxford: Oxford University Press
- PATTON, M. Q. 2002. *Qualitative research & evaluation methods*. 3rd ed. ed. Thousand Oaks, Calif. ; London: Sage.
- PNU. 2015. *College Of Health and Rehabilitation Sciences: Academic Programs and Degrees* [online]. [Accessed 13-08-2015]. Available from: <http://www.pnu.edu.sa/en/Faculties/Health-Rehabilitation/Pages/Programs-and-Degrees.aspx>.
- POLKINGHORNE, D. E. 1995. Narrative configuration in qualitative analysis. *International Journal of Qualitative Studies in Education*, **8**(1), pp.5-23.
- RAMEZANLI, S. and Z. BADIYEPEYMAIE JAHROMI. 2015. Iranian Nurses' Views on Barriers and Facilitators in Patient Education: A Cross-Sectional Study. *Glob J Health Sci*, **7**(5), p43362.
- RANKIN, S. H. and K. D. STALLINGS. 2001. *Patient education : principles & practices*. 4th ed. Philadelphia, PA: Lippincott.
- RIESSMAN, C. K. 2008. *Narrative methods for the human sciences*. London: SAGE.
- ROSENQVIST, U. 2001. Patient education - new trends in Sweden. *Patient Education and Counseling*, **44**(1), pp.55-58.
- ROSS, N., J. PARLE, P. BEGG and D. KUHN. 2012. The case for the physician assistant. *Clin Med*, **12**(3), pp.200-6.
- ROTER, D. L., R. STASHEFSKY-MARGALIT and R. RUDD. 2001. Current perspectives on patient education in the US. *Patient Education and Counseling*, **44**(1), pp.79-86.
- RUEDA, S., L. Y. PARK-WYLLIE, A. M. BAYOUMI, A. M. TYNAN, T. A. ANTONIOU, S. B. ROURKE and R. H. GLAZIER. 2006. Patient support and education for promoting adherence to highly active

- antiretroviral therapy for HIV/AIDS. *Cochrane Database Syst Rev*, (3), pCD001442.
- SAGHAFI, F., J. HARDY and S. HILLEGE. 2012. New graduate nurses' experiences of interactions in the critical care unit. *Contemporary Nurse*, **42**(1), pp.20-27.
- SCHOESSLER, M. and M. WALDO. 2006. The first 18 months in practice: a developmental transition model for the newly graduated nurse. *J Nurses Staff Dev*, **22**(2), pp.47-52; quiz 53-4.
- SCHOMMER, M. 1994. An emerging conceptualization of epistemological beliefs and their role in learning. In: R. GARNER and P. A. ALEXANDER, eds. *Beliefs about texts and instruction with text*. Hillsdale, N.J. ; Hove: L. Erlbaum.
- SCHÖN, D. A. 1995. *The reflective practitioner : how professionals think in action*. Aldershot: Arena (Original work published 1983).
- SEAH, C. H., L. MACKENZIE and J. GAMBLE. 2011. Transition of graduates of the Master of Occupational Therapy to practice. *Australian Occupational Therapy Journal*, **58**(2), pp.103-110.
- SFARD, A. 1998. On two metaphors for learning and the dangers of choosing just one *Educational researcher*, **27**(4), pp.4-13.
- SHEEHAN, D., T. J. WILKINSON and S. BILLETT. 2005. Interns' participation and learning in clinical environments in a New Zealand hospital. *Acad Med*, **80**(3), pp.302-8.
- SILVERMAN, D. 2010. *Doing qualitative research : a practical handbook*. 3rd ed. ed. London: SAGE.
- SKELTON, A. 2001. Evolution not revolution? The struggle for the recognition and development of patient education in the UK. *Patient Education and Counseling*, **44**(1), pp.23-27.
- SMITH, R. A. and S. PILLING. 2007. Allied health graduate program - supporting the transition from student to professional in an interdisciplinary program. *J Interprof Care*, **21**(3), pp.265-76.
- SPALDING, N. 2000. The skill acquisition of two newly qualified occupational therapists. *British Journal of Occupational Therapy*, **63**(8), pp.389-395.
- SPOUSE, J. 2001. Bridging theory and practice in the supervisory relationship: a sociocultural perspective. *Journal of Advanced Nursing*, **33**(4), pp.512-522.
- STACEY, G. and P. HARDY. 2011. Challenging the shock of reality through digital storytelling. *Nurse Education in Practice*, **11**(2), pp.159-64.
- STAKE, R. E. 1995. *The art of case study research*. Thousand Oaks ; London: Sage Publications.
- STAKE, R. E. 2008. Qualitative case studies. In: N. K. DENZIN and Y. S. LINCOLN, eds. *Strategies of qualitative inquiry*. London: SAGE.
- STANMORE, E., S. ORMROD and H. WATERMAN. 2006. New roles in rehabilitation--the implications for nurses and other professionals. *J Eval Clin Pract*, **12**(6), pp.656-64.
- STRAUSS, A. L. and J. M. CORBIN. 1990. *Basics of qualitative research : grounded theory procedures and techniques*. Newbury Park, Calif.: Sage Publications.
- SULLIVAN, R. and N. MCINTOSH. 1996. The Competency Based Approach to Training. *Medical Journal of Indonesia*, **5**(2), pp.95-8.

- TEIJLINGEN, E. R. V. and V. HUNDLEY. 2001. The importance of pilot studies. *Social Research Update: University of Surrey*, (35).
- THOMKA, L. A. 2001. *Graduate nurses' experiences of interactions with professional nursing staff during transition to the professional role*. *Journal of continuing education in nursing*. 32 (1) (pp 15-19), 2001. Date of Publication: 2001 Jan-Feb.
- TRYSSENAAR, J. and J. PERKINS. 2001. From student to therapist: exploring the first year of practice. *Am J Occup Ther*, **55**(1), pp.19-27.
- TURNER, N. and J. GOUDREAU. 2011. From student to emergency nurse: a qualitative study of an educational support seminar. *J Nurses Staff Dev*, **27**(5), pp.210-5.
- UNLUER, S. 2012. Being an Insider Researcher While Conducting Case Study Research. *The Qualitative Report*, **17**, pp.1-14.
- UNWIN, L., N. I. O. A. C. EDUCATION, A. FELSTEAD and A. FULLER. 2007. *Learning at work: towards more 'expansive' opportunities: paper prepared for the NIACE Commission of Inquiry into 'The Future for Lifelong Learning'*. Leicester: NIACE.
- VICTOR, S. 2009. Telling tales: A review of C. K. Riessman's Narrative Methods for the Human Sciences. *The Weekly Qualitative Report*, **2**(29), pp.172-176.
- WAITE, R. 2004. Psychiatric Nurses: Transitioning from Student to Advance Beginner RN. *Journal of the American Psychiatric Nurses Association*, **10**(4), pp.173-180.
- WATT, D. 2007. On Becoming a Qualitative Researcher: The Value of Reflexivity. *Qualitative Report*, **12**(1), pp.82-101.
- WENGER, E. 1998. *Communities of practice : learning, meaning, and identity*. Learning in doing. Cambridge, U.K. ; New York, N.Y.: Cambridge University Press.
- WENGER, E. 2004. Communities of practice and social learning systems. In: K. STARKEY, S. TEMPEST and A. MCKINLAY, eds. *How organizations learn : managing the search for knowledge*. 2nd ed. ed. London: Thomson.
- WENGER, E. 2010. Communities of Practice and Social Learning Systems: the Career of a Concept (Reprinted). *Social Learning Systems and Communities of Practice*, pp.179-198.
- WHO. 1998. *Therapeutic patient education : continuing education programmes for health care providers in the field of prevention of chronic diseases*. Copenhagen: World Health Organization Regional Office for Europe.
- WILLIAMS, C. 2010. Understanding the essential elements of work-based learning and its relevance to everyday clinical practice. *J Nurs Manag*, **18**(6), pp.624-32.
- WOLCOTT, H. F. 1994. *Transforming qualitative data : description, analysis, and interpretation*. Thousand Oaks, Calif. ; London: Sage.
- YARDLEY, L. 2000. Dilemmas in qualitative health research. *Psychology & Health*, **15**(2), pp.215-228.
- YIN, R. K. 2009. *Case study research : design and methods*. 4th ed. ed. London: SAGE.

Appendix A: Example of an electronic search using Medline

1.	Therapist*
2.	Therapist*
3.	Paramedic*
4.	physician assistant*
5.	nurse assistant*
6.	dent* assistant*
7.	nurse*
8.	2 or 3 or 4 or 5 or 6 or 7
9.	nonmedical
10.	non-medical
11.	non-professional
12.	nonprofessional
13.	health
14.	medical
15.	Health Care.
16.	Allied Health
17.	9 or 10 or 11 or 12 or 13 or 14 or 15 or 16
18.	Provider*
19.	Assistant*
20.	Professional*
21.	Practitioner*
22.	Specialist*
23.	Worker*
24.	personnel
25.	trainee*
26.	18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 ((nonmedical or non-medical or non-professional or nonprofessional or health or medical or Health Care or Allied Health) adj1 (Provider* or Assistant* or Professional* or Practitioner* or Specialist* or Worker* or personnel or trainee*))
27.	8 or 26
28.	Workplace
29.	Work place
30.	Collaborative
31.	clinical
32.	interaction
33.	inter-action
34.	life long
35.	Organi?ational.
36.	vocation*
37.	participant
38.	informal
39.	Observation*
40.	Social
41.	Multi-Professional
42.	MultiProfessional
43.	Inter-Professional
44.	Interprofessional
45.	Work-Based

46.	WorkBased
47.	Proficienc*
48.	Expertise
49.	Experience
50.	Practice*
51.	Attribute*
52.	Competenc*
53.	Perform*
54.	Skill*
55.	Cooperat*
56.	profession*
57.	staff
58.	method*
59.	graduate*
60.	personnel
61.	job
62.	in-service
63.	in service
64.	employee*
65.	interns*
66.	continu*
67.	career
68.	pathway
69.	interdisciplinary
70.	inter-disciplinary
71.	multidisciplinary
72.	multi-disciplinary
73.	28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72
74.	learning
75.	teaching
76.	training
77.	pedagogy
78.	intervention
79.	program*
80.	74 or 75 or 76 or 77 or 78 or 79
81.	((Workplace or Work place or Collaborative or clinical or interaction or interaction or life long or Organi?ational or vocation* or participant or informal or Observation* or Social or Multi-Professional or MultiProfessional or Inter-Professional or Interprofessional or Work-Based or WorkBased or Proficienc* or Expertise or Experience or Practice* or Attribute* or Competenc* or Perform* or Skill* or Cooperat* or profession* or staff or method* or graduate* or personnel
82.	or job or in-service or in service or employee* or interns* or continu* or career or pathway or interdisciplinary or inter-disciplinary or multidisciplinary or multi-disciplinary) adj2 (learning or teaching or training or pedagogy or intervention or program*))
83.	Interprofessionality
84.	Inter-Professionality

85.	Deliberate Practice
86.	Professionalism
87.	wpl
88.	83 or 84 or 85 or 86 or 87
89.	82 or 88
90.	Transition
91.	becom*
92.	new graduate*
93.	newly graduated
94.	pathway*
95.	newly qualified.
96.	beginn*
97.	novice
98.	shadow*
99.	Preregistration
100.	Pre-registration
101.	Postregistration
102.	Post-registration
103.	Apprentic*
104.	first year
105.	trainee*
106.	interns*
107.	residen*
108.	90 or 91 or 92 or 93 or 94 or 95 or 96 or 97 or 98 or 99 or 100 or 101 or 102 or 103 or 104 or 105 or 106 or 107
109.	27 and 89 and 108

Appendix B: Interview Topic Guide

- Tell me about your internship
- The kind of activities that a patient educator interns get involved in.
- Aspects that have had a great impact.
- Problems encountered:
 - How are they managed?
 - Where to seek help?
- Managing new situation.
- Opinions on the training programme:
 - What helped the most?
 - What does it lack?
- if you were in charge of the training programme what changes would you make

Appendix C: Case summaries

Amber

My first rotation was in institute O. This was one the worst experiences ever, a really bad period. They told us that we would do health promotion campaigns and community education. However, we worked in a shopping mall at night talking women into doing breast cancer screening. They gave us criteria for those who can be screened, for example those who are more 35 years old and from the same city. This was weird, because every woman should learn about breast cancer. In addition, it is not appropriate to stop every woman and ask her about her age. Furthermore, it was during a holiday so there were a lot of people from villages and other cities, and even if they were interested they couldn't have the screening. We spent three months there and that was a very long time for me. I have learned enough about the topic but I didn't gain any experience. This is because they didn't teach us how to deal with the community. They only gave us a lecture about breast cancer. We, the girls, used to have discussions with each other, and used the information which we had gained during our studies to develop our own teaching techniques. They weren't able to educate us because they were not health educators, they were social workers and they didn't have medical information. The only benefit I gained there was from dealing with different types of people. In addition, I didn't like our corner there, because it didn't show who we were. This wasn't the case with other organisations which had their logos and signs to show their identity. We tried with our supervisors to make some changes in our corner to make it more attractive to women, but they refused all our ideas. This unsuccessful experience

made me depressed: especially since I had been very excited about starting my internship training in this department.

Therefore, I decided to go to another city and have a rotation in hospital J. my experience there was fantastic. I was the only one coming from city X so I was the centre of attention. I was trained in many departments; environmental health, schools' health education, diabetes, nephrology, paediatrics, OB/GYN etc. All of the specialists there were educators, not social workers or nurses. At first I was in the environmental health department, where we taught well people about healthy food and restaurants. We would gather people together, talk to them and give them brochures. I have even given lectures by myself. At the beginning I was scared and nervous, but then I loved it. Talking to people was helpful. They listened to me because they wanted to learn.

I then moved to the nutrition department, where I was involved in food inspection, but honestly I didn't like that work. After that I moved to the diabetes education department. I spent the first week there observing to gain information. Then I began practicing under observation. After that I was allowed to cover the clinic by myself. It was nice to feel that someone was depending on me and giving me responsibilities. I was confident because I had read brochures and observed before practicing. Furthermore, I was able to contact the educator when facing something new. Overall, my experience in the diabetes clinic was really nice. I liked that I had direct contact with patients.

After the diabetes, I went to the school education unit, where I participated in giving lectures for schoolchildren. I was surprised because I didn't know that

that was part of the educator's role. However it was a nice experience because I like dealing with people and answering their questions, especially those who are eager to learn.

I was then back to my city where I had my training in hospital C. I spent my three months there in the diabetes clinic with educator Hope. The training there was more thorough than the one I had in hospital J. When we started there, Hope explained to us everything related to diabetes and I asked her about things that I didn't understand. Then we observed for a month before she started asking us to partially participate in patient education. Her training technique is very good because she used to ask us to repeat things to be sure we had memorised it well. I personally like to see and practise, that is better than explaining things, which will be totally forgotten. I used to watch and write notes to read at home, which made people laugh at me. I also used to read about everything. After that training we started seeing patients by ourselves. Besides educating patients I used to answer the clinic's phone, which other girls hesitated to do. That was good for me because doctors learnt my name and referred patients to me. I tried to convince other girls to do the same because small things like this make a difference.

There were also times when I was faced by strange cases and/or questions. At those times I consulted doctors. I used to consult them behind Hope's back because I didn't want to upset her. It's not that I didn't trust her opinion, she has been a diabetes educator for 20 years, but I didn't always agree with her. Therefore, I used to mainly consult doctors. There were also times when I discussed patients' conditions with the other girls, there were four trainees, sharing our experiences and helping each other.

The hard part there was dealing with pregnant women who are usually tired, stubborn and need a lot of effort. However, this was also a very nice and useful experience. Facing an obstacle on a daily bases makes a person learn. The problem was that three months were not enough for such a complicated topic.

My fourth rotation is now in centre E. I don't like the work here because I am energetic and I like to go home thinking about my accomplishments. I don't like to sit for hours with no work. I have been here for two weeks now, waiting for the supervisor to train me, but she keeps postponing. So I am working with the girls who have been here four months. It is all new for me because we can open patients' files and write in them. However, up till now I have just been observing because I don't have enough knowledge to encourage me to open a file yet. Observing the girls is giving me negative energy, because they didn't teach me everything. It would be better to be with a supervisor; it would make me feel that I was learning and benefitting. To support my learning I am reading about new things, even about medications which patients use.

In the whole experience, I found that the most beneficial thing was working with patients in the presence of a specialist who listens, observes, directs and corrects mistakes. The downside is the long hours we spend with no work. I like to work and I don't mind working until night, but I need to be doing something useful. I recommend shortening the training period, because a year is too long and six months is enough. Good training should have a scheduled plan which starts with orientation and then two weeks of

training in each department. This will enable interns to decide their areas of interest when hired.

I love my speciality and I want the health education department to be one of the biggest departments in hospitals. However, they are teaching us that it is not important, which is not true, it is important and it supports doctors' work. However, it is oppressed, there are no standards for us as educators and we are neglected. The only educators who are valued are diabetes educators, because they are needed. Other departments don't feel the need for educators and they don't treat them appropriately. Even official institutes don't treat patient education as an important subject. This negligence and ignorance can frustrate educators and inhibit them from reaching their full potential. However, although the quality of training was influenced by these issues, it didn't inhibit me because I fully understand my role and what I need to do.

Anna

I started my training in hospital I. For the first five days there was a course based on lectures about diabetes. This course was intended for trainees, new employees and patients who wanted more information. In addition to this course we were also required to attend a monthly lecture designed specifically for staff. The lectures were very open and we were able to meet with the doctors who were presenting and ask them about additional medical information if we wanted. I really appreciated this aspect of the training as we learned new things that we didn't study in the usual university courses that we had taken. Not only did the doctors take the time to answer our specific questions but we also had the opportunity to observe them with their patients. We were able to listen to patients' questions and listen to what is important for them in their experience during this observation.

After the first five days we had two weeks of orientation. We attended clinics where we shadowed the doctors and observed how the practice ran, how the doctors talked to their patients, and how to write in patients' files. While observing we took notes and were welcomed to ask questions. It was only after all of this that we started seeing patients under the educators' supervision. After two weeks of supervision we began to see patients alone and the educators would check our work afterward.

The part that I found the most helpful during this supervision was the fact that the educators selected patients that were able to teach and correct us. I found that this really gave me confidence. I was confident of the knowledge I gained through the course and when I faced a new or difficult case I felt very comfortable to ask the doctors for guidance and felt comfortable to ask

educators to assist me in seeing the patients as a result of the comprehensive training I received. Even though this training was during Ramadhan, was interrupted by the Eid break, and I was also newly married I still was very happy because I worked with Dr Steve and his staff was really helpful and happily took their time to answer all the student's questions. –

I then moved to hospital G where Grace was the head of the department. At the beginning of our training we spent a week reading. We read about the hospital's policies and we also read the booklets that were produced by the department. We were required to read about four files a day which I felt is too much. It was a headache, I hated it and didn't gain any benefit from the practice.

After the first week we started a two week course, which is designed for new employees. This course was extensive and it covered many subjects from the anatomy, diseases, and medications and ended with patient education. We were given papers to read and study and we had a test at the end. This programme was really good because we didn't have a background in specific diseases so it was good to learn about them and it was really helpful to have the confidence in this before dealing with patients.

Unfortunately, I failed the test which was really sad for me because I have never failed an exam and I wasn't expecting this failure. However, it motivated me so I study harder during the following weekend and I passed the resit exam. It was after this course that we started visiting patients' rooms with the educators.

The educators taught the patients and explained to us the diseases we were seeing and specific terminology related to these diseases. This was like a

practical revision of the course although we weren't allowed to deal patients there.

We also attended a surgery which I didn't like at all. Perhaps it might be helpful for me as a medical professional, but it will not be of any use for patient education.

One thing I found particularly important in the whole experience was seeing the patients with complications. On the personal level I benefited from this as I started noticing symptoms that I didn't realise I was experiencing before. After speaking to the educators they advised me to see a doctor and as a result I changed some unhealthy behaviours. The entire experience made me more aware of my health and I have even brought my dad for a follow up.

My third rotation was then in the school health units. In there, interns really give a lot of themselves. I used to categorise schools, pick topics that are suitable for the students' ages and arrange the visits. In this rotation I was very independent. I really enjoyed that time because after the lectures the students get to ask questions and their excitement really showed. They made my job feel really important and beneficial. Even the head teachers appreciated my work and gave me gifts and appreciation certificates.

During that rotation I had to do so much reading because I was afraid of being asked things that I don't know. There were many occasions though that I was asked about things that I don't know the answer to and at these times I advised people to ask their GPs.

I was very happy during that time because I felt that I was helping the public. I love working with the community; specifically I like to see healthy people. I

find it very difficult to see sick people. It really affects me. I feel sorry for them and I always end up crying about their situation. It weighs very heavily on me.

My last rotation was at hospital H, this was a very bad period. I didn't benefit at all from this experience and I consider it as total waste of time.

In my first day, I went to the hospital not knowing where to go. I had no idea where to hand in my papers or even sign in. It was stressful I didn't come for the next two days. When I finally returned I was given a training schedule to spend two weeks in each health education clinic. The training in the clinic all depends on the educator. The only reason that I learned so much in one of the clinics I attended was because the educator was strict, put a pressure on me and monitored my attendance. The period I spent with her was really beneficial. I attended doctors' clinics with both her and the rest of the medical team, I observed, I took notes and I felt confident to ask the doctors questions when I needed. But in these situations there was no patient education practiced.

The rest of my training in this hospital was useless and I was absent for most of the period. It was hard for me to find the educators when I was there and there were no proof that I was attending. When I got my certificate I cried out of frustration, because I felt that I didn't learn from a place that is supposed to be so educational.

Even with these frustrations I did learn. I learned that seeing sick people can very stressful, especially at the beginning of my training and as a result of this stress I have improved a little in my own life.

I also had an incident with Grace in hospital G when I was five minutes late and she was very harsh about it so I learned quickly about punctuality. Now, although my job is flexible I am never late. This incident made me realise that punctuality is a very serious matter for me, which is a positive result of the reprimand I received from Grace.

I have learned a lot from the courses. I especially have learned how to search for information, to never keep unanswered questions in your mind and to always ask for the answers.

The problem I felt that there was with the programme was the difficulty of choosing the training places. I wasn't able to train in hospital A, which was very important to me. I also faced difficulties in dealing with patients at times. For example some were inappropriate, asking personal questions and even one asked if he can propose marriage. However, this wasn't a serious issue for me as I was always comfortable and able to deal with them. Lastly, another issue is the short period of training. I don't think a year is enough to learn everything we needed to know. I don't think that I was fully ready for work at the end.

For future trainings I would recommend giving interns courses and then involve them in work initially under supervision before they work independently. I also think it is very important for the university to evaluate the students after completing the programme. The evaluation that is sent from the hospitals is not enough. As I mentioned, I spent 3 months doing nothing at one hospital.

Brooke

I started my training in hospital G, which is one of the highly recommended hospitals because of its training programme. However, when I started I was shocked that for the first two weeks, they did not give us any work to do. Instead they gave us the hospital policies to read. Therefore, we started to look for things to do by ourselves. This could be because the manager who ran the programme had resigned, and the problem is that it all depends on the one person. I don't think it's important to read policies: it is clear anyway. I think it was just a way to keep us busy. I am not sure if they have experience in training interns. We then kept asking them to give us work to do, so they started taking us with them on their daily rounds. During the rounds we observed how they educate patients and what kind of information they give, which was very simple for complicated topics. Then they told us that there was an educational campaign soon, so me and the other two interns got excited and started preparing educational materials and arranging for the campaign. The problem there was that they complained a lot about us to the training and development department and they asked them to give us warning letters. There were times when we came 10 or 15 minutes late and they made it big deal, although we were responsible enough to tell them that we could always make up for the time we had missed. However, when we talked to the department we told them that we were not doing work and that they brought us in for seven or eight, giving us nothing to do and then criticised us for being 10 or 15 minutes late. The training department understood our situation and asked us to file a complaint to protect ourselves from getting a poor evaluation. Then we requested to

stop our training there and for them to transfer us to a different place. We couldn't take being treated like children and the fights anymore.

I then moved to centre J for a month and a half. That place wasn't prepared for health education at all, but it was temporary and I was not in a position to complain. The work there was limited to phone calls and events confirmation. Luckily, during this period there was a school awareness programme, so I got a chance to go to some schools and give lectures, which made me satisfied. I stayed there for five weeks, which is a short period to benefit from, but I still got the chance to be involved in public activity and the schools programme.

After that I started here in hospital A. my experience here is amazing and the department is well established. My training here is supposed to be for four months. During the first two months, there was rotation between all the departments: that was really nice and a different experience for me. In the departments, we observed to learn, we provided education and helped in materials production. After observation they usually ask me do a case study. Although it is not a real case, it is helpful because it makes me look for information. I have also learned from their compassion with patients. They consider patients' background, like age and level of education, and try to speak a language they understand, educate and convince them no matter how different they are. They were not just educators, they were like psychologists, they support and reinforce patients. After completing the two months' rotations, I chose to be in the diabetes clinic as an elective area. Diabetes is very interesting, patient education is tailored to every patient's need. It is very manageable, so you can set a goal and achieve it with the

patient. In diabetes, I started with observation and then I was allowed to take part in education. All my practice was under their supervision because the hospital policy does not give interns the authority to work independently. I have also taken an insulin pump course, it was really useful because it was provided by the original company, it was one to one education covering every single point and at the end I was examined and received a certificate. Another thing I have learned about is carbohydrate counting. I told my preceptor that it's not enough to tell patients not to eat carbohydrates, and I suggested that we prepare a small leaflet explaining the carbohydrates in common food. My preceptor accepted my suggestion, I prepared the leaflet and it is now being printed.

I was asked to give a lecture to nurses and that was scary because they definitely have better knowledge, but they told me that they were from different departments and they had no experience on the topic I was covering. After I did this lecture they told me, 'we have a new challenge for you; give a lecture to doctors'. That was too much, I can't give a lecture to doctors, but they told me that they are not familiar with that area and that it was them who asked for this in-service and they wanted to learn about the topic. I am being challenged every week with something new, it is scary, but once you believe that you can, you will do it, and there is nothing better than that feeling.

A good thing in my training was that in hospital A, whatever I want to learn they give me. I was also lucky at hospital A in that I got to write two articles in a newspaper. My writing skills are OK so they told me to write an article, they read it, liked it and sent it for publishing. It is very good to reach the

public, it is part of public health. Now that they have found that I have good writing skills, they asked me to work with them on the health education magazine. I told them I would love to if they extended my training here. So they sent a request to the head of the department, Holly, asking her to extend my training. She was surprised and didn't like it, she doesn't like to extend anyone's training because people who get a long training period are usually hired. She doesn't want any Saudis to be hired. However her manager Dr Carl sent her an order to extend my stay. Then she conspired with other employees to stop my training; they claimed that I am careless and I sleep at work and she said that they had changed their mind and would not extend my training. Because she was telling lies about me, and considering that the extension decision wasn't hers it was her manager's, I decided to file a complaint. I emailed Carl, explained my situation and brought in witnesses to rebut their accusations.

In general I found the internship period very beneficial. The most beneficial thing is observing and learning about different conditions. To get good training, interns should be exposed to hospital education as well as public health programmes. It helps you to apply your studies and see how it is practiced in real life. The focus is always on patient education and not much attention is given to health education. The variation of areas is very good because it makes you identify your area of interest before being employed.

Emma

When we started our health education degree we were very passionate and excited about it. We knew that there were negatives because people are not aware of the role of health educators: however, we thought after the few years we spent at college the situation would have improved. I then started my internship, which I felt was a new experience. We didn't know what our work would be and it wasn't like our expectations.

I started in the institute O because it is different to hospitals. However, when we started we were shocked that they wanted us for marketing. They wanted women to have breast cancer screening, and they have managed to do so. It was a successful programme but we were in the wrong place. We were supposed to educate people and give lectures in order to learn. I was hoping to at least learn new information, but we didn't teach patients, we didn't learn new information and we didn't benefit. The supervisor there told us that we would not learn, neither there nor in the hospitals.

After three months there I moved to hospital E. in the first two weeks, we were introduced to the department, given a training plan and our role was explained to us. My training there was really nice and I felt satisfied. I have learned everything about the conditions they cover. We had our own department; we wrote in the files and had regular follow up with patients. We were able to ask doctors and nurses about medical details. After that good training, I felt confident enough to work on my own, and I didn't need a supervisor with me. We had our name here: we were involved in a lot of activities and had a new thing every day. We participated in an international awareness day. We were there during Ramadan, so we also prepared a

corner to educate people on how to manage their condition during Ramadan. The health educators there were very interested in teaching us. We visited patients, talked to them and sought doctors' help when needed. We also provided a lecture to staff about the six thinking hats, which was a really good experience. We chose that topic because doctors and nurses don't need medical knowledge from us and that was a topic that they could benefit from. We have also prepared brochures for the patients. A very useful thing that I have learned here is understanding other health professionals' roles. I feel comfortable when I work knowing what my and others' work involves.

After these three months, we went to hospital C. There was no training plan there. We were treated like employees not trainees. They assumed that we knew everything and wanted us to go the departments and educate patients without training or even knowing what to do, and that was because they didn't have actual work to do. They were not following up with us, they didn't care about training. They asked us to prepare a brochure but that wasn't beneficial because I already know how to do it and I used my previous knowledge. We also tried to do bedside education. We went a few times to several departments and then found it useless, so we stopped and stuck with the educator Hope. She is a diabetes coordinator and I think she has a PhD. We spent the first month observing her practice and then started educating patients under her supervision. It was really good and comforting to have her with us because that assured us that we were not making mistakes and if we did she corrected us. The period I spent with her was really good and she gave us very useful information that is helping me even in other hospitals.

Now I am back to hospital E, because I had good training here and I don't want to try a new place and get a shock.

For interns, monitoring is important. Also, I expected to complete my internship knowing more stuff. In a year of training I should have learned at least five topics, but I have only learned two. They should either increase the learning outcomes or reduce the training to six months.

The best thing on the whole about training is when you start to work independently and see the patients by yourself. The worst things were being told at the beginning of my internship that I was not going to get any benefit. This is frustrating, especially when you are excited to start. Also, I didn't like doing work that is not part of our role, which was marketing for the breast screening programme instead of educating people about it. That was shocking and frustrating. Another bad thing was the carelessness of the supervisors.

A good training programme should have a plan, and interns should have clear understating of their role. Also, there should be variety in the topics covered because even specialised educators need to understand. Interns should start by reading about the topic they are learning, observe the educators work, then practice under supervision and finally practice independently.

Jane

At the beginning of our internship, people advised us to go to institute O. They told us that they were focusing on breast cancer. In addition, a representative visited our university and promised us that we'd have a good training programme. However, when we started it was a shock; the place wasn't prepared, it was messy and dusty, they had not planned a training programme and we didn't go on different rotations as promised. We had to spend three months in a shopping mall distributing brochures and promoting breast cancer screening. This training wasn't beneficial at all and when we called the university asking for a change they told us they couldn't help us at all because all the other places were full. I was frustrated and I felt that the five years I'd spent in college was a waste. I regretted studying health education and felt that it would have been better if I had studied something else like radiology or laboratories. At least those people understand their position in hospitals. In contrast, our role is unclear, some hospitals don't recognise us, and some do not have a department for us. That gives me negative feelings. People usually ask us about our role; the problem is that we do a lot of things, we engage in patient education, we participate in public events, we provide education to employees, I explain that to them but they want a precise answer and there is no such thing.

After three months of training we moved to hospital E. in the first week we learned about the department's mission, vision and procedures. In addition we were taught about medical conditions, I felt the attention. In the second week we accompanied an educator on her rounds; she taught us how to read patients' files and we observed her practice and occasionally gave

some education under her supervision. After the second week she gave us a time table and assigned different patients' rooms to each of us. We then took the responsibility for patient education and we were always welcome to approach doctors and nurses for help. We were also asked to do a presentation. That was really good because we felt that we were doing a real job. Furthermore we had our own room.

After three months, we moved to hospital C. When we arrived at the hospital on the first day we couldn't find the department, so we asked staff about it and they told us they didn't know. We then found out that it is not called health education or the health promotion department, instead it is under the media department. That was very disappointing because after all our studies we found out that we are not recognised and we don't even have a clear name in the hospital. In that department we were asked to do things that were not related to our role: some of them were even personal favours. We could not complain because we knew that the university would not do anything about it and we couldn't refuse the work because it could influence our evaluation. We knew that people usually use interns but there was no use in that so we went to educator Hope's clinic to train on diabetes education. Hope started our training by explaining about diabetes, diet, insulin intake and all related matters. We observed her practice and then we started providing patient education, and occasionally without her presence. We really enjoyed that because it made us feel that we had a position and weren't just wasting our time.

After completing my training period at hospital C, I wanted to go back to hospital E because the feeling I get there when opening patients' files is

really good. You feel that you have a status and that the years you spent in schools has paid off. I liked that I was independent and I have worked with different kinds of people.

To improve the training, the university should make some changes. First, they should send letters to hospitals providing clear goals for the training programme. This will minimise the confusion and clarify our role.

Consequently, we can speak up if things go wrong and hospitals can penalise us in cases of negligence. Second, they should follow up with the interns to be sure that they learned what they should have learned, and also to make sure that everybody has got the same amount of training. Third, the internship period should be reduced because the number of graduates is more than the hospitals' capacity. The shorter internship will increase the interns' chance of training in good hospitals. Hospitals should also put together a clear plan for interns; explaining their role, responsibilities and tasks. Interns should understand their role and limits as well as other professionals' roles.

Good training should start with education, explaining to the intern the conditions which she will deal with. After that, an intern should observe and gradually engage in education until she is able to work independently.

Katey

My training started two months after my colleagues. Before starting my first rotation, I arranged for my second rotation training in hospital A, which is known to have the best health education programme in Saudi Arabia.

Therefore, when it came to choosing a place for my first rotation my options were limited. Most of the places were occupied. I applied to hospital B and they told me that they had closed their internship programme. I was then offered a place in hospital D, but I couldn't accept the offer because of the difficulty of transportation.

Consequently I had no option but to start my training in centre J. Although I had had a previous bad experience with this centre, I agreed to go there after they told me that they have changed and that they have a planned training programme. However when we started, we found that the work given to us was volunteers' work. We answered phone calls, translated articles that have never been used and arranged appointments that we weren't allowed to attend. In the centre we didn't deal with patients because they don't actually see patients and we didn't do education because they don't have a health educator. The person who planned our training programme was not an educator but works in human resources. In addition, although we were doing volunteer work, we were treated like employees. Accordingly, we were required to be there from 8 to 4 even if we had nothing to do. Furthermore, regardless of the little work they gave us, they were not happy that we had a lot of free time. Thus, I started working on stuff that I found by myself, such as updating their database. Other than that, we asked the head of the centre, Dr X, to take us with her to the hospital where she

works but she kept procrastinating until we were finished. After a month and a half I felt that I'd had enough and that I couldn't take it anymore. I have seen their work and I have read so many articles that there was nothing more for me to learn. Consequently, I called the university asking them to change my training place but they told me that it was my responsibility to find a new place, which I did. However, when I was about to start in the new place they asked me about the reasons for quitting centre J, so I explained to them. Then someone in this new place leaked the news to centre J's manager who contacted our university to pressure them to keep us with them. Therefore, we stayed there for five months against our will. The problem with this place is not limited to us, as interns and even their employees are continuously changing. In my opinion, this place shouldn't be taking interns anymore, because they have a long way to go before they have a health education programme.

My second rotation is now in hospital A. At the beginning everything was good and in comparison with the first rotation I was very happy. The first two weeks here were for orientation with Zara the coordinator. During these two weeks we had been told that we would be placed in an elective area. It wasn't until two days before the end of the orientation when they chose for us our elective areas. After the orientation I was placed with a new preceptor, Lina, who provided us with very good training and kept us busy at all times. She started our training by allowing us to observe her practice; we visited patients' rooms, she read patients' files with us and explained their conditions and asked us to read more about them. She also involved us in weekly meetings to arrange for an awareness day.

The second period of my training in hospital A was a shock for me; I was hoping that my training in this hospital would compensate for the time I wasted in the first rotation. I believed that this hospital provided the best training. For that period, I was assigned to a preceptor called Olivia. My time with her was not beneficial at all, and it was so different from my training with Lina. Olivia didn't explain anything, didn't give me assignments, or involve me in practice. She didn't know her job, she didn't do her work and she spent most of her time doing personal stuff. At the beginning I asked her to explain things to me, but when she didn't I started teaching myself, following the same approach that Lina used with me. I looked into patients' files, read their diagnosis and treatment plans, and then used my free time to read about new things. However, reading is not the best way to learn and she was supposed to explain stuff. The problem is that Olivia doesn't hold a health education degree, she has a nursing background, which is the case with many health educators here, including the manager Holly: they have different backgrounds and they became health educators either by doing some courses or just by experience. After a month of training with her she sent me to do four weeks' training in four different units and I was then supposed to go back to complete the rest of my training with her.

I started this with one week with Chloe and another with Jessica. Both of these weeks were in outpatient clinics. I didn't like the work there because you just sit in your clinic waiting for patients and when they come you repeat the same instructions over and over again. Maybe when I get hired I would like this comfortable job, but right now I prefer working with inpatients because there you feel that you are an effective member of the health staff.

Then I moved to Sam, who is a health education graduate and she is very good, I felt that she teaches with passion, she kept me busy all the time, she is good with other health professionals, and she does whatever she is asked to. Spending one week with her taught me things I hadn't learned in a whole month. When I started with her, she assessed my knowledge, suggested reading and asked me to write about what I was reading. Then she checked my writing and corrected my mistakes. At the beginning, I started by observing her practice in order to learn. Then she started involving me by giving me tasks that didn't include teaching patients. I printed patients' name sheets, I checked new admissions and I checked lab results. I did all of that by myself because I had done it with other preceptors before. I have also done some work under observation. That was helpful because you feel that you are now doing the work of health educators.

The fourth week is where I am now with Lily in a unit based outside the main hospital. I like the work over here because it is a small place that is not very busy and at the same time my work is with paediatrics, which I love so much. I love working with children because I feel that they and their families need more support. My training here is great, brilliant and Lily (who is also a health education graduate) is very good: she even let me give education by myself. Furthermore, when I ask her for feedback she doesn't just comment on the content of my education but also on my teaching style.

At the beginning of my training with Olivia, I was not planning to complain because I didn't want to repeat the bad scenario that happened in centre J. However, when I saw the difference between my training with these

educators and Olivia I decided to make a complaint because it is my right to have good training and being with Olivia wasn't even my choice.

Therefore, I sent an official documented complaint to the department using the hospital's email; I asked for a change, explained my reasons and listed alternatives. However they didn't respond properly and refused to relocate me. They gave me two options; either to confront Olivia with my claims, or to remain silent and complete a month with her. They also promised me that if I remain silent they will approve my previous request for a training extension and it will be in an area of my choice. When I thought about it, I found that in both conditions I would remain with Olivia, and I also didn't believe their promises of the training extension because I have heard from other girls that they don't usually extend training. Consequently I decided to take my complaint to someone higher (the manager Carl). However, when Holly heard that I had made an appointment with Carl, she tried her best to contact me promising me Olivia's position which was also a lie. Then, I went to Carl and explained the situation. I told him "I didn't come to you immediately, I followed the chain of command but they didn't support me". I then asked him to relocate me with a different preceptor, as well as to extend my training in the hospital. He was very supportive and fair and he told me "you are here to learn, and my goal is to produce a good health educator, as long as you are not learning in your current place, you will be relocated so you can learn and become a good patient educator". In addition he approved my extension request. After my meeting with Carl, Holly called me insisting on a confrontation, claiming that this was Carl's orders. She told me that I must confront Olivia so they can include the incident in her evaluation. I refused to do so because it is not my job to evaluate their

employees, and this will just cause harm. In addition, at the end of the day, Olivia will be evaluating me. I was certain that Holly was lying about the matter so; I emailed Carl expressing my disappointment and explaining the situation. He responded to my email denying their claims and telling me not to confront Olivia.

In this hospital, the health education department is not supportive, I didn't feel that they want me to learn; they made me feel like a tool, they are using me for personal interest. In addition, it turned out that all the rumours that I have heard about them are true; they lie, they are unprofessional and manipulative. Holly tampers with interns' evaluations. I knew that because Sam had her internship training here and they also changed her evaluation. What happens is that the preceptors fill in the evaluation form and send it to Holly and then she sends it to the university without discussing it with the interns. However, things will be different for me because I asked my current preceptor Lily to give me a copy of my evaluation and also to send a copy to the training and development department, so Holly will not be able to tamper with it. This evaluation is important because it may influence me when I apply for a job.

The problem here is that most of the educators don't have a health education degree, they just have the experience. They didn't do a year of internship; they don't understand the needs and the requirements to train a good health educator. This also explains why Holly tampers with evaluations. She doesn't want to hire Saudis because we are health education graduates. They are not qualified for their positions and they don't want us to take their places. Nevertheless, there are some educators who

don't have a health education background but they are still good. Some of my friends had good training with these educators, this is what makes me frustrated. When I compare myself to others I found myself not getting the training I deserve. This happened to me once and I am not going to let it happen to me again. It is my chance to learn because as an Intern I work under supervision, if I make a mistake, I get corrected and I learn from it, but when I get hired it will be my own responsibility.

I love health education and I studied it because I want to, unlike others who enrolled because of their low GPA. It was my desire to enrol in the applied medical sciences college and my desire to study health education, I love my specialty and I will hopefully continue and do a postgrad degrees.

To improve training it is important to hire good health educators who care about patients and understand their needs. In addition, interns should be exposed to different departments to explore their area of interest and their training preferences. They also should be given chance to choose the area where they would like to be trained.

Linda

My first rotation was in hospital A, which provides the best internship training for health education. At the beginning we had an orientation where we visited the main hospital, the library, the clinics and the health education department. Then we were given a schedule for the training plan. Visiting the departments wasn't of any use at that stage, but I learned some important basic stuff like hand hygiene and fire safety instructions in addition to learning how to use the library. After that we started having rotations between different hospital departments, where we spent a week in each.

In the department, we attended doctors' clinics and rounds. Doctors treated us like medical students and they taught us about the cases we were seeing. The problem was that they didn't know our limits and there were times when they asked us about medications or other complicated matters. They know who health educators are, they referred patients to them, but they didn't fully understand what the limitations are for educators.

To be honest, I liked working with them because having the chance to see new cases and how doctors deal with them taught me the right way of providing appropriate education quickly. I also attended surgeries, which was very exciting for me; it wasn't part of my work but I liked the idea of seeing and learning something different.

We also spent time with the patient educators; we attended their clinics, went with them on their rounds, observed how they educate patients and eventually participated with educating, under supervision. During the

rounds, some educators used to tell patients that they were being accompanied by an intern and some told us to keep our identity as a student from patients, as they trust employees more.

In all the departments we went to, we started with observation, which was good because it gave me a chance to learn how to deal with different situations. In one of the departments I worked independently; I went on rounds, covered a clinic and had my own patients. I also had the authority to open files and document my work. That was really good and beneficial because being on my own forced me to retrieve my knowledge and experience and act upon it. At the beginning I kept notes and read from them, but over time I gained confidence and gradually was able to deal with patients independently, and when I was faced with new things, I sought others' help. There were a few units where I didn't get much benefit because either the educators were too busy to spend time with me or because they weren't interested in training. Those educators advised me to use the library for reading, but this didn't add anything to my knowledge

This was the case in my last two months, which was the time when interns get trained in an elective area. I was placed in a department that was not even my choice. I didn't like that department because there were no patients. So, my supervisor used to ask me to go to the library to read, and this was a waste of time. During this time I also attended doctors' clinics and surgeries and prepared several brochures. I did lectures for staff and they gave me very constructive feedback on them. For

example, they told me that I was a bit aggressive, which I corrected later on.

In general, training in hospital A gave me plenty of information and I learnt a lot from their media education programme, which is a new area for me. I learned because I was involved in so many activities and attended specific courses. In hospital A they taught me how to deal with difficult patients.

My second rotation was in hospital L. It was so different from hospital A. There was no work, we spent most of our time there doing nothing. The employees there didn't do much work and they spent their day having tea and coffee and chitchatting before they left early. I visited four departments there; however the only place where I felt that I had some benefit was in the diabetes department.

In the diabetes department, the educator herself was more enthusiastic. She doesn't have a background in health education; she is a nurse who studied a diploma in health education. This educator started my training by giving me a lecture before, I started practising under her observation. She then commented on my education after the patients had left. That was a good way of training because I didn't feel her presence during the education but I then got her feedback to improve my work.

After the diabetes, I went to the oncology department. The training there was really bad because the educator was a new graduate. She didn't know her work and she was not qualified to work in oncology. I actually had better knowledge because of my training in hospital A. This was proved once when we disagreed on information and had to ask the

doctor, who supported my opinion. I didn't benefit from them as much as they did from me.

I then went to the OB/GYN department where the education wasn't provided by educators but instead was given by midwives. That was good because they had good knowledge and experience. It was because of this that I liked the work there, they were very keen on promoting breast feeding and they were giving from their hearts. The breastfeeding component made the hospital a baby friendly hospital. I didn't practise in that department: instead I observed the midwives in their clinics, when they gave lectures and I even attended a normal delivery. I learned from them how mothers should carry their babies, breast feed and store milk. I also gave a lecture once about gestational diabetes. It was a very nice and different experience to see people from different classes; some are interested, some aren't and some ask strange questions that make you wonder how there are people who think that way. However as an educator I shouldn't give them the feeling that I am shocked, I openly accept their ideas and deal with them. I had a great benefit from training in that department. However, it was upsetting and disappointing to find that the only benefit I got from this hospital was from the two departments that were not under health education.

I then moved for my third rotation, in school health units. There I was responsible for giving lectures in schools. When we started, the head of the unit asked us to decide the topics we wanted to cover and plan a schedule for school visits. To do this I contacted the schools to identify their needs, looked at scientific websites to read about the topics and

then used the knowledge I had got at university, such as using ways to communicate with children to develop my presentation.

With the students I gave lectures about hair lice, personal hygiene and menstrual periods. I also gave a lecture for the teachers at one of the schools about epilepsy, to teach them how to deal with an epileptic student in the school. I had a bit of a benefit in terms of learning how to deal with children and by refreshing the knowledge I gained from the university, namely communication skills. However, spending three months there was a waste of time, a month or two would have been more than enough.

I then moved to Hospital D. The focus in that hospital was on planning and making surveys. This is because the department is still in the developmental phase. This is very different from the work at other hospitals, which is more practical. While there, I was involved in research that assessed the improvement in patients' knowledge. At the beginning of the research I attended clinics, wrote notes to develop a questionnaire and then started data collection. That work helped refresh my knowledge about the research process. After that I moved to the antenatal clinic to learn about patient education. There I observed for four weeks and then worked with patients under supervision.

During the whole training I found that practising makes a difference in learning because you may forget what you see but you never forget what you do. The most beneficial thing for me was working independently. As a downside, I would say what inhibits learning is the feeling that your supervisor doesn't trust your work and you feel that he is right because

you are the student and consequently he doesn't give you any responsibilities.

To teach me, they should involve me in work and allow me to develop. It would be good for interns to visit different departments in different hospitals to learn. I don't think all interns got as much benefit as I did because they didn't have the same training as me. For example, those who didn't have their training in hospital A missed a great learning opportunity. Interns should also be involved in different kinds of work like paper work and research, so they won't lose these skills.

Ruby

I started my training in hospital F. There were nine departments covered by the health educators. We spent a week in each of them. During each week, we observed for three days and then we were allowed to educate a patient or two under supervision. I liked observing because at the beginning I was a bit scared of talking to patients and it helped me to overcome that fear.

Working under supervision was also good because although we didn't make mistakes, educators were able to complete the education and add the things that we might have missed. We also accompanied the educators during the doctors' round, we observed their practice and saw the way they asked medical students who struggled to answer, it was like the movies. I was thankful that I hadn't studied medicine. I liked that a lot because I gained a great deal of medical information and learned about patients' conditions and needs. In addition to that, each educator gave us an assignment that had to be completed by the end of the week. Some asked us to make brochures, some asked us to participate in educational campaigns and one asked us to conduct a group session with the patients. This was a very nice experience, she gave us the freedom to pick whatever topic we wanted, so instead of picking a health related topic we talked about positive thinking. The assignments in general were beneficial because I had to research and write about different diseases. However, personally I don't like public events because I don't like designing. I prefer working with patients and learning medical information. We also went with them on school visits. These were very beneficial but we didn't go much because it was just once a week. The only problem I had in this hospital was that there were days when we spent hours doing nothing. We had to work from eight to four every day so there

were times when there was nothing to do. As interns we should have fewer working hours: from eight to twelve for example. This got worse in the last three weeks. After finishing the nine weeks' rotation we had no specific plan. Therefore they gave us different tasks that are not part of our role. For example, I was given a number of booklets about Crohn's disease to translate. Although I have learned a lot about this new disease, I wasn't happy about doing the job. We also observed them preparing educational videos. I was very disappointed with the quality of these videos. They had a big budget for it and there are good actors on YouTube and they could have benefited from them.

My second rotation was in hospital G. I didn't like the atmosphere there, but I learned a lot about their area of speciality. They had a specific training plan which is two weeks training with every educator. They set a task for us to prepare educational material. We observed for six weeks, and then they asked us to give education under supervision. After each session the supervisors gave us constructive feedback: for example, one of them told me that I speak fast and I should slow down. All the educators were covering the same topic, so three months was too long, it was boring. Six weeks would have been enough. I was very lucky to start my training with educator Jewel. She explained everything to me, from anatomy, terminology, diseases, treatments and finally how to educate patients. I have noticed a difference between me and the girls who didn't get that training. Unlike those girls, when observing the educators, I was able to follow and understand what was being said.

In the last month, there was an educational event. It was supposed to be the educators' work but they delegated everything to us. We prepared for the whole event; designed all the educational materials. We were really exhausted, it wasn't part of our role and we didn't even attend the event because it was after the end of our rotation. However, I am happy that I worked on the event because I have learned new things like designing and using Photoshop. Anyway, they were nice to us; they threw us a goodbye party and asked us to come again to attend the event. At the beginning of the training, I felt that it was all about memorising and reciting. I memorised what the educators taught me and then repeated it as it was to the patients, regardless of their differences. That could be the result of beginner's fear, the fear of making mistakes or forgetting something, especially when being observed. Now I have changed, I am more confident of my skills and I feel in control so I listen to patients to find out what suits them.

After that, I moved to hospital M, and that was a very different experience. Hospital M is very good for training but the problem was that it is private so those who get their training there don't receive the monthly allowance. Therefore, some interns wanted to be trained there but they were not willing to give up their allowance. However for me it wasn't an issue because I am not eligible for the allowance anyway. It was a specialised hospital covering an area that is not covered in any other hospital, and they had never trained interns there before. I was trained by Heather, who had never trained anyone before. From the beginning she treated me like an employee not an intern. Of course I started by observing, but from week one she told me to prepare myself for independent practice. In addition to observation, she asked me to prepare educational material and provide a lecture every week.

The topics which were covered were specific topics like stroke in patients with diabetes. The educators in that hospital provide a lot of lectures for patients. I liked attending these lectures to learn and then with time I started helping the lecturers in taking the attendance and collecting patients' evaluation sheets. The lectures were very helpful because these were new topics, so I learned plenty of information. This information helped in doing one to one education. I appreciated these lectures because I didn't get any formal training, unlike interns who started after me and attended a three-week course which is followed by an exam.

Being involved in all kinds of activities was very tiring but I have benefited a lot. All my hard work turned out to be very beneficial. From the third week I started doing one to one education. I wasn't happy with the quality of the education I provided, and I told her that I preferred being with her, but she told me that wants me to be independent because it will help me kick off and give the patients more. After that I moved with another educator who got his degree from the United States. Likewise, after the third week he let me see patients and give lectures. That was different from my previous rotations, for which I provided one lecture in the whole period. With him I gave about three lectures a week. This made a great difference; I have learned useful skills in giving lectures and providing one to one education.

In the three hospitals, I was required to write reports about our work. I think that was really helpful because identifying our achievements can be very satisfying. However, a year is too long for an internship; six or seven months is enough because after trying different areas, an intern learns and can

proceed. The working hours were too long, and it was boring and exhausting. Interns shouldn't be treated like employees and work from eight to four. The actual work is two or three hours and the rest of the day is a waste. Working hours should be flexible: you stay if there is work to do, and if not you can leave.

In my first and second rotation I was with other classmates and I wasn't bothered when we were criticised. However, now that I am alone in hospital M, I feel that the criticism is personal and it really annoys me and it isn't motivational. The only positive thing about the criticism is that if you feel a person is picking on you maximise your effort to not give him a chance to find anything to criticise. Being with other interns is good in terms of the emotional support. I don't think I could have tolerated the bad atmosphere in hospital G without my colleagues. We also helped each other, for example we divided the work between us when we prepared for an event and every one of us did what she liked the most. However, the negative thing about being part of a group is that the staff won't recognise you as an individual and as a result don't understand your skills. A problem that faced me as an intern is being used by the staff. Some used us to do things that are not part of our role, such as monitoring maintenance staff when fixing and hanging posters. Also, I didn't like that we learned superficial topics, it would have been better to gain in-depth information, especially about basic topics like diabetes.

Dealing with inpatients is challenging. You can't easily find them and their rooms and if you do they are usually sleeping. I have seen the educators waking them up but I don't think this is right because the readiness to learn

is important. However, I did this a few times because their policy requires documenting the education within the first three days of admission.

The best way to learn is; first of start with reading, it is very important for interns, also asking them to prepare educational materials can be very useful because it forces them to read. Then, observing is also very important. And working with doctors: working with doctors is not just an opportunity for interns, even the educators learn from working with doctors. Being involved in practice is really important.

Sara

At the beginning of our internship, the university gave us a chance to choose between different training places. However, when it came to reality we didn't get our choices; instead we were placed in different hospitals. Anyway, we weren't actually clear about which places give good training and which don't. As a result, we consulted previous interns and university staff and most of them told us that we would not gain any benefit from the internship, at least if not with certain instructors.

The first rotation of my internship was in the institute O, where I spent three months. We chose to go there because they promised to give us intensive training. We were promised that we would take courses, do school visits and more. I was excited to have part of my training in a place other than hospitals to have a different experience. However, going there was the biggest failure in my life; it was a shock because what we actually did was so different from what we were promised. When we started we were placed in a shopping mall to participate in a breast cancer awareness campaign. The problem was that everybody does the same job; there was no difference between us as health educators and everybody else. It was frustrating to see people with other backgrounds doing our job. How come we are the only department that allows people from different disciplines to practice our job just after taking short courses or diplomas? In this campaign, everybody did the same job and provided people with the same piece of information about breast cancer. This was very disappointing and at one point made me regret studying health education. Therefore, we contacted the person in charge requesting

better training, but we were told that this was what they had for us and if we didn't like it we could leave. So, we were forced to stay as there were no training opportunities at other places at that time.

Working there was useless in terms of gaining knowledge and all we did was repeat ourselves over and over again. However, there were a few times when people asked about things other than breast cancer and at most of these times I was able to answer. In three incidents I was hit with new questions, so then I took the people's phone numbers and contacted them later with the answer. The only upside of this period was having the chance to deal with different kinds of people.

In addition to the breast cancer campaign, we went on a few school visits to give lectures for students. Because the supervisor of the institute O was aware of the poor training they provided she decided to complain about our poor performance so we couldn't criticise her training, and so she did. However this was not an issue as we had proof of our good performance which were letters of appreciation from the schools that we had visited. In addition we asked the university to see how we performed in other places, to compare.

The second rotation was in centre E, and it was a very good experience. At the beginning the supervisor gave us lectures about everything we were going to deal with, and all related conditions and treatments. After that she allowed us to practise, initially in her presence and subsequently independently. In this rotation, for the first time in my life I had the chance to open patients' files, write in them, fill in forms, and see patients. I did all of that by myself; this made me feel alive again and I finally felt like a

real health educator. It made me recognise the difference between me as a health educator and other health professionals.

The third rotation was in hospital C; which many people advised us against. Many interns and even university staff told us that training in that hospital is not beneficial as there is no work to be done. However, we found out that in this hospital it is up to the intern to gain benefit or not. It is true that the health promotion department does not provide a chance for practice; they don't have a training plan and they don't assign work related tasks to interns. What happened in reality is that they asked us to go to patients' rooms without providing any guidance and when we asked for their help they kept postponing until it was too late. The other kind of tasks that they assigned to us were personal tasks such as writing someone's daughter's project, which made us avoid them as much as we could.

However, interns who wish to learn can always go to the diabetes educator clinic and get good training. Consequently we went there, and in the first two days, everything related to diabetes care was explained to us. After that we were given time to observe the educator practising, and then we practised under her observation while she occasionally interposed when required. This was a very good way to learn because we gained confidence and learned from our mistakes. Next, we started educating patients without her observation, yet she was always near and we could ask her whenever we felt uncertain. Having access to her was very useful and gave me more confidence and motivation. Nevertheless,

there were a few times when we had to cover the clinic by ourselves and I was fine with that as well, it also felt good and made me confident.

For the last rotation I couldn't find a vacant training position in any new hospitals, so I had to make a choice between going back to centre E or delaying my training for a few months to find an opening somewhere else. So I chose to go back to the Hospital E as my experience there was not bad and my work was well appreciated. I was also used to the work there and happy to practise independently with no supervision. The sense of confidence to work independently in centre E may be the result of the nature of my work as I just give patients general information. This is different from my previous work in diabetes, which was a more sensitive topic that requires being around a supervisor. In addition, wearing the interns' green lab-coat allows patients to identify us as trainees and as a result ask fewer questions. There were times when I used the employees' white lab-coat; this is when I mostly faced tricky questions. When this happened, I contacted the supervisor to check the right answer. Nevertheless, some patients ask question which are not the responsibility of a health educator they just assume that I am the do-it-all employee, and in this case I direct them to who the right person is.

The problem is that a lot of people don't understand what the role of a health educator is. This includes patients as well as staff. Sometimes I over hear people talking to each other about it and sometimes they ask me directly. For those who ask me I explain my role but when I hear them talking among themselves and I can't reply, I feel devastated.

Furthermore, some people make me doubt myself and rethink my role.

They disrespect us and they tell us that our job is not important and that what we do is already being done by other health care professionals.

However, as difficult as it is, it doesn't hold me back: instead it motivates me to work harder to lift the name of health educators and show people who we really are. However, this disrespect is not always the case, some people happily accept me when I describe my role to them, and this makes me feel so good. When doctors call me to help and see patients, I feel that I have my own identity, and it lifts my spirits a little bit. I actually love my department and I am planning to resume this career and honestly I feel happy and excited when I see the name of the health education department hanging up in corridors. Anyway, although this experience is hard and challenging, it has still provided me with a good chance for learning.

The internship period gives you a chance to understand the work and examine your level of tolerance, which helps you to make the right choice for a job. To have the best benefit from this period, the university needs to ensure the quality and diversity of training experience and the hospitals should always provide a supervisor, guiding training and supervising practice.

Sophia

My first rotation was in hospital F. This period was very beneficial for me, it was brilliant, fantastic. It was particularly helpful in developing my personality. They have a well organised training plan. We were trained in all departments, spending two weeks with each specialist. We went on rounds with doctors and other health care professionals. We observed how doctors communicate with patients and we learned new things. Although the doctors knew we were interns, they still asked us to provide some education.

Furthermore, specialists sat with us and explained everything, and then we observed their practice for few days to learn from their experience before we started practising. However, there were differences between different specialists. Some allowed us to sit with doctors and some asked us to prepare brochures, fliers or do a daily power point presentation. I have benefited a lot from this hospital, but it was mutual benefit, a give and take.

My second rotation was in hospital G. This hospital helped me in learning medical information and also in building personality, but not much in terms of practice. Before starting there, I'd heard a lot of bad things about them and the way they treat interns. Yet I had a 50% desire to go there because of teacher Diana. Being trained with her was a very exciting idea for me. When we applied there, she interviewed us and thanks God, we were accepted. However, when I started I was shocked to find that she had left. That made me scared and I have even regretted choosing that hospital. However, thank God, I managed and handled it somehow. I was actually relieved because unlike what I had heard, they were very, very courteous, I think this is because we earned their respect.

We spent two weeks with every specialist. Some of the specialists sat with us before going on rounds and explained everything related to the area they were covering, their role, common diseases, the measures taken and the education provided. Other specialists used PowerPoint presentations and others used patients' brochures. We then went on the rounds with them but we weren't allowed to deal with patients until we were half way through our rotation. Although I liked what I had done in hospital F when I worked with patients early in the rotation, this experience was also good as I learned that patient education is not a piece of cake.

The most beneficial thing I did there was working on an event. I took full responsibility for a community event, I got to use my talents; I used photo shop to design brochures and fliers and I even prepared the event advertisements. We were of great benefit to them. In this hospital I have given more than what I have taken, or maybe it was 50% giving and 50% taking. They were supposed to teach us and give us knowledge and experience. Instead, they took the breath out of us, they exhausted us just because we were interns and we would do whatever we were asked to do. They actually kept coming to us all the time asking for new ideas. This could be because they have been there for a long time and they needed fresh blood. They were actually astonished by our work, and although they were planning to stop the internship training programme, I have a feeling that after working with us they will change their mind and keep it on. In terms of the benefit, people's opinions vary. Some said they didn't benefit at all from this hospital, but for me I looked at it in a different way. I was giving because I know this will help me in my future practice.

My third rotation was in Hospital E. I chose that hospital because it could be helpful in terms of learning a new area which I hadn't learned about before. I was hoping that by being there I could learn something new. Another reason to choose this place was that Jennifer the head of the department has a very good reputation, I was inspired by her. In addition, she promised us good training. Surprisingly, this wasn't true. They were miserable; they had no specific training plan for interns. I was also frustrated because I only met Jennifer once during the whole training period, and it was an annoying situation. We were in a room that employees use as a library; waiting for a specialist to take us on a round. She came to the room, she didn't greet us, she asked who we were, and when she found out we were interns she asked us to leave the room and wait in the nurses' residence. This incident made me shrink from her a little. According to her promises, she should have sat and talked to us. Anyway, I said to myself that after all, she might be right.

The way we worked in this hospital was different from other hospitals. We weren't visiting all the patients; instead we used to enter the rooms, shout, asking if anyone needed an educator, and then leave. We also wrote in patients files. Unfortunately we used to do that by ourselves. That was embarrassing and weird; I have developed fear and had a setback. We were supposed to have a specialist with us, but I can understand, maybe they were busy and had a lot of things to do. This could also be because when I started, there was an intern who had been there for six months, she was brilliant and they told me to go with her instead of a specialist.

The great benefit I had there was from giving an in-service presentation.

That was, wow, a fantastic experience. It was the first time I had presented in front of doctors, nurses, and administrators, in front of men, and in Arabic and English. Another good thing was that I read a lot and when I educate patients if I get it right I get really happy and enjoy it, but if I fail it is fine, what can I do about it anyway?.

Other than that, there was nothing interesting, no events or anything and the three months passed quickly. I was frustrated because I wanted to benefit but I didn't. Furthermore, they used to give us tasks that were not part of our job. For example they asked us to do paperwork that we were not even authorised to do. They also asked us to clean gifts and move boxes, and that was exhausting. It was also frustrating; because even if we are interns, we are still specialists. They treated us like nurses, or even worse, they treated us like house keepers. I think they were doing that because they had no one else to do it. It is not nice for them to do it and not nice to keep asking the housekeepers, we were the easiest option.

The main problem in the three hospitals was the space. There was no room for us, they have to understand that interns have their own identity and need special arrangements. In hospital F we weren't given a room and we were expected to wander around the hospital and use waiting areas. Then when we talked them into it, they empathised with us and gave us a place. It wasn't a great place but at least it was a room to work and relax in. In hospital G we weren't given a room, but we used a meeting room which was noisy, and they even used to come there all the time to gossip or even shout

at each other without giving us any respect. Finally, in hospital E, we felt that we weren't welcome, and they sent us to the residence, which smells bad.

To improve internship programmes, they should look at other training programmes and adopt effective practices. There should also be a structured training plan. Interns should have less working hours and be kept busy all the time, because long working hours which have many free hours have a negative effect and make them bored. Furthermore, there should be a good working environment and a comfortable room for them. Finally, interns should observe and talk to doctors and specialists for at least two weeks before working with patients.

Appendix D: Example of analysis grid

Place	Expectations	Experience	Emotional responses	Personal Action	comments
M	They told us that we would do health promotion campaigns and community education	we worked in a shopping mall at night	the worst experiences ever		
		They gave us criteria for those who can be screened even if they were interested they couldn't have the screening	every woman should learn about breast cancer it is not appropriate to stop every woman and ask her about her age		
		We spent three months there	that was a very long time for me		
		They didn't teach us how to deal with the community. They only gave us a lecture about breast cancer.	I have learned enough about the topic but I didn't gain any experience	We, the girls, used to have discussions with each other, and used the information	

			<p>They weren't able to educate us because they were not health educators, they were social workers and they didn't have medical information.</p> <p>The only benefit I gained there was from dealing with different types of people</p>	<p>which we had gained during our studies to develop our own teaching techniques.</p>	
	<p>have logos and signs to show their identity</p>	<p>because it didn't show who we were.</p>	<p>I didn't like our corner there,</p>	<p>We tried with our supervisors to make some changes in our corner to make it more attractive to women, but they refused all our ideas.</p>	
Overall impression					
<p>(This unsuccessful experience made me depressed: especially since I had been very excited about starting my internship training in this department)</p> <p>Therefore, I decided to go to another city and have a rotation in hospital J</p>					

Hospital J	Expectations	Experience	Emotional responses	Personal Action	comments
		<p>I was the only one coming from city X so I was the centre of attention</p> <p>I was trained in many departments</p>	<p>My experience there was fantastic.</p>		
		<p>All of the specialists there were educators, not social workers or nurses.</p>			
		<p>I spent the first week there observing to gain information. Then I began practicing under observation. After that I was allowed to cover the clinic by myself.</p>	<p>It was nice to feel that someone was depending on me and giving me responsibilities. I was confident because I had read brochures and observed before practicing.</p>		
		<p>I have even given lectures by myself.</p>	<p>At the beginning I was scared and nervous, but then I loved it. Talking to people was helpful. They listened to me</p>		

			because they wanted to learn.		
		I had read brochures and observed before practicing. Furthermore, I was able to contact the educator when facing something new.	I was confident because.....		
			I liked that I had direct contact with patients.		
	I didn't know that that was part of the educator's role.	I participated in giving lectures for schoolchildren	I was surprised..... However it was a nice experience because I like dealing with people and answering their questions, especially those who are eager to learn.		
Hospital C	Expectations	Experience	Emotional responses	Personal Action	comments
		spent my three months there in the diabetes clinic with educator Hope			Personal choice
		Hope explained to us everything related to diabetes and I asked her about things that I didn't understand. Then we observed for a month before she started			

		asking us to partially participate in patient education. Her training technique is very good because she used to ask us to repeat things to be sure we had memorised it well. I personally like to see and practise, that is better than explaining things, which will be totally forgotten.			
		I used to watch and write notes to read at home, which made people laugh at me. I also used to read about everything.			
		Besides educating patients I used to answer the clinic's phone, which other girls hesitated to do.	That was good for me because doctors learnt my name and referred patients to me.	I tried to convince other girls to do the same because small things like this make a difference.	
		There were also times when I was faced by strange cases and/or questions. At those times I consulted doctors. I used to consult them behind Hope's back because I didn't want to upset her	It's not that I didn't trust her opinion, she has been a diabetes educator for 20 years, but I didn't always agree with her.	I used to mainly consult doctors. There were also times when I discussed patients' conditions with the other girls, there were four trainees, sharing our experiences and helping each other.	
		The hard part there was dealing with pregnant women who are	This was also a very nice and useful experience. Facing an obstacle on a		

		usually tired, stubborn and need a lot of effort.	daily bases makes a person learn.		
Hospital E	Expectations	Experience	Emotional responses	Personal Action	comments
		have been here for two weeks now, waiting for the supervisor to train me, but she keeps postponing	I don't like the work here because I am energetic and I like to go home thinking about my accomplishments. I don't like to sit for hours with no work.	So I am working with the girls who have been here four months.	
		up till now I have just been observing	I don't have enough knowledge to encourage me to open a file yet. Observing the girls is giving me negative energy, because they didn't teach me everything. It would be better to be with a supervisor; it would make me feel	To support my learning I am reading about new things, even about medications which patients use.	

			that I was learning and benefitting.		
<p>I love my speciality and I want the health education department to be one of the biggest departments in hospitals. However, they are teaching us that it is not important, which is not true, it is important and it supports doctors' work. However, it is oppressed, there are no standards for us as educators and we are neglected. The only educators who are valued are diabetes educators, because they are needed. Other departments don't feel the need for educators and they don't treat them appropriately. Even official institutes don't treat patient education as an important subject. This negligence and ignorance can frustrate educators and inhibit them from reaching their full potential. However, although the quality of training was influenced by these issues, it didn't inhibit me because I fully understand my role and what I need to do.</p>					
<p>My comments:</p> <p>Amber who described herself as an energetic person who likes to go home thinking about her accomplishments; had very high expectations, clear goals and determination to make the most of her internship. As a result when the training didn't meet her expectations she was shocked and depressed. Amber had strong opinions about the quality of education that should be provided to patients and as a consequence judged the competencies of her instructors. Therefore whenever she doubted her instructors' abilities she sought support from other health professionals and sometimes her peers. In addition she supported her learning by reading and retrieving previous knowledge. She also showed determination in improving her learning when she didn't care about her peers bullying (writing notes even when they laugh about it). Furthermore, she valued being the centre of attention and being recognised. She considered this recognition a chance to receive good training. Other than that she discussed the importance of the health education as a speciality in many occasions. In one occasion she stated that she the training was poor because the instructors were not health educators. She also articulated her feeling of disappointment when there were not any signs showing that they are from the health education department. She expressed her passion about health education, her understanding of the importance of it, her desire to improve its status, and her clear understanding of the role of health educators. She also stated that regardless of the importance of health education, it is neglected, oppressed, and lacks standards. She finally explained that although this is frustrating and may inhibit others, it will not affect her. Instead these obstacles encouraged her to work harder to achieve her goal of improving the status of health education. For me I feel that this PEI is resilient, determined and a fighter and her expectations and pre-existent identity motivate her.</p>					

Appendix E: Pilot study participant information sheet

Study Title - Learning during the First Year of Practice: The Patient Educators' Experience in Saudi Arabia – Pilot Study

Research Team – Fatmah Almoayad (CI), Dr Naomi Quinton & Dr John Sandars

We would like you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and decide if you wish to participate in this study. Talk to others about this study if you wish. Ask us if there is anything that is not clear. This project will form part of a PhD study being undertaken by Mrs Fatmah Almoayad at the University of Leeds.

What is the purpose of this study?

The purpose of this pilot study is designed to improve and validate an interview guide and interviewing process. This interview guide will be used to conduct in-depth semi-structured interviews to investigate patient educators' learning during their first year of practice. For this research patient educator describes any practitioner who is exclusively assigned to provide health education for patients in clinical settings. Interviews are expected to last approximately 1 hour. The findings of the main study will inform the design and development of patient educator training, and as a consequence potentially improve service provision.

Why have I been chosen?

You have been chosen to participate in this study because of your experience as a health care professional.

Do I have to take part?

No it is entirely up to you to decide whether or not to take part. There will be no adverse consequences for you if you decide not to take part. We will describe the study and go through the information sheet. We will ask for your formal, written consent prior to your participation in the study. You can withdraw from the study at any time without giving a reason. There will be no consequences of you not choosing to take part in this study.

What do I have to do?

You will have to agree to one interview, lasting approximately 1 hour. You will be asked to provide any feedback which you feel would improve the interview. It is important that you share an honest feedback in order to ensure the interview is valid for the study. Specifically, it is important to identify if the guide and process are understandable, clear, non-offensive, and completed within a suitable timeframe.

What are the possible risks of the research?

We do not anticipate that taking part in this research will incur any risks.

What are the possible benefits of the research?

Whilst the information may not be of direct benefit to you personally, the information we gather will help to improve and validate an interview guide and process of the current study which is intended ultimately to be of benefit to future patient educators and therefore potentially of benefit to patient care.

Will my involvement be confidential?

Yes. We will follow ethical and legal practices in respect of confidentiality. The interviews will be audio-recorded, transcribed and translated to assist accurate analysis and will be stored securely with an anonymous code. The custodian of the data will be the Chief Investigator of this research project. Typed transcripts and field notes from the study will be stored anonymously. All data will be handled, processed, stored and destroyed by the research team in compliance with the Data Protection Act 1988. All data collected from you will be anonymised and given a unique identifier. Only the research team will have access to the data. If your interview is conducted in Arabic the anonymised transcripts will be translated by an external translator. However no personal data including your name or job or work location will appear in the transcript.

Who is organising and funding the research?

The research team is based at the University of Leeds and is accordingly supported and regulated by the University.

Who has reviewed the study?

The research is looked at by an independent group of people, called a Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by the University of Leeds, Faculty of medicine and dentistry research ethics committee.

Further Information

If you have any further questions please do not hesitate to contact any of the research team:

Fatmah Almoayad

Tel: +447853085924/ +966504202001

Email: hs08f2a@leeds.ac.uk

Dr Naomi Quinton

Tel: +44113 343 4911

Email: n.d.quinton@leeds.ac.uk

Dr John Sandars

Tel: 0113 343 4193

Email: J.E.Sandars@leeds.ac.uk

Professor Vikram Jha

Tel: +44 (0)151 795 4362

Email: Vikram.Jha@liverpool.ac.uk

Appendix F: Pilot study participant consent form

Consent to take part in the pilot study:

“Learning during the First Year of Practice: The Patient Educators’ Experience in Saudi Arabia”

For this research patient educator describes any practitioner who is exclusively assigned to provide health education for patients in clinical settings.

Add your initials next to the statements you agree with

I confirm that I have read and understand the information sheet/ letter datedexplaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. Contact numbers: Fatmah Almoayad: +447853085924/ +966504202001 Dr Naomi Quinton: +44113 343 4911 Dr John Sandars: Professor Vikram Jha: +44 (0)151 795 4362	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the reports that result from the research. I understand that my responses will be kept strictly confidential.	
I agree for the data collected from me to be used in relevant future research.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change.	

Name of participant	
Participant’s signature	
Date	
Name of lead researcher	
Signature	
Date*	

Appendix G: Participant information sheet

PARTICIPANT INFORMATION SHEET

Study Title - Learning during the First Year of Practice: The Patient Educators' Experience in Saudi Arabia

Research Team – Fatmah Almoayad (CI), Dr Naomi Quinton & Dr John Sandars

We would like you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and decide if you wish to participate in this study. Talk to others about this study if you wish. Ask us if there is anything that is not clear. This project will form part of a PhD study being undertaken by Mrs Fatmah Almoayad at the University of Leeds.

What is the purpose of this study?

The purpose of this study is to investigate patient educators' learning during their first year of practice. For this research patient educator describes any practitioner who is exclusively assigned to provide health education for patients in clinical settings. To do this we intend to interview patient educators about their views and experiences. Interviews are expected to last approximately 1 hour. The findings of this study will inform the design and development of patient educator training, and as a consequence potentially improve service provision.

Why have I been chosen?

You have been chosen to participate in this study because of your position as a patient educator.

Do I have to take part?

No it is entirely up to you to decide whether or not to take part. There will be no adverse consequences for you if you decide not to take part. We will describe the study and go through the information sheet. We will ask for your formal, written consent prior to your participation in the study. You can withdraw from the study at any time without giving a reason. There will be no consequences of you not choosing to take part in this study.

What do I have to do?

You will have to agree to one interview, lasting approximately 1 hour.

What are the possible risks of the research?

We do not anticipate that taking part in this research will incur any risks.

What are the possible benefits of the research?

Whilst the information may not be of direct benefit to you personally, the information we gather will help to identify factors which contribute to patient educator education and training. The research is intended ultimately to be of benefit to future patient educators and therefore potentially of benefit to patient care.

Will my involvement be confidential?

Yes. We will follow ethical and legal practices in respect of confidentiality. The interviews will be audio-recorded, transcribed and translated to assist accurate analysis and will be stored securely with an anonymous code. The custodian of the data will be the Chief Investigator of this research project. Typed transcripts and field notes from the study will be stored anonymously. All data will be handled, processed, stored and destroyed by the research team in compliance with the Data Protection Act 1988. All data collected from you will be anonymised and given a unique identifier. Only the research team will have access to the data. If your interview is conducted in Arabic the anonymised transcripts will be translated by an external translator. However no personal data including your name or job or work location will appear in the transcript.

Who is organising and funding the research?

The research team is based at the University of Leeds and is accordingly supported and regulated by the University.

Who has reviewed the study?

The research is looked at by an independent group of people, called a Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by the University of Leeds, Faculty of medicine and dentistry research ethics committee.

Further Information

If you have any further questions please do not hesitate to contact any of the research team:

Fatmah Almoayad

Tel: +447853085924/ +966504202001

Email: hs08f2a@leeds.ac.uk

Dr Naomi Quinton Tel:

+44113 343 4911

Email: n.d.quinton@leeds.ac.uk

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Tel: 0113 343 4193

Email: J.E.Sandars@leeds.ac.uk

Professor Vikram Jha Tel:

+44 (0)151 795 4362

Email: Vikram.Jha@liverpool.ac.uk

Appendix H: Participant consent form

Consent to take part in the study:

“Learning during the First Year of Practice: The Patient Educators’ Experience in

For this research patient educator describes any practitioner who is exclusively assigned to provide health education for patients in clinical settings.

Add your initials next to the statements you agree with

I confirm that I have read and understand the information sheet/ letter dated explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. Contact numbers: Fatmah Almoayad: +447853085924/ +966504202001 Dr Naomi Quinton: +44113 343 4911 Dr John Sandars: Professor Vikram Jha: +44 (0)151 795 4362	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the reports that result from the research. I understand that my responses will be kept strictly confidential.	
If my interview is conducted in Arabic I give permission for a translator to have access to my anonymised responses.	
I agree for the data collected from me to be used in relevant future research.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change.	

Saudi Arabia”

Name of participant	
Participant’s signature	
Date	
Name of lead researcher	
Signature	
Date*	

Appendix I: Approval letter received from the University of Leeds Research Ethics Committee

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I wish you every success with the project.

Yours sincerely



Dr John Sandars
Chair, EdREC

Mrs Fatmah Almoayad
PhD Student
Medical Education Unit
Faculty of Medicine & Health
Room 7.09, Worsley Building
University of Leeds, LS2 9NL

Dear Fatmah

Ref no: EDREC/12/005

Title: **Learning during the First Year of Practice: The Patients Educators' Experience in KSA**

I am pleased to inform you that the above research application has been reviewed by the Medicine and Dentistry Educational Research Ethics Committee (EdREC) and I can confirm a favourable ethical opinion based on the documentation received at date of this letter.

<i>Document</i>	<i>Version</i>	<i>Date Receive</i>
Ethics PE learning during transition 22.10.12	1	22.10.12
Interview Topic Guide	1	22.10.12
KSA_information_sheet 22.10	1	22.10.12
KSA_participant_consent_form 22.10	1	22.10.12
UK_information_sheet pilot study 22.10	1	22.10.12
UK_participant_consent_form pilot 22.10	1	22.10.12
KSA_information_sheet vs2	2	05.07.13
KSA_participant_consent_form vs2	2	05.07.13
UK_information_sheet pilot study vs2	2	05.07.13
Ethics PE learning during transition vs2 page 6	2	05.07.13
UK_participant_consent_form pilot vs2	1	12.07.13

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics Administrator for further information (fmhuniethics@leeds.ac.uk)

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

Appendix J: Approval letter received from the Vice
Rectorate for Graduate Studies and Scientific Research at
King Saud University

Leeds Institute of Medical Education
Medical Education Unit

University of Leeds
Worsley Building
Clarendon Way
Leeds LS2 9NL

Tel + 44 (0)113 343 1889
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UNIVERSITY OF LEEDS

سعادة وكيل الجامعة للدراسات العليا و البحث العلمي

السلام عليكم ورحمة الله وبركاته

تحية طيبة وبعد

أفيد سعادتكم بأني طالبة دكتوراة في تخصص التعليم الطبي من كلية الطب بجامعة ليدز البريطانية يقوم مشروع الدكتوراة بعنوان العوامل المؤثرة على التعليم خلال السنة الأولى من الممارسة بدراسة حالة المتقنين الصحيين خلال فترة الامتياز. عينة البحث تستهدف طالبات الامتياز تخصص تنقيف صحي المتخرجات من كلية العلوم الطبية التطبيقية و أداة البحث هي المقابلة الشخصية. وحيث أن جامعة ليدز تفرض قوانين خاصة بتطبيق أخلاقيات البحث العلمي فإني أتقدم لسعادتكم بطلب الموافقة على المقابلات و توجيه كلية العلوم الطبية التطبيقية -قسم التنقيف الصحي بالتعاون معي و ترتيب الإجراءات اللازمة التي تمكنني من مقابلة الطالبات و التواصل معهن وذلك لإتمام ما بدأته علما بأن هذا البحث يهدف لتطوير تدريب طلاب و طالبات الامتياز.

مرفق خطاب موافقة لجنة أخلاقيات البحث العلمي في جامعة ليدز على إجراء البحث و المستندات المطلوبة.

شاكرة و مقدره حسن تعاونكم

فاطمة المؤيد

فاطمة المؤيد

فاطمة المؤيد

جوال : السعودية 00966504202001

بريطانيا 00447853085924

ايميل: hs08f2a@leeds.ac.uk



Appendix K: Amendments approval letter



UNIVERSITY OF LEEDS

**Faculty of Medicine and Health Research Office
School of Medicine Research Ethics Committee (SoMREC)**

Room 10.110, level 10
Worsley Building
Clarendon Way
Leeds, LS2 9NL
United Kingdom

☎ +44 (0) 113 343 4361

20 January 2014

Fatmah Almoayad
Leeds Institute of Medical Education
Level 7.09 Worsley Building
University of Leeds
Clarendon Way
Leeds, LS2 9NL

Dear Fatmah

Ref no: **EDREC/12/005- – Amendment_1**

Title: **Learning during the First Year of Practice: The Patients Educators' Experience in KSA**

We are pleased to inform you that your amendment to your research ethics application has been approved following review by the School of Medicine Research Ethics Committee (SoMREC). This approval is based on the following documents received from you:

Document	Version	Date
Amendment_form[1]	1	14.01.14

Please notify the committee if you intend to make any further amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please contact the Faculty Research Ethics Administrator for further information (fmhuniethics@leeds.ac.uk)

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

We wish you every success with the project.

Yours sincerely

Dr Roger Parslow
Co-Chair, SoMREC, University of Leeds

Dr John Sandars
Co-Chair, SoMREC, University of Leeds

(Approval granted by Dr Roger Parslow on behalf of SoMREC Co-Chairs)