Educating for Autonomy in Practice: the experiences of undergraduate physiotherapy students

Jill Roberta Higgins

Submitted in partial fulfilment of the requirements for the degree of
Doctor of Education

Department of Educational Studies
University of Sheffield

August 2000

Contents

		Page No.
	Summary	3
	Acknowledgements	5
	Introduction	6
1.	**Contexts of the Research**	9
	• The Changing Focus of Health Care	9
	• Becoming Professional; Constructing a Professional Identity	11
	• Reflective Practice & the Autonomous Practitioner	13
	• Education & Society	15
	• Physiotherapy Undergraduate Education	19
	• The Physiotherapy Programme Under Study	22
	• Knowledge Generation within the Curriculum	26
	• Researcher Perspective	30
2.	**Concepts of Self & Identity Construction**	34
	• Identity Construction	34
	• Symbolic Interactionism	37
	• Perspectives on Symbolic Interactionism	39
	• Identity Construction beyond SI	41
	• Self & the Developing Professional	43
	• Personal Socialisation	47
	• Role Accomplishment	52
	• Restricted & Elaborated Linguistic Codes	55
3.	**Methodological Considerations**	57
	• Data Collection Method Selection	61
	• Gaining Ethical Approval	62
	• Informed Consent	66
	• Method	67
	• Data Collection - In depth Semi-Structured Interviews	69
	• Determination of Interview Schedules & Topics	70

- Data Collection - Reflective Diaries 70
- Data Collection - In depth Case Studies 71
- Data Analysis - The Interviews 71
- Data Analysis - The Reflective Diaries 72
- Validity & Reliability versus Dependability & Credibility 72
- Limitations of the Study 73
- Treatment of the Data 73
- Results of the Analysis 74

4. Biography of the Students 76

- Student Background 76
- Impact of Pre-University Education 77
- Student Activities 82

5. Student Self and Relationships 104

- Self & Educators 105
- Self & Peers 115
- Self & Patients 118

6. Student Self Evaluation 125

7. Dynamics of Identity Construction 138
- Core Skills 138
- Image of Physiotherapy 139
- Professional Identity 139

8. Reflections on Findings 157

9. Further Reflections, Critique & Conclusions 173

- Impact of Organisation of the Curriculum 173
- Autonomy, Empowerment & Identity Construction 174
- Impact of Clinical Education 175
- Strategies for Change 178
- Concluding Remarks 181
- Practical Recommendations 183

10. References 186

11. Appendix 1 200

Summary

An ethnomethodological approach has focused on the perspectives, strategies and culture of physiotherapy students, as a way of understanding their world, and exploring the process of professional identity construction in the context of their development as autonomous practitioners.

The following significant themes arose from the data:

- biography of the student
- student self and relationships
- students' self evaluation and use of role models
- dynamics of construction and movement towards the accomplishment of professional identity, incorporating evidence of mastery of subject.

Key findings were:

- the curriculum structure experienced places emphasis on acquisition of propositional and professional craft/process knowledge
- the perception of disempowerment within the university learning environment, when compared to the clinical environment
- potential difficulties in managing role changes leading to role conflict
- construction of professional identity via the use of negative rather than positive role models
- judgement of personal performance only on the basis of formal transition points and the use of high status external cues
- little acknowledgement of the value of personal knowledge and understanding of self

- the learning experience does not facilitate professional identity construction
- students have an awareness of autonomy but are not enabled to function autonomously.

Recommendations include 'unloading' the curriculum and restructuring of the context of learning as experiential, offering students opportunities for the integration of knowledge, competencies, the exploration of self and enhanced self awareness. Increased understanding of self will promote skill in self evaluation, encourage emulation of more positive role models, enhance justification of effectiveness, and encourage movement away from the focus on time served and patient numbers treated as the bench-mark for denoting professional expertise.

Acknowledgements

My grateful thanks to:

- the student participants who gave freely of their time and their thoughts, allowing me to share in both their triumphs and disasters along the way, and providing me with some moments of great humour which I shall treasure. I wish them all much success in their careers as thoughtful practitioners

- the physiotherapy department where the study took place for the financial support, and colleagues past and this present for their personal support. I hope the findings allow us all to move forward in offering an enhanced experienced to our students

- Glenda, for her transcribing skills, and for providing another, unsolicited and humorous source of data interpretation

- Professor John Quicke and Professor Mairtin Mac an Ghaill, latterly from the University of Sheffield, Department of Educational Studies, for their supervisory support during the initial writing up, and to Dr. Alan Skelton, of the Department of Educational Studies, for his support and help in the latter stages

- my husband Bill, special thanks for your ever present support, patience, gentle cajoling and enduring faith in my abilities

- my family and friends, all of whom I have neglected considerably in the past months. I look forward to restoring 'normal communications' as soon as possible.

Introduction

This work explores the lived experiences of physiotherapy students during their undergraduate years, as they construct[1] their identity as physiotherapists.

Achieving the goal of autonomous practitioner in physiotherapy means the demonstration of skill in self evaluation, and that self evaluation is self validating. The individual physiotherapist perceives him/herself as competent, and feels competent to make such a self judgement, demonstrating reflexivity. Such is the goal for undergraduate physiotherapy students.

This study is based upon the following initial questions:

- How do physiotherapy students become professional?
- How does autonomy in practice relate to becoming professional?

These lead to the development of the interview scheme (Appendix 1), used as a starting point for the interviews.

A key statement within the learning outcomes for any physiotherapy undergraduate programme of study is that the graduate will be able to function as an autonomous practitioner. My thesis is that whilst these undergraduate physiotherapy students are educated about autonomy in practice, they are not enabled to function autonomously by the time they graduate. A corollary to this is the issue of

[1] within an Symbolic Interactionism (SI) framework, behavioural acts are constructed (Garfinkel, 1967); if such acts give rise to professional identity, then identity is constructed rather than accomplished.

whether a professional is in fact ever autonomous in practice. These issues, in conjunction with the key concepts of professionalism and professionalisation, will be explored in Chapter 1: Contexts of the Research.

I have identified what for me are the confounding factors which seem to suggest there is a gap between stated, expected and actual outcomes. Firstly there is a lack of cohesiveness in philosophical approach of university educators in facilitating professional identity construction, largely emanating from the lack of consideration of the principles of reflective practice which are held in common (Quicke, 1996). Secondly there is a desire to enable these students to be as other university students whilst they undertake their studies, and thirdly, in the clinical practice experienced by the students, there is the adherence to a time served apprenticeship model of learning (Richardson, 1999b). These are the key issues which have arisen following reflection on informal conversations with both staff and students involved in the programme under study.

I also suggest that these differences are compounded by the changing focus in the health care environment within which these students will find employment, as well as the changing role of physiotherapy. Such issues will be explored fully in Chapter 1: Contexts of the Research.

This study explores the experience of becoming a qualified physiotherapist, such that understanding the experience may both answer the questions posed and shed light on how a student is enabled to construct a professional identity. It is important to identify at the very outset my own positionality in this work. Within this work there is the lived experiences

of the students, and whilst I have explored with an open mind, it is not an empty mind. Indeed as Parry (1997) indicates, a researcher's personal view of the world influences generation and formulation of the research questions posed. What follows is my perspective on what is happening from my role as researcher, and as a founder member of the academic team. Any critique is therefore, from my position within this team. Exploration of research methodology (see Chapter 3: Methodological Considerations) suggests that the best way of understanding what is happening to the students is by asking the students themselves; thus the focus of the data is to see the world of the physiotherapy student as they see it, setting this against the personal perspective of the researcher.

The main theoretical resources for the work are theories of identity construction, Symbolic Interactionism (SI) and more recent work on identity construction from a post-structural perspective. These resources are explored in Chapter 2, and have been used as justification for the methodological approach of exploring the students' perspectives, strategies and culture as a basis for understanding their world. Other background contexts which set the scene, within which this research took place, are included in the first chapter.

The remainder of the thesis consists of analysis and interpretation of data, based upon the theoretical resources identified. The final part of this work is clarification of the problems within the curriculum studied, the suggestion of possible solutions, and an attempt to situate this work within the wider remit of education and educational research.

1. Contexts of the Research

Physiotherapists work within an ever changing and complex environment and the educational process for new entrants to this profession is also complex and confounded by a wide variety of contexts. This chapter will explore the following contexts within which the work has been carried out:

- The Changing Focus of Health Care
- Becoming a Professional; Constructing a Professional Identity
- Reflective Practice & the Autonomous Practitioner
- Education & Society
- Physiotherapy Undergraduate Education
- The Physiotherapy Programme Under Study
- Knowledge Generation within the Curriculum
- Researcher Perspective

The Changing Focus of Health Care

The many recent government initiatives[2] have all served to change the focus of health care in response to population changes, financial constraints and changed attitudes towards health, illness and disability. Health care is now patient centred rather than disease focused, there is a palpable shift towards prevention rather than treatment of illness, and patients now have the expectations of a purchasing consumer within the health care environment. These changes are primarily in response to changing demands upon the over-worked National Health Service (NHS) system. The

[2] The NHS & Community Care Act (DoH 1990); The Health of the Nation (DoH 1991); The New NHS: Modern, dependable (SoS for Health 1997); Our Healthier Nation (SoS for Health 1998).

increasing size of the elderly population, awareness of individual rights and the recognition of need for a cost effective system within limited resources, have precipitated the shift towards prevention and health promotion. There is now an expectation upon all health care professionals to be accountable both in terms of the outcome of their practice and in terms of their use of resources (Richardson, 1999a), which has been further formalised through the advent of clinical governance. The period of continual change in the health service, the move towards multi-disciplinary working and primary health care have substantially changed the role of physiotherapy, resulting in an increase in clinical autonomy and higher professional status (Sim, 1997). With this change comes the need for physiotherapy to redefine itself as a profession. Richardson (1999a) states clearly:

> *"Physiotherapists need a clear view of the purpose and intent of their profession and a conscious awareness of a professional identity which encompasses purposeful actions. ... "* (p.462).

One of the key changes in the way health care is delivered is in the acceptance of a much less paternalistic therapeutic relationship. Historically paternalism has been associated with the individual being the passive recipient of health care. From a sociological perspective, paternalism is viewed as a legitimation of power in decision-making by the health professional. The rise of consumerism has evoked a shift from this paternalistic biomedical model to an autonomy model, emphasising the right of the individual in decision making (Singleton & McLaren, 1995). Whilst some individuals may waive their decision making rights, and for others paternalistic intervention may be justified, the

majority of patient encounters within physiotherapy will expect a negotiated consultation with respect to outcome. This is the challenge new entrants to physiotherapy have to meet.

Becoming a Professional: Constructing a Professional Identity

This time of change in the NHS and health care provision impacts upon all health care professions. It is useful here to explore concepts of profession and becoming professional in respect of physiotherapy, and I have used a variety of theories in re-thinking these issues. The following section recounts my thoughts.

Formal definition of being professional is bound up with the acquisition of a specific body of knowledge, but what distinguishes an individual as being professional is less obvious, and probably has its basis in a recognised and stereotypical set of behaviours, or behavioural competencies, which are identified as the hallmark of being of a particular profession. Friedson (1994) described profession as synonymous with occupation, defining it as

> *" ... esoteric, complex and discretionary in character, requiring knowledge, skill and judgement that ordinary people do not have, may not wholly comprehend and cannot fully evaluate ... "* (p.200).

In this, Friedson agrees with Haworth (1977) who indicated that professionals do not merely exercise complex skill, but also identify with it: there is a *"devotion to craft for its intrinsic value "* (Friedson, 1994, p.215). Waddington (1985, p.650) identified traits of professional activity as the possession of skill based upon theoretical knowledge, provision of training and education, testing of competence of members, organisation, adherence to a code of conduct and

altruistic service. Identifying and reproducing traits for the professional implies an *"ideal type'"* which according to Bines & Watson (1992) has been constructed in a particular cultural and historical context which ignores some of the important aspects of interaction between professions and society, and is based on nothing more substantive than personal preference. Historically within physiotherapy there was such an implication, but in recent times, with the drive to widen access for the profession and with the advent of equal opportunities, there has, thankfully, been considerable movement away from such specificity. Bines & Watson go on to identify that what is of importance is not the recruitment of the *"ideal type"*, but the process of achieving professional status. Professionalisation denotes issues of status and professionalism concerns the rights and obligations to determine one's own tasks, i.e. how to use those behavioural competencies. Professionalisation then, may be viewed as the process by which status is developed and achieved and is related to control and autonomy (McCulloch, 1995).
Autonomy may be defined as the *"capacity to think, decide and act on the basis of such thought and decision freely and independently"* (Gillon, 1986, p.60). According to Dworkin (1988) autonomy is an aspect of liberty which is further defined as *"the ability of a person to do what she wants, to have options that are not closed or made less eligible by the actions of other agents"* (p.14). Autonomy is therefore related both to action and to thought and decision making, and Sim (1997) identifies the ethical principle of respect for autonomy as central to health care in general and to the activities of therapists in particular. Øvretveit (1985) identifies the very different concept of *"professional autonomy"*, the ability of a profession to control and regulate its own professional activities in an independent manner. Clearly the different

interests involved are a likely source of tension between patient autonomy and therapist autonomy.

Reflective Practice & the Autonomous Practitioner

Professionalism constitutes the behaviours, attitudes, frames of reference and personal constructs by which an individual utilises this body of knowledge. Professionalisation is the process of developing professional status, and therefore constructing professional identity, linking the process to developing autonomy and control (McCulloch, 1995). Implicit within professionalism must be a response to the professional education process experienced. One of the findings from data analysis in this work which will be returned to in detail later, is the lack of ability within the students to be self validating, a fundamental part of autonomy. McCulloch (1995), in linking identity with autonomy and control, suggests that where there is a lack of ability to function autonomously, there is a deficit in professional identity. Since there is clearly a link between construction of professional identity and autonomy, it is worthwhile at this juncture to explore the notion of the autonomous practitioner and as a component part, reflective practice.

The rhetoric of the programme under study accepts totally Schön's definitions and descriptions about how professionals learn and what defines reflection, but there has been little analysis of common principles upon which there is agreement. Physiotherapy has embraced the notion of the reflective and autonomous practitioner, whilst other professions such as education have critiqued the term as one that has no clear meaning (Calderhead, 1989, Quicke, 1996, Lucas, 1992, Gilroy, 1993, Cross, 1993). Calderhead (1989)

identifies three conceptions of reflection, whilst Lucas (1992) describes a situation within a department where at least four different interpretations of reflection exist; thus the term is widely used to describe both the teaching process and the practice, reflection may be said to be an *"essentially contested concept"* (Gilroy, 1993, p.127) where meaning shifts to accommodate the interests and interpretations of those using the term. It is therefore merely *"common rhetoric"* (Gilroy, 1993, p. 127). Gilroy (1993) gives a lengthy discourse on the fallibility of Schön's underpinning epistemology for reflective practice, and ultimately, whilst accepting that there may be some truth, suggests there is much in the work which needs re-thinking.

Quicke (1996) identifies reflective practitioners as individuals with the capacity for self reflection, reflecting upon assumptions which inform their practices, which in turn are grounded in self definitions. It is therefore self-examination, with a focus on personal narrative, which when articulated results in a form of self understanding which enhances autonomy. Quicke further defines autonomy as implying self can consciously reflect upon the determinants of action and is consciously aware of the full range of alternative courses of action. The self is always encumbered (Sandel, 1984) by that which constitutes identity, and as such individuals may perceive themselves autonomous, but be constrained by commitments from which they cannot free themselves – therefore they are effectively fixed in outlook. It is conceivable that an individual may think they are being open and unconstrained in making choices, but they have not recognised that the intentions spring from their own nature or *"self-in-the-world"* (Quicke, 1996, p.14). These models of reflection are disempowering and resonate with my

perceptions of what happens within the programme studied. Quicke (1996) goes on to propose that educating for autonomy involves improvement, encouraging evaluation and prioritisation of commitments, fostering pluralism and diversity, facilitating the recognition, expression and development of individual 'voices'. For me, these features are not overt within the programme under study.

Education & Society

My starting point for exploring undergraduate physiotherapy education is the effect of general education on society as a whole, and the application of this to the specific society of physiotherapy. The role of the curriculum within general education, and its impact on society, has been explored by theorists such as Bowles & Gintis (1976), Silver (1980), Giroux (1981), Apple (1982), Kemmis & Fitzclarence (1986) and Kemmis & Stake (1988).

Bowles and Gintis (1976) developed what became known as a *"correspondence theory"* of social reproduction (Kemmis, 1990, p. 38), using the concept that schools are given the role of reproducing values and practices appropriate to different levels in society. The effect therefore was to maintain correspondence of social class structure from one generation to the next, despite the possibility of social mobility. Such theory is challenged by the likes of Giroux (1981) and Apple (1982) who introduce the concept of contestation: that the broad structure of society remains the same but it is impossible to predict the actual location of individuals; this would be achieved on an individual basis via a process of cultural contestation. By this it is suggested that individuals adopt forms of social life and patterns of interaction which fit more comfortably with a particular social or economic group.

Feinberg (1983) looked at education as a form of social reproduction, in that it maintains inter-generational continuity and identity of a society even in the context of significant change. He goes on to suggest that education has two functions:

> *" ... reproduction of skills that meet socially defined needs ... also those habits and behaviour patterns that maintain social interaction in a certain structured way."* (p.37).

Subsequently Feinberg indicated that this is not just about interactions in everyday life, but also about patterns of behavioural relationships between individuals with different skills; he cites *"doctor and nurse"* (Feinberg, 1983, p.37). School (educational provision) is then the formalisation of the moments of reproduction into a structured curriculum. Within physiotherapy there are identified periods of significant change, but, according to Feinberg, the identity of the society (profession) is maintained via social reproduction. However, changes in health care provision and delivery per se have precipitated significant role changes for physiotherapy and in the patient therapist relationship; thus the maintenance of this *"social interaction in a certain structured way'"* (p.37) is insufficient for the new entrants to the profession. Their socially-defined needs have changed substantially in tune with the change from paternalism to patient autonomy, but the profession itself is slow to respond within the clinical environment and a mismatch is presented between the university based experience and that in clinical practice.

To understand the process of professional development, the work by Friedson (1994), and Bucher & Stelling (1977) is helpful. This work identified the interaction of structural and situational influences in training programmes as being responsible for producing the professional characteristics of that programme, such that outcome is determined by the nature of the programme. Such a 'programming' effect may be explained as a form of social reproduction in that, as Feinberg (1983) suggests, skills are being reproduced that meet perceived needs (profession specific skills), and the habits and behaviour patterns of those delivering the programme have the potential to ensure that the social interaction (patient - therapist), is maintained in a certain structured way. The ideological perspective of those who are delivering the programme is therefore important in shaping outcome, and dependent upon responsiveness to change within those charged with the education of new entrants to the profession.

If such theorising is imposed on the development of the particular society of physiotherapy, it may be suggested that the educational process has moved from correspondence theory towards contestation, with the university being charged with the responsibility for reproducing appropriate values and practices. Correspondence theory might explain why little change has occurred from generation to generation with the custom and practice of learning to be a physiotherapist and the career structure left largely unchanged and unchallenged. The recently imposed changes have had the effect that the broad structure of the profession may remain unaltered, but it is not possible, or even desirable, to predict the career or developmental pathway for the individual. Kemmis (1990) indicates contestation theories as taking a dynamic view of society suggestive of continued

development, which leads comfortably into the current ethos of continued professional development and lifelong learning. Contestation is also suggestive of a dynamic process which encourages open debate and leaves room for differences.

It was the work of Marx and Engels (see Williams, 1973) that forms the foundation of theories of social and cultural reproduction which link curriculum and culture. Subsequently though, it was Gramsci's ideology, shaped and structured by hegemonic groups, which has had most impact on current educational research. The net result appears that through Gramsci drawing attention to the processes of contestation, by which reproduction and the transformation of culture, society and the economy occur, we can see the school (education provider) not only as constructing views of society and culture which it selects and represents as the 'official' written curriculum, but also raising the question of the 'hidden' curriculum.

> *"Through analysing such media of social interaction as the languages and discourses in which people understand and communicate about their world, the material activities and practices through which they interact, and the social relationships and forms of organisation by which human interaction is structured and regulated, it is possible to articulate increasingly clearly how school curricula reflect and reconstitute, reproduce and transform the patterns of life of different groups in society ... "* (Kemmis, 1990, p.40)

It is not difficult to see that although the focus above is on schools, the rationale may be applied to physiotherapy and the impact of both 'official' and 'hidden' curricula within a specific educational institution. It is necessary therefore to explore the impact of the overt professional education experience of the undergraduates, and attempt to identify if

other more hidden messages about the profession are being given.

Physiotherapy Undergraduate Education

Marked by a change in the bylaws of the Chartered Society of Physiotherapy (CSP), physiotherapists gained professional autonomy in 1977. Prior to such change, the training and assessment of physiotherapists was the over-riding responsibility of the medical profession (see Parry, 1995).

In January 1989, as part of the Conservative Government re-organisation of the National Health Service (NHS), 'Working for Patients' (HMSO, 1989) was published, outlining changes to NHS professional training and laying down guidelines for the planning and provision of such training. The most fundamental change was the extension of consumerism philosophy into the education sector. Educational institutions were invited by Regional Health Authorities to tender for the provision of physiotherapy education. Some qualifying programmes had already established links with universities and by 1995, all physiotherapy education was conducted within the higher education sector.

The challenge for the curriculum is to ensure that graduates are equipped to cope with the demands of contemporary professional practice. To achieve this, it is important that physiotherapy educators have a true understanding of the experiences of students of the profession, and have themselves constructed a substantive professional identity. Assurances of the success of a professional education programme can only be gained by exploring both the processes by which new entrants are inducted into the ways of the profession, and examining how the ways of the

profession are changing to meet the changes in the health care environment. How students learn to act as members of their chosen profession, adopting the mantle of professional identity and performing in an ever-changing arena, is central to this work. The question arises from a perception that the undergraduate education experience is to be endured rather than enjoyed, that it produces a role conflict for the student, and does not engender the development of self evaluation.

The recent changes in the manner of educational provision offer potential for conflict. One such opportunity is within the curriculum itself and how it fits [or otherwise] into the general scheme of a university education system. Another emanates from the so called 'hidden' curriculum. Lundgren (1983) suggested that what is chosen by curriculum makers reveals how those curriculum developers are ideologically bound. Where the curriculum is developed by one group and implemented by another, such hidden elements are unacknowledged.

Within teaching teams one might expect periods of intellectual as well as personal conflict resulting in the consideration of the group as less of a team and more of a collection of individuals without the depth of understanding of each other that was originally perceived. Rowland (1993) describes an experience from his teaching where he wished to explore the rhetoric of active learning and conducted a workshop with no structure, to allow the experiential exploration of active learning, with particular respect to negotiating personal learning and exercising control over personal activity. In the final analysis individuals felt safe enough to voice concerns about intellectual capability, lack of understanding of the discussions which everyone else

seemed to be following and seemed important to them. Such personal revelations are difficult and may only be articulated in a supportive and non-judgmental environment. I use Rowland's example to illustrate what for me is a key to many of the issues around the hidden and also the official curriculum of which I am part; that much of what is thought to be understood is left unarticulated, thus it is never overtly clarified for fear of judgement. Progress is therefore, inhibited and as a consequence one might suggest that mixed messages are given out to the student body, a very likely source of conflict, anxiety and misunderstanding. Rowland (1993) writes of *"Pedagogy in Confusion"* (p.16), and how educational theories and models should be treated with caution. He states that for tutors and participants on professional courses, i.e. the caring professions, the relationships between tutor, learner and subject matter, and therefore, understandings of pedagogy, come from a variety of sources. Within the caring professions there is a focus upon the well being of the subject, indeed that is a fundamental tenet of care. This focus is replicated in the educational environment in that a learning relationship is constructed or negotiated. Concepts such as independent learning and student-centred learning used to be considered rather radical (Friere, 1972). Now such terminology is the required rhetoric of all in higher education, especially within the health care environment where it is seen to gel with empowerment. If however, the learning relationship is falsely constructed, it may serve to increase dependence and disempower.

Kemmis (1990, p. 40) writes of curricula in terms of a *"cultural map"*, and states that the primary purpose of the curriculum has to be to identify what should be selected from

the culture as appropriate and realisable in teaching. Lundgren (1983) suggests that curriculum development is ideologically bound and that the main problem is to identify those aspects of the life and work of a society (context of production), to be represented in school (context of reproduction). The choices made by curriculum makers say something about how these individuals perceive and participate in this society and culture, and of their social location - as agents of hegemonic groups. Kemmis (1990) explains that many theories of cultural and social reproduction make analysis and evaluation of curricula possible, not only in terms of their intended aims, but also in terms of the ways in which the curriculum and pedagogy create forms of life for the students and how these reproduce or transform forms of life in society at large. By superimposing such theories onto a smaller specific society, analysis and evaluation of the curricula should be a tangible focus.

The Physiotherapy Programme Under Study

Whilst the philosophy of the programme advocates integrated study and blurring the distinctions between research and practice, it is my perception that the programme readily fulfils a *"technocratic model"* (Bines & Watson, 1992). I base this on the following: firstly there is development and transmission of a systematic knowledge base, secondly the interpretation and application of this knowledge base to practice, including problem solving principles and processes and socialisation into particular values and behaviours, and thirdly, supervised practice in selected placements.

This model is based upon what Schön (1983, 1987) referred to as *"Technical Rationality"* (TR), embedded within which is a

hierarchy of professional knowledge in which research is expected to provide the substance from which to derive theory to solve problems. Such a separation of elements results in a curriculum which offers first the relevant basic and applied science, then the skills of application to real world problems of practice. Within this particular programme, the curriculum also offers an interim stage where the skills of application are simulated in the university environment prior to the opportunity for adoption of the role in the real world. From the viewpoint of TR real knowledge lies in the theoretical basis and therefore must come first, application to problem solving comes later. It can also be said that the physical arrangement of this specific curriculum reflects the basic divisions among the elements of professional knowledge, and consequently teaching roles tend to reflect the same divisions. How does TR fit with social reproduction? I would suggest that the one encourages the other. The constraining nature of the TR model which suggests a linear pathway to knowledge, and a constrained definition of knowledge, can only encourage the reproduction suggested by Feinberg (1983) that skills are being reproduced that meet socially defined (profession specific skills) needs. If these are inaccurately defined then the reproduction is inappropriate.

During the three years of the programme students gain a body of knowledge which is essential for the reasoning and decision making which are central to professional practice. It is my belief that the ways of knowledge made available within all aspects of this curriculum follow a scientific method which is part of an empirico-analytical paradigm (Higgs & Titchen, 1995, a, b) and the presentation of the curriculum leans heavily towards a medical model, failing to

utilise the human capacity for self reflection or reflexivity, and not utilising the influences of previous experiences in the development of knowledge.

The medical model is increasingly recognised as inappropriate in physiotherapy, and indeed the documentation for the programme under study does not advocate its use. It appears there is a mismatch between the philosophical, documented rhetoric and the actual experience. Higgs & Titchen (1995a) cite the work of Habermas (1972) who identified three different classifications of how knowledge may be derived; the empirico-analytical paradigm cited above which gives rise to technical knowledge that is predictive in nature; the interpretative paradigm which gives rise to practical knowledge that is embedded in human interaction and meaning; and finally emancipatory knowledge which is linked to the critical paradigm and advocates awareness of the social and historical construction of thinking. Within physiotherapy, as in medicine and other health care professions, technical knowledge is more valued than both practical and emancipatory knowledge, and it is this limited appreciation of the derivation of knowledge which will inhibit the development of the profession as a whole, and cloud the identification of purpose and intent of the profession (Richardson, 1999a)

Pathways to knowledge are many and varied. That described by Carper (1978) for nursing, and subsequently added to by Sarter (1988), offers a sound focus for physiotherapy undergraduate education. This pathway has knowledge emanating from empirical, aesthetic, personal, ethical and interpretative pathways, and suggests that restriction to any single way of knowledge limits both the range of knowledge

and depth of understanding available for problem solving. Schön (1987) confirms that effective professional practice requires a combination of different paradigms. It seems the learning experience of the curriculum studied is constraining rather than facilitatory.

Carr (1995) writes of teaching as a social activity and much as for teaching, undertaking physiotherapy is a way of thinking and acting, into which novice practitioners are initiated. It is maintained through the routine, everyday social activities that occur within physiotherapy departments. Carr uses Gramsci's phrase of *"mechanically imposed"* form of thought (p.53) from which common-sense craft knowledge is derived. Within the community of physiotherapy, it is what 'everybody knows', and this has the ring of reproduction theory about it and takes no account of the individual's experience and understanding. From an SI perspective this is contrary to the individual's negotiation of understanding of experience. Carr also suggests that teaching practices in general fall more or less into two philosophies, *"traditional"* and *"liberal progressive"* (1995, p.54). Within the institution under study, there is a desire to follow a liberal progressive philosophy, with its guiding educational slogan of learning from experience with weak subject differentiation (Carr, 1995, p. 55), but this is hampered by the constraints of a curriculum content which is often subject-centred with rigid differentiation, particularly in the minds of the participants in the programme. The traditional philosophy is suggestive that a predetermined set of knowledge is the foundation for further intellectual development; the progressive approach focuses on the concept of the already thinking participant who needs facilitation in coherent thought to enable development. It is recognised that there is some mismatch

between the rhetoric of the underpinning philosophy and reality in provision. The likelihood is that this discrepancy arises within the teaching team from the differences in what we say we do and what we actually do, and paucity in articulation of the 'shared' meanings of the underpinning philosophy. Hammersley (1983) when discussing the notion of natural settings indicates variation in what teachers say and do in the staffroom when compared with what they say and do in classrooms. Hammersley, in the same work, also indicates that in the staffroom different contexts are created depending on who is present. Ball (1983) confirms the importance of shared understandings within the education environment, and suggests that much of the social life in any complex organisation *"trades on the consequences of previous encounters, events and incidents"* (p.80) and stresses the importance of understanding the linguistic codes utilised by members of a particular organisation.

It is because of the complex nature of the situation that an ethnographic methodology was adopted. Such a methodology acknowledges the ethnographer as participating in the lives of the individuals within the study for an extended period of time (Hammersley & Atkinson, 1995), and the sense I as the researcher make of what is observed is influenced by the ideas I bring with me both from my experiences as a physiotherapy student and physiotherapy educator, and as Hammersley (1985) indicates, by my experiences in the field and the role I have adopted in the setting under study. The methodological considerations of this work are explored further in Chapter 3.

Knowledge Generation within the Curriculum

Knowledge is commonly classified as propositional and non-propositional (Polyani, 1958, Kuhn, 1970), and the domains

identified earlier fall into these categories (see Higgs & Titchen, 1995a, p.525). Non-propositional knowledge is derived from practice and experience, propositional knowledge encompasses book knowledge and the formalised relationships between concepts and constructs (Benner, 1984). Propositional knowledge is derived from research and scholarship and is given greater status because of a hierarchical relationship which has developed from the need for professions to establish themselves within an academic arena. The result of this is that science superseded craft or artistry, and technical knowledge with its origin in a scientific paradigm became the foundation for organising the knowledge of the professions (Schön, 1983, Eraut, 1985, Higgs & Titchen, 1995a, b). Higgs & Titchen (1995a, b) offer three overlapping and interactive types of knowledge:

- ***propositional*** which has been ratified by the field
- ***professional craft knowledge*** which incorporates 'knowing how' with tacit knowledge of the profession, referred to by Williams (1998) as process knowledge
- ***personal knowledge*** , the knowledge which is tied to the individual's experience or reality.

The authors also cite their agreement with Barnett (1990), that it is unreasonable that propositional knowledge should have such status in a world of complex problems without definite solutions. In order to prepare the new professionals in physiotherapy, the education programme needs to facilitate students in developing knowledge and skills to work in this changing context. This is indeed the stated philosophy of the programme under study, but is not, I would suggest, the actuality of it.

Whilst the need for evidence-based practice and a persistent preference for quantification remains, the changing focus of

the NHS has precipitated a move away from the philosophy of care just being science based technical practice. To be able to fulfil the redefined role of physiotherapy in a patient-focused health care service requires a change from the:

> *" ... traditional notion that knowledge is only generated by academics through research"* and the promotion of *"the equally valuable notion that practitioners generate knowledge through their practice and through their own personal search for meaning"* (Higgs & Titchen, 1995a, p.529).

Effective clinical practice is underpinned by the harmonisation of knowledge (Higgs & Titchen, 1995a, b), thus any undergraduate curriculum, in terms of its content and delivery, must facilitate the integration of propositional, professional craft and personal knowledge. Students are exposed to and influenced by many variables throughout their undergraduate period (Sabari, 1985). Gathering of knowledge, both by the students and those in the educator role, and its lifelong nature is an experience which is seemingly marked by implicitness of learning rather than explicitness (Oleson & Whittaker, 1968, 1977; Tompson & Ryan, 1996; Houle, 1980). It should be acknowledged here that the educators are also embarking on a knowledge gathering process, because, in their own way, the tutors are also cast in the role of learner (Hall, 1996), as they must adjust to life in education rather than clinical practice, and to the changing role of physiotherapy in the changing NHS. All physiotherapists, and especially those involved with new members of the profession, need to have a deeper understanding about the nature of knowledge and its generation (Higgs & Titchen, 1995a, b; Higgs & Titchen, 2000), such that the profession may be enriched and evolve. If physiotherapists wish to promote effective, autonomous

clinical reasoning then the learning environment should promote learner self-direction, responsibility and flexibility of thought (Terry & Higgs, 1993; Titchen & Higgs, 2000). Brookfield (2000) suggests that only by critical appraisal and the thinking skills of clinical reasoning being central to practice, can a professional be safe and effective.

Historically the university environment is identified with a didactic model of teaching and learning. The tutor has the responsibility to define the students' learning needs and to provide appropriate instruction. In this arrangement the students' only responsibility is to respond appropriately. This may be seen by those new to the education environment as a relatively safe way forward, the tutor having the most control. Largely, with the existence of the Curriculum Framework (Chartered Society of Physiotherapy, 1996), the students' learning needs may be thought to be fully identified – however within this framework is the requirement to foster the skills of lifelong learning. Approaches are required which will offer the student responsibility for their own learning, but within the context of fulfilment of specified outcomes. I would suggest that the skill is to fulfil the required outcomes but offer a process which allows 'room' for individual responsibility, establishing a 'power-sharing' relationship.

Within the programme studied other strategies of teaching and learning have been employed which are perceived to be geared towards giving responsibility to the student. However, the manner in which the responsibility is given is probably just as didactic as the traditional tutor/learner relationship. Utilising workbooks may be seen on the one hand as giving responsibility to the reader, but a package of

programmed learning can be even more didactic, just allowing learners to work at their own speed. With so much control with the tutor, the individual learner is not encouraged to think in a challenging or controversial manner, or even to identify a little bit of themselves in the learning. The didactic model suggests that learning is objectively pre-specifiable and exists within a context in which both knowledge and social status are hierarchically determined, and serves to replicate these social relations (Rowland, 1993). As suggested previously, Feinberg (1983) looked at education as a form of social reproduction, maintaining intergenerational continuity and identity even in the context of significant change. By indicating that education functions to reproduce skills, habits and behaviour patterns to maintain the predetermined manner of social interaction, it is perhaps that the education for such reproduction is in fact, too specific and explicit, leaving little room for the incorporation of personal socialisation, personal identity negotiation and construction. Alternatively, change is too rapid for educational process or it is unrecognised as taking place in social needs.

Researcher Perspective

Any understanding I may develop about becoming a physiotherapist will be situated, at least initially in my own experiences of becoming a physiotherapist, and in my experiences as an educator and researcher of the programme studied.

Training to be a physiotherapist, for that is how it was described, consisted of an initial period of subject based study with regular examinations. If successful in these, one was allowed to begin clinical work. The next year continued half

day school based study, half day clinical in a wide variety of clinical environments.

There followed a year of further half time clinical and half time school based study with changed topic areas. Study now focused on pathology, treatment skills and strategies and practical skills continued. The final year consisted of clinical work, with some afternoons dedicated to 'finals lectures' on how to succeed in your final examinations. These were practical examinations, the examiners being a physician of some description and a physiotherapist (Parry, 1995). Following success in finals, the usual practice was to undertake a 'rotational' post, working in a particular clinical area for three or four months, then 'rotating' to another, the idea being consolidation of pre-registration experience. A junior may be expected to be in post for 18 months to two years before seeking promotion. This is still very much the expected route in an employment career, specialising from graduation is considered poor practice by many clinical physiotherapists, but is the norm within three to five years of graduation.

I became a student teacher at a hospital-based school of physiotherapy, and remained in this environment to complete my teacher training and undertake my first post as a qualified teacher. The many organisational changes which occurred subsequently within the NHS began to take effect on provision of physiotherapy education, a result of which was the development of a new undergraduate programme for physiotherapy. Previous physiotherapy education was carried out in a hospital-based School of Physiotherapy, with most clinical experience being gained in the one hospital. Physiotherapy students did not mix with other students in

higher education, largely because the course, its structure and point of delivery actively precluded contact with anyone other than other health care students such as nurses, radiographers and occupational therapists, who all had similar training programmes. Hence physiotherapy students were not really in higher education, but 'professional education'.

Today, physiotherapy is an all degree qualification, largely situated on university campuses, an accepted presence within a university structure. There is increased opportunity for interaction with other students on other courses of study. The desire that physiotherapy students should be seen as part of the university scene and therefore as ordinary students whilst in the university, is part of what, for me, generates a conflict for the students. There is an expectation of certain types of behaviour within physiotherapy, for example in practical skills classes, where practice should be carried out in a 'professional manner'. It is difficult to adopt the mantle of 'typical student' in one part of the university, only to have to adopt a different persona for another activity. In these circumstances, with students who are already immersed in a period of indecision about their identity, this can only increase anxiety.

Summary

This chapter has given some background to the variety of contexts in which this study has been undertaken. I have identified the current philosophy of health care provision and its impact on the role of physiotherapy. I have also identified my starting point for looking at the experiences of undergraduate education and commented upon the programme embarked upon by the participants of this study

in conjunction with my understandings of the development of professional knowledge. What is apparent within the literature is the depth of debate about the concepts of reflective practice and autonomy which physiotherapy has yet to explore. With such differing understandings of the concept of reflection, it would be very difficult for students of the profession to have a unified view of reflection and their experiences of it in practice are likely to differ widely (Gilroy, 1993).

There are other contexts which have yet to be explained, to allow the reader to understand how I have interpreted the data. For this I have utilised theories of social education, child socialisation and personal development, personal and professional socialisation and identity construction to rationalise both the starting point for these students on entry to the programme, and the experience recounted. Identity construction from a Symbolic Interactionism (SI) perspective focuses on the acting individual rather than the social system; other more recent work explains identity construction from a post-structuralism perspective. The following chapter explores the concepts of self, becoming a person, the strengths and weakness of SI and post-structuralism as theoretical concepts of identity construction, and how this relates to becoming professional.

2. Concepts of Self & Identity Construction

Identity Construction

Students embarking on a programme of study do not enter that study as blank sheets, rather they bring with them a socialisation process which has been forming since birth. Personal socialisation results from family influences, peer influences and previous educational experience. Implicit within a professional education programme is the final outcome of the graduate professional. This development is experienced as change and this experience of change superimposed on the pre-existing personal socialisation. The changes experienced are personal, affecting physical and psychosocial development, and environmental. All new students encounter this, irrespective of time/life stage. The rationalisation and relative importance of each aspect of this experience will again be personal and individual and have a foundation in the personal socialisation of the individual. Such a process has been referred to as the development of maturity, *"becoming a person"*. Boelen (1978, cited Bentz, 1989, p.1) indicated that becoming mature is a process rather than a state of being, not a finite achievement but something that is always a possibility for everyone. Becoming implies nothing about stages or necessary progressions, which in common usage are automatically implied with the concept of development. According to Bentz (1989) the mature person is someone who:

> *" ... is in dialogue with the child in herself, and with the ghosts and spirits of significant others who have become part of her being"* (p. 225).

In this context the terms *"ghosts"* and *"spirits"* are used to identify two sides of a development and maturation phase

with its origins in childhood. Ghosts are the internalised voices of significant others from childhood, that haunt us to think and act in immature, negative ways. Bentz asserts that these voices have been with us for so long that if we reflect upon them we see them as our own thoughts or feelings. Spirits are seen as the significant others, again from childhood, who encourage and inspire us to be mature selves – in effect they are exorcised ghosts. It is worthwhile remembering here that there is a difference between retaining childlike as compared to childish voices. Maturity does not preclude the ability to act in childlike ways.

Clearly the experiences of childhood are the foundation for adult life. There is continued debate over theories of development and the relative contributions of the characteristics of the individual and the environmental effects upon behaviour – nature versus nurture. The significance of this is fundamental if the environmental experience of professional education has a unifying effect on the individual characteristics, such that in the given environment, natural characteristics are suppressed in favour of professional, learned characteristics of an *"ideal type"* of professional and a desire to inhibit individual identity construction (Bines & Watson, 1992).

Reigel (1987, cited in Sameroff, 1991), suggests there are models of relative contribution for individual versus environment in any interaction, suggesting both a transactional contribution between the individual and their environment, and an interactional one between nature and nurture. Both are active contributors and necessary for the developmental process. Extensive longitudinal research by Sameroff & Chandler (1975) and Sameroff & Seifer (1983)

identified the starting point for an individual as not indicative (or predictive) of the outcome.

The whole nature/nurture debate is a long-standing issue with psychologists, although most would now agree the symbiotic effect of each on psychological development. Within this debate sits the process of identity development, and here the work of Erikson (1963) is useful. The age when the majority of students enter physiotherapy education is situated within the adolescent period of transition from childhood to adulthood. It is during this period that the young person establishes an identity as an individual apart from the family (Atkinson, RL, Atkinson, RC, Smith, Bem & Nolen-Hoeksema, 1996), and the questions of *"Who am I?"* and *"Where am I going?"* are confronted. Erikson (1963) coined the phrase *"identity crisis"* to refer to the active process of self definition which is an integral part of healthy psychosocial development. During this time many beliefs, roles, behaviours and ideologies are challenged, accepted or discarded whilst the individual attempts to shape an integrated concept of the self. There is a fundamental review by the individual of their personal socialisation. If during this period parents, teachers and peers all project consistent ideologies and values, identity formation is easier. Thus it might be concluded that exposure to a consistent professional ideology is needed for professional identity construction. This is suggestive of inherent passivity and complete acceptance of the ideology presented, a reductionist viewpoint, and not my understanding of what being professional is about. However it indicates great potential for any 'hidden' curriculum to have substantial impact at a time when personal vulnerabilities exist within the students.

Successful construction of identity means that the individual has, amongst other aspects, arrived at a coherent sense of vocational direction and ideological perspective, which is not fixed but amenable to further development and growth. Marcia (1966, 1980), building on Erikson's work, suggested that unless the identity crisis is resolved, the individual has no consistent sense of self worth or set of internal standards by which to evaluate major aspects of life. This later work established a four stage identity construction continuum which distinguished the stage of development of the individual. The research indicates that the state of identity crisis peaks during the first two years at college, although during this time, there appears greater definition regarding vocational choice than identification of personal ideology. This suggests the existence of a period of intellectual vulnerability, which is currently unacknowledged within the 'official' curriculum, but may be potentially more receptive to aspects of the 'hidden' curriculum, and highlights the very great importance of the first two years in setting the bench-mark for future identity construction.

Symbolic Interactionism

The main agent of socialisation is the family and this unit has experienced fundamental restructuring with changes in patterns of child rearing, decreases in family size and a more nuclear rather than the extended family set up, familiar to previous generations. This has been compounded by greater dispersion of the nuclear unit and the changing position and role of women in society (Tattum & Tattum, 1992). The impact of other agencies within the community must also be considered as a fundamental issue in the socialisation processes of individuals. It is no longer only the immediate family which impact upon the growing child, but a whole

range of professional input now exists, such as health visitors, antenatal clinics, family doctors, community nurses and obstetricians. All such groups stress the importance of the early years on future development. There has been the changed emphasis on personal and social education, underpinned by the theories of Symbolic Interactionism (SI) in which there is a dynamic interaction between man and society. The 'self' is viewed as a process not a structure, it is active and responsive not passive and fixed (Tattum & Tattum, 1992). SI theories are largely based on the work of Mead which subsequently informed the work of Blumer (1962) and Meltzer, Petras & Reynolds (1975). SI refers to the fact that social interaction rests upon taking oneself (self-objectification) and others (taking the role of the other) into account. The individual and society are inseparable (Meltzer, Petras & Reynolds, 1975). Such theories are directly counter to the deterministic and uni-directional theories of social reproduction. SI suggests that human behaviour results from the way an individual interprets his/her present situation and is not caused by it. Behaviour is not predetermined and released but is constructed as the individual reflects on the physical situation, takes account of others present, reviews the situation in light of his/her own previous experiences and with cognisance of future consequences. Self interaction is active in forming and guiding how human beings conduct themselves. Man does not simply react but evaluates, criticises, defines and then acts in light of personal interpretation and personal construction of reality. Hence, the process of identity construction and accomplishment may be seen as active, evolutionary and something which may be nurtured within an educational forum.

An essential assumption of SI is that social experience is unique (Tattum & Tattum 1992). We each acquire a unique social self through the social experiences in which we engage and through creative reflexivity we give meaning to our social environment (Hammersley, 1979; Woods, 1979; Pollard, 1980). To understand this social self, we need to understand the emergence of self, how the infant becomes a social person. The questions of identity crisis (Erikson 1963) are meaningless outside of social interaction because the 'self' is a social concept. Tattum & Tattum (1992, p.12) cite Mead's definition of self:

> *" ... as that which can be object to itself, that which is reflexive, i.e. which can be both subject and object ".*

An individual may then be the object of his/her own actions in the same way as he/she may act towards other individuals. An individual may analyse and criticise his/her own behaviour and motives and may modify actions following review of previous actions and their effect upon self and others. The reflexive self therefore incorporates the following two ideas: that people have a view of themselves and they can evaluate this self view, and that this self view is based upon, and can ultimately only survive within, certain sets of relationships (Tattum & Tattum, 1992).

Perspectives on Symbolic Interactionism

There are various sociological perspectives of contemporary SI differing in theoretical stance and the resulting image of humans. Blumer (1962) identifies human beings as active agents in creating the social environment, which in turn influences their behaviour. This image dictates his phenomenological methodology. Blumer begins with a

depiction of human behaviour and interaction as emergent and entailing dialogue in the course of which acts are constructed. Kuhn however starts with a scientific concept and a basically deterministic image of human behaviour and dismisses the possibilities of emergent behaviour and focuses on faithful adherence to positivism. Hence the Chicago School (Blumer) and the Iowa School (Kuhn) have fundamental diversity in methodological approach (Meltzer, Petras & Reynolds, 1975). It was Goffman (1959, 1968) who added the manipulative element of human behaviour in his dramaturgical departure from the works of Mead via Blumer. Goffman's premise was that when human beings interact, each desires to manage the impressions the other receives, effectively giving a 'performance', enacting a role, making use of the setting, the props and position with respect to the 'audience' (Goffman, 1959). It is advantageous for the individual to present themselves in a manner which will best serve the identified need. The self becomes an object about which the actor wishes to foster an impression (Meltzer, Petras & Reynolds, 1975). The common link between this and the Chicago School is the assumption that roles determine the behaviour of humans. The major criticism of Goffman's work is in its inherently cynical and disenchanting view of humans and their society, reconstructing, as it does, the previously presented image of humans in society. Goffman's work laid the foundation for the study of the everyday world, which provided the subject matter for ethnomethodology (Meltzer, Petras & Reynolds, 1975). Ethnomethodological studies analyse everyday activities by paying the attention to common place activities usually accorded to extraordinary events, in this way seeking to learn about them as phenomenon in their own right. This methodological approach concerns itself with the process by

which humans understand the work, examining human behaviour on both conscious and 'taken for granted' levels. This also closely resembles the Chicago School in methodological preference, incorporating sympathetic introspection and participant observer research (Garfinkel, 1967).

The most common criticism of SI is the failure of all perspectives to agree on the concept of 'self', other than a preference to see it as a single rather than multiple entity. Although a contested concept, the greatest strength of SI is that:

> *" ... it directs attention to the social derivation of man's unique attributes ... it describes how the members of any human group develop and form a common world; it illuminates the character of human interaction by showing that human beings share one another's behaviour instead of merely responding to each other's overt behaviour; and, in numerous other ways, it implicates the individual with society and society with the individual ... "*
> (Meltzer, Petras & Reynolds, 1975, p. 121).

Identity Construction beyond SI

The key concepts of SI (Blumer, 1969) are essentially that life consists of the fitting together of the action of all individuals, that humans develop reflective and reflexive ideas of who they are through communication with themselves and others. This is a humanistic pragmatist approach to understanding society as the framework within which social actions take place. As such an image is created in which society is not fixed, but an ever-changing network of interactions. This gives rise to an incomplete image of a professional society such as physiotherapy, as an ever changing social world in which all individuals, educators,

students, patients are symbolic active creators of this social world, and the construction of professional identity might be approached as something which emerges through interactions occurring in naturalistic settings. Such a concept of self and identity as processual and changing has been reworked by theorists who have given greater value to the role of structures in identity development (Plummer 1998).

Prior to Mead and Blumer, Durkheim, (discussed in Stones 1998), explored the relationship between the individual and society, suggesting social phenomena cannot be explained in terms of the characteristics of the individual and that society is an emergent phenomena relative to the characteristics of the individuals. The work on structuralism and then post-structuralism, which has in some aspects taken over from SI, is underpinned by Durkheim's insistence that society is a thing in itself which could be studied, a hierarchically structured organisation with its own reality, which is not reducible to the interactions between individuals. This, for me, offers another incomplete, and complementary image of the professional society of physiotherapy.

In pre-modern times aspects relevant to identity, for example status and lineage were fixed and transitions were governed largely by institutional process. Individuality in the pre-modern era was not prized. The idea of individual character and uniqueness is very much a post-modern concept, with recognition of self as a *"reflexive project"* (Giddens, 1991, p.75), individuals having the potential to be what they make of themselves, in light of the society in which they perform. Giddens (Cohen, 1998) effectively sits in the middle ground here, explaining society as both the theory of collectives and the theory of the individual, the structure of society having a

reality all of its own that provides the conditions, opportunities and constraints for social actors when they act.

In establishing the methodology for this research, I have returned to the concepts of SI, tempered by the knowledge that data generated explores one aspect of a highly complex interaction. This work would have been greatly enhanced through the exploration of the society within which these participants were undertaking their learning experience, thus addressing both the individual and the collective elements of identity construction.

Self & the Developing Professional

A fundamental part of being an autonomous practitioner is the ability for reflection both on and in action (Schön, 1983, 1987), which tends to remain focused on professional activities and as such is one dimensional. Reflection per se describes the way we learn from experiences. At an unconscious level it is an automatic human response, but at a conscious level it is less automatic and less equal. We may reflect only on good experiences and ignore bad, thus the degree of reflection is haphazard and unstructured. It stands to reason then that learning from such reflection would also be haphazard and unplanned. A professional education programme should encourage evaluation and foster pluralism and diversity (Quicke, 1996), to enable the learner to interpret personal significance, and to enable integration of learning into everyday experience. It is during this reflective phase that professional and personal dimensions merge (Baldwin & Williams, 1988).

Reflexivity may be seen as the internalisation of these reflections, such that the individual practitioner may take

those reflections and analyse the view he/she has of themselves within these behaviours and within the context of a variety of relationships, for example with patients, with clinical educators, with other health care professionals and with peers. To undertake such personal exploration takes courage, support and a great amount of inner confidence and security, that one might deal with the less welcome aspects of self development which are inevitably to be unearthed. Such self discovery may only take place where individuals perceive security in the environment; it requires high self esteem (Dickstein & Hardy, 1979), an internalised locus of control (Fink & Hjelle, 1973), and it may be too much to expect of individuals already immersed in a period of perceived identity crisis. If the educational process does not offer such supported reflection, individuals will continue in an unstructured and haphazard manner, with the potential to look only at experiences which confirm rather than challenge existing practice, thus restricting their opportunities for developing both personal and professional autonomy.

Self may be seen as a constantly changing entity, with an enduring central core which is potentially less vulnerable. All aspects of the self are socially derived and identity changes can result from changes in position within that society. Identity (our view of ourselves) is constantly under threat, especially in *"person changing institutions"* (Tattum & Tattum, 1992, p.13) such as schools, and by implication, in professional education environments such as physiotherapy. Geer (1968) refers to teaching as an assault on the self, indicating a not necessarily painless process and suggesting that resistance to teaching may be explained as an unwillingness, largely unrecognised by the individual, to upset one's inner self.

Just as we hold opinions and beliefs about other people and physical objects, so we hold opinions and beliefs about ourselves. This set of beliefs constitute the self concept or the totality of thoughts and feelings about oneself with reference to oneself as an object (Rosenberg 1979). There is however a distinction between self concept and the concept of self. The self is according to Mead (1932, 1934) the process of interacting with oneself, talking to oneself. Self concept may be seen as more of a mental structure or organised set of self attitudes which are used in the process of self communication (Tattum & Tattum, 1992). Self concept is of great importance in student development. Heiss (1981) identifies what he refers to as four 'content areas'. These are an identity set, a set of qualities, a set of self evaluations and levels of self confidence. The identity set consists of positional labels referring to social categories to which an individual belongs i.e. mother, daughter, physiotherapy student, physiotherapist, teacher, clinical educator. The set of qualities may be physical characteristics i.e. tall, blonde or may be more affective in origin i.e. thoughtful, cheerful. The self evaluations most easily recognised are those attached to identities i.e. a hardworking student, a skilled clinical educator. The final category is really a measure of how the person estimates his/her ability to master challenges and overcome obstacles. This aspect is a very important component of self concept, and the ability to self evaluate is a fundamental component of autonomy. Issues of self concept, self evaluation and identity construction are overt within the data collected.

The emergence of self is the product of social relationships, arising from a process of social experience and activity (Mead 1934). Recognition of individual consciousness of self

emerges and Mead suggests that this is indicative of the existence of 'Mind' i.e. the capacity to respond to one's self as others respond to it. Self conception is acquired by communication in social interaction, for example with teachers and students, clinical educators and students. Much early learning takes place in family settings where parents may be the significant others. In physiotherapy education the significant others are likely to be the university tutors, clinical educators and patients, fellow physiotherapy students, and those significant others external to study, such as partners and family.

Young children learn early how to influence the feelings of significant others in order to control some of what happens to them. This self learning process has been termed *"looking glass self"* (Kando, 1977, Cooley, 1902, 1909, 1918 cited in Meltzer, Petras & Reynolds, 1975, p. 12, Cooley, 1902 cited in Tattum & Tattum, 1992, p. 17) and is a concept which describes the self as our imagination of our appearance to others, their judgement of us and our consequent feelings. It is not too great a step from here to imagine Goffman's (1959) dramaturgical perspective of playing a role in respect of need and in relation to situation. It is also reasonable to suggest that undergraduate physiotherapy students learn to influence the feelings of significant others in order to control some of what happens to them. The data generated highlighted issues about knowing the 'rules of the game' whilst on clinical placement, and how the rules may change from placement to placement. The most highly rated placements were those where it was apparent the rules quickly became known and the students could have some influence by adopting what seemed the most appropriate role.

Personal Socialisation

Mead explored the process of socialisation as the means by which an individual adopts the culture of the social group. Thus communication is seen as a facility for both giving and receiving messages or symbolic gestures, thereby giving meaning to social situations. Primary socialisation in childhood and secondary socialisation throughout adult life incorporates learning, and to be successful within the group, it is necessary to understand the meanings that objects, situations and ideas hold for certain groups. Human society is based upon shared meanings and common understandings where each individual is able to respond to his/her own symbolic gestures, holding the same interpretation as others. Probably the most important symbol is language and sound, for this conveys an image. Linguistic communication is not only the agreement of categorisation of an object but also an overt demonstration that an individual can put him/herself in the position of another and view the situation from the other person's perspective, taking on the role of the other. The verbal development of an individual cannot take place outside of a social group, and it closely reflects that specific group and culture. Students enter the programme of study with established language skills. Language is verbal symbolic communication (Kando, 1977, p. 133) and it is this capacity for symbolic behaviour that sets humans apart from all other species. People in different cultures use different sounds arbitrarily to infer a variety of meanings (Kando, 1977), and within physiotherapy, there is the immediate need to adopt a new set of sounds (language) in order to communicate within the professional world. In applying this to the emergence of self, Vygotsky (1962) indicates that language structures thought, and the ability to think abstractly fully depends upon language. By determining how and what a person thinks,

language also determines what a person becomes. According to Kando (1977), in determining the self of an individual, language is in part responsible for the development of self concept, identity, personality, attitudes, social and personal adjustment. In effect what is developing is an individual's self awareness:

> *" ... symbolic communication is central to Symbolic Interaction's approach to the progress towards self consciousness"*
> (Tattum & Tattum, 1992, p.20).

Socialisation then, is the process of how we become the person we are, the process of seeking to understand how the new-born infant becomes an adult member of society. It incorporates formal education, acquisition of values and beliefs, attitudes and habits, skills and language. All this is relayed to the individual via the family, peer groups, mass media and educational establishments. These individual agents of socialisation work to produce at any one time both harmony and conflict within the individual, and construct the commitments within which reflection may take place.

As a fundamental concept, socialisation has been subject to much theoretical discussion both from sociological and psychological perspectives. Early theorists offered a strongly deterministic approach. Child (1943) suggested that socialisation was the process by which offspring were moulded by society into the prescribed pattern of that society's culture. Suggestions that the process is passive and the individual is malleable are concerning. Wrong (1961) was heavily critical of this social determinism and suggested that individuals play an active part in developing their personal attributes within their interactions with others. This might

more accurately be described, because of its inherent activity, as the construction of identity. Children [students] should be seen as active beings capable of innovation and change. From a psychological perspective, socialisation has been seen as the 'shaping' of behaviour in response to externally applied reinforcements. Work as recent as 1969 by Langer, indicated that the behaviourist view of socialisation was that activity is initiated by events from outside of the individual rather than originating from within. This theory leans heavily on the conditioning, imitation and mediation work of the likes of Pavlov (1927), Watson (1924) and later Skinner (1938) and is based on a mechanistic stimulus/response approach in which behaviour is then explained in terms of reinforcement. This gives an explanation only for overt or objective behaviour which is seen to be controlled by external forces such as family and teachers. There is no mention of the impact of personality or the sense of self and its contribution to active development of behaviour (Allport, 1961) and behavioural competence.

The interactionist approach to understanding socialisation has as its emphasis the learning experiences of the individual and the adaptation strategies undertaken in the various situations encountered on a daily basis. The process is seen as ongoing and active, reciprocal, lifelong and cumulative (Tattum & Tattum, 1992). The interactionist perspective is of exploration of a process rather than seeking to describe the product. Progress occurs with mediated interaction. The best way of interacting is to learn the common language, and this becomes significant in physiotherapy when a new 'professional language' must be learned. Humans are actively involved in interactions; they do not simply accept other people's meanings and apply previously learned meanings,

but accept, revise or reject them through an interpretive process (Berger & Luckmann, 1967; Shipman, 1972). Human behaviour is emergent and acts are constructed on the basis of dialogue between impulses and social definition (Blumer, 1962).

With age, socialisation becomes a much more reciprocal process. In a lifetime one plays many roles and learning occurs from the role performance of both ourselves and others. There is the establishment of expectation with respect to role, for example father/son, teacher/pupil, patient/physiotherapist. There exists a degree of bargaining and this is closely associated with the power relationship within the roles. Concepts of role and role models become important when analysing how participants evaluate their progress. At primary school pupils take what the teacher tells them without question, at university students may expect their views to be heard. Within physiotherapy education, my experiences were of placid acceptance of what the 'expert' teacher said to be true, even when, or perhaps more especially when, they were reading it from a very large textbook. There is an expectation of today's physiotherapy student to challenge and question the knowledge to which they are exposed. Role definition and expectation is what may be seen to give social, and for that matter, occupational life, its framework. It identifies expectation with regard to individuals and gives a certain degree of predictability to behaviour (Burns, 1986; Goffman, 1959). If there is a confusion within the profession about its role, how can new entrants to the profession be facilitated into this role?

Debate about continuing adaptation and the effect of early experiences continues. What is accepted is that early learning

is vital as it gives an awareness of identity and a sense of unity of self, and that socialisation does not end with adolescence (Tattum & Tattum, 1992). What is suggested is a process of primary socialisation which is mainly concerned with the acquisition of knowledge and internalisation that this knowledge is correct. Subsequently a secondary socialisation occurs in which the concepts of doubt, questioning and possible re-interpretation appear. At this time individuals are at a stage of beginning to choose between institutions, groups, values and beliefs. It is these aspects of socialisation which may be seen as lifelong and ultimately giving rise to a cumulative process. Each situation is seen from the standpoint of having previous experience and knowledge. An individual takes his/her social learning with them day to day. As Tattum & Tattum (1992) point out, *"we are not all that free today from what we experienced yesterday"* (p.10). Discontinuity with past experiences may potentially have a destabilising effect on an individual, especially if that past experience has not prepared an individual for the new social situation. Discontinuity of social experience and discontinuity between socialising agents may be a fundamental key to the particular issues of students moving into higher education, especially since this is also a recognised time of identity crisis and construction (Erikson, 1963). Potential for conflict may arise in the expectations of significant others both within family, peers and within the new educational regime. These issues will be revisited in later chapters as the data is explored, with particular reference to the process of change experienced by the participants in the study, from year one through to year three and graduation.

Earlier I referred to linguistic communication as an overt demonstration that an individual can put him/herself in the

position of another and view the situation from the other person's perspective, i.e. taking on the role of the other, the speaker is able to put him/herself in the position of the other because the speaker internally, reflexively interprets his/her own words at the same time as imagining their interpretation by others. Teachers must be able to put themselves in a child's shoes to appreciate learning and behaviour problems, physiotherapy educators must be able to put themselves into a student's shoes to appreciate the learning difficulties experienced. To be able to do this means developing a "*repertoire of perspectives* " (Tattum & Tattum, 1992, p. 21), to enable an individual to take on a multitude of roles and subsequently project oneself into the situation, beginning to see ourselves as others see us, becoming object to ourselves. In order to accomplish our own role, we must learn the roles of others in order to contextualise that role. The educator's inability to accomplish the role of the student, leaving behind the personal experience of the role of the student as it was, is likely to be a source of conflict, as potentially is any difficulty experienced in moving away from the role of clinical specialist, into the role of educator. Making such a transition exposes the individual to at least moments of identity crisis and perceptions of de-skilling, as he/she moves from one role to another.

Role Accomplishment

Role accomplishment is closely linked to the concept of significant and generalised others. Significant others are influential in the organisation of the behaviour of an individual, such others are in a position of authority or influence. An infant would adopt the standards and attitudes, values and beliefs of such significant others, as it is these people who provide a way of perceiving the world. In this

context it would constitute primary socialisation. Of the student starting on a professional education course, there is an expectation of adoption of the standards and attitudes, values and beliefs of significant others, but this is presented in the context of contestation of professional knowledge, the changing nature of the physiotherapist's role, and the imposed changes within the health care environment, making adopting such standards without question, an unlikely event.

Strauss (1956) cites Mead's introduction of the concept of generalised other to refer to the roles of several others because interaction tends to take place with a range of individuals simultaneously. It is the obligation of the individual to put him/herself in a range of roles to identify the collective thought. Generalised others may include people not physically present at the time. Shibutani (1955) talks of reference groups whose outlook is used as a frame of reference. Reference groups may be normative, the source of the individual's values, or comparative. The importance of relationships within such reference or peer groups is explored in the data. Mead also suggests that the individual and the emergent self are encapsulated in the terms of 'I' and 'Me'; the 'I' being the response of the individual to the attitudes of others, the 'Me' the organised set of attitudes one assumes for oneself. The attitudes of others constitute the organised 'Me', and the individual reacts towards that as an 'I' (Strauss, 1956). According to Kando (1977) Mead was expressing the two dimensional aspect of self; that the 'Me' is partially a product of learned roles and partially socialised, partially predictable and partially self aware. The 'I' indicates the emergent nature of the self in that 'I' always examines, evaluates and interprets environment including own past behaviour and how 'I'

behaves this time, is not just a mere reflection of the past but, always something more – it is reflexive.

Societies in general regard the family as a fundamental unit which, in sociological terms fulfils functions which are important to the society or which no other institution can adequately fulfil. The two basic functions are procreation and socialisation, i.e. renewal and maintenance of society. In the context of this work, family is responsible for the integration of primary socialisation experiences. Schaffer (1988) and previously Shipman (1972) refer to this process as interaction rather than indoctrination, except perhaps in the very earliest stages.

Socialisation transmits via a process of ongoing manipulation of sanctions, a pattern of normative values, attitudes and behaviour which are essential for the maintenance of good order in society. In contemporary society the structure of the family has altered and society's perception of conventional family life and child-rearing has changed with changed legislation on divorce, homosexuality and abortion. Thus, the nature and quality of relationships will have changed. Remember too, that this changed background is concurrent with changes in health care provision brought about as a result of government policy changes to the management of the welfare state, and hence change in professional roles.

A child is born into a family where primary socialisation takes place. In SI, this is the biographical model of socialisation concerned with acquisition of selfhood as a reciprocal and lifelong process. Within the family unit the child learns its role but also the role requirements of other

family members. Thus the child's view of him/herself is dependent upon how others view and respond to his/her behaviour. Eventually a much wider range of roles from outside the confines of the family unit are experienced; to each situation the individual takes a history of social experiences. This interplay between the historical and situational dimension results in the unique social self. It is during primary socialisation that the individual acquires a sense of identity and a sense of location. It is during this time also, that children learn they are reflexive beings, they can communicate with themselves in much the same way as they communicate with others. Implicit within the biographical model is the relationship between primary and secondary socialisation, a lifelong continuous process. Secondary socialisation builds upon role identification, via the cognitive framework of school (Open University, 1980). It is here the child is presumed to acquire the intellectual and social skills necessary for later life. Since language acquisition is central to SI, and physiotherapy students have to learn what is in effect a new language at the start of their professional education, it is worthwhile exploring here the use of restricted and elaborated linguistic codes (Bernstein, 1970).

Restricted & Elaborated Linguistic Codes

The restricted code is a form of speech that can be predicted by the observer, usually involving short, simple sentences where speech is descriptive and narrative rather than analytical and abstract. Restricted code focuses on concrete items and contains implicit meanings, the manner and circumstance of the speech are as important as the content. Elaborated code however consists of much more explicit meanings, is difficult to predict and is analytical and abstract. The manner of the speech is less important than the content.

Bernstein linked these two codes to the socialisation processes in different social classes. The normative system of the middle classes gives rise to the elaborated linguistic code whilst a working-class child is socialised using a restricted code. The relevance of social class to mastery of professional language is reviewed subsequently in the data analysis. An elaborated code is a fundamental requirement for an individual to succeed and Bernstein (1970) indicates that children whose lifestyle requires them to be adept at using an elaborated code are at an advantage in participating in education and learning.

Bernstein in the same work also linked the use of linguistic code with the type of family unit. In positional families, decisions are made according to formal status of a person's role, giving rise to closed communication which is less likely to encourage verbalisation of individual differences. In person oriented families, decisions are made on the grounds of psychological and individual differences and open communication encourages discussion and the expression of individual difference. Social control in this unit is through verbal elaboration and does not rely on formal status and power. It is argued that there is a relationship between working class, positional families and restricted codes, and middle class, person oriented families and the elaborated code. Bernstein recognised that this relationship was based upon differences rather than deficiencies and that there should be emphasis on the education system adapting to meet the needs of the child, rather than the child to meet the needs of the education system. This aspect was further reflected upon during data analysis.

3. Methodological Considerations

This study has the complex central topic of people – thus an ethnomethodological stance was adopted as the model of inquiry since it allows emphasis of such complexity. As a perspective of SI, ethnomethodology concerns itself with the process by which humans understand the world, examining human behaviour on both conscious and taken for granted or unquestioned levels. Filmer (1972) remarks that everyday or taken for granted activities are characterised by an implicit order that emerges in the course of interaction and the activity itself. This order makes situations capable of explanation. Ethnomethodology attempts to move beyond the meanings constructed by each individual in a social interaction, to search for shared meanings and how they become taken for granted in society. Everyday reality is continually being constructed in response to subjective interpretation of each situation.

The focus of ethnomethodology is in the process by which a sense of social structure is produced and sustained (Mullins, 1973 cited Meltzer, Petras & Reynolds, 1975). Whilst this chosen methodology has similarities with the Chicago School, there is within ethnomethodology a greater awareness of the role of history in behaviour, as well as the more traditional SI components of time, place and situation. The acknowledgement of history is not without its critics (Denzin, 1969), but in this work it is fundamental to understanding how changing professional roles and expectations are reflected in behaviour. Warshay (1971 cited in Meltzer, Petras & Reynolds, 1975), stated that Goffman's perspective of SI appeared content to study the drama of

coping in society, whilst Garfinkel deliberately inflicts conditions upon participants.

I find myself occupying the middle ground here. Whilst wishing to observe and comment upon the dramas witnessed, by being an active participant in the research I am cognisant of changing the conditions in which social interaction and negotiation of acts occurs. It is of great import that there is no duplicity between investigator and participant, and to this end an ethnographic method was adopted as it acknowledges the ethnographer as participating in the lives of the individuals (Atkinson & Hammersley, 1994, Hammersley & Atkinson, 1995, Holloway, 1997).

Such an approach to data collection has congruence with data collection within the therapeutic relationship. It is of value to consider here how such a methodological stance was developed. Has clinical experience lead to this point or have all the options truly been considered and this point reached on the basis of complete appropriateness? I am drawn to consider the relationship between theory and practice and the notion of theory arising out of practice. In this respect, I suggest the route to this methodological stance is crowded with actions, interactions and responses from both clinical and educational experience, within which I would like to believe that all options have been appropriately explored.

In undertaking a study which explores the experiences of participants in a given environment, it is essential that the environment is as undisturbed as possible, manipulation and control being highly undesirable (Polit & Hungler, 1993, Robson, 1993). Naturalism suggests that as far as possible the world should be studied in its natural state (Hammersley &

Atkinson, 1995), thus using the artificial setting of an interview may be seen as less appropriate. However, one of the primary requirements of naturalism is:

> *" ... fidelity to the phenomena under study, not to any particular set of methodological principles"*
> (Hammersley & Atkinson 1995 p.7)

and as such it draws upon symbolic interactionism, phenomenology and hermeneutics to justify that human actions are a continuously revised stream of interpretations of a multiplicity of phenomena and not simply a stimulus response behaviour (Azjen & Fishbein, 1977). It is upon such beliefs that the research was carried out.

Phased data gathering is highly appropriate in exploring the process of identity construction and 'becoming' a physiotherapist. The major difficulty for me within this paradigm is attempting to integrate the roles of teacher and researcher – a delicate balance between bearing responsibility for the outcomes of teaching and assessment with the need for the impartiality of the researcher (Rowland, 1993), whilst recognising that my interpretations will be grounded in my personal experiences of this environment.

The notion of 'becoming professional' implies less formalised stages and milestones of achievement, yet it does have an inherent structure for advancement, since for me this implies the evolutionary or dynamic construction of a specific identity. The implicit looseness of the term is also an attempt to indicate a wish to understand the meaning of the processes and experiences which may constitute the accomplishment of professional identity.

I have explored the work of Bentz (1989) on maturation and this, along with the work of Ricoeur (1981) and Gadamer (1960), which explains hermeneutics and the hermeneutic circle, have formed my philosophical basis for this work. Such an approach includes all aspects of experience, both textual and non textual, focusing on consciousness which is "*intentional and constitutive*" (Bentz, 1989, p.2). On a phenomenological level, there is potential for subjects in similar situations to see part of themselves in the descriptions and interpretations generated. In this sense the data collected may be generalisable to more than just those involved in the study.

Constructing professional identity in physiotherapy, explored as hermeneutic phenomenology allows exploration of the abstract concepts of attitude, sensibilities, awareness, realisation and knowledge that together constitute behaviour identified as professional. This research focuses on the change process undertaken by new students entering onto a professional training programme to become physiotherapists. Bucher & Stelling (1977) indicate that new entrants onto a professional training programme have varying degrees of:

> *" ... clarity, specificity and definitiveness in their views of their discipline and its potential career opportunities, and thus their level of commitment to it"* (p.19).

What are the effects of the institution, the course and the people in shaping the behaviour of the individual? Each student undertakes the same programme, but for each it will be a personally different experience of learning. Each will accept or reject different aspects and rationalise the experience in different ways. Part of the challenge in researching in this

area is exploring the individuality of the experience – thus data collection must encourage evolutionary disclosure by the participants.

By following such a research paradigm, the researcher becomes part of the observed world (Atkinson & Hammersley, 1994, Bassey, 1995, Hammersley & Atkinson, 1995), therefore effecting change within it. The analysis of human action is based upon social meanings and the effects of inter-relationships changing those meanings. The interpretive paradigm necessitates a self-critical approach to research. Viewing events from the perspectives of people under study requires flexibility in order to respond to changing circumstances. Fundamental to this approach is the belief by the researcher of the significance of the context in which all social realities exist. The challenge for the researcher is to see, from the students' perspective, their day to day lives as undergraduates, whilst maintaining the stance of the researcher within the role of educator. The research had to be flexible and able to move with people, events and contexts (Leininger, 1995). I have attempted to adopt a self-critical, self-analytical approach to allow me as the researcher to identify which personal qualities have been affected by the research process and have influenced the research data (Peshkin, 1988, Phillips, 1993).

Data Collection Method Selection

The process was explored via the use of a longitudinal study using semi structured interview following a group of students at varying stages within their undergraduate programme. The specific focus of these interviews changed as the study evolved, but the fundamental premise was always *"to learn about you and your world"*. (Bucher & Stelling,

1977, p. 34). Students were also asked to maintain a reflective diary of incidents deemed significant throughout the programme. This aspect of the data collection the students found difficult to maintain after the early part of the research and latterly no subject maintained upkeep of a reflective diary. This may be seen as a key hurdle for the participants in light of identity construction and the identified worth of autobiographical journal keeping (Giddens, 1991).

Gaining Ethical Approval

Initial application for ethical approval for this research was denied. Issues raised which caused concern centred around the use of subjects who may also be members of my personal tutor group; the influence of the power relationship[3] upon the data collected; safeguards for members of staff who may be referred to during interviews; how information about staff members will be used and the strategies to be used to minimise use of the information beyond the study. Subsequent application with supporting text to address the issues raised by the panel produced still more heated discussions, but approval was finally granted with the following recommendations stated on the approval form:

> *" ... the committee feel that you should acknowledge the power relationship does cause a problem - your strategies for dealing with these are fine;*
> *the committee will require further information as to the nature of and the issues to be explored in the in depth case studies;*
> *It is recommended that the final document should be a 'closed document' for a defined time span so that access to it is only with permission from yourself, as author".*

[3] relates to the impact I as their personal tutor may have upon the progression of a student through the programme

All the issues raised by the panel are worthy of greater exploration, but the experience has also raised issues about the power of ethics committees in relation to individuals and their control over the profile of the research activity within a department. Such an approval process underpins the whole concept of peer review and as a quality monitoring process it must be recognised for its inherent fallibility.

I am aware also that there are issues for the committee associated with unfamiliarity of this type of research, in appreciating this work as a philosophical approach to the study of the human experience, a philosophy rather than a research method, which maybe used to explore the lived experience of people (Holloway, 1997). Burgess (1989) talks of the relationships between the researched and the researcher and the research process as being at the heart of any ethnographic (i.e. within a specific culture) enterprise. Punch (1986) also suggests that developing a close relationship over a considerable period of time is the subtle underpinning of the outcome of the research and the nature of the data generated. The relationship between the researcher and the subject is surely pivotal to the success of the research. It would be foolhardy to exploit the power position[4] with regard to the student participants in this study. This would offer enormous opportunity for undermining the integrity of the research process and therefore undermine the validity of the research data. However there are issues raised about openness and trust and of course confidentiality, but the relationship must surely respect the rights of the individuals to privacy and the participants should not expect betrayal. It was well documented within the application that the basis for

[4] a single tutor can only strongly recommend action for or against a student and any decision must be supported by appropriate evidence.

discussion within the interviews is very much the world from the perspective of the participant i.e. the physiotherapy student, and it would be a very poor researcher who made overriding judgements about the quality or otherwise of a colleague's work, on the basis of the memories and interpretations of relatively few students.

This experience has also raised questions about the whole concept of volunteer participants, their credibility, why students volunteer to take part and others do not, about the power issues around both researcher and participant within the student/tutor relationship, and the power of the members of the ethics committee to influence both the students and research undertaken. These issues lead into the complexities of informed consent and what this means for the volunteer subject, and finally how the data generated is affected by these and other *"artifactorial"* disturbances (Rosnow & Rosenthal, 1997).

To generate subjects for this research volunteers were recruited via a memo sent to all students fulfilling the age criteria for inclusion. Many questions came to mind with respect to the nature of the individuals who volunteered for the study, based on the question of why might I so volunteer? I would like to feel my motives would be altruistic and I would be looking at the sacrifice for the 'greater good', but most probably it would be because I felt I ought to and thus that there might be some unseen gain to be made; this brings us back to the issue of power in the relationship. Since I am not particularly different from most students, I would imagine a similar 'guilt complex' drives most to volunteer. What then, are the subjects' expectations of the study, and the researcher's expectations of them? To volunteer for a study a

subject must surely feel they are 'a good subject'; the subject must feel that he/she has a part to play in the successful outcome of the research. By volunteering the subject is giving tacit approval. Beecher (1970) intimated that by their very nature, the volunteer subject may not be representative of the general population but may be motivated by personal goals, which are not articulated and may not necessarily even be recognised. People often volunteer in the hope of helping science (Orne 1962 cited in Rosnow & Rosenthal, 1977). In acknowledging the power relationship between the subjects and myself in this study, one might also suggest that a personal goal for a volunteer subject may be to be seen as helpful, interested, a 'good student'. So it is likely that volunteers are different from non volunteers. Rosnow & Rosenthal (1997), in their meta-analysis of volunteer studies, identified distinguishing features of volunteers and grouped them into 'confidence levels'. Those with the highest confidence level indicate that volunteers tend to be higher in their need for social approval than non-volunteers and in general, more sociable. This factor is important when considering the power relationship issues raised by the ethics committee. Other factors identified as situational indicate that people who are interested in the topic, have expectations of being favourably evaluated, and perceive the topic important, are likely to volunteer. People's feeling state is important at the time they are asked to volunteer and those who are made to feel good, to feel competent or are offered incentives are more likely to volunteer. The personal characteristics of the researcher are likely to affect volunteers – higher status and prestige encourage volunteers, people are also more likely to volunteer when it is seen as normative, expected and appropriate.

How does the power relationship impact on the concept of volunteering for research being normative and appropriate? Staff members can influence the establishment of a research ethos within a department; if these same individuals can then influence the type of research undertaken by denying approval for any research process which may elicit 'sensitive' data then the control of a few individuals may be seen as infinite and ultimate. The panel should work democratically evaluating research for its own worth, not being directed by personal fears. However, since all individuals are composites of their own developmental processes, experiences, fears and concerns, it is unrealistic to expect any other evaluation to take place. What is of gravest concern is the power of any one individual within a group situation and this raises the issue of judgement by one's peers, and the importance of ensuring that those undertaking evaluation for approval are of sufficient experience and breadth of knowledge to fulfil the role.

It should be considered that the volunteering subject may have a specific goal in mind, perhaps with respect to a particular issue, a 'point' which they wish to make. In as much as this may be the subject's hidden (or not) agenda, the researcher may also have similar, unarticulated motives. Researchers refer to ethics when alluding to the rigour and integrity of their research process. There is the ethical ideal of 'informed consent', a contractual obligation in research involving human subjects. The questions raised by the ethics committee prompted exploration of this notion.

Informed Consent

The principle of informed consent is predicated on the assumption that subjects are entitled to know what they are

getting themselves in to, what are the essential details of the study, for example its purpose and nature of data collection. Some researchers (Rosnow & Rosenthal, 1997), seem to imply that the greater informed the subject, the greater the artifact introduced into the data, therefore diluting its significance. The alternative might seem to be a covert research procedure, but there are ethical implications for this too. It is possible that in this specific situation, a particular role could be adopted which might encourage the subjects to make disclosures about other staff. This however, is not the purpose of the data collection, and in effect, the power status of the researcher has been reduced in that at that time, no role as an officer for the undergraduate programme was held. An example of how the mere inclusion of an individual into the research process alters the data generated is demonstrated by one participant who stated in passing one day that he had found himself wondering what I would want him to recount in it, what would I think important. It is impossible to prevent such developments – in fact this is fundamental to the nature of evolutionary research. It is also impossible to elicit truly informed consent from a subject involved in such a study – for how can a researcher inform of such a development? Within this research, subjects have been contented with the knowledge that they are free to answer or disclose as little or as much as they desire during the interviews and in the acknowledgement that this may vary over time.

Method

A self-selecting sample of male and female undergraduate physiotherapy students was obtained from all three years of study. Students were canvassed to take part in the study via memo and the sample population was developed on a 'first

come, first served' basis. The table below indicates the distribution of students and years of study.

Relative Distribution of Respondents by Year of Programme and Start Year in Study

Student Group at Start in Study	1st year	2nd year	3rd year
Year 1			
Year 2			
Year 3			

Key: Shaded areas represent period when students were involved in the study.

There were minimal exclusion criteria from the study, the requirement was that all respondents were in the age range 18 - 25 years. This age group is by far the largest group of undergraduate students and whilst incorporating mature students, excludes those who are likely to have greater external influences. It is also the age group identified by Erikson (1963) as undergoing a period of identity development.

As each respondent volunteered they were given an information sheet about the study components as well as a verbal explanation. Individual informed consent was obtained, and a mutually convenient appointment for the first interview was made. It was stressed throughout the whole study period that respondents were free to withdraw completely if they so desired, and that they were free not to

respond to any of the prompts within the interview, without prejudice. Reassurance of anonymity was given throughout the study period, and that no data from the interviews or from the diaries would be attributable to an identifiable individual.

Data Collection - In-depth Semi-structured Interviews

All interviews were carried out in a private office: this was either the researcher's office within the physiotherapy department, or a small office at the clinical site where a student was working. There was no fixed time period for the interview, most lasting between 50 and 90 minutes and were largely under the control of the interviewee, although continuation of the discussion was successfully negotiated in most circumstances, where it seemed appropriate. All interviews were confidential and took place on a one-to-one basis. Interview schedules of areas of interest were developed prior to the interviews. Each interview was taped, to which there was no objection raised by any respondent, other than an initial concern about what they might sound like on tape. Initial assurances with respect to confidentiality were re-affirmed. Interviewees were encouraged to be as far reaching as they wished in their disclosures. Respondents were interviewed at the start and towards the end of each of two consecutive years of study, excepting those starting their final year at the start of the research. Data from previous interviews informed subsequent interviews with the same respondent. Advice from the data protection officer within the university was sought with regard to how the data should be stored on computer. By use of identity code only and no names, this was seen to fall within the terms of the licensing agreement of the university.

Determination of Interview Schedules & Topics

Whilst it would have been more true to the ethnomethodological approach to immerse myself within the student environment for a prolonged period of time, adopting the role of a student and observing the interactions as they took place, it was impractical for this to happen within my own environment. In trying to determine the most appropriate way to understand about the students' experiences, I elected to establish a loose framework of my perceptions of their experiences upon which to begin the data collection process. Subsequently the data collection followed the lead of the participants. By doing this I have indeed imposed conditions onto the participant group and directed my methodological stance further towards that of Garfinkel than Goffman. Such imposition has been acknowledged within the data analysis, and it is felt that the prolonged period of data collection and the relationship of mutual trust developed between researcher and participants has allayed some of the effects of alteration of the environment.

Data Collection - Reflective Diaries

The purpose of the diaries was explained to each respondent in the study, and their willingness to maintain such was obtained. It was anticipated that the respondents would document significant events, thoughts and personal reflections throughout the study period. Respondents were asked to pinpoint any personally significant periods within the year which were regarded as a period of transition or growth. However, throughout the course of the study, it became apparent that the respondents were having difficulty keeping up the diary and it became yet another task for them in an already overcrowded schedule. In light of this, if the diary was available it was accepted gratefully, but after the

initial submissions of diaries, where respondents indicated they had not completed it, it was not emphasised as a data collection tool. The respondents continued to be enthusiastic about the interviews and it was felt that this was the most revealing data source, and therefore the most important to maintain.

Data Collection - In-depth Case Studies

It was anticipated that once personally significant periods were identified by the respondents, further in-depth study would take place exploring what was actually happening during this period. Ethical approval was not granted for this part of the study. When in-depth case studies were desired, individual approval was to be sort from the ethics committee. In the event, respondents were not able to articulate well periods of great significance or transition, and with the previous experience of seeking ethical approval for this study, the option was not taken up.

Data Analysis -The Interviews

The tape recorded data generated from the in-depth semi-structured interviews was transcribed. Analysis started from the beginning of data collection. Transcripts were read and re-read to gain a sense of the data (Tesch, 1990 cited in Creswell, 1998). Feedback on initial summaries was obtained by taking the information back to the respondents in the study. From here the process of reducing the data began, and via inductive content analysis, codes and categories were developed. Themes and constructs were subsequently derived from the data without imposing a previously developed framework, or counting the frequency of words or categories. This analysis generated general patterns in the data and working hypotheses about the experiences of the respondents.

Although a specifically developed framework was not imposed, and the data was approached with an open mind, it is realistic to assume that knowledge of prior research into the development of professionals would have directed this search for themes and constructs.

The data analysis approach undertaken takes from both the general biographical approach advocated by Denzin (1989) and from the more specific approach to phenomenological analysis advanced by Moustakas (1994). Denzin's (1989) approach identifies the researcher seeking concrete, contextual biographical material in the data which is then expanded upon in subsequent interview. I was seeking patterns and meanings to reconstruct the biography of the respondent, the focus being understanding the experiences of another.

Data Analysis -The Reflective Diaries

The relatively small amount of data generated through this route was managed in a similar way. The data was explored for key statements of personally significant events indicating periods of transition or growth. Where these were available, the diaries were useful in supplementation of interview transcripts. The diaries were also useful in directing aspects of the follow up interviews.

Validity & Reliability versus Dependability & Credibility

Validity and reliability are important elements in authenticating research and are terms traditionally associated with quantitative research. The use of such terms in qualitative work may be seen as defensive because such language is incongruent (Ely et al, 1991 cited in Creswell 1998). Lincoln & Guba (1985) use the alternative terms of credibility

and dependability, where credibility corresponds to internal validity and indicates that the researcher's findings are compatible with the perceptions of the respondents under study. Verification of findings was undertaken through a member check, the findings and interpretations of the data being returned to the respondents.

Adjudging this research dependable can only happen through a visible audit trail identifying the decision making process as consistent and accurate. Detailed description of the path of the research is included to generate such a visible audit trail (Lincoln & Guba, 1985).

Limitations of the Study

The data generated within this study concerns the experiences of undergraduate physiotherapy students on a single programme of study, in a specific higher education environment. However, there are many similar programmes across the country. The purpose of qualitative research is to uncover the essence of the phenomenon, and as such, specific recommendations for the curriculum under study may be made. If the phenomena identified within this data can be verified in another site, there is potential for generalisation (Morse 1994).

Treatment of the Data

The data collected explored the participants perspective on their experiences, looking at the world of the undergraduate physiotherapist as they saw it. The research set out to explore what effect the institution, the course and the people with whom the student made contact during the course, had in shaping this change, and the effect on and of the individual within this change process. As the research process evolved

the specific focus of these interviews changed, but the fundamental premise was always that the researcher was there to learn about the experience of the individual student. The data generated consisted of some 142,000 words of transcribed tape, from approximately 27 hours of interview. This was supported by diary narratives completed fastidiously by seven of the 11 participants in the early stages of the study, but which had tailed off completely for all participants by the latter part of the study. This second part of the study coincided with either a period of absence of the participants from the university on clinical placement or an assessment period.

This work is the exploration of a specific learning experience with a focus on the construction of professional identity as an autonomous practitioner. The work acknowledges that each student will begin their undergraduate experiences inculcated with their own personal socialisation processes. The data clarifies the background of individuals to set the scene and then explores the experiences both of that individual and of the participant group. Thus data analysis has two routes: a vertical perspective, exploring the experience for each individual, and a horizontal perspective exploring the experience within and across years.

Results of the Analysis

For clarification the following definitions have been used:

Category	conceptual label given to higher order concepts which are grouped together; takes place after coding
Code	initial labelling of phrases and/or concepts in the data
Construct	abstract concept built up from specific observations; a number of constructs build into theories
Theme	the result of grouping of categories

(adapted from Holloway, 1997).

Following coding, categorising and re-categorising of data, the data was reduced to the following:

- Student background
- Pre-university education
- Student activities
- Student and educators
- Student and peers
- Student and patients
- Student evaluation of self
- Role models
- Indications of development as a physiotherapist

Further reduction of the data was achieved when these categories were subsequently grouped into the following themes:

Biography of Student

- Student background
- Pre-university education
- Student activities

Student Self & Relationships

- Student and educators
- Student and peers
- Students and patients

Self Evaluation

- Student evaluation of self
- Role models

Development & Mastery of Physiotherapy

- Construction of identity

Each of the themes identified will be addressed in subsequent chapters.

4. Biography of the Students

Student Background

The study participants were made up of two male and nine female students all within the age range of 18 - 24 years. The profile of the students was such that five were just beginning their final year at the start of this study, four were beginning their university studies for the first time, two were in the midst of their studies embarking on the second year of life as an undergraduate physiotherapy student.

Commonly, the typical cohort of physiotherapy undergraduates is predominantly white and female, with an historical predisposition for a 'middle class' background. This may prove to be relevant in terms of linguistics, when exploring the adoption of professional language as part of constructing the identity of a physiotherapist. All participants found giving definitive classification of individual background difficult, were seemingly confused by the concept and were, I felt, uncomfortable with either the concept, or articulating something which was of direct relevance to their family background. The difficulties are amply demonstrated in the following quotations:

"I don't come from an affluent background at all ... I don't come from an affluent background because my Dad ... got hit very hard in the recession ... my mum didn't work before but she's had to go back to work now ... I think I'm middle, middle class. I think the way we act. I mean my mother is such a snob ... she doesn't act like a person who doesn't have any money ... but I think I was very lucky because even though my parents didn't have much money, their priority in life is to give us the best education they could and I went to private school ... "

"I mean a lot of people say I am, I am middle class ... but I wouldn't say I was middle class by any standard ... I never

been in a working class type of ... It's not been quite like that, its just been middle class I suppose, if you're going to put it in a class but a very hard, no money type of single parent. I don't know, it's sort of been in between the two ..."

Impact of Pre University Education

The importance of the pre-existing socialisation cannot be under-estimated. In SI terms social interaction is unique and therefore uniquely re-interpreted. Identity is constantly changing most especially in person changing institutions such as schools (Geer, 1968 cited in Tattum & Tattum, 1992), the impact of schooling will shape the approach of the individual to higher education. The participants had clear recollections of their first experiences with education, either in the form of their very first teacher, or an enduring memory of school.

"I didn't like her ... because she was strict, I suppose, for a teacher of that age group she was pretty strict"

"I can't remember her actual name but she used to call me (play on participant's name) and she would say that I was like a bull in a china shop and just used to run around and cause chaos and be really loud ... I had good relationships with all my teachers"

"Oh my God yes. She used to shake me ... no she did she used to shake me. I'll never forget ... I remember sitting there and I coloured over the lines and she just used to come up and shake you if you did something wrong.

... I was terrified and really upset. I used to hate it. .. I didn't want to learn, I don't think I ever really wanted to learn ... "

Personal recollections of schooldays are fixed on the need to disappear into the mass, which is at such variance to the learning styles incumbent on physiotherapy students today. Those teachers who recognised differences and nurtured rather than berated had much greater success in releasing potential than others.

Considering the age of some of the individuals at the time, the memories were vivid and instant. Understanding of self emanates from an understanding of how self emerges. Since self is a constantly changing entity, such experiences must contribute to the understanding education and learning potential. Indeed, as Knowles (1990) indicates, an adult learner's self concept influences the approach to learning.

Entering higher education may be seen as the beginning of a new career and new status within the emerging biography of the individual (Tattum & Tattum, 1992, Goffman, 1968). As part of the continuing process of socialisation, it is unlikely that entering such a new phase will be a completely smooth transition in terms of the meaning of this new status. Within SI the problems of continuity/discontinuity are absorbed into the broad concept of career because it allows the bringing together of the objective events, with subjective re-interpretation by the individual. Once a student has been admitted onto the programme there is a need to accommodate to the new situation in terms of both physical environment and social relationships. Thus there is a process of situational adjustment construction of the new identity of physiotherapy student, the first step to construction of identity as an autonomous physiotherapy practitioner. If one uses Goffman's (1968) example of the moral career of the mental health patient, it is only when there is a shared set of meanings between the new student, peers and clinical educators that this new student may be said to have been re-socialised, the process complete, and identity developed. Potential areas for conflict lie in the image the individual carries of physiotherapy and where or how the individual sees themselves fitting in to this profession; indeed how their

personal socialisation 'fits' with the professional; how one identity 'fits' with the other.

Images of the profession were not clearly formed by the participant group. Much of the image is inextricably bound up in the 'romance' and 'Casualty' factor of the hospital environment:

" ... being in a caring profession, being someone who is approachable".

" ... it was helping people without all that disgusting stuff". [later defined as bodily fluids]

" ... reacting to people and ... I just liked their nature.. I think that was part of it ... there seems to be a certain type of person that seems to be a physio quite often" .

"The reason I was so interested was because she was so nice to me, she explained everything to me ... ".

"I thought is was like a nursing assistant, I thought it was for old people ... people who were in wheelchairs and they just needed a massage ... ".

All physiotherapy students are expected to have undertaken work experience related to physiotherapy to broaden understanding. These perspectives on the image of the profession are being voiced following such experiences, and serve to highlight unrealistic expectations that such experiences will clarify the role of the profession.

What is being set out here is the background within, or upon which, professional socialisation and identity construction will take place. Concurrent with situational adjustment are the concepts of anticipatory socialisation and status passage (Tattum & Tattum, 1992). The transition from school to higher education, from paid work to higher education, can be as traumatic as the transition from home to school for a

young child. How that transition is managed may determine the students' acceptance of the environment and all that it offers in terms of professional education. Consequently it will have impact on the individual's ability to achieve. The participants' understanding of the meaning for them in attending university is fundamental to understanding how this experience will be interpreted by each individual. Thus we can explore subsequent data with knowledge of the pre-existing image of the profession for the participants, and have some understanding of the meaning for the individuals of coming into a learning environment to gain the requisite skills to fulfil this image. Many of the participants alluded to the initial experience of attending university:

"Because of having the experience with all the physios telling me what they had been through. ... and then when we got here there were so many hours ... but that didn't come as a shock. I didn't really expect to go to the pub every night like all my friends do at other universities" .

" ... I like being at home and it was the first time I've ... it was a really big step for me and I absolutely hated the first week. I couldn't stop crying. Loathed it to be perfectly honest. It was the fact of being here and not knowing anyone rather than anything else. You just did not know anything and anyone and I don't think I have ever been in that situation ... and [she] was like 'yes away from home' and I was like 'take me back' and its not a nice feeling when you've worked so hard to get somewhere and then you're there ... ".

The meaning of coming to university was less overtly stated and it is apparent that the timing of this event within the family situation either added to or alleviated some of the pressures associated with this transition. For those participants who had a sibling who had already gone through the process, often the initial move was easier, however in one situation where the sibling had had a poor experience,

this prevented one participant seeking support from home during her less happy moments:

"I looked forward to coming away, and it wasn't sort of a huge surprise about being in a university world at all. My sister had already been to university three years before and I had been up to visit her - it wasn't a complete surprise to me ...
My sister put my parents through a lot of stress when she was at university ... seeing as we live so far away there is nothing that my parents can do, so I'd rather get on with it, I know it's my problem. I know they would be there if I needed them but I would rather not worry them" .

For others, being the first child to enter university acted to change the child's status within the family group, whilst for others the transition was reflected upon as a time of great change and the learning of abrupt lessons:

"... he sees me as like oh my biggest daughter has gone to university, look how clever she is. He is really proud of what I am doing, in the past it was oh you got 7 A's and 2 B's, is an A the highest you can get? I am like no A and he's like oh well never mind. What do I have to do? But now he's proud and my mum looks after me more than she ever did when I was at home."*

" I had a lot of hassle with that ... but I wasn't prepared for the jump ... moving out on your own ... I found that quite hard to adjust.
Just spending £1.70 on just cleaning your clothes, things like that stick out. It was the sheer fact of washing and having to pay for things. You take it for granted ... it never would cost you to wash clothes at home"

"I knew it would be alot less structured and it would be a lot harder work and I would have to be alot more responsible for myself. ... I know that I would struggle with that, but I knew that it would be a good thing" .

Part of understanding the experience of these students is appreciating how individuals become shaped by what Tattum & Tattum (1992) refer to as *"person changing institutions"* (p.13). These individuals are not passive recipients of change

but are developing their own identities as physiotherapists and bringing to the process their own predispositions. The focus is on how these individuals become transformed into professionals. Bucher & Stelling (1977) comment that individuals usually leave a professional education programme substantially changed in outlook, presumably having gained the prerequisite skills to practice and also a different set of values, beliefs and priorities about their chosen profession and future professional life.

"Well, you've got the doctors who kind of wander around giving out orders but don't actually spend much time with the patient and don't look at things from the patients point of view and the nurses who are very caring and do their best to get them better, to get them back to a level that they were at before, and physios who are always like just encouraging the patient pushing the patient just get a bit more ... that's like nurses get two nurses to get a patient out of bed 'cos they are so caring and we don't want you to get stressed and to work too hard but physio it would just be one so come on do everything for yourself, get some independence back for them ... I thought physios were told what to do by the nurses, the nurses said oh go and teach that patient breathing exercises and the physio went oh, okay and went along and did it" .

Student Activities

Contextualizing the data requires a clear picture of what the students were actually doing throughout the research period, the range of activities and how these relate to the work of the physiotherapist; whether these activities are seen as central or peripheral to physiotherapy; how these activities are evaluated by the students; issues of *"clarity and consensus"* (Bucher & Stelling, 1977, p.60) about what the students should be doing, students expectations of their role and encounters with other people's conceptions of the student role; opportunities for the students given to perform in the role of a physiotherapist, and responsibility and the student. The following section presents an empirical description of student

activity which is translatable into the categories identified below:

1. What were they actually doing?
    - part of physiotherapy
    - central or peripheral?
    - range of activities
    - evaluation of activity
    - opportunity to perform as physiotherapist?

2. Is there clarity and consensus about student activity?
    - student expectation
    - varying conceptions of role

3. Responsibility

All students are engaged in a variety of activities consisting of attending classes which include lectures, smaller group working, tutorials, practical skills classes, clinical education placements and self-directed learning. Built into this physiotherapy programme are a series of specified hurdles which students must successfully negotiate in order to receive their degree and consequently become eligible for Membership of the Chartered Society of Physiotherapy and State Registration.

In the early stages of the curriculum much time is spent learning the fundamentals of anatomy and biomechanics, physiology, pathology and physiotherapy patient management skills. Throughout the first two years students complete formal study of the normal functioning and common dysfunction of the neuromusculoskeletal system, the cardiorespiratory and vascular systems incorporating all regulation and maintenance physiology, and study of the

brain and nervous systems. Latterly in the second and into the third year there is increased input on research methodology to support the students in undertaking their final year research work.

Physiotherapy patient management skills encompasses physiotherapy practical skills i.e. profession specific skills, and a substantial element of psychology, social sciences, research methodology, clinical reasoning and the decision making process. The timing of the delivery of the curriculum apparently reflects the inherent complexities of each area and is phased to follow a logical progression in the development of a knowledge base and the acquisition of physiotherapy practical skills. In year one coverage is of relatively discrete areas of interest which form the necessary prerequisite knowledge that will facilitate understanding of more complex topics in year two. It is anticipated that the areas of study covered in year one will be extended to higher levels of understanding in years two and three whilst on clinical education placement. Year three expands further on previously explored areas and demands that the student extend their knowledge to develop an understanding of the contribution of physiotherapy to health care provision within the UK. Students at this level are also undertaking an independent, supervisor supported, piece of research work. The participants were in agreement about the academic demands associated with the physiotherapy undergraduate programme. The programme incorporates just in excess of 1000 hours of clinical practice, thus the university based time is very intense. All students are informed of the format of the programme such they might gain an appreciation of the workload involved. One of the aspects of the physiotherapy undergraduate curriculum is the requirement to gain

competency in the profession specific skills thus there is a higher than average contact time per student when compared to a non-professional degree programme. It is 'custom and practice' within physiotherapy education that a large amount of contact time is spent on practical skills teaching and that a substantial proportion of the students' self-directed study time is spent on rehearsing these skills which are subsequently examined, both within the university and on clinical placement.

It is perceived as important within the programme that a variety of learning and teaching methods are employed to engender within the students the ability to operate as self-directed learners. Such methods employed are selected on the basis of appropriateness to the nature of the material being covered. A high proportion of classes involve practical sessions in which students are asked to apply theoretical knowledge and develop physiotherapy handling and treatment skills. The programme philosophy indicates the theoretical base is taught by methods such as seminars, laboratory work and lectures, not characterised by didactic presentation of information. The students' active participation is encouraged.

"Good fun. Very sociable. One of the main things is it's very hard work. I found, the first year, I thought was hard work. Actually learning the stuff, the anatomy and treatments and what not."

"I think the first term. That was an absolute nightmare - there was no other word for it".

"I just thought God - I'm working, studying really hard all the time ... I panicked and thought God I'm never going to know it"

A common feeling also described by the same student in her diary indicated that there is considerable anxiety provoked by the university-based study:

"I must admit when you are bogged down with never ending study you get so fed up you wonder if it will all be worth it".

For many students finding the right balance for work is difficult, although this is an aspect which should be encompassed within the personal tutor role.

"I do think I worked far too hard in the first term because I was unsure and unconfident about achieving a respectable standard of work. As a result I became fed up with the whole thing. There are only so many hours in the day you can spend doing the same thing before becoming completely bored with it.. I found that instead of enjoying the lectures I was dreading the thought of more work to add to the ever increasing pile."

It is however, difficult for a student, with the amount of work to be covered within the curriculum, and the added pressures of clinical education, to step back and be realistic about what is achievable.

" ... so quickly and we've learnt so much, but I feel I haven't learnt enough".

For the students, the overriding element throughout all the interviews was the amount of work they undertook, and the significance of critical points within the programme of assessment. Some students identified that for them there was a discrepancy between the amount of effort exerted and the reward gained. For some students too, the whole grading issue and success in all forms of assessment had a very competitive element linked with individual achievement. There is clear apprehension around issues of effort equating to reward, but reward as far as the students are concerned is

seen only in terms of the immediate piece of work rather than the long-term goal of qualification:

" ... my essay marks were quite good, I suppose. I was a bit disappointed ... I thought I had done better because I put so much effort into it ... if I get a fail and its because I didn't do anything, then I think that's what I deserve. I mean if I get a low grade and I've tried my hardest then I don't think that's fair and I'm disappointed" .

The students have a perception of being watched whilst in the university and indicate that they feel they *"can't afford off days"* . Many of the participants used the term *"scary"* to describe their study periods in the university. Whilst appreciating the colloquial nature of the use of this word, the frequency of its use causes some concern. Other comments used to describe university based study were:

" ... it's a drag.....it's a slog "
" ... I don't feel like a physiotherapist at university" .

The learning environment experienced by these students within the university should be one in which students feel secure enough to try out ideas. Much work is carried in smaller groups of up to 24 students, often working as 12 pairs. One of the purposes of establishing learning groups is to engender support for students, and as a method of encouraging ownership of learning, thereby giving some control and increasing motivation for learning. Groups also go some way to establishing equality in relationships between the learner and the educator (Baldwin & Williams 1988). It is however vital that such purposes be made clear at the beginning of the course of study and be carried out across the board. Developing such a climate for learning needs to be managed and not left to chance following a brief introduction to the idea.

The participants expressed mixed feelings about the relative worth of each type of class as well as the centrality and importance of the topic areas, the success achieved in generating a secure environment, and their own ability to work well in teaching and learning groups:

"The afternoon lectures are better, it's in the morning you're not really awake, most of the time it's not too bad ... ".

"Tutorials are quite good, it depends what they are, the quizzes that we had were quite good but if we'd known that in advance it would have been better, 'cos if you keep revising throughout the year ... "

" ... practical classes are quite good. It's kind of daunting at first, to get naked in front of people you don't know but it's good in the end and I have quite a few unusual features ... ""

"Well I've enjoyed all of it I have to say because at the end of the day it's all physiotherapy. The fact that you know it's going to lead to a goal gives you something more to strive for, the fact that I have a passion for it as well ... I think that it's a vital part of physiotherapy to get hands on experience. So if we had a whole year of lectures, I would probably lose interest in it because I wouldn't see it as real enough ... I always ask silly questions, obviously if I have a problem with something I usually ask ... with practical classes ... I'm not always the patient I'm not always just sitting out and not doing it yes I definitely get involved in what we are doing. Tutorials, similar thing because you are in small groups, you have to basically you find one of the people that have a fiery attitude as well I suppose and debate between you. Fortunately most of the people in the year obviously want to do physiotherapy so you obviously have that in common when you are talking to them. So its easy to debate with them, the topic you are on ... I refuse to be lead but at the same time I refuse to lead I think. I don't maybe with what we do I'll put in and if someone disagrees we will talk about it or if they put in I will listen, but it's not always that someone will talk and I will listen or its not always I will talk and someone else will listen. No it doesn't seem to happen that way".

"I think the practicals sometimes they seem a waste of time but only if you know what you are talking about or if you do something again that you are quite sure of that you've done ... I know it's a good feeling when you know something but

sometimes you think Oh God I've got so many other things to do I've got to concentrate on that. I've got that to do or ... I should be doing this."

Some of the subjects studied are more readily ascribed to physiotherapy than others, particularly by less aware new students. All students immediately grasp the importance of learning anatomy, physiology, an appreciation of the mechanisms of injury, common pathological processes and how these may be influenced by physiotherapeutic techniques. What students are often less clear about is the relevance to their future profession of psychology, social sciences, and an understanding of research. It is during these subjects areas, and in particular when applying these subject areas to physiotherapy, that many students express difficulty. In relating this to academic levels, it may be seen as acceptable that at year one students are very content oriented. However, the students differentiate between core physiotherapy content and what they consider to be peripheral to their learning needs at this level. It is only as they have worked through to year three that there is recognition of the need for such subject areas to enable their holistic practice. One student, reflecting on the completion of her year three studies wrote in her diary:

" ... has had a large impact on me with regard to 'opening my eyes to the world and making me appreciate wider issues relating to physiotherapy ... I have realised about [the importance of] 'where the patients are coming from', hopefully this will enable me to understand patients more fully ... made me recognise them as people" .

Some perceptions of the learning environment change over time and are closely associated with success in assessment. The element of public scrutiny remains, that both praise and reproof are public:

"I'm not embarrassed anymore if I make a mistake whereas at the beginning the first term everyone was frightened to say anything in case they made a mistake ... in case anyone thinks that they're stupid or they don't know as much. You never know how much everybody else knows, you think oh maybe everyone else is better than me, more clever than I am. Maybe its a fluke that I got my exams" .

"At university it doesn't matter if you don't know something or you get something wrong ... it doesn't matter if you do something stupid ... because you know the setting. You know the lecturers, you know your friends" .

"It all came in the first year. I remember being asked a question in one of the tutorials and I just didn't know and I felt really ... but I can still remember it. It makes me blush ... I know that this question was coming round to me, they started off at one end and I happened to be one of the last people, so every bit of knowledge that I did know had already been said. And when I got asked the question I just didn't have a clue. It was about the thorax. That remains with me all the time, I just can't believe I made such a fool of myself. You always think I didn't know ... how embarrassing ... I remember coming up afterwards and saying to the person "Oh God I should have known that" and they just didn't acknowledge it, it was like well perhaps you should have done" .

Students are encouraged to form mutually supportive learning groups. For these groups to be effective, participants indicated that it took time to find the 'right' group and a certain maturity to appreciate that the 'right' learning group may not consist of one's close friends or flatmates. Most of the participants had worked through this problem by the middle of their second year of study, but all expressed how difficult it had been in terms of sustaining or discontinuing friendships, and acknowledging that their individual priority was to learn for their degree; thus they had to withdraw from certain situations which were not facilitating their personal learning. Although there was often a distinction identified between the students 'working' and learning there is an overriding feeling that there is a growing knowledge about aspects of the self,

particularly to do with personal learning, development, and recognition of what you might be good at:

"I think our friendship group has actually changed quite a bit. Well it has in my bit. Because some people who I hung around with a little bit more before, aren't so much keen on working together and sharing ideas, whereas I have developed a kind of different friendship group where we're more helping each other rather than competing against each other. I got to a stage where you know, people were keeping secrets, because it was a good thing for their essays and things like that. It's just silly really because it's not a competition ... "

" ... we have had such a lot to do I feel it's been really valuable, sharing ideas ... "

"It became a conscious change. It started to evolve and then it became a conscious change because I realised it was just silly. I still see them socially, but I don't work with them anymore. I don't think it helps me. I am more or less making a huge effort to share everything with everybody, kind of thing, like different books and articles, and even though it sounds like a really small thing, because everybody is out there fighting for books at the moment, it is a big thing, because you know, you can get the crux of an essay, you can just grab it and share it with everyone else who hasn't got it yet or whatever. Or it can be the other way round. People give you help ... not really so much about learning, working yes, but as far as learning, um ... I have been learning very specific things ... because of all the essays. Because it's priorities isn't it? I get marks from essays and they're more important at the moment."

"I think that learning how to get along with other people helps you to study because you use people as your tools as well rather than just books" .

The documentation supporting this programme of study cites Higgs (1992) explaining physiotherapy as a profession in which individual practitioners address a wide variety of patient problems, which are responsive to physical intervention. The skills which enable the professional to operate in an efficient and effective manner are based upon a sound knowledge of formal theory, competence in collecting

data, effective interpersonal skills and an ability to make clinical decisions in a co-operative manner with professional colleagues and with patients. The large number of physiotherapeutic skills and the diversity of their application prohibits teaching of all skills in anything other than a very formal, didactic and prescriptive manner, which is at odds with the underlying philosophy of the programme. One of the key aspects of the physiotherapy curriculum is the large volume of content addressed. Such a volume predisposes students to surface approaches rather than deep learning (Ramsden, 1998; Entwhistle & Ramsden, 1983). In this programme the students are encouraged to think in terms of transferable skills and acknowledge that both the university and clinical practice may be a site of primary learning.

For such a policy to be successful requires unity in approach with accurate, appropriate, meaningful and frequent feedback. It has already been stated that the participants felt that there was little correlation between effort and reward in terms of grades achieved, which in fact meant that because there was no apparent pattern to feedback, it made it difficult for the students to estimate or predict their performance with respect to a particular piece of work and subsequently to their work in general. Some did imply that they felt an increased awareness of self and appreciation of their strengths, but this seems to be over-ridden by the effort for grades issue which is most probably directly related to:

"I get marks from essays and they're more important ... "

This is a fundamental issue for students when trying to evaluate their own performance in respect of efforts made. It is also worthy of note here that stated objectives for the programme include that at the end of the programme

students should be able to analyse and evaluate their professional performance and recognise the need to facilitate their own lifelong learning and continued professional development.

The second aspect to consider in describing what the students were actually doing is the activities undertaken whilst on clinical education placements. The following text is adapted from the course documentation supporting the programme in which the participants in this study are currently involved. In the interests of maintaining total confidentiality of the participants, it has not been formally identified or referenced, but is identified as follows [ ]. The reader is asked to accept the text on this basis.

[Clinical education is seen as a progression of learning and providing the opportunity for the students to integrate areas of study which are fundamental in developing skills and competencies of the qualified physiotherapist. Clinical education provides the most appropriate environment for primary learning and reflection; its importance is in its ability to accurately mirror the working environment that the students will encounter once their professional life begins. The teaching and learning methods encountered revolve around the principle of patient-centred health care. The majority of the student's time on placement is spent in patient contact situations in which the students take the primary role of practitioner whenever possible. The student's learning is supported by appropriate observational opportunities and tutorial input from clinical educators and visiting academic staff.

It is a requirement of the professional body that every student must successfully complete at least 1000 hours of clinical education before they may be permitted to graduate. Clinical education takes place in all years of study but the majority is spread between the second and third years. Clinical education provides students with the opportunity to encounter the complex environment of clinical practice which will stimulate their development. Is it really the only opportunity for students to modify and refine their knowledge base of formal theory and to develop personal theory through concrete experience in real life situations.]

It is in this environment where the students have a real opportunity to adopt the role of the physiotherapist.

[Physiotherapy conforms to Schön's model of professional practice (1983, 1987). In this model he argues that professionals cope daily with unexpected, unforeseen, previously unknown, uncertain and unique human situations. Schön suggests that the procedures and techniques, learnt within traditional academic components of professional educational courses, focus on expected or predictable, practical situations and are not directly applicable to the real circumstances of everyday practice. The students must therefore modify their techniques and skills to address individual situations. Thus the student must learn how to adapt pre learnt formal theory to real life situations, a process which can only be fostered in an environment that encourages and demands the testing and refinement of hypotheses and principle based expectations, in authentic practice situations.

During clinical education placements the students are encouraged to make use of structured observation, critical incident review and behaviour analysis to develop a reflective approach to learning through practice. Following placement, students are encouraged to reflect upon, and discuss their experiences such that personal experience may be integrated into the individual's knowledge base (Fish, 1989).]

Where possible a maximum of two students are assigned to a single clinical educator and no student will be sent on placement alone, although they may be working in the particular specialism without another student, there is usually at least one other present in the same heath care unit. The participants in this study were extremely positive about their clinical education placements, for the opportunity to perform in the role of the physiotherapist. Whilst recognising that they felt the need to constantly impress on placement, they appreciated the element of *"clean slate"* which they took with them when they were away from the university. It was this aspect which rather set it apart from the university-based study. It is also the area where there is greatest recognition of their developing interpersonal and decision-making skills. This issue and the impact on the personal versus professional socialisation processes will be followed up in the 'Self and Others' section.

Some participants indicated that it was only on clinical that they felt like a physiotherapy student; others indicated that they were not only performing in the role of physiotherapist, they were actually playing a role and not being themselves. This was characterised by feelings of holding back on one's personality particularly in the early stages, although it was

recognised that there came a time when the students became more aware of themselves and their behaviour in respect of others, and in effect, became more themselves:

"At the moment I'm still quite shaky about the whole thing so ... whether I'll gain in confidence ... I'm sure I will and then I'll either feel happy and settled in it or I'll suddenly realise that its definitely not for me or whatever ... I think you always have to have a professional from when you're at work ... you can't be yourself. I can't jump around the corridors if I feel like jumping around the corridors. There's behaviour that I would normally do that I wouldn't do when I'm at work ... I think I haven't always had the option I feel on placement to be myself. I feel like I tread around people a lot more than I do normally.
I suddenly began to feel at ease with my clinical educator who had first had annoyed me a lot and I didn't think I was getting on with him at all. And then suddenly he fed back to me that he picked up on all these things about me.... and I suddenly thought - yes you do understand me and obviously he's looking closer at me than perhaps other people have. And because he said that, I felt I was able to open up more to him and just develop the relationship. And then I realised that I hadn't been opening up at all on my other placements. There was always a reserve ... I mean your friends that you have in your normal life are people that know you for a reasonable amount of time. On a placement you don't want to do anything - if you've got a side to your personality, I'm not saying that I've necessary got a bad side - but if there's part of my personality that would have clashed with someone then you tend not to let that part out all. Not voice certain opinions about things and things like that. Issues and things, which you could feel quite passionate about.
He'd say things and I'd think that wasn't true - and don't you think you should look at the other side? ... and he was asking me basically to voice my opinion at which point I realised that I could say it to him and he wasn't going to take it against me ... normally you just go on placement and do what you're there for rather than get to know the person ... I still think I don't want to do anything to damage what they're going to think of me. I don't want to risk that. "

Within their patient contact situations, students should be given gradually increasing responsibility with respect to patient care. In recognising the advanced application and evaluation of theoretical knowledge required to perform in

the clinical environment, the reasoning skills required to manage real patient problems and primary learning of clinical knowledge, all clinical education has parity with university-based education components of the programme.

[At Level 1 (year one) the major benefits the students are expected to accrue are in terms of interpersonal communication skills, defined by Higgs (1992) as an important element of the clinical reasoning process. Students are expected to be operating at the first level of learning where the focus is content (Gardiner, 1989). Students participate in aspects of patients' assessment and treatment and will be able to experience all the factors that contribute to complete patient care but are not placed in the position of having responsibility for total patient care. The ability to judge the appropriateness of assessment or treatment procedures is dependent upon an individual's personal knowledge, as well as upon rational theoretical argument. In recognition of their lack of experience at this stage, and the psychological stress the students inevitably experience on their first exposure to patient care, the students are not expected to make unsupported decisions regarding the choice of procedures. Such decisions are made by the supervising staff who designate tasks that the students' abilities allow them to undertake. Students are expected to evaluate the outcome of their interventions.

At Level 2 (year two) students are expected to progress quickly to focus on the process of learning and recognition of diversity (Gardiner, 1989). They are primarily concerned with consolidation of their theoretical knowledge and developing personal knowledge through concrete experiences gained by treating patients. The students are expected to be fully

involved with complete patient management from assessment through treatment and discharge. Students are expected at this stage to be able to offer suggestions regarding treatment choices and be able to discuss the relative merits of each. Following a period of initial guidance from the clinical educator to support interpretation of data, making treatment choices, and evaluating outcome, the students are expected to develop their understanding such that towards the end of this level of placement the students are in a much better position to make relevant decisions.

At Level 3 (year three) students are expected to move towards learning which is characterised by meta-learning and the demonstration of versatility; an example would be the ability to generalise from a particular experience and subsequently apply those generalisations in a new and different situation or practice environment. It is anticipated that this process is stimulated by students re-encounter with problems addressed during Level 2 placements. Whilst still requiring some guidance from clinical educators, at this level students are expected to assess patients' problems, interpret the data gathered and make relevant treatment choices in commonly encountered situations. Involvement with patients extends to include family and carers.]

Within the clinical education placements students are expected to formulate a learning agreement in collaboration with the clinical educator and visiting academic tutor. This agreement involves establishing individual's roles, identifying student learning objectives and the opportunities and actions required to facilitate their achievement.
All students within this study made reference to the fact that out on clinical placement, there are certain unstated

expectations of them as either a year one, two or three student, irrespective of their time/stage within that year.

"They made assumptions that, well, they turned round to me and said I was doing very well, considering I was a first year ... well to me it means you're obviously doing well at ... they obviously make assumptions at what level a first year should be from their own experiences, obviously. Um ... personality, plus your level of ability, if it goes well together, you're going to do better than they expect anyway" .

"The second week I had to change again and I went to like an acute ward which was really heavy respiratory and I hadn't looked at that at all and I was out of my depth completely and I was just expected to go and do my own thing and it was only on the third day that I found it was because they thought I was a second year student and not a first year" .

"Well I think the label of the third year changes a lot, it changes attitudes towards you because you are a final year student. You get a definite change in attitude ... its definitely the label of final year student, definitely. It definitely changes clinical educators attitude ... It was almost like they didn't ask me questions any more, they just assumed that I knew it ... and sometimes they could come out with things and I hadn't got a clue what the hell it is but I wouldn't say it. I'd just go home and read it instead ... which in a way was nice because of sitting down and going through stuff again and again the knowledge, they let me get on with doing my own background reading and just let me get my hands on when I was actually there in the daytime, which was good. There was a definite attitude change and then there was ... they therefore trusted you more because the assumed that you had this more knowledge and that you were so much more experienced ... because I was aware of it I could make sure that I could live up to their expectations. It gave me a bit of a rude awakening, I was like they are trusting me with this so I need to make sure I know my stuff and it's not going to be long until I haven't got a clinical educator hovering over me ... that was good and the trust level increased, you get more of your own caseload and sometimes they actually took on board what you said in suggestions and everything. A couple of times the clinical educator would say oh yes I wouldn't have done it like that, but I can see why you did it and it's something I might remember to do for the future. So they were actually taking on board, it felt more of a two-way relationship rather than teacher pupil, which was nice" .

Such expectations also come from patients and were clearly the source of some anxiety for the students when the expectation either exceeded the students' self-perceptions, or was completely dismissive of them. However, for some it allowed them to demonstrate their abilities with less overt supervision than might have been otherwise expected, and to recognise a change and development in both themselves and their way of working, and in how this impacts on their relationships with others.

"Yes they have said oh you are a student, what year are you in and I said oh I was in my first year and they go on well I don't want you to treat me because you won't know what you are doing. You'll damage me, you'll make me worse" .

It is clear that the students on the whole, enjoy their clinical placements and have high expectations of what will be achieved during a placement. In general terms there is recognition that what may be achieved on placement cannot truly be achieved at university, as per Schön (1983, 1987).

"I think we have done a lot of anatomy and a lot of techniques and general learning about the body and I think the placement helps to understand ... I don't think the uni can do what you can in a clinical placement until you actually see the patient" .

" ... all the information and you don't ever see how its going to make any difference to how much you know. And then you go on placement and it just suddenly comes together. This is why you've been learning it. You can see why ... Put everything that I'd learned ... hands on experience and that's what made it real in the end".

Most respond well to the responsibility given, and whilst verbalising lack of confidence and insecurity on placement, demonstrate increasing confidence in mastering their subject as they progress through the degree programme.

"I suppose all my doubts in some ways and the reality of it came from one of my patients who I happened to ask how she was one morning when she came in, and she said oh feeling very tired. I said oh, have you been doing too much walking and she said no I haven't because I've got this pain in my calf and I spent about 15 minutes feeling the calf and getting myself stressed because as far as I could see she had a DVT and that really disturbed me because I had to make a decision all of a sudden. And I knew what I had found, it was a lump, it was red, it was swollen, it was hot. But for some reason I didn't believe it .... and I think the treatment I was going to give her was some kind of interferential type thing anyway which was quite serious if I had done it. But I took my time, probably about 10 minutes, it probably felt a lot longer, just generally chatting to her and feeling her legs again and thinking I'm going to look really silly if I say this to my clinical educator and it's not, but at the same time I knew it was. And I told my clinical educator, and she was like umm, well, a bit doubtful of me - and said we'll get the doctor to come down and he admitted her. And that really brought it home to me. I suddenly felt so responsible that that was dramatic. I suddenly thought oh my God I could have treated her, the only reason I didn't was because I'd had that conversation with her ... I think it was a chance conversation ... she was a patient, I didn't know her very well I had only met her once before ... I suddenly felt very responsible" .

Clinical education is seen as a site of primary learning and what the students actually do encompasses undertaking initial assessments of patients to identify specific problems, interpreting the data generated from this initial assessment, deciding on their rationale for treatment, applying treatment and evaluating outcome. Students are also involved in the administration of their caseload, booking appointments, writing up case notes, writing discharge letters to GPs etc., attending clinics, going to theatre, liaison with other members of the multi-discipliniary team: a whole range of activities varying on whether it is an out-patients or in-patients placement, the nature of the patient group involved, and the nature and approach of the clinical educator involved. The majority of educators have undertaken a course in the facilitation of work-based learning, but a

reasonable degree of flexibility is required to enable the educator to facilitate the students development within the constraints of the specific department. Indeed it is worth noting that the flexibility even extends to the degree of supervision students are given. It is possible for a student to get through to their final year of study without ever having actually been observed treating a patient; and in some situations the students seems to be viewed as an extra pair of hands, when in fact, they are deemed supernumerary to staff numbers.

" ... if I'm with the educator and she says well ... well I've never been observed you see, I've always just been told to just go off and do it on my own, but I always come back and say this is what I did, this is what I found out and I think it might be this or this and the educator will way why do you think its that and I will have to explain why ... I've never actually been watched never, I've always just been told to go off and do it on my own. I do prefer it like that because I imagine that if I had been watched I would be extremely nervous and not able to concentrate ... I understand why I should be - I think it would be useful because I know I won't be repeating the same mistakes over again".

Summary

Physiotherapy students arrive with varying images of the profession into which they have enrolled. They undertake university-based study exploring areas of profession specific skills and professional knowledge, supported and enhanced by clinical education placements in a variety of commonly encountered environments. Grades for university-based study are cumulative and students do have opportunity to perform less well in one aspect which may be compensated for in other assessment aspects of the same subject area. Students must achieve a pass in all clinical education components.

What unites the students is their enjoyment of the clinical environment, the enormity of the workload in the university, the importance of core subjects and the potential for other subjects to become important when these core subjects have been mastered. Grappling with the complexities of the assessment system so that they might begin to accurately evaluate and predict their own performance, is also a major cause for anxiety for these students.

5. Student Self and Relationships

This chapter shows how the data indicates the students are finding out about themselves, their personal values, beliefs, attributions, and how this impacts upon their relationships with others in constructing their professional identity.

Physiotherapy undergraduates encounter physiotherapists in two primary situations: as academic tutors and as clinical educators. Previously it was identified that students see themselves as part of physiotherapy only when on clinical placement, and not when in the university environment. This may go some way to explaining why no participant identified a physiotherapist in an academic role as a 'good' role model: *"All the lecturers are pretty much across the board"*. All role models identified were currently working clinically, had been for some time, and were perceived by the student as performing in a highly skilled and specialised manner. The clinical educator was validated as a good role model if the student felt a good relationship with the clinician had been established.

The character of the relationships formed by students is critical to the process of 'becoming' a physiotherapist. Other agents of socialisation encountered are peer group and patients. To explore how these new agents of socialisation engage with the pre-existing personal socialisation, the frequency of contact and the involvement of each agent in the activities the student, is reviewed. Although for simplicity, agents will be looked at individually, it must be remembered that whilst exploring the relationships established between the student and a particular agent, this relationship will impact on the relationship established with

other agents, and therefore none should be viewed in isolation.

Self & Educators

Within the university environment, students encounter staff offering a wide variety of clinical and educational experience.

Students evaluate the university education experience well in terms of perceived central content. Those staff members who have responsibilities in areas seen as more peripheral by the students, particularly in their early years of study, were often not well evaluated by the students simply because they failed to recognise their importance. Students were far more able to relate to staff who taught what they saw as mainstream, concrete, 'bread and butter' physiotherapy knowledge. This is viewed by the students as the substantive framework fundamental to becoming a physiotherapist. Another issue adding substance to the students views about what is core to becoming a physiotherapist, is the manner of delivery of such 'core content'. Where delivery is supported by some kind of documented study guide, students evaluate this very positively. One is drawn back to the didactic nature of a package of programmed learning (Rowland 1993). Not only is the content seen as primary and the volume large, the delivery reinforces dependence and surface learning is self fulfilling. In the areas of study less well received by the students, tutors required students to express their own ideas and opinions, to suggest and debate issues: this the students were consistently less positive about in their evaluation. One student alluded to the fact that they felt their previous life experiences were not considered important within the process by either themselves or the university, and this is

compounded by the strong desire not to offer something which may be considered wrong.

"Maybe I didn't give them enough credit [life experiences] because you listen to other people and what they've done and you think wow, I haven't done anything like that".

" ... need to know you're not going to be wrong, if you think you might be, don't volunteer"

It seems that the students' relationships with the academic staff are largely dependent upon the physiotherapy specialism of the staff member, the style of teaching adopted, and the frequency of contact. Delivery within the curriculum, and the stated philosophy about teaching and learning seem at variance, as Carr (1995) suggested, there is clearly a discrepancy between what the tutors think and say they do, to what they are actually doing. Rowland (1993) offers suggestions about adopted models of teaching, writing of thesis, antithesis and synthesis, describing thesis as the role of the tutor to impart a body of prescribed professional knowledge or skill; the antithesis to this is to construct an environmental context in which learners learn as a result of pursuing their own explorations; and finally where synthesis is a combination of the other two. With synthesis, learning is socially constructed between learner and tutor, both have a responsibility for seeking to understand the other, as in a conversation.

Since no teaching will fall directly and completely into one or other model, it is reasonable to assume that there would be a continuum existing within the activities of the students in this process. From the students comments, in parallel with this continuum, the students have placed another, which interprets relative centrality of content. This identifies an

issue to which we will return, that of conflict within the curriculum, not only for the students but also for the academic staff. If students are being asked to contribute something which they do not value, to a topic area which they do not see as central to their purpose, and in a manner which they find uncomfortable, then clearly the likelihood of a favourable outcome is diminished.

Students very quickly pick up on the primary specialisms of individual academic staff, and make assumptions with regard to their abilities outside of this speciality. Should a member of staff take a session out of their 'known' speciality, the students assume a timetable change rather than the staff member actually being able to contribute to another area. Students also identify who to go to for an answer to their particular question, who will suggest other routes to search for the answer, and who will just tell them what is required.

Students indicated that they do not feel like physiotherapy students whilst in the university. This has been implicitly encouraged from the viewpoint of wanting the students to be like others when they are in the university environment. However, within the learning environment, there are certain expectations of these students to adopt a professional demeanour. There is a requirement for the student to change from one identity to another throughout the day, the impact of this in a period of identity crisis must, at the very least, increase discomfort and promote anxiety.

The second group of physiotherapists with which the students have contact is on clinical placement. As described previously, the responsibilities and expectations placed upon students increases steadily from year one through to year

three. The amount of supervision given to students on placement is variable, within as well as across levels, as is the amount of responsibility. Students undertake their clinical education in an open environment. They may be hidden behind the curtains in a department or behind the screens around a bedspace, but the arena is essentially public. Their activities in terms of patient management such as findings on assessment, analysis of data, decision-making processes, are expected to be discussed with the clinical educator prior to any implementation of treatment.

It seems characteristic of the student interaction on a placement, that a 'good' placement is described as offering a lot in the way of new knowledge, opportunities for consolidating skills learnt in the university, and experience of other areas. The best placements were characterised by the establishment of a good rapport with the educator, being able to speak up about patient treatment, challenge the opinions of more senior staff, justify such challenges, and demonstrate reading around the subject matter. Bucher & Stelling (1977) used the phrase *"roundsmanship"* (p.126) to describe such a game. Students find demonstrating their knowledge difficult, and tend not to contribute if there was any doubt that they may be wrong. However, the students who gain highest grades on placement are largely those who demonstrate that they are working, reading around and 'playing the game'.

In some instances students experience conflict between what has been learned in the university and what they see actually happening in practice. Students deal with this in one of two ways. They either ignore what they have learned and do what the educator does, or try to diplomatically indicate they have been taught something different, thereby displacing the

challenge from themselves to the university. The reasoning behind this course of action is the desire to continue to 'play the game'. Challenge may, by implication, suggest a lack of currency of practice by the educator. Depending on the individuals involved, this kind of interaction may be seen as enlightening and positive or challenging and undermining. The outcome impacts directly on to the student's overall grade for the placement. Discretion is most often seen as the better part of valour; students have about four weeks generally, to get to know the site of the placement, their clinical educator, the departmental politics, and consolidate and develop their university learning. One student expressed that you might be in the department but in effect you were still on the outside, when talking about a particular department she had worked in where each staff member seemed to have their own particular place in the staffroom:

"... like in a different area of the staff room or you are only allowed those two seats, at least if you knew what the boundaries are ... mainly the older staff not the juniors, because the juniors are generally more welcoming".

Clinical educators adopt a variety of methods of managing the placement of students. Some allow greater independence than others, permitting the student opportunity to test their competence and learn about making decisions. Others are more constraining and monitor every step. Physiotherapy has long since moved away from prescriptive treatment for specific conditions; it now offers a patient centred, problem based approach to health care. As such, to suggest a single way of treating a particular problem would be reductionist. The same problem may present in multiple ways in a variety of individuals, thus requiring a variety of solutions. Providing a coherent, evidence-based rationale can be offered for a

treatment choice, then it may be an acceptable strategy for management. For students this can be a confusing situation. There is a desire to have more black and white answers to problems, particularly in the early days of practice. What it offers though, is scope for discussion and debate about the most appropriate strategy in a particular situation. Such discussions encourage mastery of the decision making process, the development of behavioural-competencies and accountability as a professional physiotherapist.

The relationship between students and clinical educators changes as the student progresses through the programme, although it is not possible to give examples of a single student and clinical educator relationship changing since students rarely encounter the same clinical educator more than once. Each placement may be at a different health care provider unit, and it is only coincidence if a student and educator should happen to meet up a second time. There was an acknowledgement from all those interviewed that certain assumptions were made about the students on the basis of year of study:

"Yes as a second year student its like well how am I supposed to know and they seemed to think that I would know that and I was like I'd never touched a back before apart from my friend in a lesson. I found that very difficult ... "

"Well I think the label of third year changes a lot, it changes attitudes towards you because you are a final year student. You get a definite change in attitude ... "
[even though you have only just started the year?]
"Yes ... its definitely the label of a final year student, definitely. It definitely changes clinical educators attitude whether or not it was just the ones that I had or not I don't know but it seemed to ... it was almost like they didn't ask me any questions any more just assumed that I knew it, and sometimes they would come out with thing and I hadn't got a clue ,,, "

What must also be recognised is that following each placement, the student gains another set of experiences to take into the next placement, and similarly, the clinical educator has the experiences of previous students at a similar time/stage in their studies, from which expectations of how the student will/should perform are drawn.

Students who establish what they feel are good relationships with their educator, learn quickly how to exploit the educator and gain what they can from them. This is often practical rather than esoteric in nature, with the focus of the student very much at the centre, taking in terms of learning rather than giving in terms of patient care. The patients are seen only as a resource, which in their truest sense they are for they will inform subsequent analysis and decision making, the person is not paramount in the students' thinking. In some situations students referred to an almost voyeuristic interest in patients problems, a morbid fascination rather than acknowledgement of the patient as a person with a problem, a biomedical perspective. The students' relationships with their patients is explored subsequently.

As might be expected, the better relationships with clinical educators are those which are one to one or at most a two to one situation. Where a student has a single educator they are more able to focus on the individual, and learn the specific rules of the game more easily. Students have only a short time in which to establish themselves, and having to address the game with more than one educator compounds the difficulties. It is generally accepted within education that the optimum is for a single clinical educator to have charge of two students at any one time. It is anticipated that two

students would be able to cope with the workload of a single educator, leaving the educator in an advisory capacity, however, having two students together can precipitate other difficulties.

"I was with one of my best friends which was just a complete fluke but really good. However we never worked together. We are really good friends but we never actually work academically together at all because it just doesn't work. We decided that so when we were on placement I thought Oh God I hope it will be okay and um the first morning thought to myself its going to be awkward because she's going to ask us questions together and we are both going to be competing with each other. So after the first day, well even in the first morning after our first tea break we said right we'll do I'll answer a question you answer a question. If we can see someone paused for longer then we will butt in and say ... we sort of had an agreement that no one overpowers the other and we just never had a problem at all and it was really good our clinical educator was fantastic she didn't, she wasn't somebody I though Oh God I can't ask her if I wanted to, I didn't feel that I had to pretend I knew something if I didn't she made me feel really comfortable" .

Students do not appear to have the vocabulary to describe their relationships with their educators. Most of their accounts of these interactions centre on undifferentiated descriptions of personality, as in having a 'similar personality', or having a 'personality clash'. Where the interactions worked well, an element of 'hero worship' creeps in – at the other end of the scale the students can be censorious. Where difficulties do arise, students are required to make the best of it; rarely is a student removed from a placement on the basis of not getting along with their educator. Support is offered in the form of increased visits to facilitate the interactions.

Within the interaction, students expect to be treated as individuals – hence the potential difficulties if there were

two students with a single educator; however they are reasonably well united in their expectation of what the clinical educator should be doing for them in terms of accessibility/availability, giving advice, and being allowed to test out ideas safely but not allowed to make major errors. All students indicated that it was the *"bad experiences"* from which they learned most.

"I definitely learn from mistakes because it's something that makes you ... it has consequences. If consequences are usually bad and you have to pay the price for them and I think it's something that will stick in your mind and therefore you will learn the right thing all the way through ... whereas if you were right all the time you may not remember" .

In situations where difficulties arose, the difficulties were largely as a result of the style of the educator in managing the student on placement, some allowing greater independence, permitting opportunity to test competence and learn about making decisions. Others are more constraining and monitor every step. In some circumstances students said they were never observed, just left to get on and then talk about their patients at the end of the day. Others indicated that they had been questioned regularly and asked to justify their decision-making throughout the process and their treatment techniques had been observed and corrected throughout the placement. Most students preferred not to be watched and make their mistakes unseen, but recognised that they may be repeating the same errors. The most acceptable compromise was to be observed fairly closely early on, having been allowed to observe the educator at work, then for the clinical educator to withdraw to observe from a distance as the student settled in. Educators who managed to achieve this feat were also those who were more readily looked to as role models. Those students who did well on placement, and this

did not necessarily mean that they gained very high marks, but that they felt it was a good placement, were usually those who felt that they had worked very hard, that the educator had set them high standards to achieve and had never really let up the pressure during the whole time of the placement. Mostly this was responded to in a positive way, the students reporting a good relationship in which there was substantial learning for the student. However, for students it is the frequency of feedback and the nature of it that is most important from any educator. A student is aware when they have not been observed and are highly suspicious of a report which indicates that they are a good practitioner, in the same way they are deeply offended when their marks are low and they cannot identify the basis for this if they have not been, as they see, adequately monitored and evaluated. The following quotations indicate the variety of approaches:

"She just let you get on with an awful lot and at first that was really scary but I did get used to that, I think it was just the thought of being on your own with a patient and what if I make a mistake".

"Well if I'm with the educator and she says well, well I've never been observed you see, I've always just been told to just go off and do it on my own, but I always come back and say this is what I did ... "

" ... the trust level increased ... you get more of your own caseload and sometimes they actually took on board what you said in suggestions and everything".

A sense evolves of two types of clinical educator. Those who fall into a muted, rather understated approach or those whose approach is much more high profile, and perhaps at times quite intrusive. Neither approach seems to be the most popular, each has its own strengths and weaknesses as far as the students are concerned. What does become clear though is how much the students 'forewarn' each other about

placements, thereby establishing preconceptions of the clinical educator for the student. Consider this in contrast to how much the students value their anonymity on placement; when talking about 'playing the game', there are clearly different sets of rules applied. Whether a student is happy with their clinical educator or not is rather incidental. In the university, although a particular member of staff will be involved in a particular subject area, there is no real requirement for a student to have a specific interaction with that member of staff; even their nominated personal tutor may be changed, or they may simply seek advice from an alternate without making a formal request for a change, whereas on clinical placement the two are really rather 'stuck' with it. In fact, creating an issue which results in withdrawal from a placement or change of educator can give the student a reputation for being difficult, and may encourage the placement to withdraw subsequent offers. The student is encouraged to look at the issues, make the best of the situation and in fact learn to get on with people. Physiotherapy students have to learn to cope with all agents of socialisation as will be seen later when we explore student-patient interactions.

Self & Peers

For physiotherapy students, peer group is largely defined as the group who started together and progressed year on year. The organisation of the programme often limits contact between years, and it is not unusual for students to identify that there are members of their own cohort whose names they do not know. These people they often only get to fully meet during a joint clinical placement, or if the teaching groups are re-mixed.

> The large size of cohort makes it very difficult for students to get to know each other well. What tends to happen is that it is more focused into the smaller group which is used for teaching practical skills, seminars and tutorials. These students who all have self-directed study time at the same time are more likely to practise or rehearse their skills together. Although a large student group does not support development of a peer group, working in a smaller group for the practical skills facilitates group coherence. Much of the practical skills, seen as central by the students, are taught in such groups, with students working intensely, practising skills on each other. Such intimacy cannot help but break down distance and largely encourages mutual support, although the down side of this is that the students have relatively little privacy from either their peers or from the teaching staff. It is sometimes a rather claustrophobic atmosphere which becomes constraining rather than supportive, and results in individuals being excluded or excluding themselves from situations.

"It's been quite demanding socially. I think trying to get on with everyone. I mean every time you have an argument in a small knit group, it's quite hard"

Physiotherapy students are encouraged to use each other as a learning resource and not only practise therapy skills but discuss issues and articulate their knowledge with the intention of developing self understanding and autonomy (Quicke, 1996). Each student is encouraged to give feedback to the others with regard to, for example how a technique feels, comfort, accuracy. All such elements within the programme help to support the development of a strong cohort group. Students on placement are also encouraged to work together, sharing experiences and discussion strategies. In such

situations, it does not matter whether the students had met the night before or even liked each other: the focus is on learning in clinical, each getting the best out of the placement. Thus there is a kind of unity of purpose although this is not always the case. When peer groups were raised at interview, students talked about them in general terms of support and friendship, but this seems to break down somewhat, with the students becoming a little more single-minded towards the end of the first year. On the whole the students had high regard for each other because of the competitive process for entering physiotherapy. All assumed equal commitment to the profession because of the effort involved in getting in. One person was surprised at the type of people there were in her group, and how different they were from her.

"There are some very different types of people on the course, people who I would never think of as entering the caring profession but when you go out with them in the pub they are like, not caring at all, they are really brash and over the top and you know ... I just think Oh my goodness, how are they going to deal with a patient, but that's just a few, but most of them are really great people ..."

Students referred to elements of competition within the peer group and this appeared to be a negative influence, since it was not uplifting in encouraging each other to do their best; rather it was competition to achieve more highly, by whatever means.

"It got to a stage where you know, people were keeping secrets, because it was a good thing for their essays and things like that."

When asked to evaluate how they felt they measured up to their peers, each of those interviewed was characteristically modest, usually indicating the middle ground and qualifying

it with the notion that each had their different strengths. Peers are used, as is well recognised, as a comparative reference group, for individuals to evaluate personal performance and aspects of such self evaluation will be followed up in the next chapter. There is a certain degree of reassurance gained by comparison of others' progress. It identifies that each, with the exception of a notable few, had their own difficulties with the programme. All those interviewed acknowledged there were some in the cohort who were destined to get first class degrees and that was okay because they worked hard. One of those interviewed was singled out by the others as being likely to get a first because she worked all the time. The individual in question did not recognise this in herself and worked all the time because she was not able to tell when she had done enough.

Each year of students has relatively tight knit peer groups within it, and these become mutually supportive, particularly in the final year. The character of the groups changes from year one to year two and some coherence and support is lost although the focus on maximising learning remains to supersede all other requirements from the peer group.

Self & Patients

In their studies of junior doctors' socialisation into becoming professional, Bucher & Stelling make little reference to the impact of interactions with patients, and their contribution as agents of socialisation. Other than a reference to patients being used to evaluate performance (Bucher & Stelling 1977), in which such a view was considered unreliable by the respondents in the study, there is no other mention. This may be a result of a fundamental difference between the doctor-patient interaction and the physiotherapist-patient

interaction. Physiotherapy is a person-oriented, problem-focused approach to the management of patients and such interactions have considerable impact on students' progress and development.

The ages of the participants in this research are between 18 and 25 years, years identified as full of change and potential for personal conflict and identity crisis (Erikson, 1963). Many of the students have come directly from school, and although have had some 'work experience', actually having some responsibility for patients is a major turning point in the process of becoming a physiotherapist.

Students encounter patients in essentially two capacities:

- Those who are the responsibility of the educator, and who are willing to allow the educator to demonstrate and teach whilst the students observe their treatment
- Those for whom the student has part or total responsibility for their management.

The patients may be medically well individuals attending an out-patients department because of a musculoskeletal problem, or they may be patients admitted to hospital for emergency or elective surgery or those who are medically unwell. Some patients are admitted into intensive care and classified as seriously or critically ill. Thus students encounter the full spectrum of patient situations and for some it is the first time they really begin to appreciate what it might mean to be in hospital, to be incapacitated either temporarily or permanently. There is also the realisation that admission to hospital does not guarantee restoration of health and a return home. There is a gradual dawning of the transitory nature of being.

> Another opportunity for encountering patients comes indirectly from chance meetings within the department, in and around the hospital, en route to or from the wards, operating theatre or in any of the other health care environments. Such encounters cannot help but alert the student to the less glamorous side of health care. It becomes apparent to the student that simply by wearing a physiotherapy uniform brings certain expectations and responsibilities. These expectations and responsibilities do not relate to the experience of the student but are the result of assumptions made on the part of the public with respect to competence. The feelings of the participants about such assumptions ranged from awe-inspiring to flattering, recognising that within the expectations came responsibility but also that such assumptions brought power to the students. It appears this is one of the reasons students responded favourably to clinical education rather than university based study, where they felt disempowered. An interesting indication of student development which subsequently came to light was the timing of when the student felt ready to hand over elements of the power in the relationship with their patients, such that outcome was negotiated.

The students also recognise that patients, and therefore people, are not 'textbook', do not always fulfil the stated progress path to recovery and do not always do what they have been advised. There is a real shift from the idealistic to the realistic perspective and for some this is an uncomfortable and rather disillusioning experience. This shift manifests itself by realism in dealing with individuals problems, not giving false hope, being honest but helpful.

Students remarked that in their early placements their focus was on learning for themselves, not on quality of care for their patients, the patient was secondary and used as a resource for learning. However, with time there is some ideological shift from student centred to patient centred care. The participants did not recognise that the shift was complete, even as some were, on the eve of graduation. The patient was still seen as a learning resource, but discussion of their approach had made them more aware of their attitudes and they had all made attempts to ensure that as they were learning the patient was also receiving the best and most appropriate care available. One student said that this was also the result of perceived external pressure from her patients to be the best she could, to meet their implied expectations; another talked of patients treating students differently, giving them more information to help them make the right decision, and because she felt patients *"looked up to her"* she tended to have their best interests at heart. Another was quite explicit in describing how patients fascinated him by their inability to perform. This particular student was also wrestling with issues about whether a particular situation was *"self induced"* or not, and how his feelings about such things as smoking related disease, impacted upon his management of patients. He also admitted a preference to being where people got better because he didn't know how he would cope if they didn't. Much of this particular student's responses seemed to be related to his feelings of helplessness about not being able to stop the loss of his grandparents. This student seemed to be having particular difficulty facing issues about mortality, hence his stated desire to work only in areas where patients were less likely to die.

This same student indicated that he gained much satisfaction in treating patients with disabilities, and alluded to the paternalistic philosophy of *"I was treating them"* indicating the need for power and control to be his rather than in the hands of the patient. At the same time, he remarked that he *"fell in love with the patients"* . This was based upon the patient being subservient to the student and fulfilling the students desire to 'do good' for the patient. He was unhappy if he felt his patients did not like him. This student used many phrases in his interviews which are troubling. He spoke of patients as *"slabs of meat"* when talking about how he kept a professional distance between himself and the patient, and of treating patients *"mentally as individuals, but physically they were not"*.

The perception of having power has been indicated as being important from the physiotherapist perspectives, but patients have power should they both recognise and utilise it. Another student, who had experienced difficulties passing a clinical education placement, talked of a situation in which a patient had refused to be treated by her because of her student status.

" ... on the second placement in the summer I had a patient who just would not be treated by me at all, would not let me near him ..."

This same student spoke of the power she had over patients in terms of:

" ... if I tell them to get up and walk and they don't do as they are told, they are non-compliant or difficult patients".

It is not difficult to imagine there may have been problems in managing such a student in certain clinical environments,

particularly in light of her earlier view that patients exist on a continuum of fascinating through to routine to boring. This was the same respondent who identified in her first interview that she was having to learn to cope with people who were not as sharing and considerate as she, and that people should take her for what she was, they should be accepting rather than judging of her.

One of the students whose first interview took place at the beginning of her third year reported that she felt she needed to change her approach with different people, using the phrase *"knowing which buttons to press"* to get the best out of people. At the same time she felt tremendous pressure to be the person the patients thought she was in terms of fulfilling their expectations of her abilities. Another experienced great difficulty in dealing with what he saw as unrealistic expectations from patients. Others spoke warmly of patients asking permission to do certain things, of patients putting their health in the hands of the physiotherapy student and the joy of knowing more than the patients who trusted them. One particular participant felt that even though she was only a student, patients looked up to her. This comment was made in the context of comparing clinically based study with university based study. At the university, *"they know that you don't know"*, as opposed to patients making a fundamental assumption that you must know something otherwise you wouldn't be here. The idea of patients having expectations is not frightening because the students begin to recognise they can help and make an impression on a patient. Although they don't feel they know a lot, in general, they know more than the average patient, therefore they perceive the power to be on their side. This poses a dilemma when one considers the ethics of informed

consent and patient empowerment, and suggests that the students are not working within those ethical principles so are not fulfilling the patient centred focus of healthcare. Their focus is still maintaining the traditional biomedical, paternalistic model.

Summary

The interactions between patients and students constitute major personal relationships. These relationships are seen as very important to students and give an indication to the student of how successful they have been in their placement. It seems that the overriding theme from the interviews is that the students, as they put on their uniform, undertake a role which includes responding appropriately to expectations and responsibilities placed upon them by both patients and their clinical educators. Students feel able to cope with this because they perceive the power of some knowledge to be on their side with patients, and this is a fundamental difference from university-based study, where they perceive themselves disempowered.

6. Students' Self Evaluation

This chapter shows how the data suggests students undertake self evaluation, how they evaluate their success, and upon whom the students model themselves.

The work of Mead in 1934 gave the notion of self as social in origin. Mead defined 'Me' as *"the organised set of attitudes of others which one himself assumes"* (p.175). Mead also differentiated between the 'Me' and the 'I'; 'Me' being the self which immediately exists in consciousness. Goffman (1959) gives an understanding of self as being determined by the roles taken up by an individual, and that these roles are determined by others. For students just starting the journey to constructing their identity as a physiotherapist, I would suggest that construction and understanding of self is a composite of both. Throughout their studies, they are exposed to the attitudes of other physiotherapists in the university and clinical environments and simultaneously required to adopt a number of different roles, sometimes within a very short time frame. The success of these roles is largely determined by interaction with others, this establishes the attitudes of others to 'me' and thus the individual generates knowledge of self. This self knowledge must contain within it the belief one has about oneself, how one sees and thinks about oneself, and the relevance of this to social behaviour. How people see themselves (self concept), has great bearing on their understanding of that behaviour. In order to construct a professional identity students must gain knowledge of and about themselves.

There is clearly a relationship between what an individual believes about themselves and what they know. For a belief

to amount to knowledge, it must be true, but also for the belief to be rational it must be founded upon some knowledge of self. Such knowledge is based upon previous experience, but it is feasible to have false conceptions of oneself as an individual. What then is the relationship between having knowledge of your self and self knowledge? Consider the statement made by one of those interviewed about her appearance on clinical placement.

"But they just see a uniform, they see someone as a physiotherapist ... they say I have a problem you are a physiotherapist fix it. It is important to look smart because it sets you apart from everyone else, the whole package I mean, clinical you look the part sort of thing. People expect more of you or don't just see you as sporty".

This student knows that how she looks in her uniform has an impact upon other things about herself. The uniform empowers the student by affecting her personality, character and identity in the role of physiotherapist, giving the right image and enabling her to perform. Within the university environment, casual dress only is required, so as the students go out into clinical practice, they take on, quite literally, the mantle of the clinician, making a physical distinction between learning environments. When physiotherapy schools existed, there was a dress code for students and staff within the school, and in particular when undertaking physiotherapy practical skills classes. This has largely gone in efforts to integrate students into the university environment and to limit the obvious differences between physiotherapy and other students casual dress is accepted. However, it does add substance to the earlier comment about not feeling like a physiotherapy student in the university. This student seems to be indicating a recognition of difference between herself and other non physiotherapy students, which she wants to

maintain and perhaps even develop. An individual gains self knowledge by understanding how things affect them, but it is concerning that the professional mantle may be seen as superficial and potentially discarded with the uniform. Hamlyn (1977) suggests it is possible to know a great deal about your personality and character but not to really know yourself. It would appear that this participant has some self knowledge, focused around her personality but lacks insight with respect to what it means to become professional and the implications of developing a professional identity, viewing this from the superficial standpoint of public image and association with the uniform.

In searching the data for clues about how the student evaluates self, I have based my understanding of an individual coming to their self through interpretation of the experience of how others respond to them, individual analysis of personal responses to a particular stimulus, and how the beliefs about their personality are portrayed or utilised in everyday life. Some of the respondents in this study indicated they did not feel they were themselves on placement, some also said they were not themselves in the university either. This suggests either identity confusion or the possession of a considerable self knowledge within this social setting, and that they are making judgements about both themselves and the character and personality of others within the setting. Implicitly they are evaluating by comparison with the others in the setting. The data suggests the students have quite strong mechanisms for evaluating themselves, based on comparison with their peers and feedback from staff. The feedback though may be selectively received. If a student does not perceive the subject matter to be central to physiotherapy, or the individual giving the

feedback to be of importance, this acts to discount importance in the eyes of the student. Hence there is selectivity in how the students use evaluation of themselves by others. What is interesting is the basis upon which a student decides that relative worth of an opinion, on what basis does the student decide whose opinion has for them the greater validity? This is surely grounded in their pre-existing commitments (Quicke, 1996), and the prompt given is not sufficient to make the individual re-orient themselves from their existing viewpoint.

Such selectivity in acknowledging feedback matches the findings of Bucher & Stelling (1977) in their work with junior doctors. This same work also undermined the common belief that the presence of proper role models was important. For students in this research, who have not yet reached qualifying status, identifying role models seemed difficult. All those interviewed were asked at each interview if they could identify any individual who had made a significant impact upon their development, and upon whom they might wish to model their future practice as a physiotherapist. As regards an individual who has made a significant impact, respondents most commonly identified a patient.

"I think I began to understand the patients. There was a particular patient that I got on really well with and she just thought the discussions we were having and she was telling me about things she was quite emotional and she just let her emotions out on me. We'd talk and I think maybe because I was a student or whatever, she just taught me quite a lot about what it is to be a patient, she just made me realise that it's all very well having the job and going home at the end of the day but the patients are stuck in hospital and they are having to wait to go to the toilet and having to wait to get dressed or having to wait for the nurse and constantly being told I'll be there in a minute and a minute is about an hour ... it sounds obvious but it's really easy to forget it doesn't stop for them at the end of the working day".

Some identified a specific clinical educator as someone they might like to model themselves on, but they all found it difficult to articulate why this individual was singled out.

On some placements, as a result of job shares and service provision arrangements, a student may be in the charge of two or three clinical educators, which is clearly not ideal but often the only way to gain some experience of areas such as community care. Where this happens, students do not identify with any specific individual or even speak of specific traits displayed that they might wish to emulate. In these circumstances the students tend to feel they are an inconvenience. It is only when a student works consistently with one individual that they are able to begin to identify certain models they might consider emulating.

What is most obvious is the identification of negative traits. Many participants could say what they hoped they wouldn't be like. However, very few could identify one specific individual as a model; when someone did, this was usually an individual recognised within the profession as being 'highly skilled and specialised' who had a substantial reputation within their chosen specialism. No student gave any indication that the traits looked for to be a 'good' physiotherapist were present in any of the university-based physiotherapists, and although students knew what it meant for them to be a 'good' physiotherapist, each had their own conception of this.

Over the period of their clinical education, students encounter a number of potential role models, from whom it is hoped they experience 'good' physiotherapy practice. The

final year students were more able to articulate what for them was a 'good' physiotherapist, and how they had arrived at such a conclusion. Those earlier in their course had gained a lot of information and a lot of experiences to draw from, but were less able to synthesise and develop a coherent picture for themselves. Bucher & Stelling (1977) indicated their data from junior doctors led them to construct five types of role models for their respondents. These were partial, charismatic, stage, option, and negative (p.151). The undergraduates in this study identified most strongly with negative and charismatic models - effectively the two extremes of role models: those they did not wish to emulate, and those they could not hope to possibly emulate. These charismatic models, when identified, were highly idealised and rather awe-inspiring individuals who were often described rather effusively. The negative models were not the product of personal dislike of the individual by the student, rather it was the result of personal dislike of what they were experiencing at the hands of the educator. The issue was most commonly centred on social aspects rather than the technical competence of the physiotherapy clinical educator. The students did not feel they had the right to criticise that aspect of the educator. Only on specific probing would a partial model be described and just occasionally a student would refer to being told about day to day issues in the department, and how someone helped them settle in to the place. This was often a junior physiotherapist rather than the specific clinical educator. Students recognised this as important but felt it was too low key to be gained from their educator, so they often sought such information from an individual closer to them in experience and who had no input in their mark. To follow the Bucher & Stelling (1977) model, the presence of stage models are seen to be important.

Physiotherapy students then, have a charismatic model who they could never hope to emulate, a negative model who they do not wish to emulate, partial models in whom they recognise certain desirable traits but do not seem to understand how they develop such traits in themselves, and finally a stage model who is somebody close to themselves in experience and knowledge, perceived as more directly approachable and whose opinion is not sought in final evaluation.

The next phase of the analysis is to examine how the students use these models and their perceptions of what is good, to evaluate themselves and their performance, what cues do they use? The data suggests that these cues seem to originate either externally or from within the individual.

For these undergraduates, external cues were either direct or indirect. The most direct cue for all students is the grade awarded for assessment including assessment of clinical placement. Grades are perceived as very important to students although they perceive a great discrepancy between effort hours and grades awarded. This perception is heightened because of the importance placed upon receiving good grades. Students get intermittent feedback on coursework essays throughout the year. Whilst on placement they should receive, at the very least, formative feedback half way through the placement and a full summative assessment at the end. Ideally, each patient encounter should have an element of feedback from the clinical educator, but practically this is not always possible, and as the students demonstrate increased competence may not always be appropriate. Students should make use of the half way feedback to address

issues and demonstrate improvement by the end of the placement.

Other direct cues come from the educators themselves, in terms of face-to-face information about how well a student is doing on a placement, or how well a particular new technique has been learned in a practical class. It is though the feedback received in the clinical situation which is felt to be more personally rewarding in terms of really being a physiotherapist, although all students recognise the need to do well in the university-based study.

Some of the students spoke of indirect cues from others within the physiotherapy department or on the ward or unit where they were working. These ranged from being accepted into the department, other physiotherapy staff chatting with them at lunch times and being invited to join in social activities arranged in the department. Although these may be considered much more social aspects rather than elements to do with professional competence, all such actions were perceived as cues that they were performing well enough within their placement and had been accepted into the particular department. Other members of the multi-discipliniary team also contributed in the form of positive cues for the students. If a student felt they got on well with the nursing staff of a ward or the intensive care unit, if the staff approached them to discuss patients at meetings and on ward rounds rather than waiting to speak with the clinical educator, the students acknowledged this as an indication that they were at least doing well enough. Students also put much store in the cues received from their patients. If an out-patient returned indicating some improvement in their condition, such as reduced pain or increased range of

movement, or a patient in hospital was seen to be improving with a view to discharge home, students took this as an indirect cue that their treatment strategies were correct. They accepted that although correct, it must be expected that such strategies would not have been carried out to the same standards of expertise as a highly skilled and specialised practitioner, because they were students. Patients also offer what may be considered to be direct cues, in that students report patients telling the educator that the student is doing quite well, or not, as the case may be.

Students use patients as a resource for learning as well as a tool for evaluating their performance in terms of assessment and treatment skills. What the data also shows is that this is not enough. It is important for the students' evaluation of their success that the social components are present as well. The respondents saw becoming professional in physiotherapy not just in terms of competence in profession specific skills, but also in terms of integration within the physiotherapy department, suggesting that their perspective on the profession was very much to be part of the team of physiotherapists rather than a group of individuals who practise physiotherapy.

The students interviewed did not, as might be expected, refer to their peers as a major source of cueing evaluation. Some did indicate that their peer group was reassuring, but in terms of self evaluation peers seem to be used more for bench marking rather than for receiving direct cues, although all respondents did mention discussion of patient situations with their peers whilst on placement, and indirectly this gave some cues with respect to how well an individual had done in the situation under discussion. When bench-marking did

occur it either resulted in increased competition to out do others, or gave reassurance that an individual was holding their own.

The participants' internal cues for evaluation were based upon indicators such as being less anxious about treating new patients, feeling more knowledgeable, having increased confidence, feeling able to discuss issues more, being more politically aware, in fact a whole range of statements indicative of development towards being a physiotherapist. The students use their perceptions of their own work with patients, rather than the work in the university, as an indicator of progress. The work in the university is seen as a means to an end, the clinical work is seen as the end and therefore forms the most cogent basis for evaluation. The overwhelming perception is if you cannot do well in both, it is better to do well clinically than in university-based study. Students test and re-test their knowledge and ability against their previous activities and against the performance of others, generating their own set of cues as to what is indicative of development into a professional physiotherapist. When asked to explore how far each felt they had progressed in their individual journey to becoming a physiotherapist, there was no real consensus in reply. One in his second year of study felt that he would achieve it by the end of the course, another, in her final year, that it would take many years of post graduate experience. One recognised how far she had developed in herself, and another that there was now no method for her of separating herself as an individual from herself as a physiotherapist.

"Who I am as a physio is part of me ... the way I reason through problems in life is different and I impose my physio reasoning into that. I don't know that it is even conscious, I

don't really think that it is ... when I look back on decisions that you make. I can see how I've changed in time".

These students take an active role in evaluating themselves and compare themselves with their peers and with what staff feedback says. If they are in disagreement with the staff feedback they will often take this to their peer group for advice. They may also take it to their personal tutor but they do not feel empowered to discuss the issues of disagreement with the staff member concerned before having rehearsed the validity of their argument with someone else. Within themselves though, the students use their increased confidence in their increased knowledge to conclude that they are at least doing okay.

One of the issues which should have been followed up in greater depth during the interviews was about the cues which the students actually discounted in their evaluations. It was discussed earlier about their selectivity in acknowledging the worth of certain feedback. If students do not perceive the source of the negative cue as worthwhile, for example, if it comes from a negative model, or from an inexperienced member of staff, then it is largely discounted. There were also incidences where negative cues were received which the student felt were unjustified.

"Perhaps not in the way that I needed. I needed encouragement, not telling that I had done something wrong. I mean I'd go into a subjective assessment and do everything that I thought I needed to do and she would be like you are too slow. So I'd be okay so I'd go in the next time, try and speed it up and miss something out. You missed this out. I was like I know I missed out I can't do both at the moment. I just felt like I was going down and down and down ... "

Physiotherapy undergraduates are encouraged to explore the variety of different ways in which a problem may be addressed. This philosophy may lead to the perception of negative cues. As discussed previously, students may introduce a rationale which does not coincide with the rationale of the educator. Depending on the individuals involved, this may lead to negative cues for the student, who may discount this feedback on the basis of the differing philosophies of the educator and the student. When such situations of difference were described at interview, these were largely dealt with by discussion and development of mutual understanding. Such advanced ways of dealing with complex issues were only really apparent in the final year students. The more junior students took a rather different line, accepting the educator's requirements, some felt able to start some discussion about the issue, others just let it ride.

Summary

These physiotherapy students did not identify any university based physiotherapist as a role model, and those individuals identified within the clinical environment were either negative or charismatic. Some limited mention only was made of stage and partial models. With regard to self evaluation the students look to external sources for cues which may be direct or indirect, and which if negative, they may choose to discount on the basis of perceived poor validity of source. Cues from patients were given status. Cues from within are more complex and were based upon indicators such as diminished anxiety, greater knowledge giving increased confidence, and greater ability to discuss their role in patient care. The development of these self-generated cues generally, but not always, increases in line with more clinical experience. The students had a reasonably

clear idea of what type of physiotherapist they would not wish to become, thus they were constructing their identity as a physiotherapist backwards from a negative perspective, hoping that somewhere along the way they may reach an acceptable compromise between their negative and charismatic models. This acceptable compromise was individual, and success was based upon the achievement of external professional hurdles and personally constructed private goals.

7. Dynamics of Identity Construction

This final section of data analysis focuses on how these students go on to achieve their goals, documents the evidence for their increasing mastery of physiotherapy and the construction and accomplishment of professional identity. The students interviewed spoke of a variety of areas where they were experiencing change, both personal as in 'growing up' and professional, including an increasing knowledge base, greater repertoire of clinical treatment skills and improved ability to interact with patients. These changes were practically identified in terms of being able to gain more appropriate data for a physiotherapy assessment. Participants also identified becoming increasingly analytical in their questioning and feeling able to adopt a more flexible approach to the management of patient problems. It is evidence such as this which the participants used to determine professional identity construction. It is apparent that the students are becoming physiotherapists and phrases indicating this have been categorised as dynamics of identity construction and consist of the following themes:

Core Skills

Statements to do with core skills were largely focused on increasing familiarity with the use of what the students perceive as central physiotherapy skills, mastering the technical application of physiotherapy practical treatment skills. Those interviewed were less clear about whether they had in any way mastered the skills of clinical reasoning and reflective practice. Recognition of change in this area of professional development, held as peripheral in their early years, remained difficult for the students. The interviews identified there was a difference between the rate of change in

mastery of the practical skills of physiotherapy when compared with mastery of professional thinking.

Image of Physiotherapy

This was seen to change throughout the course of the programme of study. The impact of this change on the construction of the individual's professional identity as a physiotherapist was also apparent. There was a movement within the transcripts from discussions about what physiotherapists do to what *"we"* do, indicating a sense of inclusion into the profession. Another aspect was the dropping from their introduction to patients that they were a physiotherapy student, this changed to an indication that they were 'from physiotherapy'. When challenged about this they explained that their badge indicated they were a student so they were not hiding anything from the patients, and they did admit they were a student if asked, or if a problem arose for which they needed to seek advice. Having the title of student seemed to become a useful fall back position for support if needed, but was becoming increasingly expendable when things were going well.

Professional Identity

Elements about image and identity as a physiotherapist gave clues about individual's enthusiasm for the job, how committed they were to remaining in the profession and how much they identified themselves as a member of this profession. Some individuals had really quite clear career paths mapped out for themselves, either within the profession, or as one interviewee explained, outside, she would not stay forever as she got bored and needed a change. Much of the interpretation of image and formulation of an identity has its basis in the development of self knowledge by

these students. By exploring their individual experiences and how they had managed these experiences, it was possible to identify how far an individual perceived themselves to have travelled along the path to accomplishing their identity as a professional, in the image that they had of the profession. Exploring the development of self knowledge and identity made it possible to identify transition points for the students. By these I mean those events which publicly and officially marked development, and more importantly, those private and personal events which indicated movement to the individual. This movement experienced was not necessarily linear, nor was it always in a forward direction, suggesting that the individual has some control of the process, for it is being interrupted. Certain very clearly defined hurdles within the university were identified, but the hurdles of clinical practice seemed less clear. Students' descriptions of the subjective experience of change were not always positive and at times generated considerable turmoil and anxiety with respect to the future for the student. The questions of 'am I in the right place?' or 'what am I doing here?' were frequently voiced, especially during the later interviews with second/third year students. It became obvious that as the students generally gained an increasing sense of their development, this was in harmony with improved sense of mastery of the skills of a physiotherapist, although the mastery of technical versus abstract skill was variable. This finding is akin to the development process experienced by junior doctors (Bucher & Stelling 1977) who state:

> *" ... the experience of mastery and development is ... essential for the acquisition of a professional identity and making a commitment to a field"* (p.185).

The most overt and formal recognition of movement is the transition from year to year – thus it seems appropriate to view the students experience of development year on year through the programme.

Year One

Students interviewed during their early part of their first year of study expressed anxiety and difficulty settling into the environment. This initial anxiety and confusion in sorting themselves out is in harmony with the expectation of identity crisis experienced by this age group (Erikson, 1963). Placing these individuals into a totally new social environment only serves to heighten this confusion and is effective in delaying a sense of learning for some of them. This, in conjunction with the heavy workload, made the first year of life in physiotherapy difficult for some students. This confusion in a new social environment was an issue irrespective of whether the interviewee came straight from school or not. Some students spoke of feeling de-skilled; that no significance was awarded to their previous life experiences and they were effectively stripped (Goffman, 1959), of one identity but had not yet gained a new one. All students interviewed related their progress only to the successful negotiation of formal hurdles. These formal events were all taken by interviewees as direct cues of self evaluation of progress, and in effect formed the phases of perceived development through this year. Evidence of mastery at this stage was at a purely mechanistic level. At this stage the students did not describe or identify any personal development as a professional; they were absolutely focused on completing work for set deadlines and accruing the best grades possible. Not until these students were towards the end of their first year were they more able to articulate about

personal development and change, although this remained focused around technical rather than abstract competence. Interviewing these students gave the opportunity for the students to explore issues, which until the interviews, they had never considered. In looking back over their first year, all were asked to consider their contribution to the year. I used this as a means to facilitate looking at the self and subsequently personal development. None of those interviewed expressed recognition of any contribution in the knowledge gathering process, and found identifying actual examples of contributions difficult. When asked how far along in their development towards becoming a physiotherapist they thought they were, the answers also indicated that such an idea was new to them. As far as they were concerned they were first year students and they had two more to go; that was the indicator of how far they had come. As individuals they had given no consideration to where they were going, they were just dealing with day to day events. This is, I feel sure largely a product of the intensive nature of the programme. One student actually said she had no time to think about her identity as a physiotherapist, she was too busy with her identity as a student with deadlines to meet and essays to write. This group also found exploring their own personal development difficult, although some did mention feeling like they were two people, one at home and one as a physiotherapy student, suggesting recognition of the requirement to play many roles. Some participants indicated they had experienced personal change and put it down to the expected 'growing up' that occurs when one attends university. They could not offer any suggestion as to how this may co-exist with their development as a physiotherapist.

Current second and third year students were asked to reflect upon their first year as a physiotherapy student in efforts to substantiate the issues raised from the first year transcripts. These students also remarked upon the importance of the formal assessments identified, and talked of the impact of not doing well at that time. Failure gave an overt indication of the effort required to be successful and as such, for one particular student, was seen as a turning point in her management of the programme, more especially since it lead directly to further learning support for her studies. It is also noteworthy that for this same student, the memory of that failure stayed throughout the remainder of the degree programme. This same student corroborated the feelings of the first year group in terms of de-skilling when she remarked, *"you lose all the things of what you knew you were able to do"* Another final year student reflected that for her the biggest turning point was passing into year two. This same student talked throughout her interviews about being two aspects of the same person, an element referred to by the first year students in their phase of identity confusion.

Year Two

The small number of students who agreed to be interviewed from the beginning of their second year may be indicative of the memory of pressure from year one. The reader is referred to earlier writing on the nature of the volunteer subject. It is beyond the scope of this work to explore it more deeply at this time, except to offer the suggestion that those who did agree to take part could be considered amongst the more 'fragile' of students within that year group, and may have looked to the interview process and diary keeping as something of a cathartic experience, albeit unconsciously.

Year two sees an upturn in the amount of clinical education students undertake with approximately one third of this year given for students to adopt the role of the physiotherapist in the real life situation. This change of format for the year gave rise to many examples for all students of perceived progress towards becoming a physiotherapist and as many incidences of backward or zero movement. By the end of their second year students revealed considerable movement in the area of core skills of physiotherapy, self knowledge and identity as a physiotherapist. As far as core skills are concerned, students were demonstrating the largely expected increased familiarity with treatment techniques, and this was enhanced by clear improvement in the students abilities to communicate using professional language, which was now commonly used in conversation throughout the interview process. One student admitted that having now learned this language, it was difficult to explain in layman's terms, a common finding with students on placement. Having grappled with the physiotherapy language they have not mastered the art of using both interchangeably. Mastery of the language of the profession is important in developing a professional identity. Students were also becoming more adept in their dealings with people and patients, but the two categories remained separated. The participants indicated people represented less of a challenge than patients. Positive movement was reported in terms of increased confidence, the result of the enhanced mastery of the language and increased technical competence. This confidence however, remains fragile.

" ... I used to worry when I went to go and see patients, and now I don't they are not scary any more ... like I've had tougher patients as well, I have had to deal with people with depression and people with other underlying problems other than just what am treating them for ... it was nice because you can really get to grips with them ..."

"I suppose I've got better at handling patients that are awkward, I'm good at that. I've become better at coping and adapting ... then the first time I saw this patient he was in a lot of pain and he just wouldn't move whatever you said and that knocked me back a bit and I couldn't cope with that and she [clinical educator] stepped in then".

When asked how far they had travelled in terms of becoming a physiotherapist, there was general recognition, not based on any formal hurdle or time scale, that they had a long way to go.

"I've got ages I think because there are loads of things, like my last educator had been on loads and loads of courses and just knew everything it seemed and I was thinking I don't know anything compared to you".

This same student recounted her experience of being left unsupervised during her clinical placement because of unforeseen problems for the educator. She indicated that such an experience had shown her she was not yet ready to be a physiotherapist, that she needed *"maturity"* to achieve this. When prompted, this was qualified to professional and personal maturity and then the final plea of *"I just need more experience"*. Another student, speaking at the end of his second year talked of how he had used external cues from his educator to assume that he was making sound progress.

"I knew she was quite confident in me just by the way she was quite casual about, oh do you want to go and see them then you'll be fine, and I knew because if she was definitely more cautious with her patients, so I knew by the nature that she is going to be more cautious with her patients she was going to have some confidence in me".

The transcripts also demonstrated that in gaining knowledge the students could make use of that knowledge, and more

importantly recognised a lack of knowledge and when to seek help:

"I feel much more knowledgeable in clinical situations, however I know I can get much better".

With regards to their identity as physiotherapist and the path to their achievement of what as individuals they saw as a good physiotherapist, the responses were mixed. One indicated feeling it was all a long way away, another that he could act in a junior capacity now in some areas in which he had done placements. This is the same student responding to clinical educator cues about his progress, who by the time the data collection period had ended, was having problems successfully completing the programme highlighting the potential for misinterpretation of obtuse feedback.

For some, the relationship between the development of self knowledge and professional identity was complex. Commonly there was a perception of a quite subtle change, which was related to *"slowly growing up"*. Such development was often evidenced by changed interaction within the family or with friends from home, and was also responsible for feelings of discontentment expressed in terms of that which was familiar is now changed:

"Certainly a couple of weekends ago when we all went out together I just though I don't fell as though I really fit in here anymore. It's a bit odd really ... I don't know it makes you feel bad. I don't feel I'm too good for you or anything like that I'm just not interested in the same things. You move on I think ... mean I did have a really close friend that I'm not really that close with now and she never said anything to me we just sort of drifted apart really ... she's just really different and she still is, I've changed and she's stayed the same. That's how it seems ..."

"He thinks I go on and on about physiotherapy all the time ... he can see that I've changed ... he can see that I've become more confident about it ... he makes so much effort otherwise you can easily leave people behind when you go off to a different place, but he does which is good really, otherwise we probably would drift apart".

These discussions were quite uncomfortable experiences for both the interviewee and for the interviewer because of the implicit powerlessness of the researcher-respondent situation. Often where there was such discontent, there was little understanding of what may be going on or that there may be some causality between the personal changes and the professional development process with which they were involved. Other interviewees held a much more simplistic view of identity construction; for them identity as a physiotherapist would come only upon receipt of the graduation certificate. One student in particular felt that once she had this, she would be able to address all the issues which at this stage she felt lacking in confidence to do.

When third year students were asked to reflect upon this time in their course they were largely in agreement with the second year students about increasing confidence in technical skills, and with the issues about personal and professional change and identity confusion. There was also a clear link between these aspects and the process towards a form of mastery of the subject:

"I think I did come with the impression that I'd leave as this wonderful physio who was going to make everyone better. I've become more realistic, I arrived as me and I am going to leave a different person. The whole experience changes the way you think. You develop your own ideas and moral code ... now I am going to go out and still have a lot of work to do as a physio".

Those students who were first interviewed as year one students who were now completing their second year were also asked to reflect upon this past year. They were enthusiastic about the improvements made in their core skills, evidenced for them by patients getting better, recognising that they did have some knowledge although not a vast amount. With regard to self knowledge, this group were much more thoughtful, and this is possibly the result of being involved in the research process from their first year. All this group were more conversant with the idea of self knowledge and were much more self aware. This, by its very nature, tended to change the data, but had the effect of encouraging the group to explore for themselves exactly what it meant for them to develop an identity as a professional physiotherapist. All individuals in this group had asked themselves whether they were indeed in the right place. Mostly this question seemed to be for them to reaffirm they were right, rather than to consider changing or leaving. This was not something which others interviewed had acknowledged. Individuals in the group talked of growing up, maturing, feeling old as a result of their experiences, and when they compared the change in themselves to the friends they had left behind when they came to university, felt the change was remarkable. Is this perhaps the early stages of distancing the professional from the rest of society, this process which identifies professional people as a separate group, as being different from others? All students at this stage of study spoke about their relative positions as an individual and as a physiotherapist. There was resistance to physiotherapy entering into their 'normal' life, and this may be because of the element of difference referred to earlier. If there is a peak in identity crisis and intellectual vulnerability,

the desire to not be different will be intense, and any process of change will be met with considerable resistance. Most referred to the fact of taking physiotherapy home, thinking like a physiotherapist when out shopping, analysing what is wrong with passers-by, and talking about physiotherapy almost all the time. All except one of those interviewed said they wished they could detach themselves from it and not talk about it all the time. The desire for two separate lives was strong.

"As soon as that uniform goes on, yes there is and I think if there wasn't [a professional me] then I would struggle with some of the things I've come up with on placement. I think you do have to have your professional face and then be able to leave that at work and come home and relax and be yourself".

When this student was challenged that such role playing may be considered insincere and just 'play acting', she responded:

"No I don't think it is play acting ... it's just a different part of you. I don't think you could play act it would wear you out, or people would see you as being a phoney. I think its just a different part of you that you show people. Friends would see this part of you but professional colleagues and patients would see other parts of you. As well, I don't think that you're pretending to be someone else, you're just showing a different aspect of who you are. If all those people got together and talked about you they would probably find the real you".

The other side of this encroachment of physiotherapy into everyday life is the enthusiasm demonstrated and potential commitment to the profession, both clear signs of developing a professional identity. However, it did seem to be a rather overwhelming situation for the students, and one in which they sensed a loss of control. For one it had already lead to difficulties at home.

Year Three

The interviewees for this section were a group of students just starting their final year as the study began, and subsequently graduated and sought employment. This group is supported by transcripts from a group who were first interviewed in year two and have been followed through to the end of their year three and now seeking employment.

For the third years, the increased expectation placed upon them purely as a result of becoming a final year student, was a key issue for many and the cause of increased anxiety about coming to the end of student days. The students welcomed the implications of being given responsibility as a direct cue for self evaluation, and such a cue was latterly internalised when they realised they could cope.

"Yes I had responsibility and I realised I could handle it. It was still very sheltered but, no it got less scary as the year went on which is good".

For these students, they were beginning to have a clear construct of identity as an individual, all recognising that they had a broader perspective on life, and for example, had mostly become less judgemental of people. As far as recognising their own self development towards accomplishment of an identity as a physiotherapist, responses ranged perhaps as one might expect, from at the beginning of it all to being nearly there, similar in fact to their thoughts as second years. Those who felt they were at the start often had little firm idea of the route they wanted to take in physiotherapy, although they were undoubtedly committed to the profession. Those who felt they were almost home had very defined ideas of their future career pathway, down to the individual stages in the process. From the outside there was a

feeling of two very different sets of individuals developing and an interesting aside was that those who were less fixed on their futures were most often those interested in working with in patients in the acute hospital environment. Those who were apparently *"sorted"* were looking more towards the outpatients environment.

One overtly positive movement which was apparent with all final year students was the idea of elements of *"coming together"*. Many of the respondents identified events where they recognised that their learning within the university was actually being confirmed by what they saw in the clinical field, and most importantly, that what they had learned was true.

"I just thought this is exactly what I want to do. I just felt much more confident down to things like the ligament tests, some things are quite vague when you did it in the class not because you haven't been told but because you haven't seen, like peripheral mobilisations you haven't seen that they actually work, its really great when you see that they do actually do something ... It has definitely taken over my life, there's no two ways, because you talk about it and you think about it as well. Even when we went shopping the other day and I saw somebody with this stick and you could see it was in the wrong hand and I thought Oh no I can't bear it! You feel like you can see more, I don't know it feels like you were blind a bit before. You didn't read anything into stuff. You just accepted it and move on but now you sort of reason more, look into it a bit more, probably with most things you do".

It was also apparent that students at this level still think of physiotherapy in terms of *"hands on"* practical skills. Those elements which at year one were perceived central to the profession remained the most important things to be competent in by the end of the programme. Abstract professional thinking deemed peripheral at the outset, seemed to have remained so.

"For me yes, my physiotherapy skills are my hands on skill ... what I have to work on is my hands on.

In terms of where these individuals felt they were in the development process to becoming professional, the key area of positive movement which all individuals seemed to use to gauge their development as a professional, was their decision-making abilities. These abilities were often very different in personal and professional life. The data suggests that those individuals who demonstrated most positive movement towards becoming a physiotherapist were those who recognised they now used the same analytical decision making process in all aspects of their daily life, and perceived they had control of sufficient aspects of both their personal and professional lives to be able to progress towards mastery of the profession and the adoption of professional identity.

"When you look back on decisions that you make, I can see how I've changed in time, when I look back at the type of person I was when I was doing my A levels compared to who I am now, I think a lot more now before I do things".

[Do you see that you are more in control now?]

"Yes. Of my life and the situations that I am in ... Having a physio degree and the experience you have with patients you are in a position of control there and to all intents and purposes you manipulate your patient to do what you want them to do. I mean, I've sat there so many times with little old ladies and persuaded them that they do actually want to go for a walk and your are in control there. You learn that skill very early on of getting someone to do what you want them to do ... I suppose it is that I feel more in control, like I've got a more firm hold on the reigns, rather than just being dragged along".

Those who identified a distinction in decision-making processes depending on the aspect of their lives, suggest less

positive movement towards professional identity development.

"Whereas I hadn't really thought how I made decisions. I just made them. I think it's made me more reflective. I don't think I make decisions using all the models that we've learned. I think I think about it after I've made the decision and then think about how I did it. I don't have time to think about ... I'm a rubbish decision maker in life in general ... um. ... I'm useless about making decisions ... It's different I think in practice. I think you base it on different things

[What sort of things?]

"Well, information you've gathered from patents. Um ... your knowledge of whatever it is that you are making a decision about and if I've ever been unsure of a decision to make I've always gone to my clinical educator to ask advice ... I don't really know because decisions you make in life are so, across , so broad, so different, you know everywhere ... I make silly decisions every day ... I still think I make decisions differently in a clinical environment and I think I have different processes. Because you are thinking that the things that come out of those decisions are different to what comes out of decisions you make in life. The decisions you make in clinical practice involve your patients and involve whether they get better or not um ... which is really important, whereas the decisions you make in life involve money or materialistic things or what you are going to eat ... "

[You've been thinking about buying a house]

"I expect its all right if you're making it for yourself, but not if you're making decisions for other people, there's a difference depending on who is affected by the decision".

It appears therefore that in year one positive movement is attributed to successful negotiation of imposed hurdles, which are latterly and rather disproportionately used as direct cues for self-evaluation. Negative movement is apparent in terms of personal development with feelings of de-skilling, anxiety and confusion in a new social environment. In terms of the dynamics of identity development, the focus is on core

skills and formal transition points, there appears little scope for consideration of the more abstract concepts and the exploration of personal knowledge.

Year two gives enhanced opportunity to rehearse in the role of the physiotherapist in the real environment, generating positive movement in terms of increased mastery of professional language and the ability to enter into discourse with other professionals. Mastery of propositional and professional craft knowledge remains the primary objective, with patients as a primary source of feedback of direct cues for positive self evaluation. Obtuse feedback from educators may be misinterpreted. There is recognition of personal development in terms of incomplete articulation of subtle change, often attributed to 'growing up', evidenced by altered relationships with significant others. There is a suggestion of a link between increased technical competence, personal and professional change, the movement towards mastering physiotherapy and identity construction.

Third year students remain reductionist in their concept of physiotherapy as mainly 'hands on'; personal knowledge deemed peripheral in year one does not seem to have recovered. It appears that analytical decision making is a key competence which marks the beginning of congruence between the personal and professional self, and the accomplishment of professional identity is linked with individual mastery of propositional and professional craft knowledge. It is unsurprising in the context of physiotherapy as mainly 'hands on' but I suggest it may be the result of identity construction from a negative perspective rather than emulation of positive role models, although it is difficult to say with any certainty.

What can be said though is that a soon to be qualified physiotherapist has been exposed to commonly encountered situations, but has not received specialist level education in any one field. Perhaps it is unrealistic to expect such individuals to have fully constructed a professional identity when they have not mastered sufficient propositional and professional craft knowledge to feel competent in any one area of physiotherapy, and there is a lack of recognition of the value and usefulness of personal knowledge. Huntington (1957) and Mumford (1970) both indicate that a sense of accomplishment is important in constructing professional identity, and it is unrealistic to expect such a sense to be perceived by new graduates.

Bucher & Stelling (1977) indicate professional identity to be firmly linked with commitment to a profession and to be an evolutionary construct, changing with career changes. As the novice physiotherapist moves through a variety of clinical areas in their initial 'rotational' post, consolidating their undergraduate learning, this increases their confirmation and construction of professional identity.

An interesting aside to this is the consideration of identity change amongst educators of these undergraduates. All university-based staff begin as clinical physiotherapists, moving into education. This usually means eventually giving up any form of clinical practice and the loss of clinical skill to be replaced by new skills of the educator. For some educators this may be a source of conflict with the loss of one identity, and potential feelings of de-skilling, to be replaced with feelings of low competence within a new field, somewhat mimicking the feelings of new students starting

the programme. This research did not explore the experiences of educators but it is reasonable to expect that such feelings may well be reflected onto the participants in the programme, although I can only speculate on the effects this may have on what the student experiences.

8. Reflections on Findings

This chapter and the next will place the findings from the study into a theoretical context for physiotherapy and explore what it says about education per se.

Bucher & Stelling (1977) assert that the interaction of structural and situational influences of a training programme are responsible for producing the professional characteristics of that programme, the 'programming' effect. In this respect, the characteristics produced should be considered a direct result of the experience of the programme.

Final year students indicated that physiotherapy was primarily about 'hands on'; technical knowledge was far more important than either practical or emancipatory knowledge. All participants identified at the outset aspects of the curriculum they perceived more central and this seemed to be upheld, and implicitly substantiated by their experiences of the curriculum. A difference was perceived between university-based and clinically-based study in terms of perceived disempowerment within the university environment. The data also suggests weakness in the learning experience with respect to self evaluation and recognition of personal development.

Students are unaware of the value of their own thinking and do not demonstrate overt understanding of self. Such lack of recognition of personal value may be attributed to the generalised identity loss described by students starting the programme, and the delayed construction of a new identity. The data does not suggest self evaluation is overt at any time within the learning period, but this may be more a fault of

the data collection than an absence within the participants. However, it remains that self development and empowerment require an understanding of self, and this should be an important focus for early learning. The students indicate little appreciation for the role personal knowledge has as the basis upon which judgements are made, and how such judgements will be continuously re-evaluated in the light of new experiences.

For some participants, mastery of professional language was seen as a problem and may be related to background linguistic development. Tompson & Ryan (1996) agree that the ability to communicate and learning the language of the professional is an important skill and akin to learning a new language. Specific exploration of language acquisition in relation to early linguistic development may offer educators strategies for facilitating the learning of profession specific language. Within a structuralist and post-structuralist perspective (see Chapter 2), both Foucault, (see Barth 1998) and Hall, (see Barrett, 1998) indicate that language is identified as a moving social force in its own right, with signification. Language moulds perceptions and by combining with other aspects of social life, moulds social practices (Barth, 1998; Barrett, 1998). Language may be seen here as an extremely powerful force, with potential for tension between inherited language and ways of doing things and socialised language and actions.

It is important that the curriculum offered encourages the students to explore their pre-existing personal knowledge and through discourse, facilitates appreciation of its importance as a knowledge pathway, as it has a significant impact on the

ability of the individual to be reflexive and autonomous (Higgs & Titchen 1996; Quicke, 1996; Williams, 1998).
It appears that early on within the experience of this curriculum the students construct a series of behavioural criteria within which they begin to act. These criteria are constraining to the knowledge gathering process, allowing access only to knowledge pathways which lead to the core material of propositional and process/professional craft knowledge (Higgs & Titchen 1998; Williams 1998). This encourages a surface approach to learning. Functioning within such a tight framework hints at the students bidding to maintain control in a situation they describe as disempowering; fulfilling baseline requirements only and resisting the challenge of knowledge generated from personal resources.

It is unlikely that such activity is consciously constructed; rather it is a response to the learning environment and virtually describes an innate response of learning how to deal with new situations. The constructed behaviours incorporate individuals developing 'scripts' that guide their responses to various interactions. Such scripts are often well differentiated for specific social situations and the use of a specific script will vary from one situation to another (Berman, 1991). Such mechanisms have been the route for individuals to learn appropriate behaviour and develop the pre-existing personal socialisation with which they began undergraduate life. Such mechanisms may be employed in response to moving into an unknown environment. However, where there is no clear framework upon which to develop scripted behaviour, for example in learning situations which by their very nature require the use of personal resources, students experience even greater hardship and disempowerment.

In practical terms, scripted behaviour is easier, and is encouraged by a loaded curriculum which places greatest emphasis on propositional knowledge. The students indicate core skills are easier to learn, perhaps because they lend themselves to scripting. They also indicate there is no room for other areas until these have been mastered. Where practical and emancipatory knowledge are the main pathways to learning, students find the inability to script behaviour challenging. There was agreement about the lack of personal time and space for the individual, inhibiting movement away from safe, scripted behaviour. In a time pressured, volume loaded learning environment, conforming to 'scripts' may be seen as an expedient strategy.

If we return to Goffman's (1959, 1968) dramaturgical perspective on human interaction, that when humans interact each desires to manage the 'performance' and enact a role, it might be inferred that such a perspective was an accurate description of the behavioural interactions of the students. A 'performance' is offered to present themselves in a manner which best serves the identified need, i.e. succeeding at the formal transition point. Indeed none of the participants were resisting the dominant discourse, although there was indication of dissatisfaction with it.

Playing a role in respect of need and in relation to situation is how young children learn to influence the feelings of significant others in order to control some of what happens to them, the *"looking glass self"* (Kando (1977); hence there is a predisposition for such a behavioural response. A second predisposition may be argued on the basis of the students' tendency towards a 'middle class' background. Individuals

from such backgrounds are recognised as having access to both elaborated and restricted linguistic codes and in such *"closed"* settings (Bernstein, 1970), a particular form of communication is generated, which shapes the intellectual, social and affective orientation of individuals. This situation emphasises substance rather than process, the immediate rather than explaining motives or intended outcomes. It might be further suggested that such predisposition favours surface rather than the deep learning required for professional identity construction.

Physiotherapy as a profession might be considered a *"closed"* setting, especially within the undergraduate process, the nature of the curriculum often meaning little opportunity for interaction with other professions in the university setting. Out on placement, such interaction is expected and encouraged. The participants within the study may well function within personal commitments which, when teamed with the 'exclusivity' of the university environment, makes revoking those commitments very difficult, and this becomes a source of the disempowerment felt. Tattum & Tattum (1992) wrote of secondary socialisation in which concepts of doubt, questioning and possible re-interpretation appear. Where there is discontinuity with previous experiences, there is potential for a destabilising effect on the individual, especially if past experiences have not prepared the individual for the new social situation. It is unrealistic to expect that any previous socialisation will have prepared an individual for the social environment of an undergraduate physiotherapy programme, and there is considerable disparity between the expectations placed upon undergraduate physiotherapy students and other non-professionally qualifying programmes of study. Being a physiotherapy

> student in the university does not immediately reflect physiotherapy as a profession, and there is profound discontinuity of both expectation and social experience which lends itself wholeheartedly to individual doubt, questioning and possible re-interpretation of purpose.

> Whilst out on clinical placement, because less is known of the individual, [the 'clean slate'], and the student is within the patient arena with opportunity to rehearse the role of the physiotherapist, this may be perceived as a safer environment to step outside of the comfortable, scripted interactions to experience the opportunities available from a more *"open"* setting. Remember the participants, whilst recognising they had only little knowledge, felt they had greater knowledge than their patients, thus they had the balance of power. The increased safety and power shift promotes increased usage of elaborated linguistic codes, and gives the confidence to use professional language. The experience within the university is the converse, participants perceiving a loss of power and thus return to the safety of restricted codes and scripted interactions. Vygotsky (1962) indicated language as structuring thought and the ability to think abstractly, and language determining what the individual becomes, hence the emergence of self. Kando (1977) indicated language as determining among other aspects, self concept, identity and personality. It is therefore imperative that participants experience empowerment within the environment; that the environment, whilst being discontinuous with past environments, is *"open"* and does not emphasise verbally substance rather than process, or the immediate rather than explaining motives or intended outcomes. In turn this will engender safety to explore the use of elaborated linguistic codes, language and professional discourse, establish self

concept and self esteem, and ultimately, the construction and accomplishment of professional identity.

Professional identity is really the perception of oneself as a particular type of professional. As indicated in earlier chapters, it is bound up in the concept of particular knowledge and skills, a code of conduct and the altruistic perception of 'good work' (Friedson, 1994). Constructing a professional identity is paramount to becoming a professional. Those involved in educating students of professions want their students to develop a sense of themselves as professionals, and according to Bucher & Stelling (1977 who cite Merton et al, 1957, (p.7) to *"think, act and feel"* as members of the profession. Achieving this involves a change in self concept for the students and suggests an opportunity to easily slip into a 'reproduction' mode in facilitating the development of new members of the profession, rather than reflexive, new professionals.

Ramsden (1988) indicates that the notion of changing students' conceptions of the world about them is the core of education. Within physiotherapy, I would suggest that enabling individuals to consider changing the concepts of the world about them is paramount to the development of a profession able to meet the demands of the twenty-first century. As Blumer (1969) agreed, change is the very fabric of modern life and we must change our mentality to suit the new world.

In order to feel a member of a profession, it is necessary to at least begin to feel competent in the skills of that profession, and accordingly to have some confidence in the accomplishment of the role. Professional identity evolves

with increasing knowledge and skill, and may in some professional groups become identified with a particular aspect of the profession. Within physiotherapy graduation is not expected to give an individual specialist competence and an identity which places them within any one particular field of physiotherapy, but it does expect them to be able to function autonomously. Professional identity, reflection and autonomy are synonymous. The students are expected to construct a professional identity but are not facilitated in the development of the requisite skills to be autonomous. The primary expectation at this time is that graduates are qualified to move into the traditional *"apprenticeship"* model of further development (Richardson, 1999b). It might be suggested that a move away from generalist undergraduate programmes, into specialist first physiotherapy degrees is appropriate, allowing the development of more skilled, specialist practitioners to work in specifically identified areas. If the curricula experiences are on similar lines, specialisation will only exacerbate the situation, placing a greater focus still on propositional and professional craft/process knowledge. However, the one benefit would be ample opportunity to 'unload' the crowded curriculum.

The students indicate that the greater the opportunity to rehearse in the role, the greater the progress to identity accomplishment, but only in areas of core skills and professional language development. Upon reflection, this idea of negative construction of identity appears to be based upon students' observation of professional craft/process knowledge demonstrated by clinical educators. This in turn is supported by broad propositional knowledge and lengthy experience in one clinical area. These are the terms referred to by Richardson (1999b) when she wrote of professional credit

being given on the basis of years of experience and number of patients treated, rather than ability to respond effectively to individual patients. Whilst trying to gain the most credit, students will be playing the game rules of the placement, and they will imitate their educators, thus perpetuating the perception of greater value on propositional knowledge. Consequently, they are rehearsing to accomplish the role they see displayed before them in clinical practice, which is reinforcing the constrained and limited nature of the profession.

Students, I would suggest, do not start their university careers with this perspective. They arrive, as these students did, with varying conceptions about physiotherapy, as Bucher & Stelling (1977) suggest, varying degrees of understanding and clarity, but they had largely open minds. If the interactions within a training programme are responsible for producing the professional characteristics of that programme, then something within the early experiences of the programme under study, effectively shuts off the minds of the students to a whole area of knowledge. Without this, they cannot hope to construct a professional identity in which they are reflexive, autonomous practitioners.

The physical construction of the curriculum appears to give greater importance to content which lends itself to propositional and process/professional craft knowledge. The curriculum appears to constrain the students and leave little room for development and recognition of individuality via exposure to emancipatory knowledge. It is apparent that there is less significance placed upon a personal knowledge pathway which provides the basis for deriving professional knowledge. There is a far greater focus on the development of

fact, theory, and the application of physiotherapy techniques. This supports the findings of Higgs & Titchen (1995a, b) who indicated technical knowledge to be far more valued than both practical and emancipatory knowledge. The way of the curriculum demonstrates limited appreciation of the derivation of knowledge; it is constraining rather than facilitatory in student exploration, negotiation and construction of professional identity.

The desired outcome of this programme is a physiotherapist who has the professional knowledge to respond appropriately to the diversity of health care which may be encountered. Barr (1998) states that a graduating student needs confidence in the legitimacy of their own perspective if they are to be able to pursue the collaborative activities of new health care environments. If professional knowledge is the integration of propositional, professional craft/process and personal knowledge (Higgs & Titchen, 1995, 1998, Williams, 1998, Richardson, 1999b), then it is important that within the undergraduate curriculum, attention is given to all pathways to professional knowledge, with emphasis on that pathway which will engender such confidence. The data indicates that the most significant relationships for students are with patients, highlighting the significance of clinical education. It is these relationships that give the student high status external cues by which to evaluate their development. Self evaluation is based primarily on external cues although for some there is an increase of recognition of self-generated cues with experience. This is indicative of some individuals beginning to recognise the importance of personal knowledge in the construction of professional identity and autonomy of practice, but since this is something identified only by some

final year students, it probably says more about the student than it does about the success of the programme.
It is only through the use of personal knowledge to integrate learning from all other pathways, that the 'emancipation' which moves the student from being technically skilled in physiotherapy, to being a professional physiotherapist will occur.

Participants in the study remarked upon the intrusion of physiotherapy as a professional identity into personal life and actively resisted it, particularly during year two, a recognised peak time of identity crises (Erikson, 1963). Overt demonstration of physiotherapy knowledge was seen to set them apart from significant others and general society. Movement towards construction of professional identity is non-linear, and this is to be expected if it is dependent upon the construction of personal, emancipatory knowledge. At an unconscious level, reflection and re-evaluation of personal experience may be arbitrary, multi-directional, haphazard and unstructured (Schön, 1983, 1987). It is unsurprising then that some participants did demonstrate some limited recognition of personal knowledge and development, but this just served to highlight confusion about how such knowledge might inculcate their practice. Again, this is unsurprising since it is during such reflective phases that professional and personal dimensions merge (Baldwin & Williams, 1988). If the programme of study does not enable the learner to interpret personal significance and integrate it into everyday experience by fostering pluralism and diversity (Quicke, 1996), then such developments will remain unfocused and of limited use.

Students take their guide from role models only identified in clinical practice, traits were identified as properties of individuals (Quicke, 1998), people were described as being made up of portions of personality elements, and students have picked out elements of their personalities, looking to use the information and experience of these traits within their own personal construction. Experiences on placement are described in terms which are suggestive that each is seen as a new opportunity to impress powerful others. Richardson (1999b) cites her work in 1996 looking at the working environment of newly qualified physiotherapists. This work described a

> *"work culture which appeared to be built around a model of competence based on a notion of the number of patients treated ... years of experience were credited rather than the ability to respond effectively to individual patients ..."* (Richardson, 1999b, p.469).

It is into such an environment that the participants in this study are placed, giving the opportunity to rehearse the role of physiotherapist and acquire experiential knowledge. Such knowledge is gained through the students' subjective experiences of how facts are interpreted and decisions made within the clinical setting. Each experience is influenced by the unique past of the learner i.e. their individual interpretation of the learning experience in the university, as well as the current context.

Boud & Miller (1996) indicate that the major influence on the way learners construct their experiences is the accumulative effect of their personal and cultural history. Prior experience must be acknowledged and accounted for since it frames current learning, and space must be given to allow

individuals to construct their own meanings. Within the data from this work, participants referred to loss of existing identity and de-skilling as a result of perceived non-acknowledgement of pre-existing experience. Participants refer to lack of time and space for personal reflection and development of personal knowledge. The experience for these participants then is one of movement from a time-pressured environment which the individual is largely unacknowledged, into a clinical work environment where success may be attributed more to the demonstration of propositional and process (or professional craft) knowledge (Higgs & Titchen, 1998, Williams, 1998, Richardson, 1999b). It is understandable then that the perception of physiotherapy as a 'hands on' occupation remains paramount with these students, and is likely to be continued through into their working career, unless a fundamental shift occurs in the mind set of the profession. Richardson (1999b) also comments on the newly qualified physiotherapist's understanding of personal knowledge as implying a need to gain the experiences and knowledge of others. Remember the plea of the second year student, *"I just need more experience,"* supporting Richardson's assertion that there is an impression of apprenticeship rather than autonomous practice for newly qualified staff. This doctrine is indeed the experience of the undergraduate students in this work, and is supported by the custom and practice of the newly qualified undertaking a rotational post as a first job, to consolidate their undergraduate learning. The data generated about the programme under study indicates the graduates are unready for anything other than an apprenticeship model of work, since they do not have the skills for autonomous practice.

In taking an overview of the educational process for undergraduates, with its requisite mix of university-based and clinically-based study, the source of pedagogical conflict within the curriculum lies in the assumption that students will become imbued in the culture of physiotherapy implicitly, that providing the requisite propositional and professional craft/process knowledge automatically enables the use of emancipatory personal knowledge in a professionally useful way.

In the university propositional and professional craft/process knowledge (Higgs & Titchen, 1995a,b, Williams, 1998), are emphasised in what students see as core areas. Personal knowledge is emphasised in areas which the students perceive from the beginning are more peripheral. Study is largely directed, with very limited scope for personal exploration and testing of ideas. Time is very pressured as a result of the volume of content perceived to be required to be covered within the curriculum. Students comment on dis-empowerment in this environment and non-recognition of the value of their own experiences. They present an inability to evaluate their own performances in general, and in light of assessed work. Students judge progress only by formal transition points.

In the clinical environment, again propositional and professional craft/process knowledge is highly valued by clinical educators, and by patients since it is what they see, feel and respond to. Students use patients as positive cues for self evaluation – thus technical knowledge is seen to bring its own rewards. For this reason it is held more significant and therefore its importance is re-confirmed. For the students an increased sense of professional development equates with

mastery of technical skills which are observable, but the importance of personal knowledge cannot be ignored. If this pathway to knowledge is not opened up for these students, they will never be able to fulfil the claim of reflective, autonomous practitioners but remain as technicians skilled in physiotherapy.

Feinberg (1983) wrote of education reproducing patterns of behavioural relationships in everyday life, citing as an example *"doctor and nurse"* (p.37). Such behavioural relationships have changed considerably over recent times, the change from paternalism to patient autonomy in health care being a key example. For new entrants of a health care profession to function effectively, they must feel comfortable within this changed behavioural relationship which has a greater basis in equality and negotiation. It is the purpose of the educational process to induct these new professionals into this role. Patient-focused health care and the empowerment model are inherently unpredictable, especially in comparison to paternalism. Education to manage such unpredictability requires engendering flexibility of thought, welcoming diversity and encouraging challenge of the dominant discourses.

Feinberg (1983) also suggests that skills are reproduced to meet perceived needs and social interactions are maintained in a certain structured way. It might be suggested that such a philosophy no longer suits the ever-changing and unpredictable world of today. Certainly such a philosophy lends itself more easily to working within a controlled paternalistic health care environment, and does not easily address the unpredictability of the ever-changing patient empowerment model of health care. Feinberg also indicates

that the ideological perspective of those delivering the programme is fundamental in shaping the outcome. Change in outcome is dependent upon the responsiveness to change of those charged with the education of new entrants to the profession. To facilitate the development of new professionals, those offering the learning must have the reflexivity of the autonomous practitioner, show flexibility of thought, welcome diversity and be content with challenge of the dominant discourse, and this must be overt throughout the curriculum experiences. Once those delivering the educational experience have achieved this, both in the university and clinical environments the resulting educational experience for new entrants will be transformed, as will the professional face of physiotherapy.

9. Further Reflections, Critique & Conclusions

These findings from a small group of undergraduate physiotherapy students on a single programme of study, demonstrate clearly some of the key points made by Hunt, Higgs, Adamson & Harris (1998). These authors state that it is expected that physiotherapists will possess not only discipline- specific skills but also skills common to all university graduates such as thinking, communication, learning techniques and problem solving ability. Bradshaw (1985), supported by Hunt et al (1998), suggests that rather than encouraging thinking and problem-solving skills, educators focus on technical skills and this is compounded by the focus of professional groups which focus on clinical competence e.g. clinical interest groups. Shepard & Jensen (1990), indicate that the pattern of the curriculum and the focus of assessment also serve to place the emphasis on technical skill versus understanding and analysis.

Impact of the Organisation of the Curriculum

The manner of organisation of the undergraduate programme studied, places primary emphasis on the acquisition of propositional and professional craft/process knowledge, i.e. theory and skills. Aspects which are supportive of this finding are:

- the physical structure of the curriculum which emphasises centrality of some elements
- lack of awareness of own thinking and how knowledge of self informs judgements and enhances development
- lack of facilitation in the development and use of emancipatory personal knowledge

- encouragement to practise within the university and develop skill in practical techniques which offers a basis for 'scripted' behaviour

- in situations where role play may be used, there is very little movement away from the 'scripted' activity

- on clinical education placements where genuine role accomplishment may take place responsibility [empowerment] of the student is perceived

- student experience is largely undifferentiated, existing within a tight framework of behavioural criteria which encourages surface learning

- little evidence of resistance to dominant discourse of physiotherapy as currently constructed.

Within the constraints of the university environment, the structure and organisation of the learning experience reflects the beliefs and ideologies of those who have a primary role in the presentation of the curriculum; a similar experience is gained in the clinical environment.

Autonomy, Empowerment & Identity Construction

Empowerment in the role of a physiotherapist came only during clinical education placement – thus clinical education must be the key situational influence. This was the only opportunity identified by the participants to accomplish the valued role of the professional. It is also in this environment when the students have the opportunity to demonstrate competence in physiotherapy practical skills, and hence begin to develop a sense, albeit a rather simplistic one, of mastery of their subject. Unless this happens, it is impossible for the

student to construct any kind of sense of professional identity and hence any form of commitment to the profession. Unless there is autonomy in the role rehearsal and subsequent accomplishment, a full sense of mastery will not develop. Where an educator is constraining, autonomy is not perceived and conversely, where there is opportunity to explore, a greater perception of autonomy will be present, although this is still at the level of perceived core skill. The greater the opportunity to rehearse in the role, the greater the progress to identity accomplishment, but in terms of the programme under study, this was only in areas of core skills and professional language development.

Impact of Clinical Education

Since it is the clinical environment which is deemed to be most important, this should be the starting point for the exploration of what is happening in terms of impact on the physiotherapy student. Within the SI framework of understanding, Blumer (1962, 1969) and Mead (1932) indicated that people create meaning about the people and phenomena with which they work. People attempt to justify their actions in light of the meanings they see in the interactions of the social group. A physiotherapy department is one such social grouping. For the student, there is the experience of many such social groupings, as traditionally a student has a placement in many different departments throughout the course of their studies. SI theories suggest that the student will attach a symbolic significance to people and activities within these environments and this will shape their behaviour. Other individuals within the same group will think in a similar way and thus some behaviours will be reinforced. The longer a group interacts, the more defined will these collaborative actions become, ultimately becoming

the accepted behaviour for the group. Members of the group acquire a shared perspective, which will clearly affect the experiential learning of the student. The knowledge acquired through this so called 'situated learning' will have a substantial affect on professional development (Richardson, 1999b).

The professional culture of physiotherapy is:

> *" ... dominated by an established hierarchy in which there [is] little recognition that individuals could aspire to achieve a level of practice competence in less time or by routes differing from those of their predecessors"* (Richardson, 1999b, p.469).

The main practice culture tacitly follows a medical model of care, according to Richardson (1999b), citing her earlier work. It inadvertently conspires against individuals to develop their own ideas purposefully, such that taking an evaluative and analytical approach is of little value. Richardson also stated that these practitioners lacked an opportunity to explore and defend their work and this could undermine their developing confidence in interactions, the workplace culture exerting a powerful influence on professional development.

SI looks closely at human group life and the collective behaviour through 'actions'. This is also in tune with Giddens (1991) when he talks of society having its own reality and providing constraints for social actions. If it is considered that society is emergent relative to the characteristics of the individual, the implications are that physiotherapists have made physiotherapy what it is today. If the role of the profession is changing in the twenty-first century, and change as Blumer (1969) suggests, is the very fabric of modern life,

the profession must transform our mentality to suit the new world.

For students entering into such an environment there is great potential for the expectations and strong views of significant others to influence professional development. Richardson (1999b) talks of this within the clinical environment only, but within the university environment students will also be influenced. She goes on to say that individuals can more actively influence the outcome of their behaviour if they have a conscious awareness of the processes that may influence it. Personal growth and therefore professional development depends on conquering emotional blocks that inhibit self understanding. Reflexivity of self is a continuum and self identity as a coherent phenomenon presumes a narrative (Stones, 1998). The undergraduate curriculum has a primary role in developing that conscious awareness and growth within its students. To achieve this, it is implicit that the same awareness is developed in those constructing and delivering the programme. It is of paramount importance that the experiences of the university-based learning and those of clinically-based learning are united in such a way as to foster professional knowledge and develop confidence in their understanding of their professional knowledge base. This will enhance self esteem, self evaluation and promote self validation.

The learning gained in clinical placement is experiential. Experiential knowledge is according to Eraut (1994) personal knowledge, and it is crucial to professional judgement. Within the programme under study, personal knowledge is undervalued, and the data suggests that the unification of university and clinically based learning is not taking place.

Professional knowledge is constructed via the integration of propositional, professional craft/process and personal knowledge (Higgs & Titchen, 1998; Williams, 1998). Students cannot achieve this unaided and need guided participation to appreciate the contextual detail. Richardson (1999b) firmly states that:

> *" ... widespread recognition of knowledge as being constructed through individual subjective experience will show a respect for students to develop individual critical thinking skills through learning processes which are integrally linked to their practice and implicitly portrayed as separate and independent from it"* (p.472-473).

It seems that the learning experience offered to the students in this study does not prepare them for autonomous professional practice. Before exploring this further, this is probably as good a place as any to offer some critique of the process undertaken to answer the original question. This work is largely underpinned by a conceptual framework which focuses on the individual. The data would have been enhanced by greater acknowledgement of the impact of the societies or groups within this learning experience i.e. learners, educators and patients together. Data collection via focus group as well as interview may have been useful as it would have allowed triangulation and enhanced the credibility of the findings. These are issues to take forward in development of the work.

Strategies for Change

Having suggested that the learning experience offered is not achieving its intended outcomes, this requires explanation. As Culver & Hackos (1982) indicate, an environment which fosters critical thinking is more likely to promote intellectual

maturity, thus the students require time to think, assimilate and reflect on all aspects of their learning. Any curriculum change needs to promote empowerment, individualism, time and space for personal development. The curriculum must also offer pluralism, diversity, and opportunities for autonomy-enhancing actions (Quicke, 1996).

The delivery of the curriculum should move away from its technical rational focus on 'doing' and those aspects which undermine student responsibility and ownership of learning, and look towards moving key goals and learning practices from the periphery of the programme to the centre and throughout the curriculum so called 'mainstreaming' (Boud 1993). Higgs (1993) also advocates a learning programme which offers liberation in the form of both structure and freedom to learn. Part of this liberation is achieved by a shift of responsibility towards learner-managed learning (Anderson 1993).

So that practitioners may be deemed 'Fit for Purpose' they must be able to undertake practice which is dynamic, sensitive, relevant and responsive to need. Such practice must have the capability for change. Dynamic practice emanates from a dynamic and enabling education experience. Such enablement will occur in a conducive learning environment where student experience is valued and used as a basis for constructing knowledge, critical reflection and theorising about practice. Carr & Kemmis (1986) indicate learning from experience as a means of generating knowledge, fostering cognitive and metacognitive skills. These are fundamental to autonomous professional practice.

Adult learners are intrinsically motivated, but successful learning is influenced by self concept. Learning opportunities need to be developed in the curriculum that facilitate transition from dependent to self-directed learner, implicitly empowering the learner.

How might such a transition be facilitated? Adopting the principles of a philosophy such as problem-based or task-based learning is one way forward. I am not suggesting this as the only way, but this formula for medical education is well documented (Barrows & Bennett, 1972, Barrows & Tamblyn, 1980, Barrows, Norman, Neufield & Feightner, 1982). Within such a philosophy there exists greater empowerment and autonomy for the learner. Implicit within such a process is also the skill of self evaluation, and the development of confidence in understanding of the professional knowledge base, which will engender the development of self esteem. However, such change will require substantial support both for the learners and those charged with the delivery of the curriculum. The many implicit aspects of the education process under study here, need to be made overtly explicit both for the learners and for the tutors. It is important that whatever philosophy for curriculum delivery is adopted, it must not be subject to distortion in the conflict of what we say we do and what we actually do. Effective communication is paramount. Fundamental to any curriculum change is the need for increased realism in what might actually be achieved in the undergraduate programme today, in light of the changing role of physiotherapy in the health care environment.

If the context of the university-based learning is an experiential curriculum, this will offer the students

opportunities for the integration of knowledge, competencies, and the exploration of self and enhanced self awareness. Increased understanding of self promotes increased skill in self evaluation. If this is taken into the clinical environment it could encourage students to pursue more positive role models and indicate that those charismatic models whom they never sought to emulate, were attainable. The students will be better equipped to justify effective management of individual patient situations and encourage a move away from Richardson's (1999b) credit focus on time served and patient numbers treated. Bawden (1991) writes of bridging the theory-practice gap with 'being', that the link between knowing and doing is in being. By integrating knowledge, skills and attitudes the students become more self aware, more skilled in problem solving and more able to evaluate their own and others performance. Increased skill in this area and increased understanding of self will result in increased reflexivity and self validation, key elements to autonomous practice.

Concluding Remarks

Physiotherapy is a small, young profession and it has much to do to establish itself as a force to be reckoned with in the ever changing health care environment. In a finance-oriented health care system, evaluation and validation are paramount in every aspect, and are fundamental skills which new graduates from any physiotherapy programme must possess. At this time, although graduates from this particular programme are well regarded by employers, it is clear that they do not possess a depth of skill in self evaluation and validation. They fall most willingly into the apprenticeship period of junior rotation. Becoming a new professional will be extremely hard if they encounter the clinical environment

described by Richardson (1999b). Within the society of the physiotherapy department, the new graduates' desire to be accepted and 'fit', will require that they continue to play by the rules of the game, as they did as a student, unless they perceive in themselves the authenticity to promote change. Promoting and continuing such change action requires positive reinforcement by others. If physiotherapy graduates develop a strongly internalised view, this will encourage autonomy and reduce the potential for influence by external factors (Sim 1985). Such a strong self determination may be inculcated only through an educational experience which is enabling, promotional and liberating.

Richardson (1999a) cites earlier work of Peat (1981) and suggests that the manner in which physiotherapy emerges from the current changes in health care will rest on the sense of purpose and autonomy of individual practitioners. She also indicates that

> *" ... educators can use the principles of SI and situated learning to ensure that knowledge is acquired through repeated and recurrent experiences which contain rich contextual clues for professional action"* (p.472).

I would suggest it is not just an understanding of these processes which is important, but an appreciation of the wider concepts of identity construction and accomplishment, situated within an understanding of the evolution of society. For new professionals to be successful in responding to the ever changing environment encountered, they will need heightened awareness and understanding of their individual and collective roles as active agents in creating their social [professional] environment which in turn will influence their [professional] behaviour.

Development of autonomy, sense of purpose and a strongly internalised view of physiotherapy must be the primary role of undergraduate physiotherapy programmes. Those programmes must offer pluralism, diversity and autonomy - enhancing activity. Reflection must be empowering and professionally purposeful in the accomplishment of professional identity and reflexivity.

Practical Recommendations

In general:

There must be congruence between what we say we do and what we do (Carr 1995, Hunt et al 1998), this may be facilitated by:

- **A supportive environment** where both educators and students may be cast as learners, enabling exploration and debate, where the learners' own thinking is seen as important, where individuals can reflect upon their self-knowledge and explore the beliefs which underpin their practice (Quicke 1996). This may be achieved by establishing a safe learning environment for both university and clinical staff and students, such that the underpinning ethos is one of evolution and development, encouraging debate and challenge of the dominant discourses; for students this may be best achieved by reducing the changeover of learning groups and establishing static clinical practice groups.

- **Mainstreaming** (Boud & Higgs 1993) where the learning about generic skills is centrally placed and explored throughout the curriculum, resulting in greater equity in

focus between technical 'doing' and professional development. This may be achieved by incorporating learning about learning, knowledge development, exploring own self-in-the-world (Quicke 1996).

- **Liberating the structure of the curriculum**, achieved by developing learner managed learning (Anderson 1993); devolving responsibility to the learner through the use of task focussed or problem based learning strategies; reducing formal timetable contact to enable space and freedom for personal learning and to welcome differences and encouraging choice within the learning experience; more effective use of formal contact time for interactive learning which reflects the real world of physiotherapy and encourages breadth of knowledge; developing an assessment system which is congruent with the underpinning learning philosophy, encourages self evaluation and facilitates rather than inhibits development.

Specifically within clinical education:

- **Improved inclusion** of students into the physiotherapy department. This may be achieved by reducing the numbers of departments attended by students, perhaps affiliating a student to a particular provider unit for the duration of their studies, allowing the student to become a part of the department and reduce the need for 'roundsmanship' (Bucher & Stelling 1977) and promote the acknowledgement of more positive role models.

- **Realistic expectations** of students in the changing world of physiotherapy. Students are different because society has changed, physiotherapy is different as a result of the many,

many changes which health care has undergone in recent years. To offer the best learning opportunities to new entrants to the profession, existing members have to change and evolve. Students are active participants in their own learning and development, existing members must become so or the profession will not progress.

- **Facilitation of peer support** may be achieved by affiliating a group of students to a particular physiotherapy provider unit, thereby facilitating the development of a peer support group, giving a safe learning environment in which to test and re-test knowledge promoting personal and professional development.

- **Change to the assessment process** would enable the learning experience to move out of the shadow of its grade focussed process to a genuine learning experience where students might test out their knowledge and feel safe to challenge practice, where self evaluation may be encouraged and developed. This may be achieved by clinical education becoming a standalone element of the programme and not contributing to the final outcome of a degree classification.

- **Enhanced collaboration between educators** in both the clinical and university environment is the only way any form of change will happen. Clinical physiotherapists bring to this interaction their clinical skill, university based physiotherapists have their skills in facilitating learning and these must be pooled for the benefit of the students and to take the profession forward creating the conditions necessary for high quality learning and professional development.

10. References

Allport, G.W. (1961) Pattern and Growth in Personality, New York: Holt, Rinehart and Winston

Anderson, B. (1993) 'The Case for Learner Managed Learning in Health Professionals' Education' in N. Graves (Ed.) Learner Managed Learning: Practice , Theory and Policy, Leeds: World Education Fellowship

Apple, M.W.(Ed.) (1982) Culture and Economic Reproduction in Education, London: Routledge & Kegan Paul

Atkinson, P. Hammersley, M. (1994) 'Ethnography and Participant Observation' Chapter 15 in N.K.Denzin, Y.S.Lincoln (Eds.) Handbook of Qualitative Research, London: Sage

Atkinson, R.L. Atkinson, R.C. Smith, E.E. Bem, D.J. Nolen-Hoeksema, S. (1996) Hilgard's Introduction to Psychology (12th ed.) London: Harcourt Brace

Azjen, I. Fishbein, M. (1977) 'Attitude - behaviour relations: a theoretical analysis and review of empirical research', Psychological Bulletin, Vol. 84, pp.888-918

Ball, S. (1983) 'Case Study Research in Education: Some Notes and Problems' Chapter 5 in M. Hammersley (Ed.) The Ethnography of Schooling, Driffield: Nafferton Books

Ball, S. (1986) Sociology in Focus: Education, New York: Longman

Baldwin, J. Williams, H. (1988) Active Learning, Oxford: Blackwell Education

Bandura, A. Walters, R. (1963) Social Learning and Personality Development, London: Holt, Rinehart and Winston

Barnett , R. (1990) The Idea of Higher Education, Buckingham: Society for Research into Higher Education and Open University Press

Barr, H. (1998) 'Competence to Collaborate: Towards a Competency Based Model for Interprofessional Education' Journal of Interprofessional Care, Vol. 12, No. 2. pp.181-187

Barrett, M. (1998) 'Stuart Hall' Chapter 20 in R. Stones (Ed.) Key Sociological Thinker, London: Macmillan Press Ltd

Barrows, H.S. Bennett, K. (1972) 'The Diagnostic (problem solving) Skill of the Neurologist' Archives of Neurology, Vol. 26 pp.273-277

Barrows, H.S. Norman, G.R. Neufield, V.R. Feightner, J.W. (1982) 'The Clinical Reasoning of Randomly Selected Physicians in General Medical Practice' Clinical and Investigative Medicine Vol. 5, pp.49-55

Barrows, H. Tamblyn, R.M. (1980) Problem-Based Learning: An Approach to Medical Education, New York: Springer

Barth, L. (1998) 'Michel Foucault' Chapter 19 in R. Stones (Ed.) Key Sociological Thinker, London: Macmillan Press Ltd

Bassey, M. (1995) Creating Education through Research, Newark, England: Kirklington Moor Press

Bates, I. (1993) 'A job which is 'Right for Me?' in I. Bates, G. Riseborough, Growth and Inequality, Buckingham: Open University Press

Bawden, R. (1985) 'Problem Based Learning: An Australian perspective' in D. Boud (Ed.) Problem Based Learning in Education for the Professions, Sydney: Higher Education Research and Development Society of Australia

Bawden, R. (1991) 'Towards a Praxis of Situation Improving' in D. Boud, G. Felleti (Eds.) The Challenge of Problem Based Learning, London: Kogan Page

Beecher, H.K. (1970) Research and the Individual: Human Studies, Boston: Little, Brown

Benner, R.N. (1984) From Novice to Expert: Excellence and Power in Clinical Nursing Practice, Don Mills Ontario: Addison-Wesley

Bentz, V.M. (1989) Becoming Mature New York: Aldine de Gruyter

Berger, P.L. Luckmann, T. (1967) The Social Construction of Reality, Harmondsworth: The Penguin Press

Berman, P.W. (1991) 'Children Caring for Babies: age and sex differences in response to infant signals and to the social context' Chapter 14 in M. Woodhead, R. Carr, P. Light (Eds.) Becoming a Person, London: Open University Press and Routledge

Bernstein, B. (1971) 'Elaborated and Restricted Codes: their social origins and some consequences' in K. Danziger (Ed.) Readings in Child Socialisation, Oxford: Pergamon

Bernstein, B. Brandis W. (1970) 'Social Class Differences in Communication and Control' in W. Brandis, D. Henderson Social Class Language and Communication London: Routledge and Kegan Paul

Bines, H.Watson, D.(1992) Developing Professional Education, Buckingham: Society for Research into Higher Education and Open University Press

Bligh, D. (1982) 'Recommendations for Learning' Chapter 1 in D. Bligh (Ed.) Professionalism and Flexibility in Learning. Surrey, England: Leverhulme

Blumer, H. (1969) Symbolic Interactionism: Perspective and Method, Englewood Cliffs: Prentice-Hall

Blumer, H. (1962) 'Society as Symbolic Interaction' in A.M.Rose (Ed.) Human Behaviour and Social Processes. Boston: Houghton Mifflin

Boud, D. (1993) 'Experience as the Base for Learning' Higher Education Research and Development, Vol. 12, pp.33-44

Boud, D. Miller, N. (1996) (Eds.) Working with Experience. London: Routledge

Bowles, S. Gintis, H. (1976) Schooling in Capitalist America, London: Routledge and Kegan Paul

Bradshaw, D. (1985) ' Transferable Intellectual and Personal Skills', Oxford Review of Education, Vol. 11, No. 2, pp. 201-216

Brookfield, S. (2000) 'Clinical Reasoning and Generic Thinking Skills' Chapter 7 in J. Higgs & M. Jones (Eds.) Clinical Reasoning in the Health Professions. Oxford: Butterworth Heinemann

Bucher, R. Stelling, J.G. (1977) Becoming Professional London: Sage Publications

Burgess, R. (1989) 'Grey Areas: ethical dilemmas in Educational Ethnography' Chapter 3 in Robert G. Burgess (Ed.) The Ethics of Educational Research, East Sussex : The Falmer Press

Burns, R.B. (1986) Child Development. A Text for the Caring Professions, London: Croom Helm

Calderhead, J. (1989) 'Reflective Teaching and Teacher Education' Teaching and Teacher Education, Vol. 5, pp.43-51

Campbell, D.T. Stanley, J.C. (1963) 'Experimental and Quasi-experimental Designs for Research on Teaching' in N.L. Gage (Ed.) Handbook of Research on Teaching, Chicago: Rand McNally

Carper, B.A. (1978) 'Fundamental Patterns of Knowing', Advances in Nursing Science, Vol.1, pp.13-23

Carr, W. (1995) For Education, Buckingham: Open University Press

Carr, W. Kemmis, S. (1986) Becoming Critical: Education, Knowledge and Action Research, London: Falmer Press

Carter, M.A. (1985) 'The Philosophical Dimensions of Qualitative Nursing Science Research' Chapter 2 in M.L. Leninger (Ed.) Qualitative Research Methods in Nursing, London: W.B. Saunders Company

Chartered Society of Physiotherapy, (1996) Curriculum of Study, London: Chartered Society of Physiotherapy/Council for Professions Supplementary to Medicine

Child, I.L. (1943) Italian or American, Boston: Yale University Press

Cohen, I.J. (1998) 'Anthony Giddens' Chapter 21 in R. Stones (Ed.) Key Sociological Thinkers, London: Macmillan Press Ltd

Cohen, L. Manion, L. (1989) Research Methods in Education, London: Routledge

Creswell, J.W. (1998) Qualitative Inquiry and Research Design, London: Sage

Cronbach, L.J. (1984) Essentials of Psychometric Testing, (4th Ed.), London: Harper Row

Cross, V. (1993) 'Introducing Physiotherapy Students to the Idea of 'Reflective Practice' Medical Teacher, Vol. 15, No.4. pp.293-306

Culver, R.S. Hackos J.T. (1982) 'Perry's Model of Intellectual Development', Engineering Education, Vol. 12, pp.23-28

Denzin, N. K.(1989) The Research Act, (3rd ed.) Englewood Cliffs: Prentice Hall

Denzin, N.K. (1969) 'Symbolic Interactionism and Ethnomethodology: a proposed synthesis' American Sociological Review, Vol. 34, pp.922-934

Department of Health (1977) Health Service Development: Relationship Between the Medical and the Remedial Professions, Memorandum, HC (77) 3, London: DoH

Department of Health (1990) The National Health Service and Community Care Act, London: HMSO

Department of Health (1991) Research for Health, London: HMSO

Dickstein, E.B. Hardy B.W. (1979) 'Self Esteem, Autonomy and Moral Behaviour in College Men and Women' The Journal of Genetic Psychology, Vol. 134, pp.51-55

Dworkin, G. (1988) The Theory and Practice of Autonomy. Cambridge: Cambridge University Press

Eisner, E.W. (1991) The Enlightened Eye: Qualitative Inquiry and the Enhancement of Educational Practice. New York: Macmillan

Eliot, J. (1991) Action Research for Educational Change. Milton Keynes: Open University Press

Entwistle, N.J. Ramsden, P. 1983 Understanding Student Learning, London: Croom Helm

Eraut, M. (1994) Developing Professional Knowledge and Competence, London: Falmer Press

Eraut, M. (1995) 'Knowledge Creation and Knowledge Use in Professional Contexts', Studies in Higher Education Vol. 10, pp.117-133

Erikson, E.H. (1963) Childhood and Society (2nd Ed.) New York: Norton

Feinberg, W. (1983) Understanding Education: Towards a Reconstruction of Educational Enquiry, Cambridge: Cambridge University Press

Filmer, P. (1972) 'On Harold Garfinkel's Ethnomethodology' in P. Filmer New Directions in Sociological Theory, London: Collier Macmillan

Fink, H.C. Hjelle, L.A. (1973) 'Internal - External Control and Ideology', Psychological Reports, Vol. 33 pp. 967-974

Fish, D. (1989) Learning Through Practice in Initial Teacher Training - a Challenge for Partners, London: Kogan Page

Friedson, E. (1994) Professionalism Reborn, Cambridge: Polity Press

Friere, P. (1972) Pedagogy of the Oppressed, London: The Penguin Press

Gadamer, H. (1960) Truth and Method London: Sheed and Ward

Gardiner, D. (1989) The Anatomy of Supervision - developing learning and professional competence for social work students, Milton Keynes: Open University Press

Garfinkel, H. (1967) Studies in Ethnomethodology. Englewood Cliffs: Prentice Hall

Geer, B. (1968) 'Teaching' in D.S. Sills (Ed.) International Encyclopaedia of the Social Sciences, New York: Free Press

Giddens, A. (1991) Modernity and Self Identity , Cambridge: Polity Press

Gillon, R. (1986) Philosophical Medical Ethics Chichester: John Wiley

Gilroy, P. (1993) 'Reflections of Schön: an epistemological critique and a practical alternative', International Analyses of Teacher Education, pp. 125 -141

Giroux, H. (1981) Ideology, Culture and the Process of Education. Philadelphia: Temple University Press

Goffman, E. (1959) The Presentation of Self in Everyday Life. Harmondsworth: The Penguin Press

Goffman, E. (1968) Asylums, Harmondsworth: The Penguin Press

Greenwood, E. (1966) 'The Elements of Professionalisation' in H.M. Volmer, D.M.Mills (Eds.) Professionalisation Englewood Cliffs NJ: Prentice-Hall

Habermas, J. (1972) Knowledge and Human Interest. London: Heinemann

Hall, V. (1996) 'When the Going Gets Tough' Chapter 11 in G. Claxton, T. Atkinson, M. Osborn, M. Wallace (Eds.) Liberating the Learner. London: Routledge

Hamlyn, D.W. (1977) 'Self Knowledge' in T. Mischel (Ed.) The Self-Psychological and Philosophical Issues. Oxford: Basil Blackwell

Hammersley, M. (1979) 'Data Collection in Ethnographic Research' in Research Methods in Education and the Social Sciences. Milton Keynes: Open University Press

Hammersley, M. (1983) 'Introduction: Reflexivity and Naturalism' in M. Hammersley (Ed.) The Ethnography of Schooling. Driffield: Nafferton Books

Hammersley; M. (1989) The Dilemma of the Quantitative Method: Hubert Blumer and the Chicago Tradition. London: Routledge

Hammersley, M. Atkinson, P. (1995) Ethnography Principles in Practice (2nd ed), London: Routledge

Haworth, L. (1977) Decadence and Objectivity. Toronto: University of Toronto Press

Heiss, J. (1981) The Social Psychology of Interaction. New Jersey: Prentice Hall

Higgs, J. (1992) 'Developing Clinical Reasoning Competencies', Physiotherapy. Vol. 78, pp.575-581

Higgs, J. (1993) 'The Teacher in Self Directed Learning: Manager or co-manager?' in N. Graves (Ed.) Learner Managed Learning: Practice, theory and policy, Leeds: World Education Fellowship

Higgs, J. Jones, M. (1995) 'Clinical Reasoning' in J. Higgs, M. Jones (Eds.) Clinical Reasoning in the Health Professions, Oxford: Butterworth-Heinemann

Higgs, J. Titchen, A. (2000) 'Knowledge and Reasoning' Chapter 3 in J. Higgs & M. Jones (Eds.) Clinical Reasoning in the Health Professions, Oxford: Butterworth-Heinemann.

Higgs, J. Titchen, A. (1995a) 'The Nature, Generation and Quantification of Knowledge, Physiotherapy, Vol. 81, No.9, pp.521-530

Higgs, J. Titchen, A. (1995b) 'Propositional, Professional and Personal Knowledge in Clinical Reasoning' in J. Higgs, M. Jones (Eds.) Clinical Reasoning in the Health Professions, Oxford: Butterworth-Heinemann

Higgs, J. Titchen, A. (1998) 'Research and Knowledge', Physiotherapy, Vol. 84, No. 2 pp. 72-79

HMSO (1989) Working for Patients, Education and Training. London: HMSO

Holloway, I. (1997) Basic Concepts for Qualitative Research. Oxford: Blackwell Science Ltd.

Houle, C.O. (1980) Continuing Learning in the Professions. San Francisco: Jossey-Bass

Hunt, A. Higgs, J. Adamson, B. Harris, L. (1998) 'University Education and the Physiotherapy Professional', Physiotherapy, Vol. 84 No.6 pp.264-273

Huntington, M.J. (1957) 'Development of a Professional Self Image', in R.K. Merton, G.C.Reader, P. Kendall (Eds.) The Student Physician, Cambridge, Mass: Harvard University Press

Kando, T.M.(1977) Social Interaction, St. Louis: The C.V.Mosby Company

Kemmis, S. (1990) Essays on Education Victoria: Deakin University Press

Kemmis, S. Fitzclarence, L. (1986) Curriculum Theorising: Beyond Reproduction Theory. Victoria, Australia: Deakin University Press

Kemmis, S. Stake, R.E. (1988) Evaluating Curriculum. Geelong, Victoria: Deakin University Press

Knowles, M.C. (1990) The Adult Learner: a neglected species. (4th ed.) London: Gulf Publishing

Kuhn, T.S. (1970) The Structure of Scientific Revolutions. (2nd ed.) Chicago: University of Chicago Press

Langer, J. (1969) Theories of Development. New York: Holt, Rinehart and Winston

Leininger, M.L. (Ed.) (1995) Qualitative Research Methods in Nursing. London: W.B. Saunders Company

Lincoln, S.Y & Guba, E.G. (1985) Naturalistic Enquiry. Beverly Hills: Sage

Lucas, P. (1992) 'Light Half Believers of Our Casual Creeds'? Tutors' Different Interpretations of Reflective Practice: Implications for the Management of Change in Initial Teacher Education Programmes', Sheffield: Sheffield University Division of Education Press

Lundgren, U. (1983) Between Hope and Happening: Text and Context in Curriculum. Geelong,Victoria:Deakin University Press

Marcia, J.E. (1966) 'Development and Validation of Ego Identify Status', Journal of Personality and Social Psychology. Vol. 3, pp.551-558

Marcia, J.E. (1980) 'Identity in Adolescence' in J. Andelson (Ed.) Handbook of Adolescent Psychology. New York: Wiley

McCulloch, G. (1995) Teachers and the National Curriculum in England and Wales paper presented to PACT Conference, Teachers' Experiences of Educational Reform, London 2-4 April 1995

McLuhan, M. (1964) Understanding Media. London: Routledge & Kegan Paul

Mead, G.H.(1932) The Philosophy of the Present. Chicago: Open Court

Mead G.H. (1934) Mind, Self and Society, Chicago: University of Chicago Press

Meltzer, B.N. Petras, J.W. Reynolds, L.T. (1975) Symbolic Interactionism, London: Routledge & Kegan Paul

Moore, W.E. (1970) The Professions: Roles and Rules, New York: Russell Sage

Morse, J.M. (1994) 'Designing Funded Qualitative Research' in N.K. Denzin, Y.S. Lincoln (Eds.) Handbook of Qualitative Research, Thousand Oaks: Sage Publications

Moustakas, C. (1994) Phenomenological Research Methods, Thousand Oaks: Sage Publications

Mumford, E. (1970) Interns: From Students to Physicians, Cambridge, Mass: Harvard University Press

Oleson V.L. Whittaker, E.W. (1968) The Silent Dialogue: a Study in the Social Psychology of Professional Socialisation, San Francisco: Jossey-Bass

Oleson V.L. Whittaker, E.W. (1977) 'Characteristics of Professional Socialisation', Chapter 15 in R.L. Blankenship (Ed.) Colleagues in Organisations: the Social Structure of Professional Work, London: Wiley

Open University, (1980) Socialisation: conformity and opposition, Milton Keynes: Open University Press

Øvretreit, J. (1985) 'Medical Dominance and the Development of Professional Autonomy in Physiotherapy' Sociology of Health and Illness Vol.7, pp.76-93

Parry, A (1995) 'Ginger Rogers did Everything Fred Astaire did Backwards *and* in High Heels' Physiotherapy. Vol. 76, No.3, pp.310-319

Parry, A. (1997) 'New Paradigms for Old: Musings on the Shape of Clouds' Physiotherapy, Vol. 83, No. 8, pp.423-433

Pavlov, I.P. (1927) Conditioned Reflexes, New York: Oxford University Press

Peshkin, A. (1988) 'In Search of Subjectivity - One's Own', Educational Researcher, Vol.7, No. 7, pp17-21

Phillips, D.C. (1993) in M. Hammersley (Ed.) Educational Research - current issues, London: Paul Chapman Publishing

Plummer, K. (1998) 'Herbert Blumer' Chapter 6 in R. Stones (Ed.) Key Sociological Thinkers, London: Macmillan Press Ltd

Polanyi, M. (1958) Personal Knowledge: Towards a Post Critical Philosophy, London: Routledge and Kegan Paul

Polit, D.F. Hungler, B.P. (1993) Essentials of Nursing Research, (3rd Ed.) Philadelphia: J.B. Lippincott Company

Pollard, A.(1980) 'Teacher Interests and Changing Situations of Survival Threat in Primary School Classrooms' in P. Woods, Teacher Strategies, London: Croom Helm

Punch, M. (1986) The Politics and Ethics of Fieldwork, Sage University Papers Series on Qualitative Research Methods, Vol. 3, Beverley Hills: Sage Publications Ltd.

Quicke, J. (1996) 'The Reflective Practitioner and Teacher Education: an answer to critics' Teachers and Teaching: theory and practice, Vol.2, No.1, pp.11-22

Quicke, J. (1998) 'Using Structured Life Histories to Teach The Social Psychology and Sociology of Education', in P.Woods, A.Pollard (Eds.) Sociology and Teachers: a New Challenge for the Sociology of Education, London: Croom Helm

Ramsden, P. (1988) 'Studying Learning: Improving Teaching' in P. Ramsden (Ed.) Improving Learning: New Perspectives. London: Kogan Page

Rapaport, R.N. (1970) 'Three Dilemmas in Action Research' Human Relations, Vol. 23 pp.499-513

Richardson, B. (1999a) 'Professional Development: 1. Professional Socialisation and Professionalisation' Physiotherapy Vol. 85, No.9, pp.461-467

Richardson, B. (1999b) 'Professional Development: 2 Professional Knowledge and Situated Learning in the Workplace' Physiotherapy Vol. 85, No. 9, pp.468-474

Ricouer, P. (1981) Hermeneutics and the Human Sciences Cambridge: Cambridge University Press

Robson, C. (1993) Real World Research, Oxford: Blackwell

Rosenberg, M. (1979) Conceiving the Self, New York: Basic Books

Rosnow, R.L. Rosenthal, R. (1997) People Studying People, Artifacts & Ethics in Behavioural Research, New York: W.H.Freeman & Company

Rowland, S. (1993) The Enquiring Tutor, London: The Falmer Press

Ryle, G. (1980) The Concepts of Mind, Harmondsworth: Penguin Books

Sabari, J.S. (1985) 'Professional Socialisation: Implications for Occupational Therapy Education', American Journal of Occupational Therapy, Vol. 39, No. 2, pp.96-102

Sameroff, A.J. (1991) 'The Social Context of Development' in M. Woodhead R. Carr P. Light (Eds.) Becoming a Person, London: Oxford University Press

Sameroff, A.J. Chandler, M.J. (1975) 'Reproductive Risk and the Continuum of Caretaking Casualty' in F.D. Horowitz, M.Hetherington, S. Scarr-Salapatek, G. Seigel (Eds.) Review of Child Development Research, (vol.4), Chicago: University of Chicago Press

Sameroff, A.J. Seifer, R (1983) Sources of Continuity in Parent-Child Relationships, Detroit: Society for Research into Child Development

Sandel, M. (1984) 'The Procedural Republic and the Unencumbered Self' Political Theory Vol. 12, pp. 81-96

Sarter, B. (1988) (Ed.) Paths to Knowledge: Innovative Research Methods for Nursing, New York: National League for Nursing

Schaffer, R. (1988) 'Face to Face Interactions' in W. Woodhead, A. McGrath (Eds.) Family, School and Society, London: Hodder Stoughton

Schön, D. (1983) The Reflective Practitioner, London : Basic Books

Schön, D. (1987) Educating the Reflective Practitioner. London: Jossey- Bass

Secretary of State for Health (1997) The New NHS: Modern, dependable. London: HMSO

Secretary of State for Health (1998) Our Healthier Nation. London: HMSO

Shepard, K.F. Jensen, G.M. (1990) 'Physical Therapist Curricula for the 1990s: Educating the reflective practitioner' Physical Therapy. Vol. 70 No. 9 pp.566-577

Shibutani, T. (1955) 'Reference Groups in Perspective' American Journal of Sociology, Vol. 60, pp.562-569

Shipman, M.D. (1972) Childhood: A Sociological Perspective. Slough: NFER

Silver, H. (1980) Education and the Social Condition, London: Methuen

Sim, J. (1997) Ethical Decision Making in Therapy Practice. Oxford: Butterworth-Heinemann

Sim, J. (1985) 'Physiotherapy: A Professional Practice', Physiotherapy Practice, Vol.1, pp.11-22

Singleton, J. McLaren, S. (1995) Ethical Foundations of Health Care, Responsibilities in Decision Making London: Mosby

Skinner, B.F. (1938) The Behaviour of Organisms. New York: Appleton-Century-Crofts

Stones, R. (1998) Key Sociological Thinkers. London: Macmillan Press Ltd.

Strauss, A. (1956) (Ed.) On Social Psychology: Selected Papers. Chicago: University of Chicago Press

Tattum, D. Tattum, E. (1992) Social Education and Personal Development, London: David Fulton Publishers

Terry, W. Higgs, J. (1993) 'Educational Programmes to Develop Clinical Reasoning Skills' Australian Physiotherapy. Vol.39, No.1, pp.47-51

Titchen, A. Higgs, J. (2000) 'Facilitating the Acquisition of Knowledge for Reasoning' Chapter 24 in J. Higgs & M. Jones (Eds.) Clinical Reasoning in the Health Professions, Oxford: Butterworth-Heinemann.

Tompson, M.A.M. Ryan, A.G. (1996) 'The Influence of Fieldwork on the Professional Socialisation of Occupational Therapy Students', British Journal of Occupational Therapy, Vol. 59, No.2, pp.65-70

Vygotsky, L.S. (1962) Thought and Language, Cambridge USA: MIT Press

Waddington, I. (1985)'Professions' in A. Kuper, J. Kuper (Eds.) Social Science Encyclopedia, London: Routledge and Kegan Paul

Watson, J.B. (1924) Behaviourism, Chicago: University of Chicago Press

Williams, R. (1973) 'Base and Superstructure on Marxist Cultural Theory', New Left Review, No.82, pp.3-16

Williams, P.L. (1998) 'Using Theories of Professional Knowledge and Reflective Practice to Influence Educational Change' Medical Teacher Vol. 20 pp.28-34

Woodhead, M. Carr, R. Light, P. (1991) Becoming a Person. London: Oxford University Press

Woods, P. (1977) 'The Ethnography of the School', Schooling and Society, Milton Keynes: Open University Press

Woods, P. (1979) The Divided School, London: Routledge and Kegan Paul

Woods, P. (1985) 'Ethnography and Theory Construction in Educational Research', in R. Burgess (Ed.) Field Methods in the Study of Education, Lewes: Falmer

Woods, P. (1990) Teacher Skills and Stategies, London: The Falmer Press.

Wrong, D. (1961) 'The Over-socialised Conception of Man in Modern Society', The American Psychological Review, Vol. 26, pp.184-193

11. Appendix 1 - Interview Scheme

Initial Interview

Topics to be explored include:

- Academic background
- How you decided upon your chosen profession
- Images of the profession
- How you decided upon a particular institution
- What you expected to happen to you
- How do you view your future career?

Subsequent interviews will cover areas such as:

- What has happened to you in the course of the year?
- What do you think of the activities in which you have been engaged?
- Other people involved and the nature of their relationship
- What did you think of the others?
- What did you think of your performance?
- How far along do you think you are in your own development?

Other areas of exploration include:

- perceptions of professional / occupational identity
- perceptions of the role of the physiotherapist
- personal view of future career