

**Physiotherapy clinical education:  
Power interplay examined through the lens of  
Bourdieu**

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## **Attestation of authorship**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institute of higher learning.

Sarah Mooney .....

Date .....

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*We cannot be taught wisdom, we have to discover it for ourselves by a journey which no-one can undertake for us.*

Marcel Proust [1871-1922]

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## Abstract

Clinical education is pivotal to professional socialisation and mandatory registration of physiotherapy students. Traditionally, responsibility for student learning in the clinical environment resides with experienced physiotherapists in tandem with their other tasks, predominantly providing patient care. Competing stakeholder interests, however, converge on clinical educators. They are challenged to meet expectations and demands from, for example, patients, colleagues and academic staff. While crucial to the processes of clinical education, there is little known about clinical educators and their perspectives. This research, therefore, examined power interplay in clinical education in New Zealand from the perspectives of clinical educators, and contextualised by perceptions of associated stakeholders. It is located in the critical paradigm, and was underpinned by Bourdieu's theories. Recommendations for change emerged which provide strategies for enhancing relationships to promote a more cohesive and unified approach to clinical education across organisations and the profession.

Methodology, method and analysis were informed by Bourdieu's research procedures; specifically three levels of interaction between habitus and field were applied. Semi-structured interviews were conducted with a purposive sample of 18 clinical educators and 18 stakeholders in clinical education. Participants included academic staff, managers, representatives of the profession, and students. Emergent themes were affirmed by, and further explored, with seven of the 18 clinical educators.

Five key findings emerged. First, the framework verified and clarified power interplay in New Zealand clinical education. Second, clinical educators were identified as a distinctive and disadvantaged social class. Third, hierarchies were found, based on knowledge which valued 'clinical', 'education' and 'research' differently, and by association, those who imparted such knowledge. Fourth, competing value systems were symbolic of different organisation perspectives: stakeholders as service providers and consumers competed for resources. Fifth, services provided by clinical educators have become commodified, and located within the commercial world of healthcare. This was found to be contrary to the vocational origins of the physiotherapy profession, and professional obligation of physiotherapists to train the future workforce.

It is recommended that the value of clinical educators and pedagogy is reappraised by organisations and the profession. Ways of increasing the visibility of pedagogy in undergraduate curricula warrants review. Career pathways in clinical education offer another review focus. In this thesis, several strategies are proposed to reduce the dissonance in knowledge and social hierarchies including simulated learning in the

classroom, collaborative research, and joint lecturer-practitioner positions. Research is warranted that investigates the preparedness of physiotherapy graduates for the New Zealand workforce. The economic consequences of students in the workplace and the patient's voice as consumer of clinical education should be investigated by future researchers.

## THESIS STRUCTURE

This thesis is structured to include four sections. Section One consists of Chapters One, Two, Three and Four which collectively constitute the research context. Chapter One describes the research focus and aims, personal impetus for undertaking this study and the contribution of this research to physiotherapy and scholarly communities. Chapter Two provides a brief overview of Bourdieu's theories whose philosophy frames this research and through which the practice of clinical education and physiotherapy are examined. The critical paradigm and theories of Bourdieu are examined in further detail in Chapter Three which provides the lens through which relevant literature is reviewed (Chapter Four). Section Two contains the research procedures and describes methodological framework, method employed and processes of analysis informed by Bourdieu (Chapter Five). Section Three presents the findings of this research in Chapters Six, Seven, Eight and Nine. The final section, Section Four, includes a discussion of emergent themes and proposes recommendations for change (Chapter Ten). Chapter Eleven constitutes the close of the thesis and includes a critical review of dimensions of the research and future research recommendations. References and Appendices are included at the end of the thesis.

Each section opens with an overview and introduces the reader to chapters therein. The beginning of each chapter introduces the area under discussion and concludes with a summary and linkage to the next chapter. In keeping with the reflexive stance advocated by Bourdieu, personal reflections and a reflexive statement are included in this thesis. The exception is Chapter One, which describes aspects of this research from a personal perspective including the impetus for undertaking this research. Acknowledging the inability to truly suspend my presuppositions, a reflexive statement in Chapter Eleven highlights my position as researcher, physiotherapist and clinical educator relative to the thesis, and also strategies employed to bring robustness to my interpretation of Bourdieu's concepts, and research findings. Personal reflections conclude this thesis allowing me to appraise the doctoral journey and consider of my own trajectory within the dynamic fields of physiotherapy and healthcare.

## SECTION ONE

### **RESEARCH CONTEXT**

This research examines the interplay of power as perceived by New Zealand clinical educators in physiotherapy and associated stakeholders. This first section of the thesis comprises Chapters One, Two, Three and Four which justify and contextualise this research. Within these chapters, Bourdieu's theories and key concepts are explained through which the research context is explored. The contribution of this research to the knowledge base of the physiotherapy profession and other practice based professions is then justified.

## CHAPTER ONE

# La raison d'être – the reason for being

### Chapter overview

This chapter examines the research issue, focus, aims and contribution to the physiotherapy knowledge-base. It also discusses personal and professional impetus for undertaking this research, in essence, 'la raison d'être'. In combination with Chapter Two, a critique of the reviewed literature, the original contribution of this research to physiotherapy and scholarly communities is justified.

### Research focus

Located in the critical paradigm and underpinned by French philosopher Bourdieu [1930-2002], this research examines power interplay within clinical education in New Zealand as perceived by New Zealand clinical educators in physiotherapy<sup>1</sup> and contextualised by associated stakeholders. This thesis argues that clinical educators are dedicated and committed to student learning yet rely on attributes including an interest in student learning, rather than formal pedagogy. Pedagogy has limited value and visibility in the profession yet is central to physiotherapy practice and specifically patient education. It is argued that the isolation of pedagogy from clinical knowledge and skills symbolises value systems held by the profession and other stakeholders. Social hierarchies are perpetuated and clinical educators as a social class are disadvantaged. The nature of the play of power also revealed by the data of this research was detrimental to stakeholder relationships because it impacted upon development of the profession in terms of student and workforce capacity, and ultimately, patient care. Nevertheless, recommendations that emerge from this thesis show how power imbalances can effectively be addressed.

In undergraduate physiotherapy education, clinical education is vital for professional socialisation and mandatory registration. However, clinical education is problematic because many stakeholders are involved; education and practice providers being dominant stakeholders (Cross, 1995). Complexities of clinical education and relationships therein are revealed in the limited body of literature pertaining to clinical education in physiotherapy and specifically the perceptions of clinical educators. Traditionally, clinical educators are experienced clinicians with a high level of knowledge

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<sup>1</sup> For the purpose of this research, the term clinical educator is used to describe the physiotherapist with whom the student has most contact with in the clinical environment. Different roles and responsibilities are examined in Chapter Two.

and skill in a specialist field. They accept responsibility for the clinical and professional learning experiences of students (Cross et al., 2006), transforming student knowledge into competent practice, shaping professional identities and facilitating new knowledge (McAllister, Paterson, Higgs, & Bithell, 2010; Rose & Best, 2005; Titchen & Ersser, 2001). As such clinical educators have responsibility for clinical practice and also clinical education, and therefore, are subjected to multi-dimensional pressures exerted by stakeholders (Baldry Currens & Bithell, 2000), often resulting in low morale and job satisfaction (Öhman, Hägg & Dahlgren, 2005). The paucity of literature relating to the perceptions of clinical educators suggests that they have limited voice or influence in shaping practice, yet through their unique position, they are pivotal to the education, professional socialisation and registration of student physiotherapists. Failure of the physiotherapy profession to acknowledge and address tensions and power dynamics in clinical education may severely compromise the provision and quality of clinical education and ultimately, the physiotherapy profession and patient care.

## **Research aims**

The primary aim of this research is to examine the complexities of clinical education in physiotherapy and specifically the power dynamics from the distinctive perspectives of clinical educators, contextualised by the perceptions of associated stakeholders in New Zealand. Located in the critical paradigm and framed by the work of Bourdieu, individual, organisational and professional practices are explored to reveal and confront inherent ideologies and assumptions that underpin current practice in clinical education, and practice cultures. Whilst acknowledging that social friction and tension are inherent in societies (Bourdieu, 1972/1977), examination of social forces and the interplay of power within clinical education highlight areas of tension, friction and conflict. Recognition and reconfiguration of power imbalances can be used to generate a body of evidence to transform current attitudes, cultures, and practices of clinical education.

Another research aim encompasses a critique of Bourdieu's theories and applicability to this research, examination of the interplay of power as perceived by clinical educators and stakeholders, and recommendations to enhance relationships, ultimately promoting a more cohesive and unified approach to clinical education across organisations and the profession. In this way, the work and practice of clinical educators is highlighted; the continuum of clinical education becomes embedded into clinical and organisational practice and culture and is the shared responsibility of all stakeholders, not just limited to a few physiotherapists. Consequently, findings will have resonance for all

clinical educators, present and future, and stakeholders responsible for the education of the next generation of physiotherapists.

**Table 1.1 Research aims**

<b>Research aim 1</b>	<b>Research aim 2</b>	<b>Research aim 3</b>
Explore and examine power dynamics in clinical education using Bourdieu's framework to underpin the process of data collection and interpretation	Critique the applicability and relevance of Bourdieu's theories to this research	Identify opportunities, to enhance the value of clinical educators and clinical education within physiotherapy in New Zealand

Table 1.1 above summarises the aims of this research. It is not the intention of this research to examine power relations between individual participants or representatives of organisations and the physiotherapy profession. Consequently generic references are made which allow organisation and practice cultures to be examined which contributed to and often reproduced inter-stakeholder conflict.

## **Personal impetus**

As described in Chapter Three (theoretical territory) and Chapter Five (research procedures), Bourdieu requires researchers to adopt a reflexive stance (Bourdieu, 1972/1977; Bourdieu & Wacquant, 1992). As a form of critical awareness, the researcher, his or her dispositions and the social conditions that have shaped them, are declared and constantly re-examined to achieve a sense of scientific objectivity. From a personal perspective therefore, my position and motives as a researcher are described.

The impetus for this research began with a search to understand the tensions and multiple demands I experienced as a clinical educator, clinician and team leader in physiotherapy and a belief that 'things should be better'. Experience as a senior lecturer in physiotherapy and university tutor visiting students on placement further highlighted tensions between different roles, responsibilities and abilities to influence practices and cultures. Moving to New Zealand from United Kingdom, and returning to clinical practice with clinical education and management responsibilities, I was aware that such tension, power struggles and disempowerment of clinical educators were not confined to one timeframe, country, team or physiotherapy provider but were widespread and of international concern. Indeed, and of further concern, was the awareness of students' negative attitudes towards clinical education, inferring the reproduction of ideology and behaviours may continue to impact on clinical education and relationships with stakeholders. It was therefore, timely to investigate power dynamics and relations within clinical education, especially within the current dynamic context of physiotherapy provision and healthcare delivery in New Zealand.

## **Personal ontological and epistemological stance**

While understanding my personal impetus is useful, it is also important to clarify my ontological and epistemological stance in relation to this research. Although Crotty (1998) argues that epistemological and ontological issues are commonly merged, and therefore difficult to conceptually separate, both have relevance in understanding how knowledge is formed and, for example, the social world of clinical educators is interpreted.

Ontology refers to the nature of reality and the “framework in which knowledge is generated and recognised” (Richardson, Higgs & Abrandt Dahlgren, 2004, p. 8). Epistemology i.e. the theory of knowledge is concerned with deciding how different kinds of knowledge can be created and legitimised (Crotty, 1998, p. 8). According to Grant and Giddings (2002) epistemology “defines the relationship between enquirer and known, what counts as knowledge, and on what basis we can make knowledge claims” (p. 12). In essence, the source, limitations and nature of my knowledge and understanding is important to justify my position relative to this research, and in particular, the relationship with participants, methodology and analysis employed.

“Our heads are full of preconstructions” according to Bourdieu (Krais, 1991, p. 249); he continues, and “our thinking applies instruments of knowledge which serve to construct the object when they should be taken as the object”. My knowledge of the world of clinical educators (epistemology) moved from one of almost positivist/biomedical shaped by my training and education, and acceptance of assumptions that defined the role of clinical education as belonging to senior physiotherapists. With experience of working in different roles relative to clinical education, for example, my knowledge of the world of clinical education changed from an ontological perspective, I understood that the social reality and world of clinical educators was complex.

My professional ‘preconstructions’ are embedded in my professional experience and knowledge of the reviewed literature. The choice of critical paradigm for this research highlights my interest in examining power interplay and intention to reveal everyday truths of participants, otherwise disguised through mechanisms which protect interests of dominant individuals and groups (Grant & Giddens, 2002). Such preconstructions have important consequences for my position as researcher in terms of methodology, method and interpretation. Subsequently strategies, as discussed in Chapter Three and Eleven, were employed to challenge and clarify my ontological and epistemological stance, in terms of meaning and interpretation, and knowledge generation.

## Research context

This research is situated in existing background literature, albeit limited, and includes literature relating to clinical education and physiotherapy. Inter-stakeholder tension and conflict was evident in the dominant body of literature relating to different models of clinical education i.e. ratios of students to clinical educators (Baldry Currens, 2003; Baldry Currens & Bithel, 2000; Ladyshewsky, 1993; Lekkas et al., 2007; Moore, Morris, Crouch, & Martin, 2003; Stiller, Lynch, Phillips & Lambert, 2004). Other research captured tensions based on conflicting perceptions between stakeholders of, for example, perceived abilities and capabilities of clinical educators (Bennett, 2003; Cross, 1995) and foci of teaching and learning (Jones, Yeung, & Webb, 1998; Kell & Jones, 2007) in clinical education. Perceptions specifically of clinical educators revealed tensions and struggles relating to their professional role and education in Sweden (Öhman et al.,) whilst Strohschein, Hagler and May (2002) proposed a guiding philosophy to underpin clinical education, to impact on attitudes of future clinical educators and stakeholders. Power issues and conflict resolution in clinical education are discussed by Best (2005) and theoretical tensions of clinical educators specifically in New Zealand are explored in a scholarly review by Mooney, Smythe and Jones (2008).

Given the paucity of literature in physiotherapy, it was necessary to draw on knowledge-bases of other health professions that include clinical teaching. Extrapolation of findings has been undertaken with caution, acknowledging that professions such as physiotherapy are shaped by unique socio-economical, historical and political influences. Where appropriate, references are made which clarify similarities and differences that may influence interpretation of the literature or data.

The value of clinical education, and by association clinical educators, is also examined in this thesis in literature pertaining to knowledge as a resource, and how value locates different types of knowledge and imparters of such knowledge in hierarchies. Drawing on research from Eraut (1994), Eraut, Alderton, Cole & Senker (2000), Higgs, Andresen and Fish (2004a), Higgs, Fish and Rothwell (2004b), Schön (1992), Argris and Schön (1978, 1974), and Titchen and McGinley (2004), types of knowledge that constitute physiotherapy and professional knowledge are located within this research. Where such knowledge is positioned within organisations, such as, university, practice providers, and how different forms of knowledge (and imparters of such knowledge) are ranked in hierarchies provides an understanding of how clinical education and practice based learning is valued. Discrepancies in value systems inherent in the culture, ideology and

practices of organisations, provides an insight into the underlying tensions between organisations such as universities and practice providers, and their agents.

Whilst acknowledging that tension and social friction exist within societies (Bourdieu, 1972/1977) including education and healthcare, another source of valuable literature relates to tension management and in particular the work of English (2010). Key socio-economical and political milestones are documented for their impact on the profession, education and healthcare delivery. This includes the move of physiotherapy education delivery under the auspices of universities (Brook, 1994) and subsequent fragmentation of learning, learning areas and responsibilities for learning. Additionally, reorganisation of healthcare and education provision (Broberg et al., 2003) including funding and service models (Coopers & Lybrand, 1994; Haines, Isles, Jones, & Jull, 2011) is examined to appreciate the impact on organisations and stakeholders in physiotherapy, and specifically how they contributed to tension and conflict.

Reconciling tensions through understanding the origins and manifestations of power struggles provides a framework of recommendations to attain improved alignment between organisations. Ultimately education and practice organisations, and professional bodies possess a shared interest and responsibility in the education and preparation of the next generation of physiotherapists in New Zealand.

## **Research contributions**

An important contribution of this thesis is the illumination of power dynamics in clinical education, as perceived by clinical educators, pivotal facilitators of education within the physiotherapy practice environment. The paucity of literature in clinical education specifically examining tensions and conflict, justifies this research within the physiotherapy knowledge-base. Its contribution extends beyond clinical education in physiotherapy, to include relevance to other professional programmes whereby practice-based learning is undertaken in a non-university environment. Another significant contribution is the unique framework provided by Bourdieu and applied to this research. Bourdieu's framework underpins the critical appraisal of clinical education literature, informs the research construction and analysis of findings, and frames the recommendations specific to New Zealand where literature relating to clinical education and the perceptions of clinical educators in physiotherapy is absent.

## **Chapter summary**

This chapter provides an introduction to the research context and research aims. It also offers an insight into the personal impetus for exploring power interplay in clinical

education and the contribution this research makes to the knowledge base of physiotherapy and other practice-based education programmes. The next chapter introduces Bourdieu's theories through which clinical education and physiotherapy are then examined.

## CHAPTER TWO

# Using Bourdieu's theories to interpret clinical education and physiotherapy

### Chapter overview

This chapter provides background information that is important for understanding the research issue. Three levels of analysis constitute Bourdieu's lens through which the practice, process and organisation of clinical education in physiotherapy is examined both in New Zealand and internationally. Historical, socio-economical and political influences are examined to reveal evidence of power interplay, dominant interests, motives and actions to protect and maintain positions of influence. Clinical educators are located within a 'field', an arena of struggle, in which multiple stakeholders have a vested interest. As a consequence, the demands and expectations on clinical educators are complex.

### Introducing Bourdieu's philosophy

Key characteristics underpin Bourdieu's philosophy and specifically his 'Theory of Practice' which can directly be applied to clinical education in physiotherapy in New Zealand. Practices such as clinical education connect individuals and groups (organisations) to hierarchies (Swartz, 1997) based on the configuration and distribution of resources. Traditions and ideology (culture) shape beliefs regarding the value of different resources and consequently, actions and motives to acquire them. Culture, therefore, is both the forum for communication and interactions between individuals and organisations whereby resources are negotiated and are also a determinant in the formation of hierarchies based on resource inequality (Bourdieu, 1986, 1980/1990). In essence, culture "embodies power relations" (Swartz, 1997, p. 1) and practices represent the interplay between individuals and organisations (described as habitus) around the configuration and value of resources (capital) within social arenas (fields). A glossary of Bourdieusian terms has been included in Appendix A.

The continuous contestation for resources creates social tension and friction, as different individuals and groups compete for resources, and therefore, positions of influence and domination on hierarchies. This social tension and friction are considered inherent in societies (Bourdieu, 1972/1977) and central "to all social life" (Swartz, 1997, p. 6). Social hierarchies emerge from the unequal distribution of resources, creating both social classes and class inequalities, and influencing relationships and interactions between individuals and organisations.

Bourdieu acknowledges that power interplay is inherent in societies. This creates a positive lens of analysis through which to explore the practice and culture of clinical education and physiotherapy in New Zealand. The lens provides a framework for tensions to be explored from the perspective of traditions and ideologies of individuals and organisations including the physiotherapy profession, and to examine how resources are configured and contested. Additionally, social classes and hierarchies which emerge from unequal distribution of resources (capital) can be investigated. The research lies within the critical paradigm where change is the impetus; recommendations can be made drawing on Bourdieu's key concepts, for example, influencing how resources are valued, distributed and protected.

### **Key theories and concepts**

Bourdieu's Theory of Practice comprises of the dynamic relationship between three core concepts of *habitus*, *field* and *capital* which are depicted in Figure 2.1 below. Individual and organisation habitus constitute deeply embedded dispositions and values formed from periods of socialisation. Power represents a configuration as capital, i.e. resources which are contested within social spaces or arenas of struggle (fields) such as organisations, profession of physiotherapy occupied by social agents such as clinical educators, and associated stakeholders in clinical education (Bourdieu, 1972/1977). Action represents the outcome of the relationship between habitus, field and capital (Bourdieu, 1985; 1980/1990; Swartz, 1997) and power relations emerge from the continuous interplay between habitus and field as they compete for valued resources (capital) which determine position within, for example, social hierarchies, and influence trajectory towards opportunity and dominance.

$$\boxed{[(\textit{habitus}) (\textit{capital})] + \textit{field} = \textit{practice}}$$

**Figure 2.1 Constituents of Bourdieu's Theory of Practice (1979/1984, p. 101)**

Four dominant forms of capital are described by Bourdieu: *economic*, *cultural*, *social* and *symbolic*. Economic capital refers directly or indirectly to money, for example, time represents money, and cultural capital represents valuable cultural attributes such as physiotherapy professional knowledge. Social capital relates to prestigious or beneficial social networks and relationships and symbolic capital such as status (Moore, 2008; Swartz, 1997). These are further described along with supporting concepts in Chapter Three.

Other complementary Bourdieusian theories that have relevance in this research include 'Theories of Symbolic Power' and 'Symbolic Violence'. Symbolic power "is defined in and by a determinate relationship between those who exercise this power and those who undergo it – that is to say, in the very structure of the field in which belief is produced and reproduced" (Bourdieu, 1972/1977, p. 117). Systems that perpetuate symbolic power function as "instruments of domination" (Swartz, 1997, p. 83) also have a political and social function, legitimising social hierarchies, for example, and social relations including inequalities therein. Symbolic power embedded in systems that create and reinforce social ranking, relations and inequalities are manipulated through 'symbolic violence', that is, "violence which is exercised upon a social agent with his or her complicity" (Bourdieu & Wacquant, 1992, p. 167). The 'taken for grantedness' (doxa) and acceptance of social ranking produces and protects positions of dominance, and is evident not only in opportunities afforded to dominant groups but also in the withholding of, for example, resources such as time. Passive acceptance of position and resource allocation (or denial) is embedded in the habitus of lower ranked social classes. Consequently, very little effort or action is required by dominant groups to maintain their hierarchical location and position of dominance.

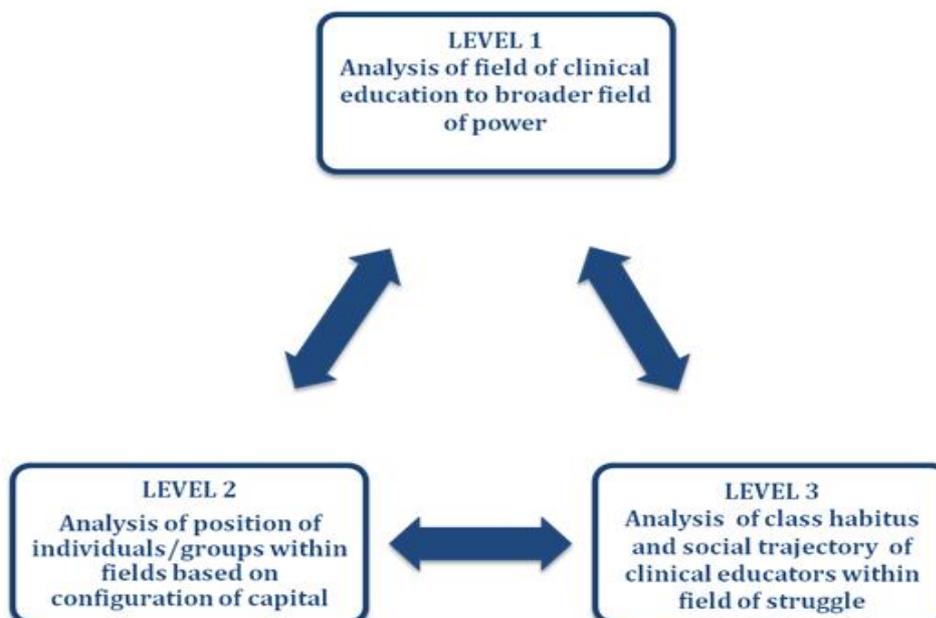
### **Levels of analysis as applied to this research**

Power dynamics between individuals such as clinical educators and organisations (universities, private practices) emerge from the continuous interplay between habitus and field as capital is continually reconfigured. Three 'levels' of interaction between habitus and field constitute Bourdieu's methodological and analytical framework (Bourdieu, 1979/1984; Bourdieu & Wacquant, 1992); and are detailed in Chapter Three. Within the context of this research, and specifically this chapter, level one examines the field of clinical education in relation to other fields, that is, the physiotherapy profession and in particular in relation to the recognised field of power. This constitutes the field of politics and government which ultimately, for example, determine resource allocation (economic capital). Level two studies individuals located within fields whose position on social hierarchies is related to the configuration of capital held, and valued by fields such as organisations and the profession of physiotherapy. The third level analyses clinical educators and associated stakeholders in clinical education as individuals, and in terms of their characteristics and attributes which distinguish individuals and social groups in terms of position within fields and social trajectory.

Although described as distinct levels of interaction between habitus and field, (Grenfell, 2008d), suggesting stratification of analysis, it should be emphasised that the

levels are dynamic and interconnected. Grenfell (2008d) argued that all three levels are required as they inform each other. These interconnected levels are presented in Figure 2.2.

This is particularly relevant given the unique position of clinical educators in the field of clinical education, formed from the overlap between fields of academia and physiotherapy practice, yet interconnected with other fields such as the physiotherapy profession.



**Figure 2.2 Interconnected levels of analysis**

(Source: Bourdieu, 1979/1984; Bourdieu & Wacquant, 1992)

Drawing on Bourdieu's key theories and concepts, the philosophical lens is provided through which the '*practice*' of clinical education in physiotherapy is now explored. As already noted, Bourdieu's theories are examined in further detail in Chapter Three and again provide the lens through which relevant reviewed literature is critiqued.

## **Physiotherapy – a practice based profession**

With historical origins of “touch, massage, hydrotherapy, exercise and rest” (Webb et al., 2009, p. 3) dated from Hippocrates and 1<sup>st</sup> century, physiotherapy as a profession focuses on the restoration of movement and function of individuals through their lifespan (World Confederation for Physical Therapy, 2011a). Inherent in the practice of physiotherapy are theoretical and practical components supported by research and an evidence base. These include discipline specific and generic knowledge and skills

applicable across different healthcare environments and models of care, and taught and practiced in uni, multi and interprofessional teams. Academic and clinical education constitute the two key elements of teaching and learning (Webb et al., 2009) with academic staff traditionally responsible for delivery of university/school based learning, and clinical education undertaken by practice-based staff usually employed by private or public physiotherapy practice providers, e.g. district health boards, private practices. 'Traditions' however, signify deeply embedded practices, and from a Bourdieusian perspective, establish relationships between habitus, capital and field. As a unique field, clinical education is formed by the overlapping of 'fields' of education and physiotherapy practice, and, therefore, is subject to multiple influences. Another relevant interconnection is the relationship of clinical education with the field of the physiotherapy profession represented in New Zealand, by the Physiotherapy Board of New Zealand. As described later in this chapter, the Board holds significant symbolic power, legitimised by the Ministry of Health and relative legislation such as the Health Practitioners Competence Assurance Act (2003). The Board establishes professional parameters which determine an acceptable code of conduct and clinical competencies that all registered physiotherapists in New Zealand must uphold. These parameters are also embedded in School curricula and form part of the assessment and registration process.

## **Clinical education**

Clinical education is "the delivery, assessment and evaluation of learning experiences in practice settings" (World Confederation for Physical Therapy, 2011b, p. 2). The term denotes the facilitation of student learning including knowledge, skills and attitudes in different practice settings in order to meet programme and professional registration requirements (Rose & Best, 2005). Clinical education programmes provides "authentic and engaging learning experiences" (Webb et al., 2009, p.10) (described in Bourdieusian terms as cultural capital) guided by an experienced physiotherapist utilising different models of clinical education. These represent different ratios of students per clinical educator and are described in the literature as models of 1:1 student/educator, 2:1, and 3:1 (Moore et al., 2003). Key opportunities provided by clinical education include the ability of the student to "learn through practise, experience and reflection", "experience professional and interprofessional behaviour", and "develop a sense of responsibility for lifelong learning" (World Confederation for Physical Therapy, 2011b, p. 3). This equates to the gradual accumulation of cultural capital by the students, determined by clinical educators whose position in organisations is based on experience, title, and economic status (cultural, symbolic, social and economic capital).

As an essential component of physiotherapy entry level education programmes and professional registration, the responsibility for organising clinical education lies with universities, under the auspices of Schools of Physiotherapy. The majority of clinical experiences in New Zealand, for example, are gained in district health boards, with experiences also available in private practices and university physiotherapy clinics. This reveals a unique relationship and dependency of Schools on physiotherapy practice providers, to ensure that students gain appropriate learning experiences, and that these experiences are facilitated by appropriately qualified physiotherapists.

The relationship between the School and organisation employing clinical educators varies on the location (Skinner, 2007) and also service agreement, such as, memorandum of understanding, and/or individual employment contract. The complexity of Schools and physiotherapy practice provider relationship is further compounded by their roles as providers and consumers whereby, for example, Schools purchase clinical education placements from physiotherapy practice providers such as district health boards and private practices.

Commoditization of clinical education, as will be discussed in later chapters, has impacted the relationship between stakeholders and in particular, when determining the 'value' of clinical education. Although the intrinsic value of clinical education as cultural capital is high based on its association with physiotherapy as a practice based profession and professional registration, its economic value (economic capital) is less clear. The disparity between different values of capital is compounded by symbolic systems such as the World Confederation for Physical Therapy who articulate the professional responsibility of all physiotherapists to "support quality clinical education" (2011b, p. 2) and the Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct with Commentary (Physiotherapy Board of New Zealand, 2011b) who advocate that physiotherapists should "willingly engage in teaching physiotherapy practice to physiotherapy students and less experienced colleagues" (p. 20). In later chapters, evidence of symbolic violence is presented (for example, it was found that clinical educator time to prepare for students was withheld).

Shortages in clinical educators and clinical education placements have amplified tensions between 'fields' of academia (Schools and universities) and physiotherapy practice providers (district health boards, private practices). In response to projected shortages in healthcare workforce including physiotherapists, a noticeable increase in student numbers and in many countries, Schools of Physiotherapy (Crosbie et al., 2002) have increased the demand, and hence value, of clinical education opportunities. For

example, university physiotherapy clinics have been established to reduce the dependency on external clinical education providers and provide additional clinical education opportunities (Higgs, Pope, Kent, O'Meara & Allan, 2010). Published research also provides evidence of alternative models of clinical education namely 2:1 students:clinical educator to increase student capacity (Moore et al., 2003). A further body of evidence has investigated the economic consequences of students, promoting students as beneficial in productivity of services and reducing waiting times (Bristow & Hagler, 1997; Holland, 1997; Ladyshevsky, Barrie, & Drake, 1998); cultural value of clinical education is, therefore, transformed into economic capital, and marketed accordingly. Whilst the increased demand for clinical placements has impacted on the economic value of clinical education and services of clinical educators, another factor that has also contributed has been changes to healthcare organisations and expectations of reimbursement for clinical education, driving competition for placements (Vroman & Cruice, 2010). Value of clinical education and clinical educators is therefore, linked both to the practical nature of the profession, and as a commodity, is located within the market of healthcare, driven by economics, and systems of supply and demand, and consumerism.

Although Vroman and Cruice (2010) advocated the reconceptualisation of allied health education (which includes physiotherapy) “as a continuum of university-based learning and fieldwork education, rather than a contrived dichotomy between education in academic and fieldwork education settings” (pp. 179-180), both fields of academia and physiotherapy practice are subject to their own socio-economical influences which, as this research reveals, are not necessarily congruent. Clinical educators, located within different ‘fields’ are therefore, subject to multiple tensions as their service (clinical education) as capital is contested.

Expectations of clinical educators are discussed as role and responsibilities in the next section, whilst in Chapter Four, clinical educator perceptions are examined within the relevant literature and in Section Three, and perceptions of clinical educators as participants in this research are examined including their location in social hierarchies.

## **Clinical educators, terms, roles and responsibilities**

Throughout the literature, different terms denote the experienced physiotherapist responsible for student learning within the clinical environment. These include: clinical educator (United Kingdom/New Zealand), clinical supervisor (New Zealand/Sweden), clinical tutor (Ireland), practice tutors (Ireland), professional/field supervisor, clinical teacher, mentor, clinical preceptors (Japan) and clinical instructors (Greece). Titles as symbolic capital reveal different educational pedagogies, and consequently, different roles

and responsibilities are ultimately revealed as sources of tension between different stakeholders including students. By way of example, Morton-Cooper and Parmer (2000) describe a mentor as someone who through a facilitatory relationship promotes personal and professional growth of the mentee. In contrast, clinical/professional supervisor implies an oversight of tasks and according to Rose and Best (2005) resonated with traditional models of clinical education. More recently, the term clinical educator has replaced 'clinical supervisor' in many allied health professions and countries and as described by Rose and Best, possesses unique characteristics compared with clinical supervisor (p. 7). A summary of these characteristics are presented in Table 2.2.

**Table 2.1 Comparative characteristics of clinical educators and clinical supervisors**

<b>Characteristic</b>	<b>Clinical educators</b>	<b>Clinical supervisors</b>
Relationships	Educative enabling and ensuring relationship	Clinical enabling relationship
Socialisation	Clinical socialisation in placement period	Clinical socialisation, focus on practice
Learning support	Highly structured learning support	Semi-structured learning support
Duration	Short duration related to length of clinical placement	
Roles	Specific education roles, and formal assessment common, gate-keeper assessment role	Medium-term duration, determined by clinical partnership and working alliance
Selection	Chosen by university and clinical site	Clinically and professionally related tasks, and self-assessment  Chosen by individual (or assigned in some "in-house" situations)

(Source: Rose & Best, 2005, p. 7)

Although different countries and Schools of Physiotherapy may have distinctive titles and expectations of 'clinical educators', the World Congress for Physical Therapy (2011b) described generic expectations of 'clinical education site instructors' to encompass roles of supervision, education, mentorship and assessment. This adds to the complexity of role and responsibility interpretation within the physiotherapy profession and associated literature, and challenges the processes that determine how physiotherapists learn to become clinical educators and associated expectations.

## **Learning to be a clinical educator**

Preparation of clinical educators has been documented as inadequate (Strohschein et al., 2002). Clinical educators were often found to be reliant on 'trial and error' (May, 1983) and natural attributes such as an interest in student learning (Bennett, 2003; Cross, 1995; Marriott & Galbraith, 2005) rather than pedagogy. Dependence on experience or trial and error was reinforced by the lack of available accredited courses and credentialing programmes in clinical education (Rose & Best, 2005). In comparison to other countries however, in the United Kingdom, an accredited scheme (Accreditation of Clinical Educators Scheme) was established as a collaboration between the Chartered Society of Physiotherapy (2004) and some universities. Unlike many accredited schemes in the United States which are compulsory, and a prerequisite of clinical educators, accreditation in the United Kingdom is optional. More recently, a number of post-graduate opportunities are available to health practitioners in New Zealand; however, as will be discussed within this research, discipline-specific and clinical knowledge and skills is prioritised over pedagogy. The responsibility of universities to prepare physiotherapists as clinical educators has become more widely accepted, with many Schools of Physiotherapy offering workshops of varying duration, and through different media, for example, teleconferencing, and promoting post-graduate courses in clinical education (albeit not funded). Contents of workshops differ; however, in general, include information regarding course delivery and content, assessment procedures and aspects of learning including learning styles. There is a noticeable paucity of literature regarding the structure and content of such workshops (Walker & Openshaw, 1994) and how these or more formal post-graduate courses in clinical education impact clinical education practice.

Unlike clinical tutors who are recruited and employed by Schools of Physiotherapy, clinical educators commonly self-select or are nominated by team leaders. Clinical tutors may be employed solely to visit students on placement, or have responsibility for students combined with other teaching commitments. As university employees however, they have access to post-graduate opportunities in learning and teaching which although available, in a study by Hurst (2010), were found to be of mixed benefit. Primary employment distinguishes the location of clinical educators and tutors within relevant fields. For clinical educators employed by physiotherapy practice providers (public or private), the dominant focus is on patient management with an optional role in clinical education. Clinical tutors in contrast are located in the university field, hence a specific focus on education and student learning applied within the clinical context. The value of different types of knowledge (cultural capital) including pedagogy, is determined by field habitus. In other words, the embedded values and dispositions of organisations such as

universities and district health boards may not be directly transferable across fields (horizontal transfer). This can result in social hierarchies, that is, vertical location based on possession of capital. Pedagogy is clearly valued within universities; it may not be valued or even recognised within a clinical practice context. Similarly, clinical educators, in relation to their clinical colleagues in district health boards may rank lower in social hierarchies and clinical tutors may rank lower compared with non-clinical staff in universities. Hierarchical ranking, however, is contingent upon the possession of valued resources such as different types of knowledge.

Influences that impact the value of knowledge are described later in this chapter, including expectations of the Tertiary Education Commission as an agent of the Government, within the context of New Zealand. The field of clinical education is described in relation to other fields, including the wider field of power (Government) and their influences on how capital is configured. What follows below is an account of the origins of physiotherapy programmes and clinical education in New Zealand.

## **The New Zealand context**

### **Schools of Physiotherapy**

Physiotherapy programmes are provided by two Schools of Physiotherapy in New Zealand: Auckland University of Technology (AUT) and University of Otago, based in Dunedin. Each offers a four year baccalaureate degree programme, accredited by the Physiotherapy Board of New Zealand, leading to professional registration and attainment of an Annual Practising Certificate. Upon completion, graduates qualify with a license to practice physiotherapy, albeit that their qualification title is different. From one School, graduates qualify with a Bachelor of Health Science BHSc [Physio], and at the other School, the qualification is a Bachelor of Physiotherapy (BPhty). As cultural and symbolic capital both awards are of equal value. In both programmes, professional and clinical competencies required by the Physiotherapy Board are embedded and assessed within curricula; however, clinical education is organised differently, and implemented by clinical placement co-ordinators, i.e. physiotherapists employed by Schools.

Historically, both Schools of Physiotherapy evolved differently, shaped by unique socio-economic and political influences, and although graduates enter the workforce with a degree in physiotherapy and professional registration, the capital held by both Schools is different. The School of Physiotherapy (formally the Dunedin School of Massage) was established in 1913. Initially administered by the Otago Hospital Board, it was not until 1989 that the University Grants Committee granted approval for a conjoint degree

(administered jointly between University of Otago and Otago Polytechnic) to commence in 1991. The Polytechnic was responsible for the clinical practice modules until 1995 when a new School of Physiotherapy was established solely by University of Otago.

In contrast, Auckland Institute of Technology established a School of Physiotherapy in 1973 and gained approval from the New Zealand Qualifications Authority to offer a degree in physiotherapy, as noted by Scrymgeour (2000) to be the only degree programme available through a Polytechnic. Auckland Institute of Technology gained university status in 1999 and became known as Auckland University of Technology<sup>2</sup>. The time lag (hysteresis) between Auckland Institute of Technology gaining university status (symbolic capital) and reconfiguring its position within the wider academic arena (field), whilst noteworthy, also highlights Auckland University of Technology's relatively new entry to the academic field compared with University of Otago, established in 1875. In Bourdieusian terms, symbolic capital held by both universities and Schools of Physiotherapy, is configured differently based on the historical determinants of status and reputation, nationally and internationally. The evolution of both Schools of Physiotherapy together with significant professional and educational dates is presented in B.

### **Clinical education**

The responsibility for the student within the clinical environment is also unique to each School. The term 'clinical educator' was used exclusively at one School and relates to the physiotherapist responsible for student learning irrespective of the clinical environment. The title reflects the all-encompassing nature of education within the clinical context (personal communication, Programme Leader, AUT, March, 29, 2006). The term was changed in 2008 to 'clinical supervisor' in keeping with the introduction of a new assessment tool (personal communication, Academic Staff, AUT, August 09, 2012). Descriptors of the clinical educator role are described in the clinical educator handbook under the section "learning in the clinical setting will take place if the clinical educator:" (AUT University, 2007, p. 10) and relate to student orientation, giving feedback and recommendations regarding how to facilitate student learning. In 2008 documentation the role of the supervisor includes similar dimensions as 2007 but makes explicit the role includes "attendance at an AUT run 'Supervisor Workshop'" (AUT University, 2008, p.20). The role describes principles of facilitating learning, for example, promoting reflective practice and setting learning goals.

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<sup>2</sup> In 1999, Auckland Institute of Technology (AIT) became known as Auckland University of Technology (AUT). In 2007, the university title was changed to AUT University.

In comparison, both 'clinical educator' and 'clinical supervisor' are terms used by the other School and relate to defined roles and responsibilities. For example, clinical educators<sup>3</sup> are employed by the University on a part-time basis or as a full-time member of the academic staff. Their role in the clinical environment is "to guide and support clinical education of physiotherapy students" (Skinner, 2007, p. 125). Clinical educators are also responsible for organisation, administration and participation in the assessment process and liaison with clinical supervisors, clinicians employed by healthcare providers whose primary role is patient management. As clinical supervisors<sup>4</sup> their primary focus is "the delivery of physiotherapy services but they also have clinical experience and teaching skills to facilitate and guide students in clinical practice" (Skinner, 2007, p. 125). They work collaboratively with the clinical educator, act as professional role models and provide quality clinical experiences for the students. The roles mirror the characteristics described by Rose and Best (2005). In some instances, as described in this research, physiotherapists held dual roles of clinical supervisor and clinical educator. The latter position was funded separately by the School of Physiotherapy under a separate contract with the clinical educator accountable directly to the School.

Both Schools of Physiotherapy run university based clinics either on or off site. Clinics are run by physiotherapists employed to work with students, albeit the titles differ and in some instances, staff have their own clinical caseload. For example, university-based clinics of one School were run by clinical educators/clinical tutors; this title was subsequently changed in 2007 to professional practice fellows. The impetus for this change is described in Section Three.

Central to clinical education, irrespective of School or staff, is a clear understanding of roles and responsibilities (field boundaries) as defined formally in job descriptions, handbooks or memorandums of understanding between Schools and physiotherapy practice providers, for example, district health boards. Of interest, is that the status (symbolic capital) of clinical educators at one School has stronger linkages with pedagogy compared with clinical supervisors, who are expected to have some teaching and facilitation skills only. The value of symbolic capital, however, may not be transferable to different fields where, for example, in district health boards, the primary focus is on patient management and healthcare provision. It is in this field that physiotherapy specific knowledge and skills as applied to patients (cultural capital) holds more value. Communication and collaboration (social capital) is readily exchanged and transferred

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<sup>3</sup> For the purpose of this research, the term 'clinical tutor' is used to describe physiotherapists employed directly by the School of Physiotherapy and whose role is to visit students on placement.

<sup>4</sup> In this research, the term 'clinical educator' is used to describe the physiotherapist responsible for the student in the clinical environment.

between fields given the relationship between clinical and university staff. Social capital is also transferred between stakeholders in physiotherapy education including the Physiotherapy Board of New Zealand and Schools of Physiotherapy, where competencies as determined by the Board are assessed and audited.

### **Physiotherapy Board of New Zealand and membership groups**

The Physiotherapy Board of New Zealand (Board) is the registration body for the profession in New Zealand. Symbolic power of the Board is authenticated by the Ministry of Health and membership elections. The Board has the authority under the Health Practitioners' Competency Assurance Act 2003, to administer legislation and through governance, determine and maintain the quality of practice within New Zealand. From a Bourdieusian perspective, the Board holds significant symbolic power both in its position as the registration body, gatekeeper of professional standards and protection of the public, and through its relationship with the Government. Given its role, the Board determines the field habitus of the profession in New Zealand, through key documents such as Physiotherapy Competencies for New Zealand Practice (Physiotherapy Board of New Zealand, 2009) and Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct with Commentary (Physiotherapy Board of New Zealand, 2011b).

In contrast with compulsory registration, membership to Physiotherapy New Zealand<sup>5</sup>, and/or associated special interest groups is optional. Membership to Physiotherapy College of New Zealand (College) is also elective; however, members must meet criteria for membership evaluated by peer and committee members. This affords membership to the College as more prestigious (symbolic capital) compared with other optional membership groups.

### **Core professional documents and their influence on clinical education**

Two core documents underpin physiotherapy practice and the profession in New Zealand: Physiotherapy Competencies for Physiotherapy Practice in New Zealand (Physiotherapy Board of New Zealand, 2009) and Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct documents (Physiotherapy Board of New Zealand, 2011b). Origins of the first competency document in 1988 emerged from the independent establishment of curricula by the two Schools (Skinner, 2007) and the need to ensure standards and competencies were met within School curricula and demonstrable in student learning objectives and outcomes. While each School embed the competencies differently into curricula, the competencies are audited by the Board on an

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<sup>5</sup> Rebranded as Physiotherapy New Zealand from New Zealand Society of Physiotherapists' Inc. in 2010

annual basis, thus maintaining the symbolic power of the Board over not only practising physiotherapists, but also undergraduate education in New Zealand.

Even though both documents clarify standards of physiotherapy practice and professionalism in New Zealand, they offer different perspectives on clinical education. The Code of Ethics document, for instance, states that physiotherapists 'should': "willingly engage in teaching physiotherapy practice to physiotherapy students and less experienced colleagues" (Physiotherapy Board of New Zealand, 2011b, p. 20). This makes the engagement in 'teaching' students explicit as an ethical and professional expectation. However, in a recent presentation, Anderson, a significant contributor to the Code of Ethics, described 'should' as a professional "aspiration" rather than compulsory requirement, (personal communication, Lynley Anderson June 28, 2012). In contrast, Competency 5 of the Physiotherapy Competency document refers to the application of "educational principles to physiotherapy practice" (Physiotherapy Board of New Zealand, 2009, p. 15). This competency specifically relates to patient/client education and makes no reference to student education and is further examined in Sections Four and Five.

### **Other relevant stakeholders in New Zealand clinical education**

There are other stakeholders who are relevant to clinical education in New Zealand. These include professional leaders, service/operations managers, directors of allied health and students. Professional leaders (PLs) are physiotherapists employed by district health boards; their scope encompasses the professional development of staff and interfacing between workforce and professional requirements (cultural and social capital). As professional leaders, however, they possess no budget. Hence they are unable to directly influence the allocation of economic resources. In contrast, and depending on organisational configuration, service/operations managers may be registered physiotherapists, allied health professionals or business managers who hold budgets (economic capital). They are responsible for the productivity of teams and departments and hence the 'economics' of physiotherapy service provision.

Directors of allied health are registered health professionals responsible for allied health groups, including physiotherapy, radiology, and occupational therapy, within district health boards. Depending on organisational structure, they may hold budgets and can, therefore, influence the direction (professionally and economically) of allied health. The numbers of staff including professional leaders accountable to directors of allied health infer that they are ranked high in organisation and professional hierarchies based on the volume of symbolic capital.

In comparison to qualified physiotherapists, students possess little capital except as consumers of physiotherapy and clinical education. Through processes of socialisation (habitus formation) both as a student and new graduate, their ability to influence practice is more obvious, given the accumulation of cultural and symbolic capital (knowledge and registration). Their dearth of capital in comparison with other stakeholders positions students low in social hierarchies (professional and organisation). Recent shifts away from apprenticeship models of clinical education and towards collaborative learning practices and communities of learning have in some way redressed the configuration of capital held by students. The resigned passivity of students to their 'place' in social hierarchies from a Bourdieusian perspective is described as doxa, i.e. 'taken for grantedness', which reinforces the social order and power relations. This is further discussed in Section Four.

### **Tertiary Education Commission**

Location of Schools of Physiotherapy within universities (academic fields) requires that Schools and their model of education fit with criteria determined by the Tertiary Education Commission, as an agent of the New Zealand Government (field of power). Configuration of economic capital is shaped by field habitus of the Government and its agents who hold symbolic power, and in turn, structures the field habitus of universities and Schools of Physiotherapy. One challenge for professional courses such as physiotherapy is that they must satisfy many stakeholders in that they have to meet criteria determined by funding and governmental bodies such as the Tertiary Education Commission. They must also meet criteria set by professional bodies such as the Physiotherapy Board of New Zealand as well as workforce and individual workplace needs.

A further challenge is the identity of professional and practice based courses within universities, traditionally dominated by theoretical courses. Despite strong historical links with polytechnics and vocational origins (Jones & Sheppard, 2008), physiotherapy programmes in New Zealand are university based, albeit that a significant component of the programme is based in clinical practice (physiotherapy/healthcare industry). Characteristics and government expectations of universities and polytechnics outlined in Tertiary Education Strategy 2010-15 (Ministry of Education, date unknown) and presented in Table 2.2 highlight the inherent tensions for programmes such as physiotherapy that are practice/industry based, yet are located in universities.

**Table 2.2 Tertiary Education Commission expectations of universities and polytechnics in New Zealand**

<b>Tertiary Education Commission 2010-2015</b>	<b>Universities</b>	<b>Polytechnics</b>
Characteristics	“Primarily concerned with advanced learning and research” (p. 24)	“Mainly focused on vocational training at certificate and diploma level and applied degrees” (p. 24)
3 Core roles	Undertake research that adds to the store of knowledge Provide a wide range of research-led degree and post-graduate education that is of an international standard To act as resources of critical thinking and intellectual talent (p. 18)	To deliver vocational education that provides skills for employment To undertake applied research that supports vocational learning and technology transfer To assist progression to higher levels of learning or work through foundation education (p. 18)
Government expectations	Enable a wide range of students to successfully complete degree and postgraduate qualifications Undertake internationally recognised original research Create and share new knowledge that contributes to New Zealand’s economic and social development and environmental management (p. 18)	Enable a wide range of students to complete industry-relevant certificate, diploma and applied degree qualifications Enable local access to appropriate tertiary education Support students with low literacy, language and numeracy skills to improve these skills and progress to higher levels of learning work with industry to ensure that vocational learning meets industry needs (p. 18)

(Source: Tertiary Education Strategy 2010-15, Ministry of Education, date unknown)

The descriptors expressed in the Tertiary Education Commission document make clear differentiation between universities and polytechnics including their contribution to society and New Zealand economy; however, physiotherapy as with other practice based courses, not only meet university criteria, but in some instances, through their engagement with industry (healthcare and physiotherapy provision), could also meet polytechnic descriptors. Contributions to society and knowledge-bases are in contrast with contributions to industry and the workforce; both of which physiotherapists and physiotherapy fulfil.

Despite strong historical links with polytechnics, Schools of Physiotherapy became the responsibility of universities, a move considered essential for academic credibility and professional kudos (Potts, 1996), i.e. symbolic capital. In addition, internationally, many polytechnics gained university status. New Zealand echoed this global trend, highlighting the interconnectivity of New Zealand physiotherapy with the international community.

Location in the university field requires that physiotherapy field habitus adjusts to meet conditions and expectations in order to maintain its status (symbolic capital) amongst other healthcare professions and within the international arena. As noted by Swartz (1997) change impacts on boundaries with other fields and positions of individuals therein; changes to the status and responsibility of physiotherapy programmes was, therefore, not without its challenges. Fundamentally, different physiotherapists became responsible for components of student learning and at different sites. By way of example, geographical and theory/practice gaps were documented as universities became primary sites of theoretical learning and clinical sites provided practice based learning (Brook, 1994; Potts, 1996). Such tensions are evident in the literature critiqued in Chapter Four and the findings of this research (Section Three), both of which are examined in further detail.

### **Economic consequences of clinical education in New Zealand**

Economic consequences of clinical education are multidimensional. From the perspective of organisations, New Zealand Schools 'purchase' clinical education from physiotherapy practice providers and Schools receive Government funding based on student numbers and completion rates. Thus, clinical education has become commoditised and economics including fiscal constraints drive healthcare delivery. Consequently a complex picture of economics emerges affecting providers and consumers of clinical education.

Specific to New Zealand are issues with funding for clinical placements which mirror tensions around establishment of physiotherapy degree courses and in particular when undergraduate programmes became four years in keeping with international trends (Scrymgeour 2000). Tensions around funding were further aggravated by the funding report by Coopers and Lybrand (1994, p. 1) commissioned by the Ministry of Health to establish:

*the relevant costs of clinical training at both a national and individual crown health enterprise (CHE) (area health board) level, so that the information can be used to assist in the formulation of policy advice on the future purchasing and funding of clinical training.*

Physiotherapy students on placement were found to have a net cost of \$1,348 based on three years of training. Of note is that "polytechnic physiotherapy tutors supervise and provide most of the training for students, there is also some Crown Health Enterprise staff input" (Coopers & Lybrand, 1994, p. B27). Both the method employed, process and funding models proposed were disputed by training centres including physiotherapy. As will be later discussed, tension between education and physiotherapy practice providers

continues and is visible within the literature particularly pertaining to the economic consequences of clinical education (Bristow & Hagler, 1997; Haines et al., 2011; Holland, 1997; Ladyshevsky, Barrie, & Drake, 1998) and tensions around increasing clinical placement capacity through different models of clinical education (Baldry Currans, 2003; Baldry Currans & Bithell, 2000; Ladyshevsky, 1993; Lekkas et al., 2007; Moore et al., 2003; Stiller et al., 2004). Whilst tensions regarding funding between education and practice providers is duly noted, Skinner (2007) also declared that “the biggest issue currently facing the undergraduate programmes in the universities is that the Schools of Physiotherapy are significantly and chronically underfunded” (p. 127) compared with other related courses in New Zealand. The lack of equity between courses and withholding of funding (economic capital), as symbolic violence, inhibits the development of courses, research (cultural capital), and building capacity (Skinner, 2007) and impacts the ability of Schools to fund clinical educators/placements. Lack of funding not only impacts on the ability of Schools to meet Government expectations of Tertiary Education Commission (Table 2.2) but has resulted in Schools organising clinical placements for students in a more cost-efficient manner. This includes the establishment of university-based physiotherapy clinics. Unlike district health boards or private practice, the primary focus of these clinics is clinical education. Clinical placement numbers are maximised with funding required for the clinical educator position only, rather than paid on a per student basis to another placement provider. Additionally, less time is spent in negotiation with other organisations to secure placements.

## **Chapter summary**

Whereas this chapter has focused on Bourdieu’s key theories in order to provide a lens for interpreting and understanding influences which have impacted upon the practice and profession of physiotherapy and clinical education, the next chapter examines theoretical territory in more detail. It also justifies this research within the critical paradigm and critiques the validity of Bourdieu.

Social hierarchies have emerged based on the configuration of capital determined by fields such as organisations and the profession. Economics have had a significant impact on clinical education in terms of commoditisation, supply and demand, and consumerism, which is far removed from the historical and vocational roots of the profession (Jones & Sheppard, 2008). This signifies a change in field habitus of organisations, whereby the profession and organisations must adapt to new field conditions, including Schools adapting to Government expectations of universities if their economic and symbolic status is to be maintained.

## **Personal reflections**

*Within two years of qualifying, I 'became' a clinical educator to students from different Schools of Physiotherapy. My personal interest in student learning initiated what has become a life-long interest in clinical education in physiotherapy. Since then several noticeable changes have occurred, which in my opinion have amplified the tensions for clinical educators and between stakeholders in clinical education.*

*As a novice clinical educator, funding was paid directly to the clinical educator as an acknowledgment for the service provided, unlike other physiotherapy colleagues. Additionally, communication with School staff was a great opportunity to network, ultimately enabling me to gain experience as a guest lecturer in physiotherapy. In such instances, being a clinical educator had its economic and social benefits which were traded against the time and energy required to facilitate student learning. However, in recent years, the economics of healthcare education and delivery has made a significant impact. Funding for clinical education has become a source of income for district health boards and private practices rather than individual clinical educators. 'Prices' are negotiated between organisations, and physiotherapists are professionally (and ethically) obliged to engage in clinical education, yet are not differentiated from other physiotherapists. In my opinion, there has also been a significant shift towards consumerism and expectations of Schools and students, which has not always been facilitated by organisations, whose dominant focus is physiotherapy service delivery rather than student learning.*

*Working in different hospitals, countries and with a number of Schools of Physiotherapy, I recognise that many of the tensions are not specific to one clinical educator, organisation or even country, but represent a tension between practice-based courses located in traditionally 'theoretical' universities. Although Schools retain the ultimate responsibility for physiotherapy students and their learning, different types of learning occurs in diverse environments, facilitated by staff whose roles, responsibilities and knowledge of pedagogy differs between Schools and countries. I have noticed that physiotherapists from specific countries consider clinical education integral to their role, while for others, it is an 'additional' skill, and in many cases described as a burden. Confusing perspectives from the profession may in some part be responsible for obligating its members to engage in clinical education, yet not making pedagogy explicit in competency documents, and School curricula.*

*Students' expectations as consumers have also changed over time. Generation Y or the Net Generation are technologically savvy, confident multi-taskers and demanding of immediate feedback. This may be in contrast with the 'generation' of clinical educators, who*

*already have multiple demands on their time. Perhaps the abilities of clinical educators to juggle such demands have evolved. Other strategies such as working late or carrying what have been perceived as excessive workloads have anecdotally been said to result in burn out, prompting experienced physiotherapists to leave the workforce. These are interesting areas for future research.*

## **CHAPTER THREE**

# **Bourdieu's theoretical perspectives and relevance to this research**

### **Chapter Overview**

This chapter justifies the relevance and applicability of the critical paradigm to this research and, in particular, the work of Bourdieu. Central to the intention of this research is the exploration of the tensions and power interplay within clinical education. Bourdieu's key 'Theories of Practice' (1972/1977), 'Symbolic Power and Violence' (Bourdieu & Wacquant, 1992) along with the supporting concepts are explained and applied to dimensions of this research. Specifically, social forces which shape clinical educators and clinical education are examined and a framework provided through which the literature is then interpreted (Chapter Four). The Chapter concludes by justifying the purpose, methodology and methods used in this study.

### **Critical paradigm, Bourdieu and relevance to this research**

As outlined in Chapter One, the research aims specifically included the motive to transform ideology and culture of individuals and organisations towards clinical educators and clinical education. Transformation was inherently linked to understanding the social reality of clinical educators, specifically exposing how social forces and power imbalances perpetuated positions of power and domination. Listening to the perceptions of clinical educators created the lens to explore social tension from their unique perspective, raising their awareness and understanding, thereby giving clinical educators a voice and a vehicle to empowerment. Given the personal and professional motives for this research, the research was clearly positioned within the critical paradigm.

Characteristics of the critical paradigm include understanding the social world and realities of subjects such as clinical educators with a specific motive to elicit change. Critical inquiry is underpinned by conviction (Grant & Giddings, 2002), with a purpose of empowering the oppressed from social injustices and inequalities (Nicholls, 2009). Silent discourses and different types of power interplay are revealed which disguise the social forces and actions that protect dominant interests and maintain the oppressed in a 'natural' state of acceptance. By raising consciousness and giving a voice to the marginalised or oppressed, emancipation is achieved, and a vehicle for change created.

Given that power is an inherent human characteristic (Carspecken, 1999) a key critical perspective is to address power imbalances to facilitate emancipation. Whereas

Marx [1818-1883] focused on emancipation through economics and productivity, contemporaries such as Friere [1921-1997] through his work in education and literacy, believed dialogue was essential in addressing power imbalances (Allman, 1994; Friere, 1971/1973). However, unlike his peers, Bourdieu believed in the inevitability of social tension and friction in societies and cultures (Grenfell, 2008a) which was central “to all social life” (Swartz, 1997, p. 6). These tenets created a positive lens for exploration, which was in keeping with the principles of this research. The reconfiguration and redistribution of resources described as capital (social, economic, symbolic or cultural) allow social inequalities and injustices to be addressed from a Bourdieusian perspective. Redressing power imbalances and evoking change are paramount to emancipation, and integral to critical theory. By interrogating the interrelationship between structures of social reproduction and the production of inequality, implicit and explicit social forces/practices are revealed which determine capital, its volume and value, and by association, those who possess it.

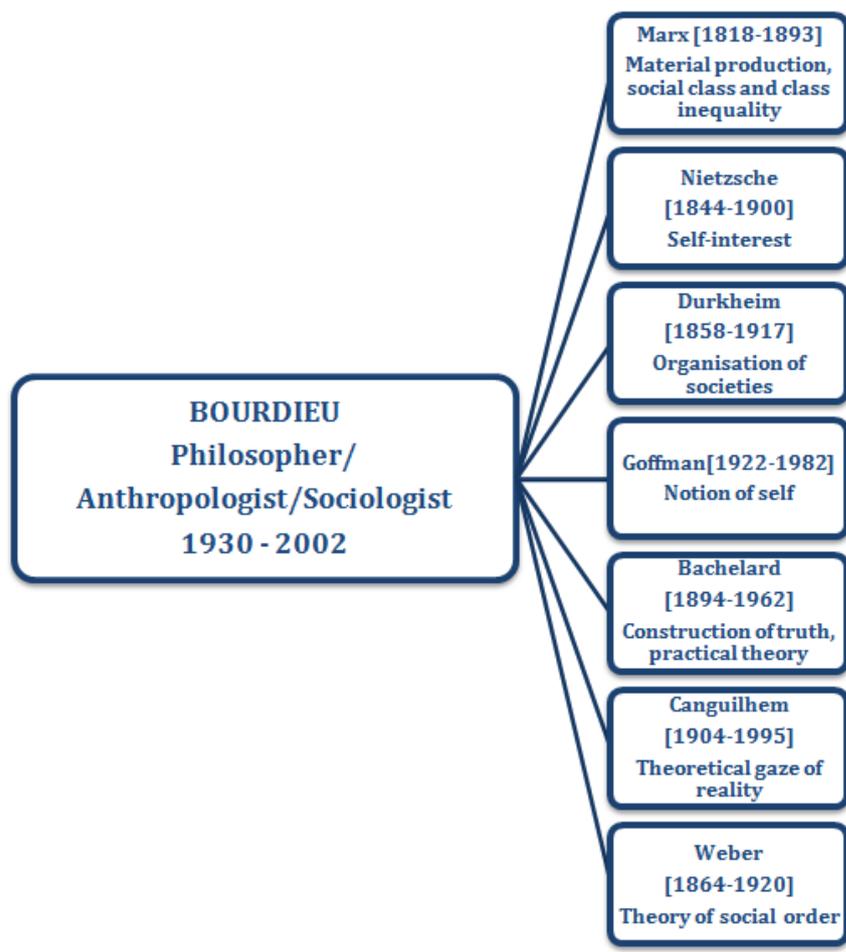
Critical analysis of social forces, power interplay and relations by researchers is both driven by the researchers’ own views and knowledge of the subject area and motive for change. Research motives are based on a privileged insight into social realities otherwise invisible to subjects, such as, clinical educators; researcher objectivity is therefore, promoted through reflexivity. Unlike reflection explained by Maranhão (1991) as indispensable and “analogous to introspection” (p. 237), and Schön’s reflective process described as a metacognitive process triggered by an outcome or unexpected outcome (Eraut, 1994), Bourdieusian reflexivity represents processes to attain researcher objectivity. Three forms of bias are described: “the position of the researcher in social space; the orthodoxies of the field itself; and the simple fact of having “free time”, liberated from the exigencies of having to act in the world – *skholè*” (Grenfell, 2008d, p. 226). For Bourdieu, “the practice of a genuine social science *requires* a “reflexive return” upon itself” (Swartz, 1997, p. 11). Unlike other critical theorists, Bourdieusian reflexivity extended beyond awareness of socio-historical influences or reflecting on research constructs (Grenfell, 2008d) to encompass both a scientific method and a critical epistemological process applicable to both participants and researchers.

The dominant focus on reflexivity by Bourdieu was another consideration in adopting his philosophy to underpin this research. It was through his reflective framework that my position and habitus as team leader/clinical educator/clinician and researcher could be considered, together with the practice/culture/environment (field) in which I worked alongside clinical educators and my personal/professional motives to

explore the world of clinical educators ('skholè'). Only by applying the same epistemological approach in objectifying the object of research, and the knowledge produced (by the researcher) is it possible to properly understand social reality (Jenkins, 1992) and relative to this research, the social reality of clinical educators. A reflexive statement has therefore been included in Chapter Eleven

### **Bourdieu's eclecticism and influences**

The importance of examining social forces shaping the social realities and personal habitus of researcher and participants has been demonstrated. A similar stance has been adopted when examining influences that have shaped Bourdieu's theories in order to appreciate the evolution of his thinking and, as described later in this chapter, its relevance to this research. Dominant influences that shaped Bourdieu's theories and concepts are presented in Figure 3.1.



**Figure 3.1 Dominant influences that shaped Bourdieu's theories and concepts**

Drawn from philosophy, anthropology and sociology, Bourdieu's eclecticism brings to this research a multi-dimensional lens to explore the social world of clinical educators. Considered by Mahar, Harker and Wilkes (1990) to transcend eclecticism, they argue that Bourdieu has "woven core ideas of Western thought into a synthesis of his own" (p. 1), building on intellectual thinking of the time to create a flexible, evolving sociological perspective applicable to many practices. This perspective allows Bourdieu to elevate his thinking beyond one tradition and above the antagonisms of different and often opposing philosophies and theories, which influence and limit thinking and perceptions of the social world under scrutiny. The selective synthesis of knowledge permits Bourdieu to project his own practical and political dimension onto newly transformed bodies of knowledge (Webb, Schirato, & Danaher, 2002) that are applicable across many realms including culture, society, practice and education, many of which are under scrutiny in this research.

Significant influences include Marx who emphasised the importance of material production and ownership relative to social class and class inequality. Although Bourdieu constantly denied any principle links with Marxism (Miller, 2003), the concept of capital was extended beyond materialism and economics to include other forms of 'capital' – economic, cultural, symbolic and social. Configuration and distribution of capital were recognised as important in determining the position of individuals within social hierarchies (Bourdieu, 1980/1990), i.e. social order, a concept developed by Weber along with concepts of field and self-interestedness. Bourdieu expanded the notion "of 'interest' beyond economic (interest and material) and noneconomic (disinterested and symbolic)" (Swartz, 1997, p. 42) and argued that all practices are fundamentally interested in owning both material and non-material goods (Bourdieu, 1980/1990). Hence, according to Bourdieu, all action is interest-orientated to possess valued capital; capital therefore, represents objects of struggle and power. Reconfiguration and distribution of capital is inherent in redressing social inequalities and is further discussed later in this Chapter.

Bourdieu has also drawn from multiple influences including Durkheim and symbolic interactionism in his thinking and work of culture and fields. Durkheim's work shows that collective representations such as moral rules bind societies together (Stokes, 2003). In comparison, Weber's concept of culture was defined "as the realm of meaning which constitutes the basis of social action and change" (Swingewood, 1998, p. xii). Both Durkheim and Weber's theories on culture introduce the concept of cultural autonomy locating the value of practices, representations within a framework of structure. This concept was further developed by Goffman in that "specific symbolic forms based on ritual

and shared meaning enable individuals to produce a complex notion of self" (Swingewood, 1998, p. xiii). Bourdieu's theory of culture transcends the work of Durkheim, Weber and Goffman by locating culture within a dynamic and open framework of social struggle, social order, possession of both material and non-material goods yet located within historical context and driven to elicit social change (Calhoun, 1993; LiPuma, 1993; Swartz, 1997; Swingewood, 1998).

Bourdieu's theory of symbolic power emerges from the work of Durkheim and Weber. This theory stresses the role of assumptions and taken for grantedness in creating and maintaining power relations (Swartz, 1997). Symbolic practices deflect away from resources and activities and disguise them as disinterest; they become misrecognised and therefore, often denied through symbolic violence (Bourdieu, 1972/1977). This is highlighted in Bourdieu's thinking of education whereby academics, owners and producers of symbolic power, are elevated to higher positions within the hierarchy of social class based on what they symbolically represent, such as, prestige, intellect, compared with others. The position of university-based physiotherapy staff within the context of this research is explored both in terms of the symbolic capital that has been legitimized by the profession and also the social hierarchy of wider society.

Bourdieu also draws on Weber's sociology of religion to conceptualise fields as competitive arenas where capital is valued and exchanged (Swartz, 1997). Bourdieu's understanding of social reality is derived from Nietzsche's (and also Durkheim and Weber) understanding that activity is motivated by self-interest and internal competition. This is evident both as 'interestedness' in acquiring, for example, status (symbolic capital) or 'disinterestedness', which represents disguised interest, not always visible to others. Actions borne out of interestedness (conscious or unconscious) are embedded in Bourdieu's concepts of habitus, i.e. motives represent habitus in action (Swartz, 1997) and ultimately relate to the accumulation of capital.

Unlike Goffman's concept of 'frame' or 'rules of irrelevance', Bourdieu's concept of field includes the social and economic conditions that are embedded in, rather than abstract from, everyday life (Mahar et al., 1990). The notion of field begins with the analysis of social structure (LiPuma, 1993); each field constituted by its own history and logic shaped by socio-economical and political influences which require examination. As an added dimension, Bourdieu does not perceive the specificities of time, place and field should be constraining forces, but rather contextual factors requiring consideration (Webb et al., 2002) locating social and power struggles, and practice within both time and space. This is of particular importance as socio-economic, political and professional

influences will have shaped data collected from participant interviews during a specific timeframe.

The construction of truth by Bachelard and the theoretical gaze adopted by Canguilhem influenced Bourdieu's analysis of social reality. Bachelard's reflexive epistemology allowed underlying assumptions to be investigated and was further developed in the reflexive stance advocated by Bourdieu. Reflexivity according to Bourdieu allows for researchers' own values, attitudes and their representations to be called to attention, normally considered removed from the formal standards of verification within other theoretical territories. The 'scientific habitus' advocated by Bourdieu represents a vigilance throughout the research process. The isolation of theory and research in sociology is rejected by Bourdieu who advocates "integrating the two at every stage of sociological inquiry" (Swartz, 1997, p. 35). Subjecting both the subject and researcher to the same level of scrutiny amounts to analysing a particular social reality and how that analysis has been constructed (Grenfell, 2008d). As previously discussed, reflexivity plays a central role in Bourdieu's work, and consequently is evident in this research.

Bourdieu provides a multi-dimensional and layered framework to this research, drawn from the influences of other philosophers and sociologists and applied to cultures, societies and education. Bourdieu's unique framework for examining social tensions and power interplay in, for example, clinical education, is based on a three level approach (Bourdieu, 1979/1984; Bourdieu & Wacquant, 1992; Grenfell, 2008d; Swartz, 1997). This approach constitutes Bourdieu's general method and framework for analysis which is examined in Chapter Five and further evaluated in Chapter Eleven. Social realities of clinical educators can be examined through Bourdieu's theories and concepts which will be further discussed in the next section.

## **Criticisms of Bourdieu's work**

Bourdieu's contribution to sociology, anthropology and philosophy is acknowledged as significant (Grenfell, 2008a; Swartz, 1997) yet his work is not without criticism. Miller (2003) criticises Bourdieu's work for being "insular" and failing "to engage with others in the field" (p. 89). Miller further notes criticisms of oversimplification of class culture and of readily extrapolating French intellectual and academic practice and culture to other countries. While Bourdieu insisted that his work is located in the time that produced it (Grenfell, 2008a), a challenge noted by Swartz (1997) included the delayed translation of his earlier and key work, which resulted in fragmentation in the interpretation and application of his theories. For example, as noted by Swartz, the effects of social

reproduction by French education (Bourdieu & Passeron, 1977) were translated before his theory of practice (Bourdieu, 1972/1977). Thus early criticisms of his work were attributed to a partial understanding of his concepts and theories. By 1994, all major books were translated into English, however later writings reflect a maturation of earlier concepts and as such, should be considered within the era of writing. The impact of translation should also be considered whereby the original intellectual contexts are removed and applied elsewhere, to be understood by others unfamiliar with the original context. As noted by Wacquant (1993), "Bourdieu's work continues to befuddle many of his Anglo-American readers" (p. 237); this includes controversy regarding his writing style, theoretical affiliations and concepts.

Jenkins (1992) suggests that Bourdieu's work is flawed with inconsistencies and contradictions. Three examples are provided. Firstly, in aiming to transcending dualisms such as objectivism-subjectivism, she believes he remains "firmly rooted in objectivism" (p. 175). Secondly, Bourdieu's production of "deterministic models of social processes" is inconsistent with his rejection of determinism. Thirdly, Jenkins challenges Bourdieu's "use of language of positivist empiricism which presents his analysis as based in a 'real' material world" in contrast to "his accounts of social life only to be read as models of social reality advocated by Bourdieu" (p. 175-176). Irrespective of these flaws, she advocates that his work remains important and relevant to the study and understanding of culture and practice.

A substantiate criticism relates to Bourdieu's denial of links with Marxism (Miller, 2003). Critics noted the concept of capital represented as an extension beyond materialism and economics (and therefore Marxism) yet paradoxically, other forms of capital represent derivatives of economic capital (Swartz, 1997). Unlike Marx who focuses on capital and physical oppression and suffering, for Bourdieu, capital represents "a complex notion of wealth defined as resources for power" (Calhoun, 1993, p. 84). Power is reproduced and dominant interests protected through capital, and in latter work, symbolic capital and symbolic violence. Interconvertibility between Bourdieu's different forms of capital is also determined by market relations and societies underpinned by capitalism (Calhoun, 1993; Swartz, 1997), a dimension of capital according to Swartz that lacks "analytical grip" (p. 81) and is noted by Calhoun as misleading. For Miller (2003) Bourdieu's "tendency to take the economy for granted is an enduring problem with his theorizing" (p. 89) yet these shortcomings are limited when compared with Bourdieu's contribution to understanding social forces and structures in which individuals and groups exist and where practices and cultures are produced and reproduced.

## Bourdieu's key theories

### Theory of practice

The dynamic relationship between individuals (habitus) and social structures (fields) such as organisations and professions, shaped by the interplay of power (capital) constitutes practice as conceptualised by Bourdieu (1972/1977). Action represents the outcome of the relationship between habitus, field and capital (Bourdieu, 1985; 1980/1990; Swartz, 1997). Power relations emerge from the continuous interplay between habitus and field as they compete for valued resources (capital) which determine position within, for example, social hierarchies, and influence the trajectory towards opportunity and success. Inevitability of social tension and friction in societies (Grenfell, 2008a) symbolises the continuous and dynamic interplay whereby capital is contested, social forces shape individual and field habitus and field boundaries change. Bourdieu proposed a formula (depicted in Figure 3.2 which is a replica of the figure shown in Chapter Two) and although weary of its reductionist and mono-dimensional nature, captures the relationship of habitus, capital and field relative to practice. It constitutes a methodological key to exploring the practice of clinical educators within this context of this research.

$$[(\text{habitus}) (\text{capital})] + \text{field} = \text{practice}$$

**Figure 3.2: Formula of Practice as provided by Bourdieu (1979/1984, p. 101)**

Power is conceptualized by Bourdieu (1980/1990; 1986) as having value in influencing relationships and interactions between individuals and organizations. Power struggles, tension and conflict are represented through the constant transaction of capital and repositioning of individuals within fields. Bourdieu's theory therefore, allows for different types of power between individuals, for example, clinical educators and managers, groups such as physiotherapists, and organizations (university, private practices, and physiotherapy departments) to be illuminated. The 'practice' of clinical education is examined through Bourdieu's key concepts (this chapter), literature review (Chapter Four) and the voices of clinical educators and stakeholders in clinical education (Chapters Six to Nine).

Dynamism and flexibility provide two distinct characteristics of Bourdieu's theory. Each are applicable to this research, accommodating, as they do, the constant state of flux of New Zealand's healthcare which has been described as the most restructured health system in the developed world (Gauld, 2009). In addition, influences that shape the

'practice' of clinical educators and organisations such as healthcare providers can be examined in relation to socio-economical and political forces and their impact on habitus, field and capital.

## **Habitus**

The concept habitus expresses the way in which individuals, groups or organisations, become themselves through a system of deeply internalized dispositions (Bourdieu, 1980/1990; Bourdieu & Wacquant, 1992). Such deeply embedded dispositions, attitudes and ideologies are formed over periods of socialisation, considered durable and slow to adapt, and transposable across a number of fields (Swartz, 1997). Habitus is both structured by its conditions of existence (past and present circumstances) and structuring, perpetuating practice and how individuals or organizations act or behave (Bourdieu, 1980/1990). Although habitus is described as functioning at a subconscious level (Bourdieu, 1979/1984, 1980/1990), it is also described in terms of explaining behaviours (Bourdieu, 1972/1977) and motives (habitus in action) whereby action is strategic and interest-orientated (Bourdieu, 1980/1990; Swartz, 1997).

Within the context of this research, periods of primary socialisation considered by Bourdieu to be responsible for habitus formation (1972/1977) are explored. For example, the shaping of physiotherapists as clinical educators, socio-economic and political influences that shaped the field habitus of the physiotherapy profession, and the influence of organisations responsible for physiotherapy education and healthcare delivery. Attitudes and ideology are further examined from the perspective of individuals and organisations, through behaviours and actions that both structure habitus and are structured by them. For example, Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct (Physiotherapy Board of New Zealand, 2011b) makes explicit that physiotherapists should "willingly engage in teaching physiotherapy practice to physiotherapy students" (p. 20). Individual habitus of physiotherapists in New Zealand is therefore, to varying degrees, shaped by the Physiotherapy Board of New Zealand through the Code of Ethics. Job descriptions which include specific responsibilities of clinical education also shape professional habitus of physiotherapists as employees and culture of the organisation (field habitus).

The durability of habitus is attributed to its origins as deeply internalised dispositions formed primarily through periods of socialisation (Bourdieu, 1972/1977). As habitus experiences new situations or periods of secondary socialisation, it is capable of adapting, however, adaptation is slow and unconscious (Swartz, 1997). Only in situations of crisis where habitus and field are disrupted (hysteresis), for example, only when

financial stakes have been raised (economic capital compromised), will a conscious and rational form of strategising occur particularly in those individuals “who are in a position to be rational” (Bourdieu & Wacquant, 1992, p. 131). In Australia and New Zealand, for example, university based physiotherapy clinics were developed in response to the growing number of students unable to be placed within public and private physiotherapy practices (Higgs et al., 2010). Failure to achieve sufficient clinical hours would compromise graduation and registration, resulting in not only economic repercussions for students, but potentially also for Schools of Physiotherapy; this demonstrates the economic stakes that prompted action.

A mutually constituting relationship exists between habitus and field, that is, field structures habitus, providing the social context; yet habitus shapes the field as a meaningful world. As both fields and habitus are constantly evolving and responding to new experiences (Bourdieu, 1972/1977; 1979/1984), relations are described as dynamic and easily result in mismatching or a time lag before congruence is achieved (hysteresis). By way of example, when physiotherapy education programmes moved to universities, there was a time lag (hysteresis) before staff and the profession adapted to the new field conditions of the university. This mismatching between habitus and field creates a gap between new opportunities that are generated when changes occur within fields and the attitudes and practices that are required to recognise and grasp such opportunities to reposition individuals/organisations within the newly defined field (Bourdieu, 1972/1977). Habitus therefore, does not act alone; it is an on-going and active process (Maton, 2008). It not only perpetuates the conditions under which it is created, it unifies shared perceptions and attitudes and further shapes individual and collective action (Bourdieu, 1980/1990; Swartz, 1997). Habitus therefore, explains the attitudes, behaviours and perceptions that shape action within the social world, such as clinical education and specifically when normal social rules are not explicit (Swartz, 1997). The relationship of habitus and field are therefore, symbiotic; they cannot exist in isolation.

## **Field**

Bourdieu’s concept of field is dynamic, structured though not confined by a boundary and constitutes the social setting in which habitus operates (Bourdieu, 1985, 1980/1990, 1972/1977). Each field constitutes a social world; it is in the field that human activity and interactions are understood and actions (possession of capital, positioning within social world) evoke interplay of power. Knowledge of the social world according to Bourdieu (1979/1984) is “an act of construction implementing schemes of thought and expression” (p. 467). As each field has its own social world, interconnected by individuals,

groups and disciplines, it is the complexity of the many fields which connect clinical education that this study explores. For example, as a unique field in its own right, clinical education is also formed from the overlapping of fields of academia (Schools of Physiotherapy) and physiotherapy practices (public or private physiotherapy practice). It is therefore, sensitive and subject to changes in either field and subsequently, is in a state of constant tension.

Three structural properties constitute fields (Bourdieu, 1980/1990). They are first, arenas of struggle for and control of valuable resources and legitimisation of such resources. Second, positions of dominance and subordination of individuals within fields are based on configuration of capital. It is capital and not individual or collective attributes (*habitus*) that determines positions within fields. Thirdly, that the field itself imposes on individuals and groups located within, that the struggles for capital and hierarchical position, are worth competing for. For example, individuals and groups accept the stakes of struggle and know how to behave in the field (*doxa*, i.e. what is taken for granted) (Bourdieu, 1972/1977).

Physiotherapists who become clinical educators, for example, must accept the value and 'rules of the game' in order to be allowed into the field of clinical education. This 'taken for granted' ideology and behaviour of the field is determined by those already located in the field who create and reproduce the conditions of misrecognition, that is, "the form of forgetting that social agents are caught up in and produced by" (Webb et al., 2002, p. xiv). Field conditions through the interplay of *doxa* as symbolic power mediated by different forms of capital reproduce ideology and behaviours (*habitus*) of individuals and the field itself. Relevant to the field of clinical education, is the acceptance by clinical educators that they abide by the conditions of the field, and other connecting fields in which they are also located, such as, physiotherapy profession, healthcare organisation. The interconnectivity of clinical education with other fields as social spaces, which constitute multiple fields, results in internal and external forces creating constant friction and dynamism, symbolic of a force-field. As fields have no fixed boundaries, they interconnect and as a consequence "change in one position shifts the boundaries among all other positions (Swartz, 1997, p. 124).

The continuous activity of opposing and often unequal forces is driven by the possession of capital, the conceptualization of power which exists and functions in relation to a field (Bourdieu & Wacquant, 1992). Capital can be described in terms of economics (economic capital), communication networks (social capital), status (symbolic capital) and professional knowledge (cultural capital). Struggle and strategy for capital within and

between fields connect the concepts which underpin Bourdieu’s theory of practice. Struggle relates to the pursuit of positioning within the social space (hierarchies); this is dependent on the possession of different volumes and value of capital. Strategy is the “intuitive product of ‘knowing’ the rules of the game” (Mahar et al., 1990, p. 17); it is neither conscious nor calculated. Reproduction strategies allow for positions to be maintained or improved; reconversion strategies, relate to the movements within social space based on the (re)conversion of capital. Examples of struggle and strategy are found in the alignment of the physiotherapy profession with the medical profession (Brook, 1994) to achieve legitimacy. Another struggle for professional credibility, located educational physiotherapy programmes in universities. In both examples, professional habitus was repositioned in fields which allowed for symbolic capital (status) to be negotiated. This highlights the interplay between struggle and strategies in physiotherapy, underpinned by contestation of capital.

## Capital

The concept of capital is integral to Bourdieu’s theory of practice (1979/1984), and also underpins his ‘Theory of Symbolic Power’ and ‘Symbolic Violence’, where possession of capital influences positions of dominance/subordination, value and distribution. Four generic types of capital emerge: economic (money), cultural (redefined later as informational: Bourdieu & Wacquant, 1992), symbolic (status) and social (networks). Types of capital are presented in Table 3.1 and examples are provided which are specific to clinical education in physiotherapy.

**Table 3.1 Types of capital**

<b>Types of capital</b>	<b>Non-specific examples</b>	<b>Examples specific to clinical education</b>
Economic	Salary, budgets, time	Clinician time Payment for clinical placements
Cultural	Culturally valued attributes, skills Physiotherapy specific knowledge	Personal attributes conducive to clinical education Experience, knowledge and skills of clinical education Expertise Post-graduate qualification
Symbolic	Status, autonomy, authority Qualifications	Status and seniority within team/organisation
Social	Communication and social networks	Membership to professional groups, i.e. physiotherapy, special interest groups

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(Source: Bourdieu, 1986; Mooney et al., 2008; Moore, 2008; Swartz, 1997)

Although Bourdieu's primary focus lies with economic and symbolic capital; subgroups emerge including linguistic and scientific capital (Moore, 2008), bureaucratic (Bourdieu, 2005) and political capital (Bourdieu, 1994/1998) applicable to the field in which they are located. Bourdieu's concept of capital extends beyond the Marxist concept of economics, material goods (Swartz, 1997) and capitalism to include cultural and social resources (Crossley, 2008). However, the notion of capital remains closely linked with value of labour, i.e. "capital is accumulated labor" (Bourdieu, 1986, p. 241) either directly in production of goods or indirectly as different forms of embodied labour, for example, time (economic capital), status and qualifications (symbolic capital). Initially, all other capital are disguised as forms of economic capital (Bourdieu, 1986) which Bourdieu described as superior based on its exchangeability and stability as a currency within advanced societies with market economies. For example, cultural capital (knowledge) and symbolic capital (qualifications) represents time (money) spent learning, which is exchanged further for a job (economic capital). In later work, however, Bourdieu (1980/1990) advocated that no one form of capital theoretically dominates over another; although he continued to emphasise the importance of symbolic capital and in particular, symbolic violence (discussed later in this chapter).

Social and cultural characteristics of individual and field habitus influence the value of capital and actions of individuals (habitus in action) directed towards accumulation of capital, and by association, position within fields, i.e. social hierarchies. Capital must exist for fields to have meaning (Mahar et al., 1990), that is, social recognition of the agents/field (Crossley, 2008). Possession of capital governs the social order of individual agents/collective groups within fields and therefore, functions as a form of power and domination (Bourdieu, 1972/1977) applicable at individual and societal levels (Calhoun, 1993). Professional experience and seniority (cultural and symbolic capital), for example, if valued by organisations (field), places individuals high in social hierarchies such as management, where through position recruitment can be influenced. In essence, social relations and practices are influenced by capital, including motives to accumulate capital and hence, positions of influence. Bourdieu holds a "highly stratified view of the social world in which individuals and groups struggle to maintain or enhance their relative

standing within a hierarchically structured social space” (Swartz, 1997, p. 145). Social inequality therefore, is attributable to the unequal distribution of capital (Swartz, 1997) which dominant individuals/groups seek to maintain and withhold from others (symbolic violence) by influencing the configuration, distribution and exchangeability.

Capital, therefore, represents a conceptualized form of power influencing the position (domination and subordination), relationships of agents/groups within fields (Bourdieu, 1986, 1980/1990) and the resultant tension as agents compete for capital. This tension is perceived as a natural occurrence and a dynamic interplay between agents (Bourdieu, 1972/1977) such as clinical educators and stakeholders in clinical education as they compete for capital, social positioning and power within the field/s in which they are located. Dynamic interplay and negotiation of capital within fields by individuals describes capital as power and powerful in further defining individual and field habitus. The outcome of the relationship between habitus, capital and field is practice which within the context of this research, includes the practice of clinical educators, physiotherapy profession and organisations including education and physiotherapy practice providers.

## **Types of capital**

### **Economic capital**

From a Bourdieusian perspective, economic capital transcends monetary exchange and economics and represents not only material wealth, but also disguised forms, for example, time. Economic capital underpins all other types of capital, converting more readily into other forms of capital than vice versa and considered easier to manage (Swartz, 1997). Whilst reductionist in nature, the exchangeability is dependent on the maturity of the society and economic market compared to those based on tradition. With respect to clinical placements, Schools of Physiotherapy fund physiotherapy practice providers for clinical placements. This represents an exchange between organisations of economic capital (money) for cultural capital (professional practice knowledge). The location of physiotherapy practice within wider fields of healthcare has shifted the physiotherapy profession away from its vocational roots into a world influenced by commercialisation, commoditization and consumerism (field habitus). Tension between vocational and commercial value of clinical placements is evident in the literature (Chapter Four) and the findings stemming from this research (Section Three).

### **Cultural capital**

Bourdieu’s concept of cultural capital as power, highlights the subtle and often subliminal ways in which attributes, such as language and knowledge, shape social

positioning and relations within a field(s). Cultural capital focuses on the way power structures are reproduced and creates and reinforces cultural and underlying social distinctions (class inequalities). The acquisition of embodied cultural capital is gained through, and over, a similar period of socialisation as habitus (Moore, 2008). Cultural capital as physiotherapy professional knowledge is gained through physiotherapy education and professional socialisation. As such cultural capital facilitates the move from one social position to another (unqualified student to qualified physiotherapist) and perpetuates social hierarchies where membership to a professional group is based on knowledge (cultural capital). Cultural capital is therefore, recognised as a form of power (Swartz, 1997), shaping interactions through inclusion and exclusion from groups, and underpins social/class inequality. Tensions arise when the same or similar cultural capital is allocated different values within the same or interconnecting fields. Within the field of clinical education, value of clinical educators and their skills do not compare with discipline-specific skills such as clinical skills, which are considered more valuable. More recently in the United Kingdom, accreditation schemes (Chartered Society of Physiotherapy, 2004) have been established to recognise and value the knowledge and skills of clinical educators and in doing so, allocate cultural capital exchangeable for status and recognition (symbolic capital). Examination of these inequalities is examined in the literature (Chapter Four) and findings of this research (Section Three).

Origins of inequalities resulting from different value of cultural capital may be attributed to cultural capital existing in three forms: embodied, objectified and institutionalised. Embodied cultural capital represents ideology and practices attributable to a specific group, i.e. physiotherapy, gained through socialisation and recognised and appreciated by other agents (Swartz, 1997). However, Bourdieu advocated that embodied nature of cultural capital serves to “naturalise and disguise forms of social disadvantage and their reproduction” (Crossley, 2005, p. 31). Objectified cultural capital exists as material representations (physiotherapy books) or non-material as in clinical education and physiotherapy practices that are identifiable as normal by the group and others, and unique to that professional group. Institutionalised forms of cultural capital exist in the form of a collection of practices such as physiotherapy training accepted as normal within a specific field. The educational system depicts an institutionalized form of cultural capital which Bourdieu believes plays an increasing role in the “allocation of status in the advanced societies” (Swartz, 1997, p. 76). The possession of cultural capital within this form influences the social trajectory of the individual; jobs/roles/positions are only available to those who possess the desired type and volume of cultural capital. Forms of

cultural are presented in Table 3.2 and examples provided specific to clinical education in physiotherapy.

**Table 3.2 Forms of cultural capital applied to clinical education in physiotherapy**

<b>Embodied</b>	<b>Objectified</b>	<b>Institutionalised</b>
Knowledge skills specific to physiotherapy and clinical education, i.e. knowledge of learning styles, assessment processes	Equipment specific to physiotherapy, e.g. goniometer, books, practices of clinical education including assessment, providing feedback	Formal training of physiotherapy and clinical education Qualification, i.e. university degree, post-graduate certificate in clinical education

### **Symbolic capital**

Symbolic capital exists in material and non-material states which signify an intrinsic value. Described as “the most powerful form of accumulation” (Bourdieu, 1972/1977, p. 179); it is in this form that other types of capital are recognised (Mahar et al., 1990). For example, the title and status of a university lecturer (symbolic capital) represents years of study and knowledge (cultural capital) legitimised by fields of academia, relevant profession and society. The value and associated power of symbolic capital lies in the social/legal recognition and legitimization (Bourdieu, 1985). If unrecognised, symbolic capital can be “denied” and “misrecognized” (Bourdieu, 1980/1990; 1972/1977), thereby holding little value compared with other forms of capital. Symbolic capital not only differentiates social distinctions and differences within fields, its value may not be directly transferable across other fields, whose individual and group habitus fails to recognize (and legitimise) its value or does not possess other forms of exchangeable capital. Inherent qualities, prestige, status, are all legitimized as symbolic capital; they are not associated with years of study or experience.

### **Social capital**

Social capital represents social networks and connections (Bourdieu, 1979/1984), and in an embodied form represents respectability. Described in the context of social relations, social capital influences the ability of individuals and organisations to advance their own interests (accumulate capital) through social position. Social and cultural capital are closely aligned compared with economic capital (Swartz, 1997). Respectability (social capital), for example, may be gained through seniority and experience (cultural capital), but may not always translate into economic capital. Social networks however, may open opportunities for advancement (accumulation of capital) including, as described by some participants in this research, opportunities to guest lecture on physiotherapy programmes. Social capital therefore, is mobile, connecting fields of clinical education with Schools of Physiotherapy. Another example of the interconnectivity of social capital

with other forms of capital includes membership to groups including the physiotherapy profession. Membership is determined by educational criteria (cultural capital), and results in qualification and recognition (symbolic capital) and access to new social networks (social capital). Whereas social capital represents networks and communication, it is through cultural capital that the value of social capital is mediated, for example, networks connecting physiotherapists such as special interest groups in physiotherapy.

### **Other forms of capital**

Key concepts of economic, cultural, social and symbolic capital dominated early work of Bourdieu; however, in later work other forms of capital were described. These are summarised below.

Linguistic capital is language specific to a group or organisation, recognised as unique and used to reproduce social relations and hierarchies. Linked with social distinction by class (Bourdieu & Passeron, 1970/1977), it is implicit in curriculum and conversations of teaching staff and differentiates staff from students (Collins, 1993). Language therefore, represents a means by which dominant classes determine and self-perpetuate the educational system. Terminology unique to physiotherapy presents linguistic capital, attributed to membership of the profession (symbolic capital).

Bureaucratic capital exists in two forms (Bourdieu, 2005): bureaucratic capital of experience and technically-based bureaucratic capital. The former represents the team leader's knowledge of staff which is accumulated over time, whilst the latter refers to knowledge of the processes/policy which can be gained more quickly. Tensions exist between those who possess either form of capital: one where knowledge accumulated through experience and seniority is valued differently to technically-based bureaucratic capital, the other where knowledge is more readily accumulated and whose motives are more competitive in terms of knowledge, efficiency and objective productivity (self or product).

Scientific capital consists of "instruments of defense, construction, argument" (Bourdieu & Wacquant, 1992, pp. 183). Bourdieu (1982, pp. 25-26, cited by Bourdieu & Wacquant, 1992), spoke of the dominance of those in possession of scientific capital compared with those who are "deprived scientifically". As a social class, they create alliances with those who have "external powers" (p. 25). This extends their dominance. By way of example, to address the imbalance of academic research (Brauer, 2003) and quantitative research (Gibson & Martin, 2003), clinicians are encouraged to contribute to

the profession's knowledge-base. However, the challenge for clinicians as noted by Brauer (2003), editor of *Physiotherapy Research International*, "is to ensure that clinician-led research is of sufficient quality" (p. iii). This infers that the standard of research (scientific capital) cannot be diluted and clinician-generated research must meet the standards of the journal and profession. Scientific knowledge emerges as highly valued within the profession as evidence based practice and perpetuated by other agencies such as the Tertiary Education Commission.

Political capital, although not directly acknowledged, is described in terms of political and bureaucratic fields (Bourdieu, 1981 cited in Bourdieu & Wacquant, 1992) in relation to socially constructed problems and public policy and political struggle (Bourdieu, 2005) amongst agents relative to the organisation in which they are employed. Critics of Bourdieu's work (Harker, 1990; Moore, 2008; Shusterman, 1999; Swartz, 1997, Webb et al., 2002) focus on the four dominant forms of capital. Others have interpreted political capital as "position, ranking, hierarchy, credibility, law, policy" (Jones, 2000, p 46) or inferred political capital which complements symbolic and cultural capital and is integral to designated positions and status of professional qualifications (Mathias, 2009).

Meta capital exists in the form of accumulated capital which establishes and reinforces the position of dominance within any complicity of others (Bourdieu & Wacquant, 1992). Physiotherapy managers through their position within organisations have delegated authority, that is, they are entrusted with the entirety of the capital owned by the group (physiotherapy staff). In effect managers have been elected by the group (district health board) through their accumulation of experience (cultural capital), seniority and status (symbolic capital). The accumulation of meta-capital under the guise of delegated authority can readily be converted into political power which they are then able to exert on other agents within the same field. Subordinate agents perceive the actions of those in authority to be in their best interests, therefore, reproduce and maintain domination by the agent. Little effort is subsequently required by dominant groups to maintain this status quo (Schubert, 2008). Interrelated to the concept of meta capital are the supporting concepts of doxa, misrecognition.

## **Supporting concepts**

Doxa, misrecognition and symbolic violence collectively underpin Bourdieu's key theories as applied to this research. Bourdieu's principles of differentiation and distinction which influence the configuration of capital are also considered.

## **Doxa and tradition**

Doxa is characterised by a taken for grantedness which is accepted as inherently true (Webb et al., 2002) by individuals located within a specific field. As a symbolic form of power, doxa exists where “tradition is silent, not least about itself as tradition” (Bourdieu, 1972/1977, p. 167) and is reproduced in the ideology and behaviours of individuals (habitus) who do not challenge the often invisible field conditions (field habitus). Expectations, behaviours and ideology are defined by doxa as necessary to obtain and maintain a place in the field (Bourdieu, 1972/1977), and determined by those in a position of dominance based on accumulation of capital, whose position legitimises their ability to manipulate doxa to their advantage (Webb et al., 2002). The mutual interplay between habitus, capital and field underpins social relations and practices, embedded in the traditions of organisations such as universities and district health boards. Consequently doxa, as well as habitus, capital and field, will form part of the analysis when examining the interplay of power in clinical education. ‘Shared beliefs’ and doxic attitudes of clinical educators will be analysed to reveal unconscious submission to field conditions such as clinical education in physiotherapy. Traditions associated with individual and organisational cultures will also be explored to reveal the presence and interplay of symbolic power.

## **Misrecognition and symbolic violence**

Misrecognition (and doxa) constitutes forms of social structuring and conditioning of agents within fields. This is enhanced by ‘traditions’ of practice, such as, social rules and taken for grantedness which agents accept without question, and perceive as ‘normal’ and ‘natural’. However, symbolic and economic capital are manipulated to protect the position and hierarchical ranking of dominance. Legitimised through symbolic systems (Swartz, 1997) such as language (Bourdieu, 1972/1977), shared values and belief systems are manipulated as symbolic violence, i.e. a “violence which is exercised upon a social agent with his or her complicity” (Bourdieu & Wacquant, 1992, p. 167). It is misrecognition by subordinate agents of the actions of dominated agents that perpetuate the silent nature and ‘taken for grantedness’ of symbolic violence and underpins Bourdieu’s theory of symbolic domination and violence (Webb et al., 2002).

Habitus plays a crucial role both in the action of dominant agents and also the misrecognition of subordinate agents. As a set of internalized dispositions which explain how agents have become ‘themselves’ and practice (Webb et al., 2002), habitus also defines the social position and trajectory of agents within fields (Bourdieu, 1979/1984). Dispositions (habitus) predisposes agents to accept their field position and determine a

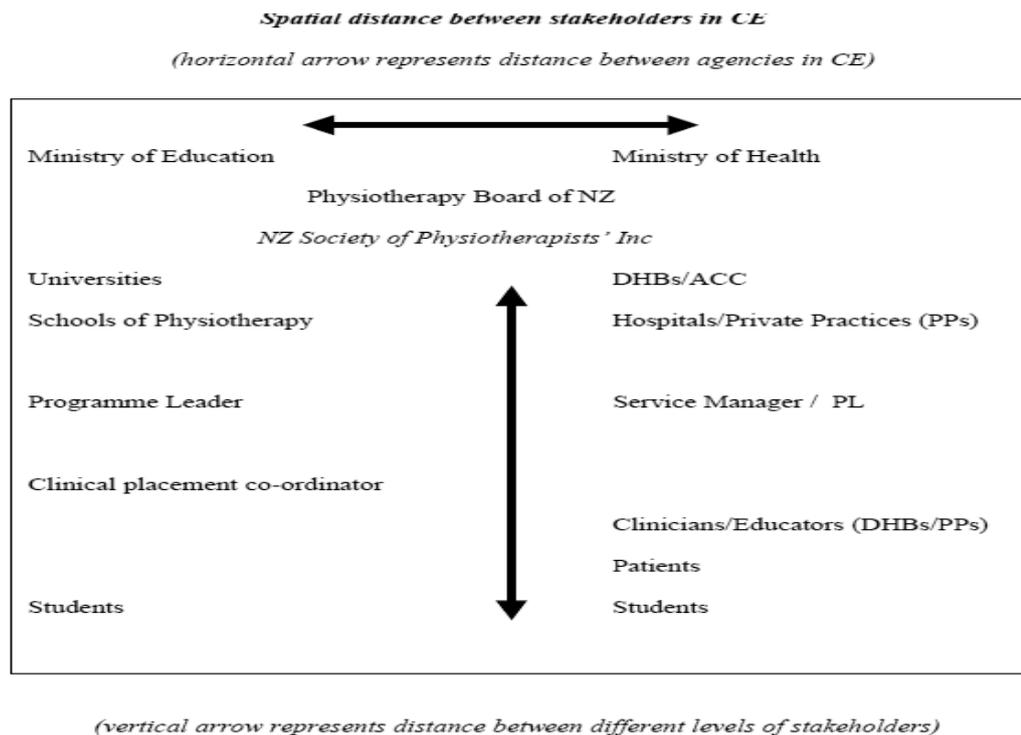
trajectory that is in keeping with other similarly positioned agents; however habitus does not explain agents' predisposition to submission or overt obedience to rules (Bourdieu, 1972/1977).

Bourdieu (1972/1977) justifies symbolic violence as a necessary system of domination in pre-capitalist economies in order to establish, maintain and restore domination within fields. Strategies include the establishment of personal dependence of subordinate agents on dominant agents, manifested as "confidence, obligation, personal loyalty" (Bourdieu, 1972/1977, p. 192), that is disguised forms of power exerted over "euphemized" (p. 191) subordinate agents. Such agents are usually 'willing' and 'interested' participants in the system (Bourdieu & Wacquant, 1992); this reinforces their subordinate position and inhibits their social trajectory. Institutionalised mechanisms and social structures within fields reproduce symbolic violence through the complicity of the whole group. Within the context of this research, the views of stakeholders such as managers, professional leaders, academic staff and representatives of professional bodies were obtained to explore the traditions, practices and distribution (and withholding) of resources within clinical education which may otherwise be misrecognised.

### **Principles of distinction and differentiation**

Bourdieu's principles (1994/1998) denote that the volume and structure of different types of capital determines the location and social order of individuals or organisations within a field relative to each other both horizontally and vertically. Distinction refers to the positioning of social groups relative to each other; spatial (social) distances between individuals resulting in tension (Bourdieu, 1994/1998). Differentiation relates primarily to forms of capital which determine how groups are positioned in social hierarchies. Configuration of capital influences the hierarchical position of individuals relative to each other; less tension and conflict exists when capital is of equal value. Within the field of clinical education, clinical educators possess large volumes of cultural capital (professional knowledge and skill), social capital (social networks), symbolic capital (status in team) and economic capital (salary), compared with students who are also positioned within the same field. Figure 3.3 presents the application of Bourdieu's

principles to clinical education in New Zealand (Mooney et al., 2008, p. 62).



(Source: Mooney et al., 2008, p. 62)

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**Figure 3.3 Application of Bourdieu’s principles to clinical education in New Zealand**

As can be seen in Figure 3.3, relative to each other, clinical educators are ranked higher in social hierarchy compared with students. In contrast, newly qualified physiotherapists possess less capital compared with senior staff, but more than students. Less tension exists between students and newly qualified staff due to less spatial distance determined by cultural capital (Mooney et al., 2008).

### **Bourdieu’s methodological framework and application to this research**

As described to date, Bourdieu provides an eclectic, positive yet critical frame to the study of the interplay of power as perceived by New Zealand clinical educators in physiotherapy. The complexities of individual, organisational and professional practices are examined using Bourdieu’s key concepts of habitus, capital and field to reveal how power is obtained and used within social hierarchies, overtly and covertly. Additionally, relationships and cultures are explored to reveal socio-economical and political influences that have shaped clinical educators and stakeholder perceptions.

Bourdieu's methodological framework (Bourdieu, 1979/1984; Bourdieu & Wacquant, 1992) represents three layers of interaction between habitus and field (Grenfell, 2008d) in which capital is contested. Level one focuses on clinical education as a field in relation to other fields which through their overlapping constitute clinical education (education and physiotherapy practice providers, for example) and wider fields of power, i.e. physiotherapy profession. Configuration and distribution of capital is examined in level two, exploring how capital shapes social hierarchies and in particular, positions of influence (domination over subordination). Individual and field habitus are explored in level three to expose ideology and professional trajectory of individuals and organisations in relation to clinical education.

As will be demonstrated in Chapter Five (Research Procedures), Bourdieu's theories, concepts and framework allows for the genesis of the person, social structures and groups to be described and analysed (Bourdieu, 1985), grounded in everyday life and the socio-economic and political influences that have both structured and been structured by them. The methodology accommodates the dynamic tension which Bourdieu perceives as fundamental to everyday life in the form of agent and field connections, the social positioning of agents and the possession of capital. The reflexive stance advocated by Bourdieu, also allows the bias and dispositions brought by the research to the subject area to be captured; this is essential based on the close proximity of the researcher to the subject area.

According to Grenfell (2008b) "everything we know about the world is both established and developed as a consequence of individual acts of perception" (p. 45); perceptions are symbolic of the way habitus has been shaped. It is therefore, appropriate that this research explores the interplay of power through the perceptions of clinical educators, contextualised by the perceptions of stakeholders in clinical education. The unique aims of this research and application of Bourdieu's framework contribute towards the originality of research within the scholarly field and improved understanding of the complexities of clinical education.

## **Chapter summary**

This chapter has justified Bourdieu's philosophy and framework as relevant to this research. As demonstrated, his theories provide a framework for exploring power interplay and the complexities of clinical education in physiotherapy. Ultimately change is achieved through the reconfiguration of capital. The next chapter critiques relevant literature through the lens of Bourdieu and specifically explores how tension and power

interplay manifested through the relationship of habitus, capital and field, and Bourdieu's other supporting concepts and theories.

## **Personal reflections**

*Reflecting on the decision making processes which led me to locate my research in the critical paradigm and use Bourdieu to guide the methodology and analysis, there were many factors to consider. As described in the introduction, my personal and professional impetus to understand the complex and multi-dimensional demands on clinical educators presented two options. Phenomenology would provide a deep understanding of the experience of being and living as a clinical educator, whereas critical/radical paradigm would seek to not only understand their world, but to change it. In the majority of research in clinical education (physiotherapy), there was a noticeable absence of philosophical frameworks. What was more visible was the significant body of research driven by motives to increase placement capacity, with authors commonly employed at Schools of Physiotherapy. Also of note, was the paradox between evidence based practice and the scarcity of research into aspects of clinical education, especially in New Zealand; yet student education was embedded in core clinical competency and ethics documents of the Physiotherapy Board of New Zealand.*

*Whilst both phenomenology and critical perspective would have provided a unique insight into the world of clinical educators, my reflections led me to consider the purpose of my research and desired outcome. My decision therefore, to frame this research in the critical/radical paradigm was based on two key reflections. First, quantitative research dominates physiotherapy journals with a slow emergence of qualitative research; phenomenology would be too removed from the 'psyche' of most physiotherapists, the very population I wished to target. In my opinion, physiotherapy as a profession was still coming to terms with the value of qualitative research, and therefore, may not embrace or value phenomenology. Therefore, to optimise my target population, the critical perspective, in my opinion, was more congruent with physiotherapists and the physiotherapy profession. Second, reflecting on the purpose for undertaking this research, I considered the desired outcome. What could I do with the new knowledge and insight gained from examining the power interplay in clinical education? I wanted to use the knowledge to transform the attitudes, practices and cultures of physiotherapists and organisations towards clinical education. I wanted to evoke change. This clear motive consequently located the research in the critical paradigm.*

*The next decision to identify a philosopher was made more easily through reading and discussing different philosophers with peers and academic staff. My intention was always to adopt a 'positive' (not positivist) approach and Bourdieu's premise of the inevitability of*

*social tension and conflict in societies resonated well. It meant that I could explore the social world of clinical educators and clinical education knowing that tensions and power interplay were to be expected, and using Bourdieu's framework, such tensions could be explored and understood. Additionally, the eclecticism of Bourdieu's work as a philosopher, anthropologist and sociologist had both relevance and interest to my research, for example, social hierarchies, culture and societies including education. The multidimensional approach provided both the opportunity and process to explore power dynamics and interplay through the perceptions of clinical educators, contextualised by stakeholders in clinical education. A further and important consideration in my choice to underpin my research with Bourdieu was the reflexive stance advocated by Bourdieu to achieve a level of participant objectification. Given my current role as team leader, clinical educator and researcher (of clinical education), it was important to me that I could sufficiently distance myself from the world of clinical educators and clinical education which I was immersed in on a daily basis. I could explore my position relative to the subject area through the use of the same conceptual tools, enhancing my objectivity complemented by peer and supervisor discussion.*

*Throughout the research process (socialisation and habitus formation as a researcher), these key considerations have shaped how I read and reviewed articles, and were integral to conversations with peers embarking on research, that is, what is the purpose of your research – elicit change (critical/radical paradigm), who is your target audience and how best can you optimise the impact of your findings on the audience?*

*Irrespective of the clinical speciality, location or whether clinical educators worked in public or private practice, Bourdieu provided critical theories to explore their social world and structures of domination which created power interplay, social tension and friction. Such theoretical frameworks allowed me to understand and make recommendations for change; ultimately transforming the practices and culture of individuals, organisations and the profession. In essence, using Bourdieu's concepts, new knowledge and understanding generated by this research, reconfigures capital within organisations and the profession (fields), and from the perspective of clinical educators (habitus), redefines their value (symbolic capital) within organisational and professional hierarchies.*

## **CHAPTER FOUR**

### **Critique of reviewed literature**

#### **Chapter overview**

The purpose of this chapter is to critique literature relevant to clinical education in physiotherapy. Literature will be examined through the lens of Bourdieu for evidence of overt and covert, explicit and implicit tensions and power interplay between clinical educators and associated stakeholders. In particular the critique focuses on the consequences of power interplay through its impact on clinical educators, both present and future. The current research is then justified within the context of the literature and gaps identified therein. Boundaries of this review are also acknowledged. A reflective statement concludes this chapter exploring dimensions from a personal and professional perspective.

#### **Review process and presentation**

Literature was retrieved using databases that cover health sciences, medicine and education, including Medline, Cinahl and PubMed. 'Keyword' searching included words relating to clinical education, physiotherapy and Bourdieu. Searching was further expanded using electronic search systems and complemented by hand searching. Additionally, attendance at conference presentations generated useful references which are appropriately referenced as published or unpublished material or personal communications.

New Zealand specific literature regarding clinical education is limited; it was therefore, necessary to draw from other countries and disciplines. Where extrapolation from other sources has occurred, relevant differences are highlighted. Moreover, given the paucity of relevant literature, the over reliance on key published papers and books is acknowledged.

Several dominant themes and 'eras' of publications relating to clinical education in physiotherapy are noted. For example, in the late 1990s/early 2000s, the most significant body of literature related to increased student capacity; this coincided with the move of many Schools of Physiotherapy into universities and subsequent growth in student numbers and demand for clinical placements (Potts, 1996). Additionally, economics emerged as a theme encompassing research evaluating the cost impact of students (Bristow & Hagler, 1994; Ladyshevsky et al., 1998), and prompted by increased Government funding in the United Kingdom, an evaluation of different models of clinical

education (Moore et al., 2003). Following this wave of research, another key feature was education pedagogy, physiotherapy knowledge and student learning (Cole & Wessel, 2008; Higgs & Tichen, 2001; Jones & Sheppard, 2008; Kell & Jones, 2007). More recently, research has included perceptions of clinical educators (Davies, Hanna, & Cott, 2011; Öhman et al., 2005; Sevenhuysen & Haines, 2011), quality issues (Langford, Gilchrist, Holland, & O'Sullivan, 2008; Morris, 2007), student and new graduate preparedness for practice (Higgs, Hummell & Roe-Shaw, 2009; Roe-Shaw, 2004, 2003), and re-emergence of research investigating the economic consequences of students in the workplace (Haines, Isles, Jones, & Jull, 2011).

As described in Chapters Two and Three, Bourdieu's framework consists of three levels of analysis between the interaction of habitus and field. Analysis is acknowledged as dynamic and levels are interconnected; this is reflected in the critique of reviewed literature. Thus while literature is discussed as three themes under separate headings, cross referencing between themes occurs. This is highlighted where appropriate.

The literature is discussed under three themes which represent dominant bodies of literature relevant to the research context. Theme one relates to literature regarding evaluation of student and placement capacity i.e. different models of clinical education, and economical consequences of students. The second theme encompasses the quality of clinical education which is examined through the body of literature capturing patient, student, academic staff and clinical educator expectations and experiences, and how these impact on clinical educators. Concepts of consumerism underpin this theme. The third theme describes education pedagogy as isolated from the identity, knowledge base and role of clinical educators. The value of education pedagogy compared with clinical or speciality knowledge and skills was found to be reduced resulting in tension and conflict that impacted on clinical educators and stakeholders, relationships and student learning experiences.

## **Student and placement capacity**

Student placement capacity emerged as the dominant theme amongst the body of available literature related to physiotherapy clinical education. Research promoted an increase in student placement capacity through the evaluation of different models of clinical education, and marketed the positive economic consequences of students in the clinical workplace. These topics are further discussed.

## **Different models of clinical education**

The need to increase clinical placements was noted as “critical” (Baldry Currens & Bithell, 2003, p. 204) and “an increasing problem” (Moore et al., 2003, p. 489) with calls for innovative solutions to address placement shortages (Baldry Currens, 2003). Evaluation of the motives to increase placement capacity were linked with increased Government funding allocated to meet projected workforce shortages (Moore et al., 2003) and growth in Schools of Physiotherapy (Crosbie et al., 2002). Less visible motives included the need to shift towards more contemporary learning experiences for students (Ladyshewsky et al., 1998) and away from traditional master:apprenticeship models of learning, and generating a body of evidence to support alternative models (Baldry Currens, 2003; Baldry Currens & Bithell, 2003; Moore et al., 2003; Stiller et al., 2004) within the climate of evidence-based practice.

Motives as habitus in action (Swartz, 1997) represent actions that are interest orientated and directed towards opportunity to improve hierarchical position. According to Bourdieu, interest orientated action is legitimised and more efficacious when its true interests are disguised: “The most profitable strategies are usually those produced, on the hither side of all calculation and in the illusion of the most ‘authentic’ sincerity” (Bourdieu, 1972/1977, p. 214). In literature relevant to clinical education, some of the economic motives are described in relation to Government relocation of funds and the need to meet projected workforce numbers. However, what is covert is the economic benefit to Schools and universities of increased student numbers. Economic capital and symbolic capital (status) are enhanced through increased student capacity, albeit inherently linked with increased student numbers. Additionally, more productive models of clinical education may covertly disguise reduced outgoings of Schools if funding is not based on a per student model. Tension and conflict is revealed through the dependence of Schools on clinical placement providers; clinical education being the only part of physiotherapy programmes where universities have little control compared with other components of the curriculum (Cross, 1995).

Evaluation of three different models of clinical education that is ratio of student: clinical educator (1:1, 2:1 and 3:1) by Moore et al. (2003) compared advantages and disadvantages from the perspectives of 48 students and 8 clinical educators. Four managers and four university tutors who normally visit the study sites were also interviewed. A preparatory workshop was undertaken prior to interviewing. This included practical advice regarding facilitating student learning in different models. The 2:1 model was recommended based on least impact on resources and optimal impact on

shared student learning. While comparable advantages were made between 2:1 and 3:1 models, increased student numbers impacted more on clinical educator time in terms of supervising students and sufficient patient numbers. Managers perceived the benefit of increased student numbers in their departments; however, academic staff were concerned about the implications of placement cancellation. Both managers and academic staff as stakeholders described dominant interests which can be translated into economic consequences. The influence of students in departments may infer positive impact on recruitment and retention (economic and cultural capital), while cancellation of placements would result in time (economic capital) to secure replacement clinical placements. The impact on students is invisible from the perspectives of both stakeholders; however, clinical educators spoke of the impact of different models from their perspective and that of the student. Of note was that collaborative learning relationships were better facilitated in 2:1 model, with optimal use of clinical educator time, which was often stretched due to additional responsibilities. Demands on clinical educator time (economic capital) were contested from the perspective of additional responsibilities and meeting student and School expectations to provide supervision and feedback.

Similar findings were mirrored by 34 clinical educators and 59 students from 12 United Kingdom National Health Service Trusts in research by Baldry Currens and Bithell (2003). Additional findings include success of 2:1 models when clinical educators delegated 50% of their caseload to students, and the hesitancy and reservation of clinical staff regarding perceived difficulty in managing different student abilities. No preparatory workshop was described which may otherwise have negated these concerns by reshaping habitus and providing necessary facilitatory skills (cultural capital). The reluctance of clinical educators to delegate patients to students may represent deeply embedded dispositions as habitus, whereby professional identity is strongly associated with direct patient contact. A shift in practice requires habitus to be reshaped through secondary socialisation, such as clinical educator workshops. Failure to reshape habitus could otherwise result in continued tension between the clinical and educational identity of clinical educators, resulting in persistent imbalance between the multiple demands on clinical educators.

In contrast to evidence supporting different models of clinical education, Stiller et al. (2004) found that a shared responsibility for a clinical education model was more established in 76 health units in Australia. However, findings indicated a preference for employing a dedicated clinical educator, stating reasons of improved consistency of

supervision and assessment, and reduced staff stress. Quality issues associated with clinical education are further discussed under theme three. It is noteworthy that there was no significant difference between respondents who had experienced both models compared with only one model. This infers that the 1:1 model, albeit based on perception or experience, is deeply embedded in the habitus of clinical educators and health units.

Despite evidence to support different models of clinical education namely 2 students:1 supervisor (2:1 model), legitimised by professional bodies such as Chartered Society of Physiotherapy (CSP) in the United Kingdom, the continued reluctance of clinical educators to adopt this model is significant. Baldry Currens (2003) reviewed 10 papers addressing 2:1 models of clinical education in physiotherapy and occupational therapy. Although a variety of authors, academic institutions and countries (namely Canada, United States of America and United Kingdom) were represented, sample sizes were small, often restricted to one academic institution, and timeframes of evaluation were limited. Final recommendations of 2:1 model were made based on confirmation from two or more studies, and on balance of practical, service, resource, and learning considerations.

Similar criticisms of research were made by Lekkas et al. (2007) who evaluated different models of clinical education internationally and in five different health disciplines. Of the 61 studies reviewed, 53% related to the discipline of physiotherapy in four countries: United Kingdom, United States of America, Australia and Canada. Six broad models of clinical education were identified within the systematic review of English language research published since 1980. Few randomised controlled trials were found compared with qualitative studies which explored different models of clinical education and the experiences of participants. Inconclusive evidence to support one model over others was concluded however advantages and disadvantages of models were highlighted and recommendations made. For example, a review of literature advocating one educator to one student model, albeit predominantly reviewed from physiotherapy literature, identified advantages of individualised student support and guidance with no adverse impact on department productivity. Clinical educators considered this relationship less demanding compared with other models. Disadvantages were cited as fostering “passive dependence” (p. 24) on the clinical educator with no value on peer or collaborative learning. The additional impact on clinical educator time was also duly noted. In contrast, multiple students: one educator model was found to have a positive net impact on service delivery, and was considered more favourable by students promoting active and collaborative learning. Disadvantages included increased stress and time demands on clinical educators, students concern over adequate supervision and competitiveness

between students. Of note, is the recommendation that such models of clinical education require preparation of clinical educators to facilitate peer and collaborative learning. Finally, multiple students:multiple educators as a model of clinical education was found to positively promote student autonomy and placement capacity. Clinical educators, however, noted the role to be time consuming and demanding, with a high risk of fragmentation of student learning. Recommendations included improved collaboration between stakeholders and “thorough preparation of the fieldwork setting” (p. 25).

Lekkas et al (2007) also noted higher quality research publications found “mostly equivocal findings, whilst lower quality publications unanimously supported the models they explored” (Lekkas et al., p. 26). From a Bourdieusian perspective, conclusions supporting the model of clinical education under scrutiny protect the dominant interests of the researchers who were found to be employees of academic institutions (Baldy Currens, 2003; Ladyshevsky et al., 1998; Moore et al., 2003).

Research promoting different models of clinical education centred on improving the student experience and promoting collaborative learning models (Ladyshevsky, 1993). Benefits to students and clinical educators were marketed overtly in research, as improved use of clinical educator time, peer learning and support, and improved clinical competence (Ladyshevsky et al, 1998; Triggs Nemshick, & Shepard, 1996). Benefits were off-set against increased demand on time due to administration and assessment requirements, or the challenge of working with students of differing abilities. Such evidence creates important marketing tools for Schools to promote different and more productive models of clinical education to stakeholders as providers of clinical education. Theme two examines the tension between creating the evidence and recommendations for change, and managing change through translation of evidence into practice.

More implicit tensions are also revealed in the non-compulsory requirement of physiotherapists to engage in clinical education. Reliance of Schools on the ‘good-will’ of physiotherapists (McMeekan, 2008; Sevenhuysen & Haines, 2011) to become clinical educators, and on organisations not to enforce clinical education as a professional obligation, was a dominant source of tension for Schools. This impacted in particular on the capacity of placements. Although respondents in a study by Sevenhuysen and Haines (2011) found that clinical education was perceived as a core role of physiotherapists with the dominant motivation “consistently reported as duty or responsibility” (p. 66); one respondent noted that the role was forced on him or her irrespective of the advantages noted by all respondents on professional development. Other research supports self-selection of physiotherapists as a dominant motivator in becoming clinical educators. This

echoes findings by Kell and Jones (2007) where external motives namely organisational expectation, internal (self-initiated) and mixed motives where initial external motives become internal, were found to influence engagement of clinical educators in student learning.

Personal attributes and an interest in student learning were found as key attributes (habitus) of clinical educators (Cross, 1995; Kell & Jones, 2007). Concerns were raised by Öhman et al. (2005) that a dilution of the quality of clinical education would result if clinical education was a compulsory requirement of all physiotherapists. Clinical educators valued themselves and their roles in clinical education compared to other stakeholders and therefore, sought to protect their role and status (symbolic capital). Tensions were described between the ability of clinical educators to provide quality clinical education to a large quantity of students (Sevenhuysen & Haines, 2011). In addition, tensions were evident between clinical educators and stakeholders, including managers, who failed to respond to staff shortages and concerns of clinical educators (Öhman et al., 2005). This represents symbolic violence where there is evidence that the voices of clinical educators are ignored. The inability of clinical educators to influence change was also described; this may infer lower social status in organisational hierarchies and limited possession of capital. This is further examined under theme two.

Evidence to date supporting increased placement capacity has focused on impact of different models on clinical education on clinical educators and students, stakeholder and service delivery. In particular, research has centred on the views of clinical educators, with outcomes marketable to managers. The culture of teams and organisations (field habitus) was found to be an important factor in the engagement of physiotherapists in clinical education (Davies, et al., 2011). Clinical educators in a study by Baldry Currens and Bithell (2003) wanted recognition and value by healthcare and education organisations, the absence of which was found by Gibson and Hauri (2000) to negatively influence nurse engagement in clinical education. This emerged as a covert theme in results which explored barriers of physiotherapists to engaging in clinical education. While a positive culture of clinical education within teams/organisations may result from a collective of individual clinical educators (social group/class), further influence can result from managers and professional leaders who due to their hierarchical ranking in organisations determine field conditions and habitus formation. The next body of relevant literature critiqued considers how Schools have marketed the economic benefits of clinical education to stakeholders such as managers, whose interests are predominantly economic.

## **Economic consequences of students**

In times of fiscal constraints, increased demand on services, and consumer expectation, a further body of literature has evaluated the benefits of students in the workplace in terms of increased productivity, consumer satisfaction, and reduced waiting times. Student deployment in teams and departments as a strategy to mitigate these issues suggests that Schools of Physiotherapy (field habitus) are utilising opportunities to optimise placement capacity.

Evaluation of literature pertaining to the economic consequences of students reveals a small number of publications which describe direct economic benefits (financial reward) for clinical educators. However, the larger body of literature relates to the impact of students on service productivity.

Reward (economic capital) was described for clinical educators and organisations (Gwyer, Barr, & Talmor, 1982). However, rewards were also presented as symbolic and social capital, when described in terms of title, access to workshops and links with Schools of Physiotherapy. Although in speech and language therapy (Rose, 2005), lack of monetary compensation was highlighted as a barrier to clinical education for individual clinical educators, who adopted the role in addition to clinical responsibilities. The dearth of subsequent literature relating to direct financial benefit to clinical educators and the focus of non-financial benefits suggests that funding has become invisible. Bourdieu's concepts of *illusio* and *doxa* disguise the taken for grantedness of this accepted practice for clinical educators which is further legitimised by governmental and professional approval.

There are cost implications with the provision of any service. These may be in terms of "physical, temporal, emotional and monetary costs that, in the extreme, can deplete the participating human and organisation systems" (Hagler, 2005, p. 37). Irrespective of these costs, benefits to the same individual or organisation may mitigate the costs and yield longer term investments. Of the literature critiqued, conclusive evidence was found that students mitigate costs of clinical educator time and positively influence productivity within the workplace.

Economic evaluations are often undertaken from the perspective of specific stakeholders (Haines et al., 2011) whose motives (*habitus in action*) may reflect the evaluation tools and costs selected. Without undermining the useful contribution of these studies, it is noteworthy that most authors were affiliated to Schools of Physiotherapy. The inference is that dominant interests of Schools are covertly disguised within the recommendations which positively promote students within the workplace (Bristow &

Hagler, 1994, 1997; Cebulski & Sojkowski, 1988; Holland, 1997; Ladyshevsky et al., 1998; Haines et al., 2011; Leiken, 1983; Lopopolo, 1984; O'Sullivan, Cassidy, & Condon, 2007).

For team and organisation practice to change, habitus, capital and field will need to be altered (Bourdieu, 1972/1977). Individual and organisation (field) habitus, as deeply embedded dispositions, is revealed in two assumptions described by Hagler (2005): students are less productive due to inefficiency and students provide services of less quality compared with experienced staff. These assumptions, according to Hagler, influence decision making around clinical education. For habitus to adapt, motives (habitus in action) need to be mediated towards opportunities of gain; in this instance, reconfiguration of capital in terms of clinical educator productivity and positive benefits of students on, for example, waiting lists. Cost analysis emerges as a dominant theme within the reviewed literature, which symbolises the location of fields of clinical education and associated fields, within the wider field of economics.

### **Impact of students on staff and service productivity and provision**

Economic theory acknowledges the relationship between, for example, number of employees, units of time and, as applied to physiotherapy, number of interventions required per patient and more recently, consumer satisfaction. Of the reviewed literature, economic evaluations were primarily undertaken using mathematical formulae. An early study by Leiken (1983) considered students as the "variable factor" (p. 57), which can influence both positively and negatively other "factors of production" (p. 57) such as, staff. A regression analysis framework was used to determine the effect of students on the provision of physiotherapy services. Data were obtained of treatment sessions (defined as 30 minutes of direct patient contact) undertaken by physiotherapy students and students studying to become physical therapy assistants and their clinical educators. Results indicated a significant effect of physical therapy assistant students and statistically insignificant but positive effect of physiotherapy students on productivity. Data were limited to a 24 day period and collected in a New York teaching hospital, whose methods of supervision may not be directly applicable elsewhere. Cost analysis focused on the quantity of treatments rather than the quality, which addresses one of the assumptions advocated by Hagler (2005), but not the assumption of inferior quality.

Another economic model was applied to hospital productivity drawing on disciplines of physiotherapy, occupational therapy and radiography (Leiken, Stern, & Baines, 1983). Similar findings were revealed regarding the positive impact of students on number of patient visits and treatment times and, in relation to radiography, number of tests. Application of economic models and subsequent findings promote the cost benefit

to department managers and hospital managers, who due to their hierarchical position can influence field conditions and shape field habitus.

Lopopolo (1984) also developed a cost analysis model. Data were captured as a time in motion study from physiotherapists with students and physiotherapists without students (controls) from three large and three small physiotherapy departments. Findings indicated a net profit of US\$89 per day per student irrespective of clinical educator time away from income-generating activities. Cost variables relating to space, equipment etc., were not included in the financial model. Findings relevant to this research include the recommendation that longer student placements optimise income generating potential and reduce teaching and orientation time. This is further supported by Cebulski and Sojkowski (1988) who found 72% increased productivity of clinical educator with student units compared with the same clinical educators over a timeframe without students. It was also noted that productivity in the first week was reduced compared with other weeks; however, overall, productivity increased from week one onwards. This equates to longer periods of socialisation to the organisation, which through accumulation of social and cultural capital (networks and knowledge) may translate into improved efficiency (economic capital).

Unlike Cebulski and Sojkowski (1988) who did not measure indirect patient contact time, namely documentation, Bristow and Hagler (1997) measured direct and indirect patient contact time and number of interventions per day. Data were captured from 38 physiotherapists and 101 physiotherapy students over 114 clinical placements in three Canadian hospitals. When compared to previous studies, this large sample gathered from eight clinical speciality areas over three years, generated more consistent evidence to support the cost benefit of students in departments. Nevertheless, this study and those of Cebulski and Sojknowski (1988), Leiken (1983), Leiken et al. (1983) and Lopopolo (1984) have focused on quantity rather than quality of services provided by students. Issues of quality are discussed under theme three, however, suffice to note that given increased productivity attributable to the presence of students, the positive impact on reduced waiting times and resultant patient satisfaction may be inferred.

Holland (1997) studied the impact of students on out-patient physiotherapy waiting lists. Measurements included number of patients seen, treatments per patient and discharge outcomes. Over the timeframe of 48 weeks, data were collected from clinical educator and student (team 1) and compared with the same clinical educator without student (team 2). Unlike an in-patient clinical environment where patient numbers are a fixed variable due to bed availability, this variable can be manipulated with additional

patients booked in as required. Findings mirror those of Cebulski and Sojkowski (1988) with increased productivity found in the clinical educator/student unit. However, the number of treatments per patient and discharge outcomes between teams had no significant difference which suggests that the quality of treatment offered by students was comparable to that of qualified staff. The authors suggest that the presence of a clinical educator may have had a positive effect on student performance by promoting progression and prompt patient discharge. Measurement of time spent in clinical supervision would have provided a useful indicator of time required to achieve these outcomes.

Studies that have investigated the economic consequences of students have focused solely on a traditional 1:1 model of clinical education. This model has been found to have increased costs in terms of clinical educator time compared with other models (Moore et al., 2003). Ladyshevsky et al. (1998) evaluated productivity and learning outcomes using 1:1 and 2:1 models of clinical education in eight Australian hospitals. A Clinical Education Quality Audit tool measured clinical educator and student time in direct and non-direct patient contact, teaching activities and administration, and time worked per day. Findings are comparable to other studies and indicate the positive impact of students on productivity. Comparisons between different models of clinical education generated interesting results whereby the 1:1 model was found to be more productive in terms of patient care than the 2:1 model. This may have been attributed to the limited number of patients within the in-patient clinical environment which Ladyshevsky et al. (1998) considered a fixed variable. The authors found that clinical educators viewed the 2:1 model less favourably, rating the teaching and learning process evaluation lower compared with the 1:1 model; this may suggest less experience in this model. However, it was noted that clinical educators failed to delegate up to 50% of their workload to students irrespective of the model used which may have contributed to less favourable attitudes towards 2:1 model. One reason postulated was that “clinicians may not like being removed from their “hands-on” duties” (Ladyshevsky et al., 1998, p. 1296). This was considered a barrier to how the 2:1 model was perceived and its efficiency. Drawing on Bourdieu’s concepts, exchanging “hands-on” patient contact time for contact with students amounts to exchange of capital, which as found by Ladyshevsky et al. (1998) did not hold equitable value. A shift from a clinical to education role also represents habitus adaptation which may not occur without adequate socialisation such as, learning to manage and facilitate student learning in 2:1 models. Tension between dual roles of clinician and educator are discussed in theme two, together with strategies such as clinical educator workshops to shape habitus.

Research by Ladyshevsky et al (1998) provides useful data regarding productivity and perceptions of clinical educators and students of learning processes. The audit tool is not used widely in other countries and specifically in the United States and Canada where the body of literature relating to cost analysis originates. Results therefore, may be limited to Australia. Similarly, extrapolation of findings from Canadian researchers Bristow and Hagler (1997) and American researchers: Lopopolo (1984), Leiken (1983) and Leiken, et al. (1983) should be interpreted with caution given that hospital and financial systems are not directly comparable with that of New Zealand.

More recently, Haines et al., (2011) proposed a conceptual framework to investigate the economic impact of clinical education in terms of cost minimisation and cost effectiveness. Included in this concept were two additional dimensions 'quality adjusted student educated' outcome and 'quality adjusted passing students educated'. These dimensions are proposed by the authors as resolving the tension between quantity and quality of clinical education by considering the successful performance of students and utilising this outcome as an indicator of quality. By incorporating dimensions of quantity and quality in an economic framework, Haines et al. proposed that "conflicting outcomes both within and between stakeholder perspectives can be resolved" (p. 62). Given that multiple stakeholders have a vested interest in clinical education, Haines et al. offered a strategy that reconfigures capital, aiming to achieve a balance in the volume and value of capital within fields of clinical education, physiotherapy education and practice provision. Tension between training sufficient physiotherapists to meet projected workforce shortages and ensuring that they are competent to work in the dynamic field of healthcare reflects the tension between quantity and quality of physiotherapists, and the conjecture, that these tensions are translated onto clinical educators.

Research reviewed has focused on the economic benefits of students on services in terms of productivity, cost effectiveness and positive impact on, for example, waiting lists. Drawing on Bourdieu's concepts, this body of research reveals class struggles and competition in terms of capital, dominant interests and social stratification. Strategies are revealed as Schools protect dominant interests in securing clinical placements and access to patients. Patients, consumers of physiotherapy practice, represent valuable capital in terms of student experiences, available only through managers. Schools must therefore, strategise by 'marketing' students to managers in terms of economic benefits (potential exchange for economic capital) and providing evidence (cultural capital). Strategies include reproduction and reconversion of capital, where capital is exchanged and reconfigured between fields.

Another strategy absent from the literature is the value of students as potential employees; in particular, research into the economic value of students in terms of recruitment and retention. Throughout the clinical placement, employers have the opportunity to recruit with confidence from a pool of students, and select students who best fit with team and organisation requirements as employees (Hagler, 2005). Evaluation of the economic impact of students as employees would provide another useful dimension which may be of particular interest to stakeholders.

## **Quality issues**

Aspects of quality in clinical education are addressed in a small body of literature which focuses on expectations and experiences of students, academic staff and clinical educators. These will be discussed separately, however, it is recognised that there is a close relationship with the preceding theme relating to student and placement capacity (quantity) and more specifically, theme three, which examines literature relating to the disjuncture of different types of knowledge such as, 'clinical' and 'education' and how this impacts on clinical educators and student learning.

## **Physiotherapy services provided by students**

The second assumption described by Hagler (2005) was that services provided by students were of a lower quality compared to qualified staff. According to Neville and French (1991), clinical educators also expressed concern that patients may be disadvantaged when treated by students rather than qualified staff. Concerns by clinical educators regarding quality were found to impact on the quantity of placements offered (Sevenhuysen & Haines, 2011) demonstrating a link between quantity and quality. Sevenhuysen and Haines (2011) proposed that strategies could be developed to obtain a better balance between both dimensions to enhance capacity whilst maintaining overall quality of the student and clinical educator experience. An improved balance could be addressed in professional development activities and reflects the importance of greater training and support for clinical educators to facilitate student learning within clinical education irrespective of their discipline (Baldry Currens & Bithell, 2000; Higgs & McAllister, 2005; McAllister, Higgs, & Smith, 2008; Öhman et al., 2005).

Of the research reviewed, few studies have included measurements related to quality. This may be indicative of the focus of the relationship between student capacity and productivity rather than quality. Holland (1997) concluded that students have a positive impact on out-patient physiotherapy waiting lists. Comparable data were found regarding the number of treatments per patient and patient discharge outcomes when

treated by a student/clinical educator team versus a clinical educator. Additionally clinical educator and student team were more productive, that is, assessing and treating more patients per day. Some inferences can be made from other reviewed studies which demonstrated increased productivity of students on services and potential patient satisfaction in reduced waiting times.

Langford et al. (2008) examined patient satisfaction with the care provided by Irish physiotherapy students in an out-patient clinical setting. Data were collected from patients discharged over a six week period using a 27 item self-completed questionnaire. Four categories were measured: communication, professional behaviour, general satisfaction and structural aspects of the service such as, appointment bookings. Comparisons were made between care provided by students (35 questionnaires analysed) and qualified physiotherapists (31 questionnaires), and data obtained from three additional questions relating to the clinical educator. Patients reported highest levels of satisfaction attributed to communication of both students and clinical educators. Professional behaviour was rated higher in patients treated by clinical educators; this, the authors postulate may be due to poor student time management. Overall satisfaction was comparable between care provided by both groups and 80% of patients treated by students were satisfied with the service provided by the clinical educator. Half of these respondents indicated they would have preferred that the clinical educator spend more time with them. It is unclear whether 'them' (p. 30) refers to the patient or the student. Also worthy of note is that students on average provided two treatment sessions more per patient compared with clinical educators, although it was noted that patient complexity differed between the two groups. Unlike previous studies, this research focused on patient satisfaction in a clinical context which utilised a 5:1 model of clinical education. Efficacy of treatments were measured in relation to number of treatments per patient; however, treatment times were double that of clinical educators with less flexibility within their day due to higher workloads. A comparison of productivity is therefore, not available. The authors duly conclude however, that "it may be cautiously implied that student physiotherapists, of an appropriate level of training and under adequate supervision, are a useful resource in the delivery of outpatient physiotherapy" (Langford et al., 2008, p. 33).

A noticeable paucity of research is evident that captures patients' perceptions as consumers of physiotherapy student-provided services. The lack of published research on patients' perceptions of service quality in New Zealand was also noted by Clemes, Ozanne and Laurensen (2001). Data relating to service quality dimensions were captured in a

telephone survey of 389 North Canterbury residents who had attended public or private hospital in New Zealand in three years preceding data collection. Service quality dimensions identified as important to participants included “reliability, tangibles, assurance, empathy, food, access, outcome, admission, discharge and responsiveness” (Clemes et al., pp. 3-4). Not surprisingly, participants perceived quality service dimensions of healthcare delivery as a ‘core’ product (outcome) as more important than dimensions relating to service delivery as a ‘peripheral’ product (food). When participant demographics were factored into the analysis, some relevant implications for clinical education and associated stakeholders can be extrapolated. For example, empathy and factors around admission were found to be important by older patients. Reliability and outcomes were also perceived as important for participants with serious medical conditions. Given the ageing population with increasing co-morbidities and expectations, students must be adequately prepared to work with more complex patients and under appropriate levels of supervision by clinical educators. This undoubtedly will create further demands on clinical educator time, in meeting demands of patients and students, as consumers of clinical education. In the current climate of consumer-orientated healthcare, consumer views hold symbolic power as a composite of satisfaction (cultural capital), value for money (economic capital), increased status (symbolic capital) and influence of consumer groups (social capital). This is an area of research which warrants greater attention as patients are pivotal to the clinical education experience as providers of student experience and consumers of student care.

### **Perceptions of students as consumers**

Clinical education forms a substantial part of the learning experiences of physiotherapy students yet data gathered from student evaluations are not available within the public domain. Evaluations in nursing noted by Penman and Oliver (2004) tend to focus on procedural aspects of clinical education; no comparable data are available in physiotherapy. Limited available literature evaluates new graduate physiotherapy and student expectations and experiences (Higgs, Hummel & Roe-Shaw, 2009; Miller, Solomon, Giacomini & Abelson, 2005; Naylor, 2007; Roe-Shaw, 2004; Solomon & Miller, 2005). Additional literature includes student perceptions of characteristics of ‘ideal’ clinical educators (Cross, 1995), learning experiences (Morris, 2007), and satisfaction trends in education (El Ansari, 2003). Student voices have also been captured in research evaluating different models of clinical education (Baldry Currens & Bithell, 2000, 2003; Moore et al., 2003; Triggs Nemshick & Shepard, 1996).

### *Student perceptions of the ideal clinical educator*

In a study by Cross (1995), perceptions of the ideal clinical educator in physiotherapy were compared between 21 clinical educators, 14 academic tutors and 96 students from years 1, 2 and 3. Participants were asked to rank a number of characteristics that best described the 'ideal' clinical educator. Findings indicated that clinical educator and student perceptions were more congruent than those of academic tutors. Personal characteristics such as 'approachable' and 'good communicator' ranked high in all student groups, as was 'knowledgeable'. These dominant characteristics were proposed to reflect student strategies to adapt to the dynamic environment of clinical education, and the personal relationship between student and clinical educator, which both groups valued. Interestingly, academic tutors ranked characteristics such as 'interested in learning' as more important than other participant groups. This may reflect dominant interests and values of academic tutors as agents of the university (field). Tensions are revealed between the different field interests and values held by fields of academia and physiotherapy practice providers. As noted by Cross, "is the confusing picture of the clinical educators and academic staff being pulled in the same and different directions, with the students in the middle" (p. 512). She further described tension between traditional and contemporary models of education arising from differences in education towards diploma and degree.

Since approximately 1993, all qualifying awards have changed from diploma to degree with only a minority of practising physiotherapists holding a diploma. However, with the move towards doctoral qualification, future disparities may again result based on contemporary education pedagogy which is slow to be adopted by clinical educators. This disparity represents hysteresis, where habitus is slow to adapt to new field conditions (Bourdieu, 1972/1977) and in this research context, may result in tension and conflict between fields of academia and clinical education and their agents.

### *Student perceptions of learning experiences*

Learning experiences have been evaluated through students' perceptions in research by Cole and Wessel (2008), Kell and Owen (2008), Morris (2007) and El Ansari (2003). As consumers, student perceptions are important, yet as noted by Morris, feedback from students is rarely published.

Research by Cole and Wessel (2008) evaluated 51 physiotherapy students' perceptions of their learning experiences during an introductory placement. Students completed a questionnaire, based on Brookfield's Critical Incident Questionnaire, at the end of each day of their placement, in the first semester of a two year entry-level Masters

programme. Results indicated that student learning experiences could be enhanced through clinical educators adopting a number of strategies. These included preparing the student and providing adequate time for students to obtain and assimilate information, providing feedback on learning and hands-on experience, role modelling professional behaviour, respecting students' as valuable resources capable of contributing to patient care and challenging students' knowledge through discussion and providing time for reflection. Students perceived optimal learning when they were directly involved in patient care; yet, as noted by the authors, challenges for clinical educators included identifying students' level of competence in order to assess the level of independence. All of the strategies, including assessing suitable patients and levels of student independence, places demands on clinical educator time and assumes that clinical educators have the knowledge of how to facilitate student learning.

Kell and Owen (2008) undertook a three part questionnaire survey to investigate potential influences of different models of clinical education on student learning. Results were analysed from 51 Year 2 and 39 Year 3 students during one four week clinical placement in the United Kingdom. The questionnaires comprised of demographic details, placement self-assessment form, and a learning approaches inventory. Results challenge the impact of multiple student:clinical educator models of clinical education as affecting student learning, inhibiting deep learning and increasing fear of failing when more than 1:1 model was adopted. School leavers were also found to have increased fear of failure compared with mature students. Results contrast with research advocating the positive impact of multiple models of clinical education (Baldry Currens & Bithell, 2003; Moore et al., 2003) as deduced from stakeholder inquiry including student perceptions. The authors encourage clinical educators to provide a safe learning environment, defined in terms of the Chartered Society of Physiotherapy (2003) as physical and psychological safety, and provide support and activities to enhance the unique learning experiences of all students, comparable with the 1:1 model of clinical education. Requirements of clinical educators therefore, extend to providing quality learning opportunities for students, meeting individual learning needs and providing pastoral, personal and psychological support to students. Meeting the needs of students however, is only one dimension of the role of clinical educators (excluding those employed by universities as clinical tutors), whose dominant role is patient care and physiotherapy service delivery. Expectations of students and Schools may not be met if clinical educators, for example, do not have the skills or time. Competing demands on clinical educator time are highlighted as a significant tension in this research and also findings by Morris (2007) and El Ansari (2003).

Learning experiences were explored by Morris (2007) in a phenomenological study of 17 students undertaking a part-time, four year physiotherapy programme. Findings revealed that direct involvement and hands-on contact with patients was greatly valued by students, compared with for example, in-service training. Students also perceived their learning was disadvantaged when opportunities to work with patients was not available. Communication and interaction between the clinical educator and student was valued in relation to learning, yet students found unrealistic expectations of clinical educators problematic. Findings mirror those of Harris and Naylor (1992) as noted by Morris (2007). Given that both studies were undertaken over a decade apart, this supports the deeply embedded value of patient contact to student learning and the professional identity of physiotherapists (*habitus*). Evaluation of Generation Y's expectations as consumers of clinical education will provide an interesting insight into whether findings by Harris and Naylor (1992), and Morris (2007) are reproduced.

Of relevance to this research, is the impact on clinical educator time in securing adequate learning experiences for students (patients), and time to interact with students. With increased patient acuity and high patient turnover, demands on clinical educator time may only increase as patients and students compete for time. The value placed by students on direct patient contact compared with other learning opportunities suggests that a hierarchy of knowledge exists. Insufficient access to patients and clinical educator time/feedback (due to staff shortages) impaired student learning and were perceived to negatively impact students' learning trajectory. Competing demands are again evident on clinical educators as they struggle to deal with increased demands due to staff shortages, students demands and potentially, positive evaluations and student feedback.

In contrast, research by El Ansari (2003) explored physiotherapy student satisfaction with their learning and teaching, and assessment performance. A questionnaire survey of 300 physiotherapy students from university (United Kingdom) was undertaken. The four aims encompassed levels of student satisfaction with their educational experiences, effects of four demographic variables and four education related parameters on student performance and satisfaction perceptions, and to test the hypothesis that satisfaction scores related to student grades. Implications applicable to this thesis include the need for educators to address the content and process of learning to optimise student success, so that educators in clinical practice possess similar skills and knowledge as School based staff. It is unclear from the data analysis whether specific findings are relevant to clinical education compared with School-based education. El Ansari concluded that strategies to meet the hopes and expectations of students should be

developed by Schools, together with evaluation of student satisfaction as a regular quality assurance activity. While clinical educators have limited influence over curriculum design and School processes, their input may help shape the whole education experience of students and therefore, enhance student satisfaction and outcome.

### *Student perceptions of preparedness for practice*

Evaluation of students' perceptions of their preparedness for practice includes research into new graduate physiotherapists from New Zealand (Roe-Shaw, 2004), Australia (Hunt, Adamson & Harris, 1998), Canada (Miller et al., 2005; Solomon & Miller, 2005), United Kingdom (Naylor, 2007), New Zealand occupational therapists (Nayar, Blijlevens, Gray & Moroney, 2011; Robertson & Griffiths, 2009) and New Zealand oral health therapy students (Smith & Smythe, 2011). Specific to New Zealand physiotherapy students, Roe-Shaw, Gall, Jones, Lattey and Sainsbury (2003) investigated the preparation of final year physiotherapy students for clinical placement.

Given that this represents a limited body of evidence and draws from different disciplines and also countries, findings have been collated and where appropriate, conclusions applied to this research. Student perceptions of their education and specifically how it prepared them for practice, provides an overview of their views as consumers of the 'product' and highlights disparities between different fields of practice.

Several issues become apparent in the reviewed literature regarding preparedness for practice. Irrespective of the discipline, all new graduates spoke of a gap between being a student and a new graduate, and what was espoused at university compared with the reality of practice. Students were also found to experience challenges transitioning from academic environments to clinical placements/practice.

In a naturalistic inquiry by Robertson and Griffiths (2009) occupational therapists as new graduates searched for clarity of their role professionally and within teams, this was compounded by inadequate clinical and professional supervision to allow them to develop new skills and confidence. Physiotherapy students in a phenomenological study by Roe-Shaw (2004) were also challenged by role confusion and lack of professional status, and also environments and encounters with patients/clients and team members. Two phases of professional socialisation were identified which related to contexts and experiences of professional socialisation. Contextual themes included the importance of peer, senior and workplace support; experiences included developing capabilities and strategies to cope with role and workplace challenges.

The first few months of practice were described as stressful as new graduates adapted to clinical, professional and organisational cultures. Student socialisation experiences in the study by Roe-Shaw (2004) were described as negative. Similar themes were found by Miller et al. (2005) who described the experiences of ten Canadian new graduate physiotherapists adapting to acute hospital environments. New graduates with an average of seven months experience described the transition as “wrought with emotional suffering” which included feelings of being “overwhelmed”, and “exhausted” (Miller et al., 2005, p. 148). It was also noted while participants felt their education programmes had prepared them for assessments and treatments, they were less prepared for working within health organisations. Described as organisational socialisation, new graduates over time learned how to adapt to team and organisation procedures and cultures. Physiotherapy colleagues were found to be pivotal in supporting new graduates and facilitating their simultaneous transition into the profession and also organisation. The importance of support systems for new graduates was also found by Solomon and Miller (2005) in another Canadian study of ten new graduate physiotherapists working in private practice. Again, adapting to organisation procedures and culture was found to be challenging and of interest, new graduates admitted selecting private practice clinics as employers based on support systems provided.

Similar findings were made by Smith and Smythe (2011) in their hermeneutic phenomenological study of five New Zealand oral health therapists (year 3 students). Students acknowledged that they felt ill prepared for the realities of practice, including working with patients for the first time. Clinical skill preparation in the classroom was described as removed from working with patients, especially children, resulting in feelings of fear and being overwhelmed. Additional useful findings were the importance of peer support amongst students, described as “non-hierarchical relationship” (Smith & Smythe, p. 19) unlike the relationship with clinical educators where a tension existed between the role of clinical educator as supporter, yet also assessor. Trust in the clinical educator/student relationship was highlighted as important as it allowed students more independence and confidence in their practice.

Preparation for clinical placements by final year physiotherapy students in New Zealand was found by Roe-Shaw et al. (2003), to be driven by fear and anxiety. In an interpretive study of twelve final year students, control of the clinical education year was acknowledged as a strong theme, with the enormity of the transition for students from academic environments to clinical practice also noted. Recommendations included orientation of students to the clinical area and pre-clinical student/clinical educator

meetings enabling students to familiarise themselves with the clinical environment and team. While the research focused exclusively on students, the impact of such recommendations on clinical educator time is worthy of consideration.

In contrast to findings described to date, analysis of 235 questionnaires returned from new graduate physiotherapists (University of Sydney, Australia) revealed that they were well prepared for workplace (Hunt et al., 1998). Additionally positive results indicated that the new graduates perceived that their undergraduate course prepared them well for clinical skills and patient management. Participants described being less prepared for communicating with patients in challenging circumstances. Resultant tensions were further compounded by limited understanding of the health industry and workplace management. Coping strategies included accessing resources and peer support which addressed to some extent these tensions. The latter strategy supports findings by Robertson and Griffiths (2009), Miller et al. (2005), Roe-Shaw (2004), and Solomon and Miller (2005) of the importance of peer support as a coping and adaptive strategy for new graduates.

Research by Nayar et al. (2011) investigated the preparedness for practice of new graduate occupational therapists in New Zealand. An initial on-line questionnaire was sent to all registered occupational therapists; 454 results were analysed and informed questions posed to five focus groups consisting of new graduates, managers, educational staff and senior staff. Findings revealed an ambiguity between practice and the professions' expectations which challenged new graduates and impacted on their transition to practice. The unique attitudes and experiences that new graduates bring to practice was also acknowledged. This is in keeping with Bourdieu's concept of habitus, where deeply embedded dispositions occur through primary socialisation, such as, family influences. Secondary socialisation occurs, for example, when individuals become students of occupational therapy or physiotherapy. Habitus adapts with time and exposure to new field conditions (Swartz, 1997) yet does not fundamentally alter the dispositions formed from primary socialisation. Habitus therefore, recognises the diversity of ideology and experiences brought by students to Schools, and then into the workplace.

The role of support systems, for example, supervision in aiding the transition mirrors recommendations by Robertson and Griffiths (2009), whereby supervision was described by participants as "essential" and "critical" (p. 130) to bridging the gap between theory and practice and empowering new graduates with confidence. However, unlike findings by Nayar et al. (2011), where results from the survey indicated that new graduate

preparedness was considered excellent in relation to continuing professional development, findings by Naylor (2007) indicated that new graduate physiotherapists had limited time to engage with research and continuing professional development; activities that were perceived as integral to the professional role of physiotherapists. However, when such activities were absent or inhibited, prevailing cultures were perpetuated, indicating that such activities were of a lesser priority compared with, for example, patient care. Findings also revealed that the apprenticeship model of socialisation dominated the workplace which is in keeping with literature relating to barriers to different models of clinical education. This suggests that team and organisation culture is based on traditional apprenticeship models (students and new staff) and is in contrast with more contemporary models of education in Schools. The disparity between different models of learning irrespective of student, new graduate or staff member, may reflect different priorities and field conditions between education and practice. All studies reviewed regarding the preparedness for practice comment on participants learning to fit in with teams; in doing so, as new graduates, they relinquish some ideology (*habitus*) shaped at School, adapting to the new culture and field conditions of the workplace. While new graduates develop knowledge, skills and confidence which represents accumulation of different forms of capital, they submit to 'rules of the game' by accumulating capital that is legitimised by senior staff, teams and the organisation. Dominant individual and field interests are therefore, reinforced as the rules are obeyed and service priorities dominate.

#### *Student needs and their impact on clinical educator time*

Evaluation of these studies indicate the demands of students on clinical placement and as new graduates on clinical educator time in supporting and mentoring, creating learning opportunities, interacting, and meeting unique learning needs. Time as economic capital is highly valued in terms of cultural and economic capital, and unless clinical educators are employed directly by Schools, such capital is also valued in terms of patient contact and service delivery. The continual contest for time is recognised as a significant tension, as is the question of whether clinical educators have sufficient knowledge and skills in education to optimise student learning and successful outcome. Without such knowledge and skills, stakeholder expectations cannot be realised, resulting in negative evaluation of potential clinical educators and clinical placements. Additionally, dominant cultures were identified in this review and found to inhibit learning effectiveness and preparedness for practice will continue to impact on individuals and the profession. It is therefore, important to evaluate research on clinical educator and academic staff expectations to reveal interstakeholder conflict and its origins.

## **Perceptions of academic staff as stakeholders**

Education “can be conceptualised as a transaction between a consumer (student) and a supplier (university) of an education product” (Haines et al., 2011, p. 54). Funds are exchanged between parties: consumers and providers. The same concept can be applied to clinical education, where a service (product) is provided by individuals (clinical educators) and organisations (physiotherapy practice providers) to Schools of Physiotherapy for an agreed cost. However, in this scenario, students and Schools are both considered consumers, highlighting the complexity of clinical education and pressures on clinical educators to meet the demands of consumers and other stakeholders such as managers, professional leaders and team members.

As stakeholders, Schools and their staff, particularly clinical placement co-ordinators and clinical tutors, have an interest in the quality of placements. Limited research is available which captures the perceptions of academic staff specifically related to clinical education. Of the available research, Stachura, Garven and Reed (2000) considered quality measurements in clinical education, while other research evaluated academic staff perceptions of different models of clinical education (Baldry Currens & Bithell, 2003; Moore et al., 2003). Academic staff and clinical educator perceptions of undergraduate physiotherapy students were studied by Cross (1999), and Jones, Yeung and Webb (1998) discussed student/clinical educator/academic staff relationships in clinical education. Further research examining disparities between academic staff and clinical educator concepts of learning and teaching and how this impacted on the quality of student learning experiences is explored in the next section.

Stachura et al. (2000) highlighted the complexities of evaluating clinical education as a ‘product’ compared with a ‘process’. The former measures efficiency and cost effectiveness and is of interest to stakeholders, while the latter measures how students learn and reflects “the pedagogical notion of the pursuit of knowledge and intellectual challenge for its own sake” (p. 118). Students from Years 2, 3 and 4 undertaking clinical placements were surveyed, along with 15 clinical educators and 22 managers. While specific to students from one university in United Kingdom, some findings have relevance to this research. Students positively evaluated weekly feedback with clinical educators and measured high levels of satisfaction with the quality of their learning experiences on placement, including the teaching style dimension. The relationship of clinical educator time and knowledge and skills in facilitating student learning were highlighted as important dimensions in attaining positive student evaluations and levels of consumer satisfaction. The authors noted that results “bear out the commitment and enthusiasm the

clinical educators give to the programme” (Stachura et al., p. 124). Such positive findings are analysed from only 10 clinical educators, whose potentially biased responses represent 10% of respondents. Findings may be significantly altered if, as proposed by Öhman et al. (2005), it is compulsory for all physiotherapists to engage in clinical education. Other relevant findings emerge from clinical educator responses and include challenges to co-ordinate student assessments with academic staff. Additionally, tensions are evident in the limited implementation by clinical educators of quality assurance procedures arising from School audits. One recommendation includes reviewing ways in which information is provided to clinical educators; withholding of information from a Bourdieusian perspective is symbolic violence, which impacts on clinical educators and their ability to meet stakeholder expectations. Hysteresis, described as the time lag between habitus adjusting to new field conditions, is also described by the authors: “Perceptions are that procedures are no sooner developed than they have to be modified to accommodate change” (Stachura et al., p. 125). The clinical environment is noted by the authors as “both stimulating and frustrating” (p. 125). This reflects the dynamic and complex world of clinical education where change is continuous, and tension is inevitable.

Findings by Cross (1999) indicated that conflicting messages provided to students by academic staff and clinical educators can impact on student learning experiences and standards of clinical education. A nationwide Delphi study (United Kingdom) of physiotherapy clinicians (not specified if these were clinical educators) and physiotherapy academics, sought to identify desirable and undesirable attributes of undergraduate physiotherapy students on clinical placement. Key differences between participants were found in dimensions relating to independent learning and critical thinking. Failure of clinical educators to recognise these as valuable dimensions may inhibit students (and new graduates) from being challenged. Similarly, differing perceptions of good and poor performance if viewed differently by academic staff and clinical educators may reflect incongruent value systems and result in conflicting messages provided to students. Recommendations included improved dialogue between staff to negotiate and agreement of a shared ideology on what constitutes desirable student attributes, and what attributes are required to manage in increasingly complex clinical environments.

Similar findings echo those of Jones et al. (1998) in their study of the tripartite relationship between student, academic staff and clinical educator within healthcare care clinical education. Tripartite discussions were implemented within the Hong Kong Schools of Physiotherapy following “few minor teething problems” which were mainly due to elements of personality and reluctance from those who favoured the “teaching-

instructing” and “student-accepting” traditional method” (p. 98). Tension and conflict between different educational philosophies is evident between stakeholders; however, as consumers, the School was able to implement weekly discussions during the students’ six weekly placement. These initial discussions were then evaluated as an action learning pilot study. Year 3 physiotherapy students (number unknown), a clinical educator and clinical tutor kept reflective diaries. Students recorded details regarding their learning experiences, and evaluation and outcomes of learning on placement; clinical educator and clinical tutor recorded reflections on learning, teaching, and guidance provided to students. Contrasting expectations were found between students, the clinical educator and clinical tutor and recommendations were made for improved role clarification and associated expectations. A lack of trust was also found between students and educators which created a vulnerability and fear of failure for students. From the perspective of the clinical educator and clinical tutor, demands on time to discuss and negotiate were limited and both staff commented on the tension between competing roles of teacher and assessor. Students perceived the tripartite discussions as useful in clarifying expectations by transparent and inclusive discussions. Trust is essential in tension management (English, 2010) and as demonstrated by Jones et al., is required for collaboration and a paradigm shift towards students as the centre of learning.

Research by Jones et al. (1998) highlighted tensions between different values and ideology (habitus) held by clinical tutors and clinical educators which may be attributed to the field in which they are located. To achieve improved congruence between expectations of students and standards of clinical education, shared dialogue is recommended. Time to collaborate, as demonstrated in the critique of literature to date, is both highly valued and contested, and yet is perceived as essential to reducing tension between stakeholders. Perceptions of clinical educators relating to quality issues will be discussed within the next section and under the subsequent theme of different values of knowledge held by individuals and organisations.

### **Perceptions of clinical educators**

Research into the perceptions of clinical educators is limited to research around the evaluation of different models of clinical education as previously described under theme one, education needs (Cross, 1992, 1994; Walker & Openshaw, 1994 ) and perceptions of their professional role, physiotherapy education and status of the profession (Öhman et al., 2005). Perspectives are also reviewed of Australian speech and language therapists (McAllister et al., 2008) as their perceptions have relevance to this research.

All reviewed literature offers a consensus on the value and importance of clinical educators as pivotal to professional socialisation of students, application and synthesis of knowledge and skills learned at School within the clinical environment, and the learning of environment-specific new knowledge. It is noteworthy that regardless of their key role clinical educators' perceptions are seldom visible compared with other areas of research in physiotherapy. This may suggest that as a unique social class, they hold different value compared with other social groups in physiotherapy such as academic staff and researchers. Additionally, the multiple demands particularly on the time of clinical educators may prevent them from researching aspects of their role and world. From a Bourdieusian perspective, clinical educators are marginalised and disadvantaged through the denial of resources and recognition through symbolic violence. Allocation of resources, or in this instance withholding of resources, maintains social hierarchies and protects the dominant interests of individuals and organisations. Doxa and illusio reinforce the position of clinical educators on social hierarchies, through their acceptance and 'taken-for-grantedness' of their position and the multiple demands on their time.

Evidence of tension is provided in research by Cross (1992, 1994) and Walker and Openshaw (1994). Research by Cross (1992), although dated, investigated the education needs of clinical educators during the transition era from diploma to degree. A needs assessment workshop was carried out with 71 clinical educators from 37 locations in the United Kingdom. Participants expressed concern regarding the disjuncture between "idealised" models of learning (p. 759) advocated by Schools and the realities of learning in the clinical environment. As noted by Cross (1992), clinical educators "for the most part, are not professional educators" (p. 759), and as such, have unique needs. Cross deduced that for a paradigm shift in education to occur, clinical educators' needs must be considered through continuous training, and collaboration between academic staff, clinical educators and students should occur to foster long-term learning partnerships. Further work by Cross (1994) described changes to the roles of clinical educators. The change from 'clinical supervisor' to 'clinical educator' highlights a fundamental shift to the underlying philosophy of those tasked with student learning in the clinical environment. Time constraints and staff shortages are noted as barriers to clinical education in the decade preceding this publication. It is worthy to note that the same barriers persist into present time which imply that they have not been addressed by stakeholders (symbolic violence), and continue to impact on clinical educators.

Many changes have occurred since Walker and Openshaw (1994) published research investigating the education needs perceived by clinical educators and students.

Results of a questionnaire survey of 24 responses from clinical educators and 43 students were analysed. Findings applicable to this thesis include only three of the 22 clinical educators had completed a School-based clinical educator workshop. The clinical educators who had attended perceived that their educational needs had not been met through the workshop, highlighting the inadequacy and limited value of such workshops to clinical educators. Training in evaluating student performance was perceived as valuable given that recent changes to clinical education (i.e. 1990s) required clinical educators to formally assess students. Additionally, clinical educators called for improved communication with Schools specifically regarding curriculum content, to ensure expectations were realistic, and with clinical tutors to ensure students were not given conflicting messages, resulting in stress and anxiety. Conclusions drawn by the authors include revision and evaluation of clinical education workshops to ensure that the needs of clinical educators were met, rather than assumed by Schools. Responsive workshop content could positively impact on the quality of clinical education, and the experiences of clinical educators and students. Preparation of clinical educators however, continues to be a long-term problem (Rose & Best, 2005) and as with student feedback, no published research is available which evaluates the content and effectiveness of clinical educator workshops.

Research by Öhman et al., (2005) involved five focus groups with 15 Swedish educators affiliated with four universities. The research sought to examine clinical educator perceptions of their role, physiotherapy education and the status of the profession. A key finding includes participant descriptions as “being at the centre of two competing and changing fields” (p. 114), indicating the co-location of clinical education between fields of education and physiotherapy practice provision. Lack of time and support by managers created stress and low morale and clinical educators perceived an over-reliance on theoretical knowledge which resulted in students entering the clinical environment with inadequate hands-on skills. Clinical educators expressed concern if clinical education was a compulsory requirement of all physiotherapists, fearing that the quality of student learning would be diluted. Students were perceived as valuable resources of continuous professional development and allowed clinical educators to keep abreast of latest research. Learning was described as a partnership between students and clinical educators whereby both parties participated and benefitted. A disjuncture between what Schools expected of clinical educators in terms of, for example, knowledge of research methodologies, and what they could access, was duly noted, but was unlikely to be resolved given that such education was not a priority for employers. Clinical educators also expressed angst regarding the lack of communication, support and

discussion with School staff, especially around struggling students. This was in contrast to the reliance of Schools on clinical educators to actively choose to engage in clinical education. Denial of resources including access to School staff represents symbolic violence where resources are withheld which would otherwise enhance the role of clinical educators. The concept of symbolic violence is further supported by clinical educator perceptions of “stress and feelings of powerlessness” (Öhman et al., 2005, p. 118) and acknowledgment of social hierarchies in healthcare where physiotherapists had a limited voice in decision-making, which maintained the low ranked position of physiotherapists and by association, clinical educators in organisation and professional hierarchies. Additional stress was noted by clinical educators around their desire to be effective educators which contrasted with their primary role in patient care and service delivery. This represented an internal tension which clinical educators sought to balance. Distrust of other stakeholders was also found, embedded in disparities in education priorities and poor communication. For tension to be managed (English, 2010), trust and effective communication are required to bridge differences and negotiate a mutually agreeable settlement and these requirements are reflected in Öhman et al.’s (2005) conclusions which call for “a need for continuous collaborative efforts between universities and healthcare institutions in order to overcome the gaps in the field of physiotherapy education” (p. 121). Disjuncture between ‘clinical’ and ‘education’ is explored under theme three.

Drawing from the discipline of speech and language therapy, findings offer this literature critique a different perspective. A comprehensive literature review was undertaken to inform a narrative inquiry with five Australian clinical educators in speech and language therapy (McAllister et al., 2008). Findings resonate with dilemmas described by clinical educators in physiotherapy which impact on the quality of clinical education and the experiences of clinical educators. Findings include recognition of the new clinical educator as a novice challenged by competing demands as they developed their own professional role as a health professional and clinical educator. The absence of adequate preparation for their role, resulted in clinical educators drawing on previous student experiences and as noted by May (1983), trial and error. Activities that promote reflection-in-action (Schön, 1987), professional development through student interactions and peer review and development of educational theory, are advocated as useful to the development of clinical educators in their role, particularly, emotive and intuitive dimensions of their role. This is further explored in theme three which examines the isolation of different forms of knowledge and the impact on clinical educators.

## **Different forms of knowledge and implications for clinical educators**

The third and final theme revealed in the reviewed literature relates to disparities in concepts of learning and teaching held by academic staff and clinical educators. These disparities reveal a disjuncture between different forms of knowledge which impact on the identity of physiotherapists as clinical educators, and their knowledge and skills to optimise student learning (and hence quality of student learning). As a consequence of the disjuncture, tension and conflict are exposed; thus inhibiting the needs and job satisfaction of clinical educators, interstakeholder relationships, and student learning. This theme draws on previously critiqued literature and specifically examines three additional studies, supported by additional research.

### **The presence and value of education pedagogy**

Research by Delany and Bragge (2009), Jones and Sheppard (2008) and Kell and Jones (2007) all provide evidence of a disjuncture between perceptions of learning and teaching held by academic staff and clinical educators. Personal epistemologies (“beliefs about knowledge and sources of knowledge”) (Delany & Bragge, 2009, p. e402) reflect findings previously described by Nayar et al., (2011) in occupational therapy, as unique, and influencing the learning and coping strategies in the workplace. How knowledge is viewed, valued and conceptualised is therefore, influenced by habitus (brought by individuals as students to the field of academia), and further shaped, to some degree, by exposure as a student at School (secondary socialisation/habitus formation). It is when the student is on clinical placement that conflicting ideology and education culture may occur, given that clinical education represents the interconnection between two fields, each with unique field conditions and value systems. It is also where the clinical educator is located, responsible to the employing organisation where patient care is prioritised over student education, yet where some physiotherapists decide to engage in clinical education and therefore, are required to meet School expectations.

Delany and Bragge (2009) undertook six focus groups with 45 third year undergraduate students in their first clinical placement block, and 19 clinical educators, following completion of the students’ placement. A key finding applicable to this thesis included the dominant education approach of clinical educators was knowledge transmission; this was also found by Kell and Jones (2007). Knowledge transmission, while relevant to students particularly in early exposure to clinical practice, is not responsive to other stages of learning. In addition, this learning/teaching strategy focused on what students needed to learn, rather than how students learned. Filling knowledge

gaps was in contrast to contemporary education models including peer learning, collaborative learning partnerships and learning communities (Wenger, 1998). Student confidence was found to increase throughout the duration of their clinical placement, and a relationship between confidence and student capacity to learn was identified. Clinical reasoning was utilised to facilitate transmission of theory and skills into the clinical practice environment, however, reinforced the dominant focus of filling gaps in knowledge and skills, rather than adopting strategies to facilitate student learning. Relevant findings from clinical educators included the “quick transition from being a student to a new graduate clinician, then a clinical educator” (Delany & Bragge, 2009, p. e406). In the absence of education pedagogy and time to reflect, clinical educators drew on previous experience as students to inform their teaching practices, and as noted by May (1983) often resulted in trial and error. Trial and error learning however, has been found to take longer to achieve levels of competency and productivity (Roseman, 1987). As noted by Kell and Jones (2007) clinical educators who had been in the role for 11 or more years, trended towards facilitation of learning rather than knowledge transmission, and utilised more media in their teaching compared with less experienced clinical educators. This suggests, that with time, clinical educators develop greater insight into education pedagogy including adult learning, albeit unknowingly. Similar findings were noted by Bennett (2003) who found that a systematic process to transition and guide clinicians to become and practice as educators did not exist. Three factors impact on the clinical educator: limited transition/socialisation in becoming a clinical educator, limited time to reflect and consolidate practice as an educator and limited processes to develop education pedagogy and principles applicable to clinical education. These appear to be barriers to becoming a clinical educator and progressing through the same learning cycle afforded to students as novice physiotherapy practitioners. Withholding of time can be described as symbolic violence, where time to develop, assimilate and synthesise knowledge (of education) is withheld either deliberately or as doxa, the taken-for-granted viewpoint of clinical educators. This reinforces that time is more appropriately spent with meeting patient and service delivery requirements. Reconfiguration of time as capital, legitimising time to reflect, develop new ways of facilitating student learning, can only enhance the learning experiences of both student and clinical educator. The authors conclude by recommending that education pedagogy and formal frameworks are made explicit and underpin clinical education.

In the absence of formal processes of learning to be a clinical educator, three motivating factors were identified by Kell and Jones (2007) which influenced physiotherapists’ decision to become clinical educators. External motivation was the most

dominant factor identified, and was linked to fulfilling a professional role. Internal motivation was described as a drive initiated by clinical educators themselves, and mixed motives describe the replacement of initial external motivation by internal motivation. Albeit physiotherapists self-selected or were selected to meet personal, professional or organisational requirements, motives did not necessarily translate into competency in clinical education. Internal motivating factors however, may suggest a genuine interest and aptitude for student learning and commitment to creating positive learning experiences. In this way, motives (habitus in action), allows the social trajectory of clinical educators towards positive experiences and matching of individual and field habitus (clinical education).

Evidence suggests that clinical educators draw from their experiences, as noted over two decades ago, yet the education needs of clinical educators appear to remain unmet. As postulated by Bennett (2003), understanding learning theory may positively impact on the quality of learning that occurs in clinical education. Strohschein et al., (2002) identified 10 models for clinical education drawn from different descriptions in the literature. These are critiqued and both advantages and disadvantages discussed. The authors conclude that the choice of model “should be considered within the context of the professional education curriculum design” (p. 170) and that more than one model may be appropriate. They also surmised that as clinical education interconnects with both the curriculum and clinical practice, improved collaboration between stakeholders could enhance the quality of learning experiences and that this, together with evaluation of different models, is worthy of evaluation.

While research has focused on clinical educators learning/teaching in the clinical environment, there is a noteworthy absence of research that has evaluated the development of education pedagogy within undergraduate curricula. Inclusion of learning/teaching strategies, framed by educational theory, could ease the transition of the student into the workplace, and from physiotherapist to clinical educator, thereby increasing congruence between student and clinical educator concepts and experiences of learning. However, to include education pedagogy in curricula, it would have to hold the same value as other types of professional knowledge. The paucity of literature relating to clinical education, suggests that both discipline-specific and clinical knowledge and skills already dominate the profession’s knowledgebase and the ideology and identity of physiotherapists.

## **Conflicts of clinical educator role and identity**

Within the clinical environment, clinical education occurs alongside the physiotherapist's primary role of providing patient care. As deduced from the reviewed literature, motives to engage in clinical education include internal or self-initiated motives, or external motives driven by organisation requirements or a sense of duty (Kell & Jones, 2007; Sevenhuysen & Haines, 2011), or mixed motives where external motives became internal (Kell & Jones, 2007). Some clinical educators described clinical education as integral to their role, but it was not compulsory (Öhman et al., 2005), and as previously described, the optional nature of clinical education was a significant tension for academic staff in obtaining clinical placements (theme one). Critique of literature relating to quality issues (theme two) in clinical education identified that clinical educators receive little preparation for their role, which in the absence of education pedagogy, (previous section), relied on trial and error, and drew from past experiences as a student. Additionally, interstakeholder tensions were found when academic staff and students held different concepts of teaching and learning, compared with clinical educators, and perceived different attributes of the 'ideal' clinical educator (Cross, 1995). A significant barrier for clinical educators was time (Sevenhuysen & Haines, 2011); this limited reflection and synthesis of clinical education experiences and created tensions between meeting workload and student/School expectations. Reviewed literature further revealed that knowledge transmission was the dominant learning/teaching strategy of clinical educators (Delany & Bragge, 2009; Kell & Jones, 2007), which may be perceived as more time efficient than facilitating student learning using different models of learning. It may also infer that discipline and clinical speciality-specific knowledge and skills are prioritised over education. The paucity of literature regarding education models in clinical education, and the relevance of these models to patient care is duly noted. Another pertinent point to emerge from the review of different models of clinical education (theme one) as a perceived barrier to implementation, was the reluctance of clinical educators to delegate their workload to students and be removed from "hands-on" clinical work (Ladyshewsky et al., 1998, p. 1296). Of interest, is that students highly valued 'hands-on' patient experiences over other forms of learning i.e. in-service training (Morris, 2007), as an important dimension in the evaluation of learning experiences (Cole & Wessel, 2008). This suggests there is an embeddedness and inherent value of 'hands-on' clinical practice in the identity of physiotherapists and students alike, and that a significant paradigm shift is required if education pedagogy is to be recognised and valued as part of the role and identity of physiotherapists and clinical educators.

A paradox lies within the profession that clinical educators, traditionally experienced physiotherapists in a clinical speciality, are assumed to have a similar level of expertise as educationalists. Only one study examined the converse transition of physiotherapy 'experts' into academia. Hurst (2010) studied eight physiotherapy lecturers in their first 4 years of higher education at one United Kingdom university. It was found that participants took between 1.5 and 3 years to transition to their new role; one of the key indicators which signified successful transition as an academic was "confidence in developing a pedagogy for higher education" (p. 240). Tensions mirror those of students commencing clinical education or as new graduates and include anxiety, concern regarding workplace and profession expectation, and meeting demands of multiple roles. Of note is that new academics initially relied on knowledge provision in a "didactic manner" (p. 242), which mirrored knowledge transmission found to be the dominant learning strategy with clinical educators. With increased experience, however, learning strategies evolved; this was also found in student learning (Delany & Bragge, 2009) irrespective of the static education strategies of clinical educators.

The need to develop education pedagogical knowledge and skills was perceived as essential during initial transition phase by novice academics. This infers the absence of such knowledge within professional training, or the association of this knowledge specifically within academia. Life experiences brought by individuals heavily influenced the decision to become an academic, which could suggest a strong affiliation with education and internal motivation. Drawing on Bourdieu's concepts, the value of cultural capital is determined by field values and habitus. Education as cultural capital may be considered more valuable in fields of academia compared with fields of physiotherapy practice, where patient care is more valued. Individuals are motivated to seek out opportunities to improve their social standing in hierarchies, and to improve congruence between individual and field habitus. It is therefore, inevitable that those physiotherapists with strong internal motivation and attributes conducive to education would seek out opportunities to become academic staff, and become full-time educators. Similar issues with transition, including transition of identity and role, represent habitus transformation, as it adapts to new field conditions. Although durable, habitus is capable of adapting, albeit over time. This is evident in the transition of students throughout their placements and as new graduates into the workplace, and as physiotherapists take on roles as clinical educators and academic staff. Common themes to mitigate tensions which emerge from the literature include improved collaboration and communication between stakeholders (negotiating capital), evaluation of clinical educator workshops to ensure that knowledge

and skills can meet student/School expectation (capital exchange) and valuing education within the clinical environment and profession (configuration of capital by fields).

## **Justification of this research**

While literature critiqued within this review has highlighted tensions and power interplay, these are commonly described as barriers to, for example, building clinical placement capacity and quality learning experiences. In essence, power interplay is only made visible when dominant interests and motives are contested. This research specifically aims to focus on the interplay of power and reveal tensions that impact on clinical educators and clinical education. Unlike the majority of studies reviewed, the research offers a unique context and understanding from the perspective of New Zealand clinical educators in physiotherapy. It is acknowledged that perceptions of clinical educators have been captured in surveys, interviews and focus groups; however, few studies have declared their philosophical or theoretical foundation. This research is explicit in its location within the critical paradigm and has implicit aims of empowering change. Both the subject area, philosophical and theoretical foundation, offers a unique contribution to the knowledge-base of the profession and scholarly community.

## **Chapter summary**

This chapter presents a critique of reviewed literature relevant to this research. The critique is framed by the work of Bourdieu, highlighting tensions and power interplay in the field of clinical education and between clinical educators and associated stakeholders. Three dominant themes within the literature were found in which power interplay was evident, where symbolic violence resulted in the withholding of resources, capital was contested and doxa reinforced the culture and practice of individuals and organisations. Some recommendations are explored to mitigate tensions and achieve a balance through the reconfiguration of capital. The research is justified within the context of the literature together with the unique contribution the research brings to the knowledge-base of the profession. The next section moves on to introduce the research procedures and describes how the research was undertaken.

## **Personal reflections**

*Reflecting on the literature, the scarcity of literature relating to clinical education is noteworthy. In comparison to research relating to clinical specialities and therapeutic interventions, educational issues have little presence in the profession's body of 'evidence' and in particular, within New Zealand journals.*

*Reflecting on my own experiences as a novice clinical educator, I remember the pressure to trial different models of clinical education, the stress in juggling competing patient and student demands, while wanting to become as good and effective an educator as I could be. Time was always at a premium and it was contested by students, team members, including new graduates, and managers. I was aware that students took precedence over new graduate learning and transitioning to the workplace; however, then, I admit, traditional models of education dominated and students were the responsibility of senior staff. In hindsight, and with experience, I have learned to optimise student learning by exposing them to different learning opportunities which is both stimulating for them, and creates time that I can spend with other staff or doing non-clinical duties. I have also made a significant shift in facilitating student learning and assisting the transition of novice educators towards contemporary models of clinical education. The responsibility for students is absorbed within the team, although for the benefit of the students, learning remains concentrated in one aspect of service delivery. Although one person is named as the primary supervisor, the culture within the service is of a team approach to clinical education. This has taken both time and effort to obtain the shift in team culture and practice. I also actively prioritise attendance of staff at workshops and constantly make links between the transferability of education pedagogy to patient care.*

*In my days as a novice clinical educator, few peers were available to share the dilemmas that were faced. As I supervised students from three Schools of Physiotherapy, I was able to attend different clinical educator workshops and synthesise the best of each into my own unique style of clinical education, and build up a network of peers. Many challenges I encountered were resolved through the same trial and error approach found in the literature, with time to reflect only available on my way to and from work.*

*Tensions identified by Hurst (2010) resonated as I transitioned from clinical practice into academia. In fact, my professional identity was embedded in clinical practice, so much so that I retained a small workload, working weekends. I recognised the importance of bringing reality into the classroom, while developing learning and teaching strategies to cope with lectures to 220 students, or practical sessions and tutorials. It took over a year to attain a balance between personal, professional and academic expectations, which Bourdieu would describe as habitus transformation. Having transitioned back into clinical practice, I have brought into and continue to value education pedagogy in my practice, for example, utilising a variety of learning resources when working with patients. In my opinion, there is a place and value of education pedagogy alongside discipline and clinical-specific knowledge and skills. How else will patients learn a new skill or exercise? If education was integrated*

*into the curricula, perhaps some of the barriers to clinical education would be negated. This would be worthy of consideration and evaluation.*

*I am convinced that there must be easier ways to transition between teams, specialities, and organisations. Students must continually adjust to new clinical educators, workplaces and professional expectations, just as new graduates rotate to new speciality areas every few months. Although it could be considered stimulating, the impact on new graduates in terms of stress, coping strategies and how clinical educators (and non-clinical educators) can assist in the transition is worthy of further and more in-depth evaluation. Integrating education pedagogy into the curricula, highlighting the value and transferability to patients and peers can reduce the disparities between clinical educators and academic staff, and only serve to improve the quality of experiences for all concerned. I believe that all clinical educators, irrespective of their motives to engage in clinical education, wish to be 'good' clinical educators and therefore, require the knowledge and skills to meet both theirs and the students/Schools expectations. In my opinion, education pedagogy needs to be more visible and valued in physiotherapy, especially within the current climate of the 'wellness' model of health and health promotion. Failure to embrace pedagogy more visibly may be detrimental to the physiotherapy profession.*

## SECTION TWO

### **RESEARCH PROCEDURES**

The following section consists of Chapter Four which describes Bourdieu's methodology and analytical framework as applied to this research. Research methods, ethical considerations and procedures, data collection and limitations of research procedures are also presented.

## CHAPTER FIVE

### Research procedures

#### Chapter overview

This chapter focuses on the research design, method and means of data collection and analysis. This includes how the design was framed by Bourdieu's theories and concepts, participant recruitment, phases of data collection, the interview method and how the data were framed for analysis. Processes to improve methodological rigour are described together with ethical considerations and limitations of the methodology employed. The chapter concludes with a reflexive stance in keeping with Bourdieu's concept of reflexivity.

#### Bourdieu's research methodology

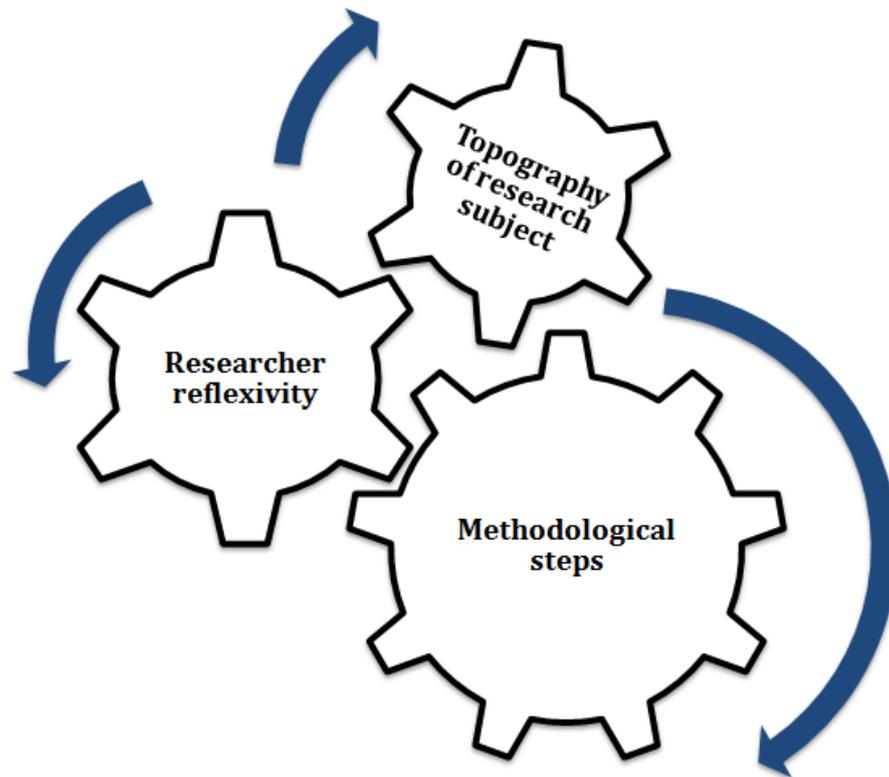
The theoretical territory and justification have been discussed in Chapter Three. Three key guiding principles underpin the Bourdieusian approach (Grenfell, 2008d): the construction of the topography of the research subject, adoption of three methodological steps presented in Table 5.1, as described by Bourdieu and Wacquant (1992), and participant objectivity through researcher reflexivity (Bourdieu, 1979/1984; Bourdieu & Wacquant, 1992; Swartz, 1997).

Unlike other research designs commonly described in terms of linear stages (Tobin & Begley, 2004) dependent on the inductive or deductive nature of research (Figure 5.1), the Bourdieusian approach is dynamic and cyclical in nature with inductive and deductive qualities co-informing the design, data collection and analysis.



Figure 5.1. Hierarchy of concepts (Punch, 2000) adapted to indicate dynamic interplay of induction/deduction (Bourdieu, 1979/1984)

A Bourdieusian approach represents a continuous evolution in understanding the social world of clinical educators and clinical education, transforming practical knowledge into theoretical knowledge. This interconnectiveness of clinical education as the social world (topography), position of the researcher relative to the subject under review (reflexivity) and the three methodological principles/steps which guide the construction and analysis of this research is represented in Figure 5.2. Each component is then further discussed.



**Figure 5.2 The dynamic relationship between Bourdieu's three guiding principles of research**

(Source: Bourdieu, 1979/1984; Bourdieu & Wacquant, 1992; Grenfell, 2008d)

### **Topography**

Topography of the social world under review (i.e. clinical educators and clinical education) was attained through an initial and subsequent continuous review of the literature. Individual, discipline and organisational habitus were explored in relation to fields including clinical education, physiotherapy, and capital, together with the socio-political and economic conditions under which they were formed. This was enhanced through participant interviews which positioned clinical educators (and stakeholders) within fields and hierarchies, and explored capital and conditions which determined their location and interconnectivity with other fields.

### Three methodological steps

The three methodological steps which informed the construction of the research and guided the research design, method and analysis are presented in Table 5.1. Details of how the methodological steps informed the interview schedule are provided in Appendix C. By way of example, clinical educators were asked what their relationship was with other organisations. This helped to inform the position of clinical educators within practice and organisational hierarchies.

**Table 5.1 Three methodological steps**

<b>Step One</b>	<b>Step Two</b>	<b>Step Three</b>
The research must analyse the position and practice of the field (clinical education) in relation to the broader field of power, i.e. professional and organisational culture and practice.	Research should analyse the position of clinical educators within practice and organisational hierarchies, based on the distribution and type of capital	Research must examine the habitus (including ideologies, values, motives) of clinical educators in relation to stakeholders and organisations and their influence on their social trajectory within clinical education and other fields such as physiotherapy and healthcare practice and education.

(Source: Bourdieu, 1979/1984; Bourdieu & Wacquant, 1992)

### Researcher reflexivity

Researcher reflexivity takes the writing style into first person language. It allows for potential sources of bias to be identified including my values, perceptions and attitudes (habitus) as a clinical educator and physiotherapist, how these have been shaped (field habitus and location) and how they may be projected onto the scientific process. This includes the scholarly gaze, that is my interest and motivation (habitus) in the subject area, my perceptions of the subject area (habitus), position in relation to the research and clinical education (capital and field), which according to Bourdieu (1997/2000; 1980/1990), can both be a source of bias and limit the interpretation of the social world. My reflexive stance included in Chapter Eleven is therefore, declared from the outset and woven throughout the research process including the literature review and data analysis. This was drawn from a reflective diary maintained throughout the research process.

### Ethical approval and considerations

The following section describes how key ethical principles including implications and consequences for participants were managed within this research. Supporting material has been provided in Appendices.

## **Ethics application**

Approval was gained from the Auckland University of Technology Ethics Committee (AUTEC). Subsequent amendments were approved to include 'clinical supervisor/educator' within the documentation, an increase in the participant numbers from 12 to 18, and extension to accommodate data collection. Approval documents are provided in Appendix D. Clarification was sought from AUTEC regarding the involvement of Maori within the research. This is addressed in the section relating to Te Tiriti o Waitangi.

## **Ethical principles relevant to this study**

Ethical respect for participants, knowledge, democratic values and rights, research quality and academic freedom (British Educational Research Association, 2004; Tolich, 2001; Tolich & Davidson, 1999) underpin principles of ethics and acknowledge the researcher's responsibility to participants, the research process and community. Such principles are not confined to the approval process prior to embarkation on the research, but embedded in the research process through to dissemination of findings. These principles encompass the rights of participants to make decisions based on clear, truthful and transparent information, respect for confidentiality including storage of information, and integrity of the researcher in writing for publication or presenting findings. Ethical principles and how they were managed within the research are presented in Appendix E. Two key principles are specifically addressed under participant confidentiality and Te Tiriti o Waitangi. These acknowledge the small community of New Zealand physiotherapists and the bicultural context of New Zealand.

## **Participant confidentiality**

Pseudonyms were chosen and generic references made within the thesis to protect the identity of participants. Participant confidentiality and anonymity is critical in this research. The New Zealand physiotherapy community is small and interconnected, with only two Schools of Physiotherapy and a limited number of clinical educators. Any identifying details including roles in Schools of Physiotherapy, Physiotherapy professional groups, geographical location, were changed within the transcripts and thesis.

## **Te Tiriti o Waitangi**

Consideration of Maori in research recognises the bi-cultural nation of New Zealand (Health Research Council of New Zealand, 1998). This includes where Maori are participants. Of relevance to this research is the small number of physiotherapists who self-identify as Maori in workforce data. In 2005 data, 3.9% of physiotherapists identified

themselves as Maori (Ministry of Health, 2006) and 3% of membership (inclusive of students) of the New Zealand Society of Physiotherapists' Inc. (personal communication: Janet Copeland, NZ Society of Physiotherapists' Inc., August, 10, 2006). The exact number of Maori who are clinical educators is unknown as this data are not collected by Schools of Physiotherapy.

The purpose of this research was to gain an insight into the perceptions of clinical educators and stakeholders in clinical education in, New Zealand. All clinical educators registered with both Schools of Physiotherapy were invited to participate; recruitment did not focus on Maori, but included Maori. The purposive sample of participants was therefore, not based on or biased towards Maori. Ethnic data were not obtained from participants, it was agreed that if a participant identified as Maori, in conjunction with the participant, consultation with experienced researchers, Maori colleagues and research supervisors would take place to ensure the culture, beliefs and traditions of Maori were respected from the perspective of the individual and his or her iwi. One participant self-identified as Maori. At the request of the participant, no consultative process was made; this was discussed retrospectively with Maori colleagues and research supervisors and considered acceptable based on the wishes of the individual.

Research findings would be presented and published in forums accessible to all physiotherapists including Maori and supports fundamental principles of collaboration and reciprocity, important to Maori.

## **Accessing and recruiting clinical educators and stakeholders in clinical education**

Guided by Bourdieu's methodological principles and belief that data are attached to individuals or institutions (Bourdieu, 1979/1984; Bourdieu & Wacquant, 1992), clinical educators and stakeholders were recruited to represent different fields and relations. These included representatives of Schools of Physiotherapy, physiotherapy profession (Physiotherapy Board of New Zealand and New Zealand Society of Physiotherapists' Inc.), professional leadership (professional leaders) and management (physiotherapy managers, allied health managers) and students. A summary of participant recruitment and selection is included in Appendices G, H and I.

### **Questionnaires**

In order to select a purposive sample of clinical educators and stakeholders, it was necessary to ascertain details regarding the exact population. A research pack (Appendix F) was sent to all clinical educators registered with both Schools of Physiotherapy,

managers, professional leaders and representatives from Physiotherapy Board of New Zealand and New Zealand Society of Physiotherapists' Inc. from databases, and information held in the public domain. The research packs included a covering letter to identify the purpose of the research, stressing anonymity and confidentiality both of the individual and their place of work, a questionnaire seeking demographic details, an invitation to participate, and a reply letter indicating consent to participate in an interview or focus group, and a pre-paid envelope.

The questionnaire was piloted with three physiotherapy colleagues/clinical educators who worked directly with the researcher and were therefore, excluded from the research. Minor amendments were made to the wording. To optimise success of the questionnaire, close attention was paid to the overall format, design and delivery (Polgar & Thomas, 1995) and included a pre-paid envelope (Oppenheim, 1992).

### *Clinical educators*

Research packs were provided to all clinical educators (in conjunction with pre-placement information) by programme leaders/clinical placements co-ordinators of both Schools of Physiotherapy. Distribution occurred over two months prior to commencement of placements; this allowed for changes in clinical educators and placements. No empty packs were returned from the universities; neither were additional packs requested.

The inclusion criteria indicated that all clinical educators must be qualified physiotherapists, hold an annual practising certificate (compulsory requirement of practising in New Zealand), and be directly responsible for the supervision and education of undergraduate students associated with either School of Physiotherapy. Clinical educators who worked directly with the researcher as a team leader were excluded from the study.

Demographic details were requested within the questionnaires provided to clinical educators. This included years of experience as a physiotherapist and clinical educator, approximate number of students supervised, models of clinical education used, qualifications relevant to clinical education and details of attendance at university based study days/workshops. In addition, details regarding area of practice and place of work, and preferred venue, method and time of interview were also obtained. Finally permission was sought to retain respondents' details on a database should the researcher wish to contact them for further information throughout the duration of the study. Consent to participate in the study was implied through the return of the questionnaire.

### *Stakeholders in clinical education*

University staff were recruited from personal correspondence and university websites. Research packs (Appendix F) were sent to Dean and Associate Dean of one School of Physiotherapy, Head of Division and Head of School of the other School, and programme leaders and clinical placement co-ordinators of both Schools of Physiotherapy.

Research packs were sent to all professional leaders and managers as members of the Professional Advisors, Leaders and Managers Group, a special interest group affiliated with the New Zealand Society of Physiotherapists' Inc. Names and contact details were obtained through membership secretariat, hospital and district health board websites.

All committee members from the Physiotherapy Board of New Zealand and the New Zealand Society of Physiotherapists' Inc were sent research packs. Committee membership details were obtained from professional websites and newsletters.

Ten research packs (Appendix F) were sent to clinical placement co-ordinators at both Schools for random distribution to five Year III and five Year IV students at each School. Students were excluded if they had completed a placement with the researcher to date or were likely to over the subsequent two placements (data collection period).

### **Purposive sampling**

Purposive sampling implies that participants are selected because of certain characteristics or attitudes based on the researcher's knowledge and specific purpose (Schutt, 2006). The purposive sample allowed for a stratified purposeful selection of clinical educators and stakeholders, highlighting particular characteristics of subgroups that could be used to facilitate comparison (Patton, 1990) on the research topic. As previously described, selective sampling enabled individual and organisation habitus and field to be explored in relation to clinical educators and clinical education.

### *Sampling of clinical educators and stakeholders of clinical education*

Phase I interviews: An initial survey of all clinical educators registered with both Schools of Physiotherapy, and stakeholders was undertaken. This allowed a purposive sample of 18 clinical educators to be recruited to participate in Phase I interviews, representative of different perceptions, positions and relationships within the field of clinical education. For example, participants selected held different years of experience both as a practicing physiotherapist and clinical educator, different specialty areas and places of work, e.g. private practice, community, hospital, university based clinic. Both Schools were represented and consequently, different roles captured, i.e. clinical educator and clinical tutor. Profiles of the clinical educators selected to participate in Phase I are

presented in Appendix G. Eighteen stakeholders were also selected as participants through purposive sampling. Details of participant response profile and type of interview is provided in Appendix H. To protect the identity of participants (clinical educator and stakeholders), some of whom were purposively selected from, for example rural areas, or due to their unique role, details of participant location has been deliberately omitted.

Phase II interviews: Seven clinical educators who participated in Phase I interviews were purposively selected and participated in Phase II interviews to explore themes which emerged from Phase I interviews. Recruitment was informed by participant contribution to the rich data generated from Phase I interviews, whilst also retaining wide representation of different years of experience, practice as a clinical educator, practice area and geographical location. Participant profiles are included in Appendix I. In Appendix J, Phase II semi-structured interview questions are presented, informed by Bourdieu’s methodological framework.

A summary of clinical educators and stakeholders including students who participated in this research is provided in Table 5.2.

**Table 5.2 Participants recruited to this research**

<b>Research Phase</b>	<b>Clinical educators</b>	<b>Stakeholders</b>
Phase I Interviews	18 (total)	18 (total) 6 Academic staff 2 Allied health directors 3 Professional leaders 1 Representative of Society of Physiotherapists’ Inc. 1 Representative of Physiotherapy Board of New Zealand 2 Year II students 3 Year IV students
Phase II Interviews	7	N/A

## **Data collection method**

Within the context of this study, individual participant opinions, confidentiality and a safe environment were selected in preference to focus groups which Sim (1998) argued do not reflect individual participants’ opinions but tend to represent attitudinal consensus. Self-expression of participants through in-depth one-to-one interviews was perceived by Sim to create a more conducive environment to free flowing conversation which would generate insightful data. In addition, selection and availability of participants throughout New Zealand made co-ordination of focus groups or tele-conferencing unlikely. Individual

participant interviews also allowed concurrent cyclical analysis of the data to be taken to subsequent participant interviews.

Semi-structured interviews were employed which allowed preliminary themes to be explored and engage the participants. Flexibility of the interview schedule promoted a responsive and fluent structure to the interviews (Mason, 2002) and allowed for unexpected themes and topics to be explored (Barbour & Schostak, 2005). Conscious that inherent in my position as researcher/interviewer, the knowledge of the subject area creates a position of power which unknowingly may manipulate the interview, I adopted the pose of a listener which allowed me to mirror the language of the participants. This strategy, together with my reflexive stance, helped created an open dialogue whereby my views were not consciously imposed on the participants being interviewed. The power imbalance was to some degree negated through the self-selection of clinical educators and stakeholders to participate in the interviews and their choice in deciding the location, time and method of the interview, i.e. telephone interview or face-to-face. Although De Vaus (1993) found that telephone interviews are less affected by the opinions of the interviewer unlike face-to-face interviews, Sapsford (1999) argued that the remoteness and formality of telephone interviews does not result in the quality that face-to-face interviews generates. Choice of location and interview method was central in ensuring that geographical location did not prohibit participation in the research.

A verbal research contract, as postulated by Burman (1999) to increase the success of interviews, was made at the start of each interview; this guaranteed confidentiality, discussed issues around anonymity and allowed the participant to terminate the interview at any point. The contract also gave participants the authority to edit the transcript and offered a copy of the results on completion of the research. The subject area was introduced prior to the interview, to decrease the element of surprise and reinforce the legitimacy of the interview (Burman, 1999).

### **Interview schedules**

The interview schedules were informed by the critiqued literature and framed by Bourdieu's methodological steps. Questions were specific to the participant group being interviewed: clinical educators, stakeholders in clinical education, and students as stakeholders in clinical education. The interview schedule consisting of semi-structured open and closed questions consisted of three components as advocated by Tolich and Davidson (1999). First, introductory questions were employed to engage the participant in general and with the subject area. For example, participants were asked to explain their role and relationship within clinical education. Second, time contrasts encouraged

participants to talk about their own experiences in chronological terms, as a student, more recent and their views on the future. This allowed for professional, organisational and individual milestones to be captured and for socio-economic and political determinants to be explored. Third, questions relating to spatial contrasts allowed the experiences of participants to be captured specific to their social position within different fields of practice, i.e. comparison between experiences of clinical education in other countries and New Zealand, different organisations and teams. The interview schedule was multi-dimensional, yet responsive to emerging themes. 'On the spot' decisions regarding the phraseology of questions and the direction of questioning (Coolican, 1999) were modified based on the participant's response (Schloss & Smith, 1999). The relationship between questions posed to participants and Bourdieu's framework of enquiry is provided in Appendix C (Phase I) and Appendix J (Phase II).

### **Interview schedule and equipment testing**

The interview schedule and interview process were tested with two clinical educators/colleagues who were excluded from the research as they worked within the same team as the researcher. The 'interview rehearsal' was a valuable exercise enabling the researcher to become familiar with the interview schedule, gain confidence in the process and test the recording equipment.

### **Method and location of interviews**

Interviews were conducted based on the preferred method (face to face or telephone), location and time preference of participants. Five telephone interviews were conducted with clinical educators, recorded at the participants' place of work, the remaining 13 were recorded as face to face interviews, with only one interview was undertaken in the clinical educator's home environment. Two telephone interviews were recorded with stakeholders; one from the stakeholders' home and two of the five student interviews were conducted by telephone.

### **Research programme**

The research programme was divided into three phases, Phase 0 recruitment and selection of participants through survey methods; Phase I interviews of clinical educators and stakeholders in clinical education; and Phase II interviews undertaken with a purposive sample of seven clinical educators who were selected from Phase I participants. Phases of the research programme are presented along with participant response data in Appendix H.

## **Post-interview schedule**

Following each interview, a process of review was instigated. The review included documenting notes about the interview, reflections on and of the interview immediately post recording, and reviews of the audio-tapes and interview transcripts.

## **Post interview notes**

After each interview notes were recorded either in written form or using mind-mapping (Buzan, 1993), a graphic technique which incorporates images, dimensions, colour (right brain activity) and words, analysis and logic (left brain activity). This enabled emergent themes to be recorded and relationships identified between them. These included generic observations regarding the participant's history with clinical education, his or her position within the organisation and relationships with other individuals and organisations, e.g. one participant held roles as a team leader, clinical educator and also placement organiser within her district health board. Other participants held dual roles, for example, academic staff member and also committee member of the Physiotherapy Board of New Zealand. It was important therefore, to appreciate the possible origin of the viewpoint that may have been taken from each position and explore potential tensions. Notes also captured key themes and prompts for further exploration; in some instances when interviews were within a tight timeframe, that is, the morning and afternoon of the same day, notes were brief, however, detailed recordings were made at the end of the day. Finally notes captured my reflections, and guided by Bourdieu's reflexive stance (1972/1977) allowed me to consciously analyse my own position within the interview, that is, my own habitus as a set of dispositions brought to the field under scrutiny and explored within the interview, and how this may have presented or projected itself within the interview. More detailed reflections were constructed when reviewing the interviews (listening to the audio-tapes and reviewing the transcripts) and adding to the initial notes. Critical awareness of my scholastic gaze as a researcher with a motivated interest in the subject area, and field location are sources of bias which promote more objective and scientific investigation (Bourdieu, 1972/1977, 1997/2000; Swartz, 1997). It is only through such a stance that the researcher can obtain a desirable degree of objectivity and "genuine freedom" (Bourdieu, 1997/2000, p. 118) on the world under scrutiny. My reflexive stance was often challenged within supervision and research peer meetings to promote further objectivity. Critical reflections were therefore, central to the research and interview process.

## **Transcription etiquette**

Interviews were transcribed verbatim by an independent and experienced transcriber. As a fellow research student and health professional, the transcriber was also familiar with the subject area. A confidentiality agreement was completed and filed (Appendix K). In addition to the process of transcription, the transcriber also provided a commentary of the interview which supplemented data analysis.

Each audio-tape was reviewed several times alongside the transcriptions to ensure accuracy and to enable the researcher to become immersed in the data. This was undertaken prior to returning the transcripts to the participants and in conjunction with a review of the 'field notes' and reflections.

## **Interview transcripts**

Transcripts were returned to participants for editing and verification, confirming that the transcript was an accurate account of their interview. Some participants requested editing of language or sarcastic comments, grammatical corrections; others requested that sections were not used as they were considered strong personal views or they identified the participant. In two telephone interviews, participants were able to make corrections to the text which was adversely affected by poor recording or background noise. Reminders were sent to five participants requesting that they acknowledge and verify the transcript within a three week period otherwise the transcript would be accepted per se (Appendix F). One clinical educator and one student failed to respond to the reminder and one stakeholder did not return the transcript with any corrections however, emailed permission for the transcript to be used with the proviso that any quotations used that were attributed to her and may identify her position would be discussed with her prior to inclusion/publication. This ensured that her contribution could be included as a key stakeholder, while maintaining anonymity. As no identifiable references were made or could be attributed to this stakeholder in this research, no discussions were therefore required.

## **Qualitative analysis and triangulation methods**

This section describes the management of the data in terms of analysis and methods employed to validate the data. Three levels of analysis were employed congruent with Bourdieu's framework as described in Chapter Two and Three.

## **Interview transcripts**

Analysis of the interview transcripts involved three phases underpinned by the Bourdieu's methodological principles. This included the analysis of participants' habitus

and position within the field of clinical education, analysis of their position in relation to different forms and volumes of capital and consideration of the field and habitus of clinical education in relation to other fields including the field of power).

### **Phases of analysis**

A cyclical and spiralling process of analysis was undertaken after each interview. This allowed for the emergence of initial themes to be compared within interviews and comparisons made between interviews with clinical educators and stakeholders, and carried forward to the next interview for exploration. In combination with post-interview notes and reflective analysis, a more in-depth level of understanding was obtained. Phases are presented as levels, as with each level a greater depth of analysis was achieved. A further phase of analysis was undertaken on completion of Phase I interviews, with dominant themes brought back to 7 clinical educators in Phase II interviews. On completion of Phase II interviews, all the transcripts were reviewed and analysed.

The **first level** involved translating themes through an open coding system from interviews into mind maps where linkages and relationships between themes are explored (Buzan, 1993) as they emerged at different times throughout the interview. Themes were then colour coded, highlighting statements and words which reflected Bourdieu's key concepts of habitus, capital and field. Concurrently these were then grouped together and referenced to profiles of participants, seeking an understanding of the social position of participants relative to each other, and location and interconnection with other fields. The transcripts were reviewed multiple times and colour coding was refined as I become more immersed in the data and the work of Bourdieu. This dynamic and cyclical process was combined with a reflexive stance, captured within a reflective diary.

**Second level** analysis involved identifying broader concepts of cultural and symbolic reproduction, symbolic violence, doxa, misrecognition and *illusio* within the data. Colour coding was again undertaken and at this point, electronic mind mapping was undertaken using Inspiration 8.0 IE. Concurrent and cyclical analysis of common themes such as time was reviewed in relation to Bourdieu's framework of cultural and economic capital (Swartz, 1997) and social position and from the perspective of different participants. This enabled the data to be explored from different viewpoints, for example, clinical educators and stakeholders (managers, professional leaders, students).

Within the **final level** of analysis, emergent themes were examined which revealed how clinical educators were shaped through primarily processes of self-selection relying on natural attributes rather than specific skills. Clinical educators and clinical education

were ranked low in social and professional fields based on different values of knowledge within physiotherapy, and power relations, essentially individual and organizational tension emerged through the commoditization of clinical education.

With increased familiarity of the theoretical underpinnings of Bourdieu, each phase and level of analysis was reviewed, resulting in the interpretation of rich descriptive data. Processes of analysis, interpretation and reflection were dynamic and cyclical as presented in Figure 5.3.

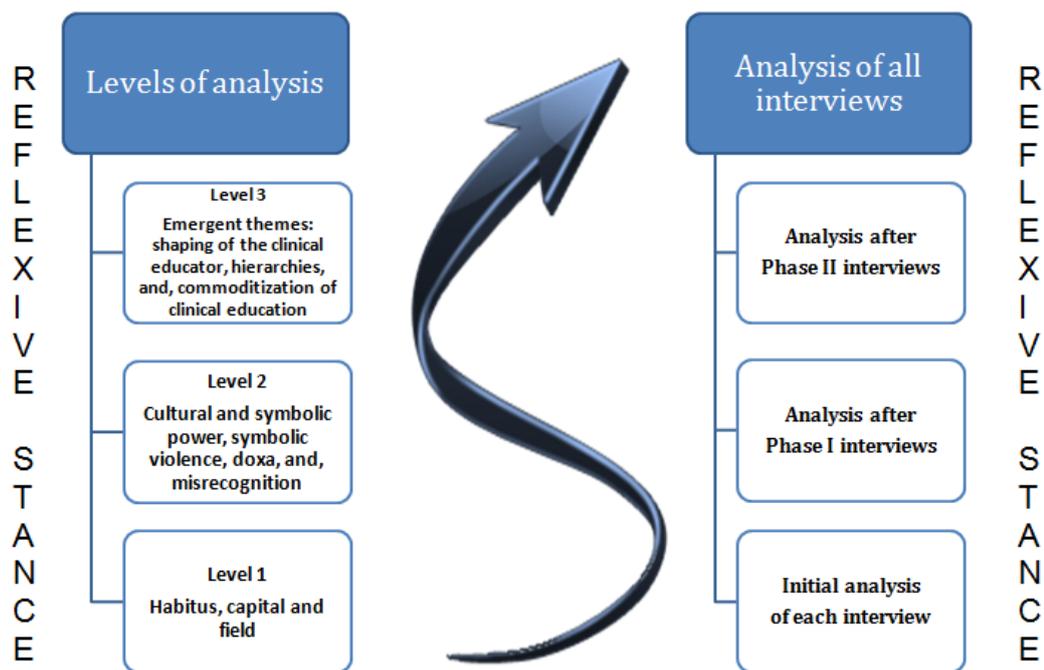


Figure 5.3 Phases and levels of concurrent analysis

### Quality and value of data

Bourdieu argues that “to be able to see and describe the world as it is, you have to be ready to be always dealing with things that are complicated, confused impure, uncertain, all of which runs counter to the usual idea of intellectual rigour” (Krais, 1991, p. 259). It was, however, considered essential to demonstrate legitimacy of this research from the perspective of the researcher and reader, and the scholarly community. Assessment criteria can demonstrate legitimacy and rigour of research, yet evaluation of qualitative research remains controversial (Johnson & Waterfield, 2004). For the purpose of this research, this was demonstrated through concepts of trustworthiness and truthfulness of data. Additional strategies of sampling, respondent validation, triangulation, audit trail and reflexivity were also utilised; the latter based specifically on the work of Bourdieu.

Trustworthiness and truthfulness of data were examined in relation to credibility, truth value, dependability, auditability and confirmability (Johnson & Waterfield, 2004). Credibility was achieved through a wide representation of clinical educators and stakeholders as participants in the research; this enables individuals to recognise and identify with the multiple realities of their lives. Confidence in the 'truth' of the data, its interpretation and the research context was achieved through purposive sampling, a transparent audit trail of decision making, and methods of triangulation including participant, peer and supervisory review. This attained congruence between what was concluded from the data and participant perceptions and interpretations. Dependability and auditability relate to the stability of the research design and data. This was accomplished through semi-structured interview format, an audit trail and Bourdieu's methodological principles of interpretative analysis. Methods of triangulation, a transparent audit trail and reflexive stance were undertaken to ensure confirmability or neutrality of the data and interpretations.

To demonstrate the quality and value of findings, Morse (1991) and Rolf (2006) argue that rigour of the research process must be demonstrable. Rigour is the means by which integrity and competence is demonstrated throughout the research process, including data analysis. As a concept, rigour offers qualitative research a means of demonstrating legitimacy, which within quantitative research would otherwise be demonstrable through validity and reliability (Tobin & Begley, 2004). However the relevance and application of validity and reliability to qualitative research is questionable given their location within the positive paradigm. Qualitative research unlike quantitative research is where reality is socially constructed by participants, interpreted rather than measured and understanding cannot be viewed as separate from context (Johnson & Waterfield, 2004; Tobin & Begley, 2004). Validity, for example, cannot be tested as is based, for example, on assumptions of object reality and application of findings to the wider population (Johnson & Waterfield, 2004; Krefting, 1990; Mays & Pope, 2000). Reliability as argued by Sandelowski (1993) is also not a useful criterion in qualitative research as, again if reality is assumed to be constructed, repeated attempts to demonstrate reliability merely represents forced consensus of data, and may compromise the meaningfulness of data interpretation. Morse (1999) argues both concepts hold merit within the scientific process and to reject these concepts outright, may undermine the value and contribution of qualitative research to knowledge and the research community. Qualitative equivalents as described by Johnson and Waterfield (2004) have therefore been utilised. These include credibility and truth value (internal validity), transferability, applicability and fittingness (external validity) and dependability and auditability

(reliability). A summary of how trustworthiness and truth value of data were achieved within this research is presented in Appendix L.

## **Triangulation of method and data**

Various types of triangulation are described within the literature: data, investigator, theoretical and methodological. Traditionally, triangulation is employed whereby data pertinent to the subject area or research question is collected from at least three different perspectives or using different kinds of data to cross-validate findings (Somekh & Lewin, 2005). Pope, Mays and Popay (2007) however, argued that triangulation methods risk “focusing the analyst excessively on similarities between sources and methods, since it assumes that the addition of a source or method is designed to confirm an existing interpretation” (p. 51). Triangulation therefore, should extend beyond the confirmability of data relative to fixed points of comparison, to provide multi-dimensional points of reference to enhance the completeness of findings (Tobin & Begley, 2004). A transparent process including reflexive analysis for dealing with data from different sources or methods that represents convergent, divergent or even contradictory findings is recommended. Within this research, several dimensions of triangulation were employed as advocated by Mays and Pope (2000).

**Respondent verification:** interview transcripts were returned to participants to check for accuracy and ensure that the transcripts accurately captured the interview.

**Respondent validation:** perceptions of clinical educators were contextualised by stakeholders in clinical education, i.e. representatives of related and interconnecting fields. Cyclical analysis of interviews enabled findings to be brought to subsequent interviews. Additionally, emergent themes arising from Phase I interviews were brought to a purposive sample of clinical education for validation and further exploration. Although argued by Mays and Pope (2000) as a means of establishing dependability of data and credibility of findings, respondent validation may also generate additional data requiring analysis. This was evident in Phase II interviews whereby additional themes emerged which required interpretation.

**Audit trail:** trails relating to decision making and also levels of interpretation were maintained to provide transparency in the evolution of the research and findings.

**Peer de-briefing:** informal and formal presentations and discussions were held throughout the research. This included discussions with research supervisors and peers, and presentations at university and professional forums.

Reflexivity: transparency of my role as a researcher, prior assumptions and experiences brought to the research and stages of interpretation were captured in a reflective diary maintained throughout the research process.

Attention to negative cases: contradictory explanations were included in the interpretations; this helped to challenge the analysis and acknowledged the importance of individual habitus within the research.

Fair dealing: a wide range of different viewpoints is advocated to ensure that the sole truth is not attributed to one group or one situation. Clinical educators represented different locations, practices etc., and stakeholders represented different relationships and organisations connected with clinical education. Additionally, the timeframes in which the interviews were conducted (Phase I: March – July 2007 and Phase II: June – August 2009) position the research within a specific point in time.

## **Limitations of methodology**

Bourdieu's key principles as described in Chapters Two and Three provide a robust framework for data collection and analysis. The social world of clinical educators was analysed in relation to the broader field of power (physiotherapy, healthcare), their position within practice and organisational hierarchies and individual and group habitus and their influence on their social trajectory in immediate and interconnecting fields. These three levels of analysis Grenfell (2008d) argued should be reviewed simultaneously rather than considered sequential or linear. This proved challenging given the vast wealth of data which was generated by the 36 participants interviewed. There is an inherent risk of omission given the volume of data generated. Sampling of clinical educators and stakeholders sought to represent a diversity of experience, relationships, areas of practice and employment and geographical location. On receipt of the questionnaires, it was apparent that all facets of practice and relationships within clinical education could not be adequately represented; however, sufficient diversity from the purposive sample would be captured. Findings and interpretations cannot therefore, be generalised to all clinical educators and are specific to a point in time of data collection.

The interview schedule and sequencing of interviews was influenced by the availability of participants; cyclical analysis therefore, took place following individual or closely-timed interviews (morning and then afternoon). The impact of interviewing all clinical educators followed by stakeholders (or vice versa) on data collection and interpretation remains unknown. Improved scheduling of interviews may have resulted in more in-depth analysis and reflections to take to subsequent interviews.

The research design incorporated stakeholders who were connected with clinical education through formal and professional contracts and relationships. Patients as consumers of clinical education could have provided a unique insight into clinical education from a different perspective. The inclusion of patients as stakeholders is further discussed under research limitations in Chapter Eleven.

Focus groups may have enhanced the richness of data by providing group discussion and another source of data triangulation. Focus groups were deemed to be logistically improbable due to factors including geographical location and participant availability and access to video-conferencing equipment. Additionally, focus groups were also considered an unlikely forum whereby participants would voice individual and honest opinions. Group dynamics particularly, if the group consisted of clinical educators and stakeholders (including students), or solely stakeholders, may have reproduced the social hierarchies in which symbolic violence is practised. The benefits of one-to-one interviews were reaffirmed as the most sensitive and responsive method in which to capture true perceptions and practices of participants.

## **Chapter summary**

This chapter provides a bridge between Bourdieusian theory and the current research, the method of data collection and analysis. The three principles of Bourdieu's approach underpinned the method and analysis. One-to-one semi-structured interviews, the interview schedule and cyclical analysis allowed for themes to be explored within subsequent interviews. This reflected the dynamism of Bourdieu's methodology and analysis. The research process was justified from ethical and data quality standpoints and compared against established criteria, including triangulation and adopting a reflexive stance, key to Bourdieusian research in understanding the position of the researcher and the lens through which data is interpreted. Analysis was multi-dimensional and dynamic and revealed a complexity inherent in the relationships, histories and practices of clinical educators in physiotherapy. This was supplemented by the perceptions of stakeholders. Interpretations are presented in subsequent chapters revealing the social tension and friction in clinical education and the social forces and dynamics which shape, influence and dominate.

## **Personal reflections**

*My unique habitus as a physiotherapist, team leader and clinical educator creates a bias based on my knowledge and experience of the research topic and my fundamental interest and motivation to explore its complexities. Previous experience as a senior lecturer*

*in physiotherapy and visiting clinical tutor have also shaped my interest in this subject area and given me an insight from another viewpoint. The strong links with clinical education, whilst creating credibility, were multi-dimensional and therefore, not biased towards one participant group or the other. A sense of neutrality and transparency regarding the research purpose was openly promoted to encourage honest discourse with participants.*

*Interconnectivity of clinical, educational and research fields in which I am positioned has the potential to influence the lens and scholastic gaze in which not only is the data interpreted, but also the research method. The smallness of the New Zealand population which Tolich (2001) considers to be in itself an ethical concern, is highlighted further given the small number of practising physiotherapists and that there are only two Schools of Physiotherapy within New Zealand. Familiarity with some participants was therefore, unavoidable. Several of the stakeholders interviewed were known to me through professional relationships, whilst others were recognisable at national physiotherapy forums. Whereas my exclusion criteria could preclude colleagues and students with whom I had direct and regular contact, other stakeholders by nature of their position and contribution to this research were included. Inherent in my skholè, i.e. "economic and social privileges of the scholastic posture" (Deer, 2008, p. 128), is the opportunity of interviewing clinical educators and associated stakeholders from around New Zealand. Interviewing would enable me to network with peers and enhance my understanding of health systems and organisation of clinical education in different practice environments. Moreover by interviewing participants associated with both Schools, I was able to address any potential bias towards one School and clinical education staff with whom I was more familiar. This was important to present a balanced interpretation of findings that could be applied nationally.*

*Although several methods were employed to make decision making processes transparent, I am conscious of the academic space which shapes the method, interpretation and writing of this research. Tension between being a student and researcher of one of the academic institutions under scrutiny must be acknowledged, as should the relationships with stakeholders. Throughout the evolution of this research, my role in clinical education became removed from direct involvement with students to supporting new clinical educators within my team; this created a distance, a 'space' in which to objectify and understand the tensions evident in the research and interviews. Several methods were also employed to promote transparency in my decision making in relation to data collection and analysis, e.g. audit trails, peer and supervisor review. Mindful of the importance of reflexivity, I acknowledge that my skills, and depths of reflection and reflexivity evolved alongside my experience and understanding of Bourdieu and this research.*

## SECTION THREE

### RESEARCH FINDINGS AND INTERPRETATIONS

#### **Overview of findings chapters**

In the following chapters, four key themes are presented which emerged from interviews with participants as interpreted through Bourdieu's framework of analysis (1972/1977). As previously discussed, Bourdieu advocates a three level approach which represent distinct levels of interaction between habitus and field. Each chapter draws on a specific level of habitus/field interaction, whilst acknowledging where appropriate, other levels of interaction. Clinical educators are firstly presented as a social class, shaped by field conditions including personal and professional socialisation. Subsequent chapters examine the location of clinical educators and associated stakeholders in relation to the configuration of capital and position in hierarchies, and historical and socio-economic and political influences that shape field conditions, practice and culture.

**Theme One** presents the characteristics and dynamics of clinical educators as a distinct social class which are described in terms of habitus formation, tension and conflict to protect self interests including personal values and beliefs. Class inequalities are described in terms of different value systems held by others and how these manifest as symbolic violence, for example, whereby resources are withheld.

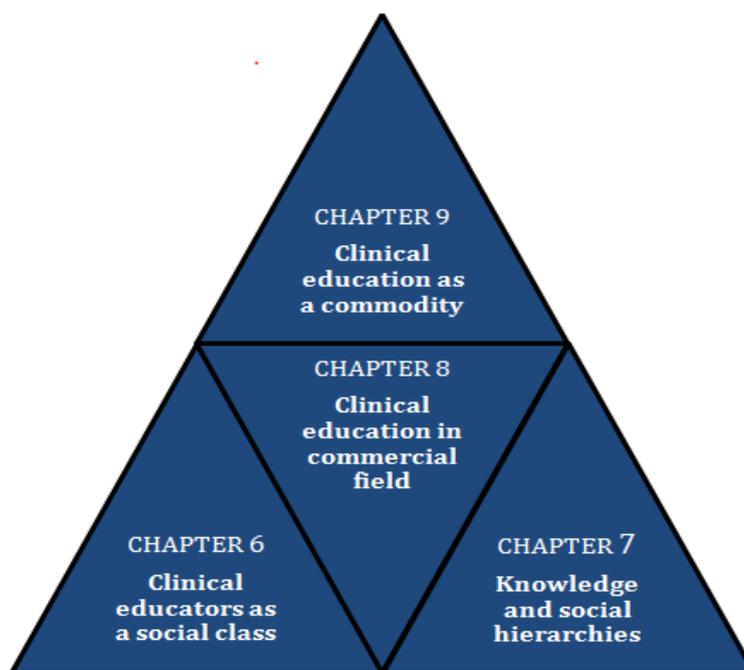
**Theme Two** focuses on the co-location of clinical education within fields of education and physiotherapy practice and emergent tensions arising from the continual contestation of clinical education as capital. Inter-stakeholder conflict is explored in relation to a disjuncture between, for example, fields of 'clinical' and 'education'.

**Theme Three** examines clinical education in relation to the wider field of power and specifically, socio-economic and political influences. Consumerism and commercialisation are explored through their impact on clinical educator and stakeholder relationships and in particular, relationships as consumers and service providers.

**Theme Four** explores the concept of clinical education as a commodity and examines the economic influences that impact on clinical education, and by association, stakeholders in clinical education. Power interplay is revealed as the economic value of clinical education is contested. This includes the tension between professional obligation of physiotherapists to train the next generation of physiotherapists and the economic climate of healthcare and physiotherapy service delivery.

These themes, I argue, provide evidence of the power dynamics and interplay within clinical education in physiotherapy in New Zealand. Implications for clinical educators and stakeholders including the profession of physiotherapy are summarized at the end of each chapter and further discussed in Chapter Ten.

A diagrammatical presentation is included in each findings chapter (Chapter Six, Seven, Eight and Nine) which highlights the theme under review. Figure S3.1 presents the four themes which emerged from this research.

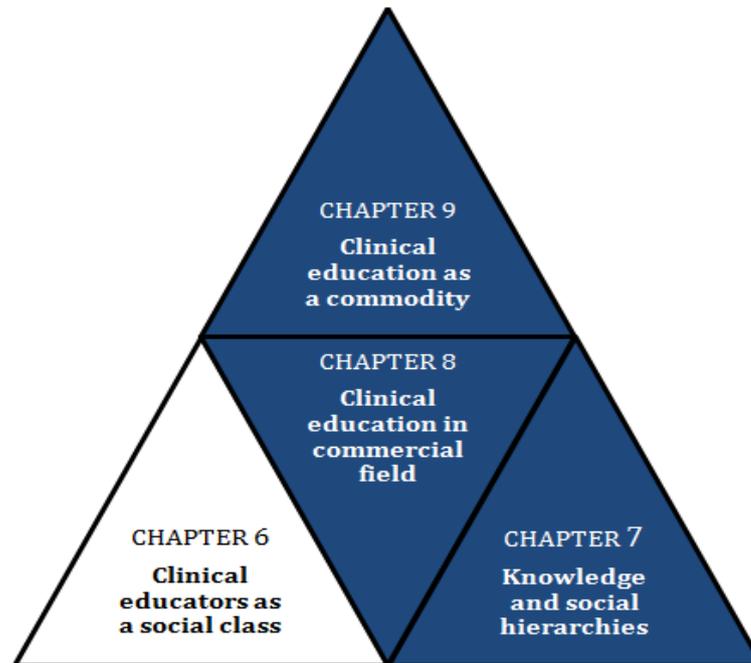


Chapter 6 Clinical educators as a social class
Chapter 7 Knowledge and social hierarchies
Chapter 8 Clinical education in commercial field
Chapter 9 Clinical education as a commodity

**Figure S3.1 Summary of themes which emerged from this research**

## CHAPTER SIX

### Clinical educators as a social class: becoming and being a clinical educator



<b>Chapter 6 Clinical educators as a social class</b>
Chapter 7 Knowledge and social hierarchies
Chapter 8 Clinical education in commercial field
Chapter 9 Clinical education as a commodity

Figure 6.1 Summary of themes which emerged from this research: Chapter Six

### Chapter overview

This chapter presents **Theme One** pertaining to the unique habitus of clinical educators as a social group, located within fields of practice and education. Distinct ideologies and motives that define clinical educators are examined in terms of value and how they position clinical educators in organisational and professional hierarchies. Characteristics of clinical educators as a social class (in comparison to other physiotherapists) are explored as tension and conflict to protect self-interest including personal values and beliefs. Within the context of this study, such attributes, ideology and

motives as embodied forms of capital, hold value within limited fields. This results in tension between clinical educators and other stakeholders influenced by value systems bound with other interconnecting fields. This thesis demonstrates that some student participants recognise power dynamics and challenges for clinical educators and in some instances students spoke of distancing themselves from clinical education upon graduation. Undermining clinical educators as a social class or perpetuating class inequalities, therefore, has implications for the next generation of clinical educators and the future of physiotherapy practice and the profession.

## **Clinical educators as a social class**

*Social class is not defined by a property ... nor by a collection of properties (of sex, age, social origins, ethnic origin ... income, educational level etc.), nor even by a change of properties strung out from a fundamental property (position in the relations of production) in a relation of cause and effect ... but by the structure of relations between all the pertinent properties which gives its specific value to each of them and to the effects they exert on practices.*

Bourdieu (1979/1984, p. 106)

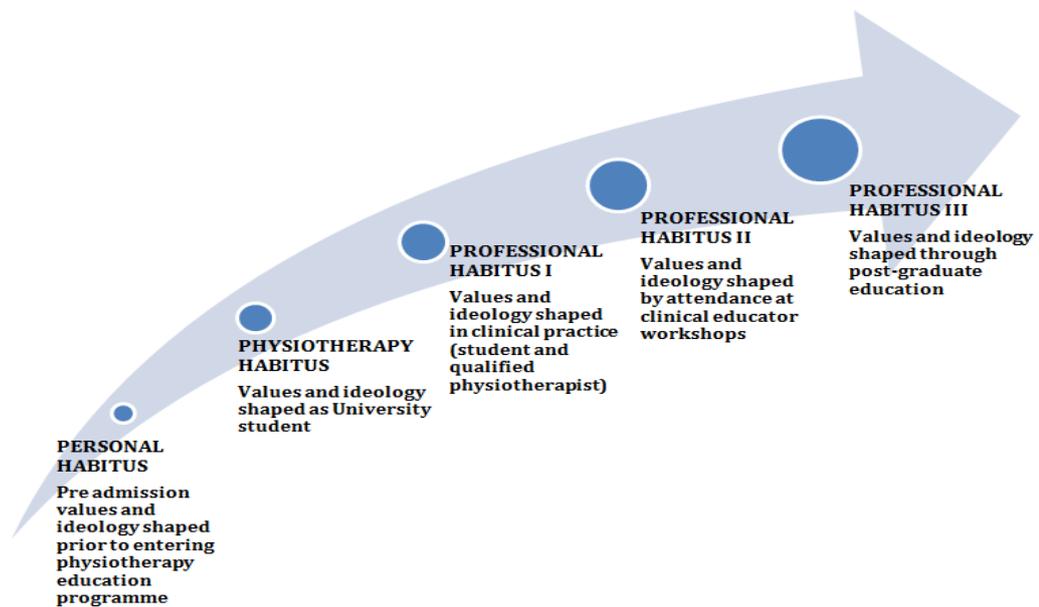
Unique personal and professional attributes, ideology and motives were identified which defined clinical educators as a social class with a distinctive habitus. These are described as 'valuables', drawing on Braithwaite's (1975) concept of professional valuables which are acquired during professional socialisation. In this research, the worth of valuables as embodied forms of capital is influenced by value systems bound with other interconnecting fields, i.e. education and physiotherapy practice. Two sources of data have been used to demonstrate this: perceptions of stakeholders as representatives of other fields, and literature relating to clinical educators. This includes 'perceptions of the ideal clinical educator' (Cross, 1995), qualities of good instructors (Marriott & Galbraith, 2005) and effective clinical teachers (Irby, 1978), perceived abilities and qualities of clinical educators (Bennett, 2003) and how these are formed and reproduced during periods of socialisation (Cant & Higgs, 1999).

Two distinctive periods of socialisation were identified within this research. Primary socialisation describes personal habitus brought by individuals to undergraduate education (university) as students, formed from early life experiences. Secondary socialisation recognises four phases of shaping habitus unique to participants and included socialisation as a student both in university and within practice and communities, attendance at clinical educator workshops and also as socialisation as post-graduate students. Phases of socialisation are presented in Table 6.1.

**Table 6.1 Phases of socialisation**

Primary socialisation	Secondary socialisation
<i>Personal habitus</i> as internalised dispositions formed from early life experiences and brought by individuals to undergraduate education (university) as a student	<p>Physiotherapy habitus, dispositions shaped by experiences as a student physiotherapist, within the university</p> <p>Professional habitus I, shaped through socialisation experiences of working (as students and qualified physiotherapists) within communities such as private practices, district health boards</p> <p>Professional habitus II, shaped through socialisation experiences and attendance at university based workshops</p> <p>Professional habitus III, shaped through socialisation experiences as a post-graduate student</p>

Phases of socialisation are not compartmentalised as Table 6.1 would suggest, but represent a continuous phase of transition, often overlapping with other phases, such as, Professional habitus I and III where the physiotherapist is both working as a qualified member of the profession/staff and also undertaking post-graduate education. Clinical education, within the context of this research encompasses periods of socialisation at university (physiotherapy habitus) and practice-based learning within clinics, hospitals and the community (professional habitus I). Figure 6.2 presents phase of socialisation in relation to the environment where dominant forms of learning occurs.



**Figure 6.2 Phases of habitus formation from student to clinical educator**

The durability of personal habitus formed through primary socialisation (Bourdieu, 1972/1977, 1979/1984) in which dispositions become deeply internalised was demonstrated as habitus adapted to new field conditions (physiotherapy and workplace communities) rather than fundamentally altered (Bourdieu, 1980/1990). This suggests that personal valuables brought to clinical education are already embedded as dispositions in individuals and are a dominant influence in the social trajectory of physiotherapists to become clinical educators. Additionally, secondary socialisation which occurred within the university and practice environment was also found to shape habitus as a physiotherapist and specifically, as a clinical educator. Workplace communities, for example, were found by Cant and Higgs (1999) to shape and challenge career aspirations and choices, with workplace micro-culture and management acknowledged as influential in shaping individuals' motivation towards learning (Eraut et al., 2000). This is in keeping with Bourdieu's (1980/1990) work on social trajectory, whereby aspirations and actions are shaped towards achieving a sense of place and congruence (Bourdieu, 1979/1984).

Although the relationship between primary and secondary socialisation is unclear (Swartz, 1997), participants in this research were found to orientate themselves toward a profession and workplace that was congruent with their personal habitus, and also towards clinical education which further complemented their unique dispositions (personal habitus). By way of example, Shelagh (district health board based physiotherapist) describes her personal motivation (habitus in action) to become a physiotherapist:

*I really only wanted to be a physiotherapist and that's what I wanted to do and I still want to do, and I'm very happy in my choice.*

Su moves beyond her commitment to physiotherapy to speak of congruence between her present role in educating patients in the community and working with students:

*My job as you know, is teaching people to be better self managers and getting a better quality of life and that really, is not dependent on getting an intervention from a health, health professional. It's them taking control of their own lives and consulting with health professionals when they require it. So that it's more of a consultation role, I will go and see someone and get help with this because I know I need help and I will take this advice. And I will either utilise it or I won't. That's what we do. And that's how I see my role. As teaching people to do, or to pick up the things that we see as best practice or getting the best end result, the best health outcome. So that's my clinical role and so I don't see that there's not really, any huge line between doing that and teaching a student.*

Other stakeholders such as Rebecca (professional association representative) spoke of natural selection in identifying clinical educators, yet acknowledged the role of

organisations such as district health boards in shaping and valuing learning in the wider sense:

*I think natural selection is going to find the educators. I think the way that they're nurtured and developed is a different issue, and that's an issue of the facilities like your hospitals, developing systems in place where they recognise the value that that adds to their staff because let's face it clinical education within hospitals is not just about undergraduates.*

She continues:

*I think well in terms of within your peers it's identified, who picks up something and I mean, there's enough concerns and stresses for the university and what they're trying to do anyway with the undergraduates without trying to pick out potential educators. I think that is something that basically gets sifted out eventually, and those people realise that they have a desire and like that part of the work so they tend to go that way.*

Natural and self-selection are described as dominant influences in determining the trajectory towards clinical education. As described by Rebecca, organisations such as hospitals also have a role in selecting physiotherapists as clinical educators, nurturing their interest in student learning or embedding clinical education as in professional development and career advancement of physiotherapists. In contrast, universities are described as responsible only for students, and meeting registration requirements through their undergraduate programmes. Responsibility for clinical educators appears linked to their primary location within specific fields, rather than a shared and collaborative responsibility of stakeholders in clinical education and the profession. Personal habitus as embedded dispositions therefore, emerges as a significant factor in orientating some physiotherapists towards clinical education or organisations compatible with learning.

## **Personal and professional valuables as habitus**

Although study participants were not asked directly what valuables they perceived as essential for clinical education, distinctive personal attributes and ideology emerged from the data. Personal valuables were demonstrated through interactions, with, for example, students such as empathy, flexibility and adaptability, and motives related to personal development. Professional valuables were described in relation to learning, and commitment to the next generation of physiotherapists and the profession. Additionally, valuables were revealed as motives of clinical educators to build meaningful relationships with school staff, for example, in order to develop opportunities for advancement. Such valuables were analysed in terms of symbolic and cultural power and what individuals brought to clinical education as a field and the power evoked within. This included shaping field habitus and field conditions to influence students, peers and practice culture.

By way of example, physiotherapists were able to change team culture and practice through role modelling as clinical educators, successfully embedding clinical education within teams.

### **Empathy and empathic behaviour**

Fourteen of the 18 clinical educators spoke of empathy (also described as compassion) towards students and stakeholders in clinical education. Empathy described as “the first step towards communicating across boundaries” (English, 2010, p. 246), which when combined with an ability to project into the ‘shoes’ of others, along with skills in communication, culminates in effective tension management (English, 2010). Successful outcome however, is dependent on the relative positions of both parties in what Bourdieu (1985) calls ‘social space’ or ‘fields’, described by Swartz (1997) as “arenas of struggle” (p. 122). It is within fields that valued resources are contested. Empathy within this research was found to bridge spaces between educators, students and associated stakeholders, and fields of clinical practice and academia. In some instances, however, being empathic did not translate into empathic behaviour and became a source of tension. The following examples demonstrate empathy within different relationships. This includes clinical educators and students.

Katie (qualified in 2001) speaks of empathy towards students compared with other staff:

*I think its maybe because it's not all that long ago that I was actually a student myself and I feel I probably have a bit of an insight into what it's like to be a student. And perhaps some of our older members of staff, first of all they didn't complete a bachelors, it was a diploma. So I think that maybe makes a difference.*

Andrew (district health board based clinical educator) empathises with struggling students:

*It must be incredibly hard to be a student and be struggling and be in that situation where you're not going to know if you pass or fail. It's going to add on to that stress level and make you more nervous and more likely to fail and more likely to doubt yourself, and less likely to become better at what you do. But I think it's the name of the game when you are in a practical environment, you do have to have a practical way of assessing someone's skills.*

Although being empathic towards the struggling student, the ‘game rules’ as described by Andrew, determine that students must demonstrate competency. Empathy therefore, attempts to reduce the dissonance created between clinical educator and student. Ultimately, Andrew’s role and position as assessor, legitimised by the School, will always result in a power differential, based on symbolic power.

Julia (district health board based clinical educator with experience of working with 20+ students) further highlights the impact of power imbalance between clinical educator and student and their relationship:

*I know with my staff, understanding what makes them want to come to work is the most important thing you can find out and I don't know if we really get that opportunity [with students]. Obviously there are barriers between what a student will tell a clinical educator because of the power that the educator holds. I think that probably limits the relationship but I don't know how you'd provide clinical education without having some sort of a power difference there.*

Space, from the perspective of the student, can maintain the distance and position between clinical educator and student. This is in contrast to Julia's relationship with team members where she seeks to create a more personal relationship. The spatial distance between Julia and students is acknowledged through her appreciation and empathy for the position of students relative to clinical educators within social hierarchies.

Empathy towards colleagues was also evident, as described by Sandra and Tania, School employed staff in relation to other physiotherapy colleagues.

Sandra (clinical tutor, employed by School):

*I think they're [clinical educators] quite busy and the feeling I get is they're quite busy with just dealing with their day to day stuff. They do need to spend quite a lot of time, with the students in those first three weeks definitely because they [students] come feeling quite sort of overwhelmed.*

Tania (university employed clinical educator):

*I think they [clinical educators] definitely see themselves as physios first but I don't see myself as an educator first but I think that the role I have is quite unique. That's why I like it because I'm an education sort of type person. I like the education and because I like that part of it I like the role but if I was a physio first and then an educator I think that would actually make that quite difficult, I could see that's quite a stressful situation to be in.*

As university employees, Sandra and Tania's unique position represents congruence between personal and field habitus, given that both relate to education. For other clinical educators, for example, employed by district health boards or private practices, competing demands of service provision and student education are recognised by Sandra and Tania as stressful. In particular they are empathic towards the impact of students on clinical educator time, and the demands of meeting dominant field requirements which focus on patient and service requirements.

In other relationships empathy was also described. Clinical educators spoke of managers being empathic in times of staff shortages. Tensions with manager are revealed by Andrew, another district health board-based clinical educator:

*They [managers] perceive it as something that again we should do and we should offer but not if it impacts negatively on our service provision. So if, our wait lists are going to go up or it's going to stress us out too much or anything like that then they would say no, don't take a student at this time. So I think they would weigh up the positive effects of clinical education versus the negative effect it has on the service provision.*

Julia (district health board clinical educator) speaks of her manager's views on clinical education when short-staffed:

*She was a physio. She's just been here a short time. I haven't really had discussions with her around clinical education. I know when you get short staffed and stressed it's something that they want to cut.*

Given that all actions are interest orientated (Bourdieu, 1972/1977), strategies proposed by Andrew and Julia's managers to negate stresses, are bound to preserving service supply and staff productivity (economic and cultural capital). This was in contrast to clinical educators who were committed to service delivery and clinical education. Being empathic, can be described as a means to bridge tensions; yet in the case of managers and clinical educators, can also be described as a source of tension, when strategies to reduce stress challenge the professional valuables of clinical educators. To reduce personal and professional tension created due to multiple demands on time including staff shortages, clinical educators such as Julia, strategized to obtain a better balance. She describes manipulating the waiting list, for example, to maintain and protect her commitment to clinical education and avoid conflict. This represents deliberate action to protect valuables associated with being a clinical educator. Julia:

*Well obviously you have to manage things at the time the best you can, and it's a practical decision but it's not a long term decision to stop having students. I don't think it's a long term solution to do that. And how we've set that up now that we do it continually, we're prepared for fluctuations with our staffing, so hopefully we won't get to that situation again.*

Embedded in the valuables of clinical educators, is a personal knowledge, described by Titchen and McGinley (2004) as an "awareness of values", shaped by life experiences (p. 113). What emerges from interviews with student participants is that empathy is already internalised and present as personal habitus in students. For example, Tara (year III student with experience of one clinical placement) describes empathy towards patients:

*I think from my own experience as a mother, having a child in hospital I think that whole power dynamic is something that probably concerns me and something that I can see. I place importance on it, so I think people who are vulnerable; I can really feel for them. So probably a sense of empathy with being in that same situation or having an understanding of what it's like, especially in the hospital system.*

Empathy is described by Tara and Jamie (year IV student) towards clinical educators and their challenges. Tara continues:

*I mean it must be really stressful to have some utter morons on your team and you know that they're not going to be good physiotherapists and that they're wasting everybody's time. It must be very stressful and yet you've got to impart some knowledge to these people, or people who are just not suited to it, who really should be looking elsewhere.*

Jamie (year IV student):

*Just have a student because they're not like just a student on the side who's going to do their own thing, they're someone who's your responsibility, so I think it's pretty tough.*

Being empathic towards clinical educators however, does not appear to translate into behaviours that are considerate of the demands on clinical educators.

Jamie (year IV student):

*I know from my point of view I see you know I've got five weeks of opportunity to learn as much as I can, to get as much knowledge and get as much as I can out of the placement, because you've only got so many five week blocks before you graduate and so I want to get as much information as I can not just my patients but also you know educator and other people in the team as well. So I'm, pretty constantly asking them questions.*

The relationship between being empathic and behaving empathically, appear to be contradictory. For example, Jamie although empathic to the demands on his clinical educator does not alter his behaviour and motives to learn during the placement. Motives as habitus in action although self-orientated are specific to the field in which the student is located. Although empathy allows projection into the 'shoes' of others, English (2010) acknowledged that it does not always result in appropriate action. Of interest is the disjuncture between what Jamie, for example, can gain from the placement and what he can contribute to patients and teams.

Personal values such as empathy (habitus and embodied cultural capital) emerge as a strategy to attain congruence between relationships and the values of interconnecting fields in which the clinical educator is located. Empathy therefore, has been described as bridging imbalances in positional power, different values of knowledge (capital) and system awareness (field habitus). As illustrated by Tara and Jamie (students), empathy is evident as an embedded disposition (personal habitus), and is brought to the physiotherapy domain. However, individual motives and behaviours to accumulate cultural capital (students) or protect economic capital (managers) dominate over being empathic, i.e. towards clinical educators.

### **Flexibility and adaptability, skills and strategies**

Flexibility and adaptability emerged as other important valuables described by 13 of the 18 clinical educators. As an ability to respond to different student personalities and learning styles, flexibility refers to a capability to adjust behaviour to the nuances of

individuals (students and stakeholders), and challenging social forces such as changing expectations in healthcare (English, 2010). Such valuables however, disguised the clinical educators' ability to maintain control and represented both an attribute and a behaviour. From a Bourdieusian perspective, flexibility and adaptability represent the dynamic adaptation of habitus (Swartz, 1997) responding to new situations, to manipulate resources, tactics and personalities in order retain control. As a strategy which orientates individuals towards their social practice (Grenfell, 2008c), flexibility and adaptability are actions that are not only conscious, but subconsciously orientated towards profit, i.e. position within a field, balance between tension and conflict. The notion of 'interest' therefore, underlies all actions (Bourdieu, 1994/1998); "interest is habitus incarnate" (Grenfell, p. 154), and flexibility/adaptability is the means of navigating through tensions, to ultimately protect interests or capital. Flexibility and adaptability are recognised as inherent in the proficient practitioner (Benner, 1984) and given the degree of rapid change in healthcare provision, are key individual and organizational traits essential to maintain and excel (Senge, 1990). Within this research, such valuables were illustrated by clinical educators' responsiveness to the unique needs of many students, and manipulating work situations to meet the demands of roles and differing expectations. This allowed clinical educators to create positive learning environments and learning outcomes for students, which were both self-fulfilling and rewarding. Flexibility and adaptability were also complemented (and disguised as *illusio*) by a genuine interest in the learning process, as described by all 18 clinical educators. The following quotations demonstrate how flexibility and adaptability as personal and professional habitus were found within this study.

Stephen (clinical educator in private hospital) describes the challenge of working with students:

*Working with the different personalities and the way that they learn is all quite different, so I guess it challenges you to try and find the best the way that each student learns.*

Andrew (experience of 0-5 students) describes manipulating the waiting list to create flexibility to complement student learning and reduce his stress in juggling student and service demands:

*Having control over my patient load and that's because I do the wait list. It means that I can determine the time frames that I want and the type of patients that I want for that student, and it means that I can also block off time at the end of the day, at the end of the week for reflective practice or for tuts [tutorials] needed. That's probably the biggest thing that makes my life smoother.*

The evidence presented by Stephen and Andrew indicate scenarios in which flexibility is required, and also created, disguising an interest and responsiveness to

individuals and learning environments. Andrew in particular reveals a strategy that is complementary to student learning; yet more importantly, reveals that his actions of controlling the patient load/times, are an illusion for making his “life smoother”.

Bourdieu’s notion of interest, whilst not being goal orientated (Swartz, 1997), is a medium of economic action (Grenfell, 2008c), which as Andrew demonstrates, is realized though his hierarchical position within the team, and his ability to “control” the waiting list, primarily for making his “life smoother”. Speed and flexibility demonstrable in proficient practitioners, compared with competent practitioners (Benner, 1984), represents an ability to manoeuvre dimensions of the social world through the interplay of habitus, capital and field, i.e. practice (Bourdieu, 1979/1984). Unlike Stephen and Andrew however, other clinical educators described inflexible environments or excessive demands which resulted in the perception of clinical education as an additional rather than embedded role (to be discussed later in the chapter).

As with empathy, flexibility and adaptability are characteristics present in personal habitus of students such as Tara (year III student), who has experience of one placement to date. These characteristics are described as coping strategies when working with people and also working within the healthcare environment. Tara:

*So I think we were prepared in an informal way, for the fact that, our theory didn't prepare us for everything and it can't, and perhaps, that's one of the things that we learn in clinical education is, we kind of have to go with the flow a lot. Humans aren't all by the book, you know so these are the kind of lessons.*

Flexibility and adaptability emerge as important valuables, brought as personal habitus and shaped by fields of university (physiotherapy habitus) and organisations (professional habitus). Although habitus is described as durable and requiring a substantial catalyst to change, these valuables represent an ability to orientate action towards achieving success (Swartz, 1997) including navigating through challenging and unpredictable situations and encounters.

### **Interest in learning and concealed strategies**

An interest in learning processes was described by all clinical educators with five educators specifically indicating receptiveness towards students. Stephen and other clinical educators describe how such interest conceals personal motives to develop professionally and also, to recruit students to their clinical areas. Stephen, for example, speaks of his contribution to students and what is exchanged in terms of his development:

*I like the challenge in my learning, helps me to further my own development. And so, I think I've learned a lot from the students in terms of different ways that they*

*assess, different ways that they approach problems. I like to think I make a positive difference in encouraging them in the area of musculoskeletal physio.*

For another clinical educator Su, the value of clinical education was intrinsically linked with her professional development:

*What value do I put on it [clinical education] for the students? Not for me because I mean you get some value in it yourself. Because like I said, the students, they teach us too. It's not all just a one way street. And the world changes and the younger people teach us how to change. You know what I mean? And they keep you on your toes. They often ask questions and I think well that's a really good question. So like I said, they do teach us because they make us go and look things up.*

Clinical education for others bridged geographical and generational gaps, as described by Jean, the manager of a rural hospital:

*Being quite isolated, we're very open to people telling us what is current.*

Jean further speaks of the positive impact of students on her staff:

*You could see that the physio that was looking after her, the two of them it was almost like the two of them gained from each other. You know it got enthusiasm back in to, not that she didn't have enthusiasm in the first place, but you could see there was this new spark they were talking about patients, they were discussing things and it was two heads instead of one at planning treatment and it was just fantastic to see.*

The mutual benefit of students on departments was also described by university staff such as Shoba:

*I think that there are benefits which you can't quantify in terms of dollars, that these people [clinical educators] have that keep them [students] on their toes, and keep them refreshed and so I think the people who have students really do enjoy it and have a lot of fun with the students. I suppose they're mainly young people, but really enjoy having those enthusiastic students around.*

Of interest is the inference by Shoba that clinical educators are mainly 'young' implying that they are more receptive to students, flexible and adaptable, and in terms of years of qualification, more closely positioned to students. Although clinical educators in this study were not asked for their specific age, their clinical experience averaged at 12.5 years, suggesting that only some were 'young'. This demonstrates that irrespective of age, individuals not only possess distinctive attributes and an interest in learning, but possess strategies to maintain their position (symbolic capital), and knowledge including technological (cultural capital) and efficiency (economic capital). When such strategies are formed during phases of habitus formation is unclear, but nevertheless they exist to maintain pace with the worlds of healthcare and technology, and protect positions within organisations. Motives of some clinical educators were transparent to students as described by Jamie:

Jamie (year IV student):

*The ones [clinical educators] that I was with, they were keen to improve their own knowledge as well and things and that could be part of the reason why they chose to have a student to see what the new fresh ideas and what the new graduates thought, early graduates are being taught.*

Motives, as habitus in action, are designed to protect self-interests and positions of domination (Bourdieu, 1972/1977) and demonstrate the structuring nature of habitus to shape one's present and also future position and practices. Motives to learn from colleagues and students, when combined with regular reflection and self-evaluation, allows professionals to "retain critical control over the more intuitive parts of their expertise" (Eraut, 1994, p. 155). Self awareness is further discussed in relation to strategies of self-preservation, retaining critical control of capital and influencing professional trajectory.

### **Self awareness/confidence and self-preservation**

Self awareness and self confidence were described by all clinical educators within this research. Being self-aware and professionally confident (although not described specifically in relation to competency or being knowledgeable as with Cross, 1995), created an atmosphere of openness and reciprocity. This type of awareness and interest described by Trede and Higgs (2009) as critical interest, not only results in clinicians questioning their practice, but the values, beliefs and systems that frame practice. This type of interest "separates reason from authority and draws out the ideology and hidden agenda behind truth claims and facts, and may result in behaviour and process changes" (Trede & Higgs, 2009, p. 96). Although critical interest is described within the context of patient care, extrapolation to clinical education is relevant, given that "these changes mean a shift in attitudes and perspectives, and they empower self and others" (Trede & Higgs, 2009, p. 96). Critical awareness and in particular when combined with self confidence, suggests a level of practice that is expert (Benner, 1984) and critically and consciously reflective (Schön, 1983). This is an extension of professional competence, described by Gonzi, Hagler and Athanasou (1993) as encompassing "a set of relevant attributes such as knowledge, skills and attitudes" (p. 5), and Eraut (1994) described as capabilities.

Within the context of this research, self interest and self-confidence allude to knowledge of self and self-preservation strategies to accumulate capital and maintain hierarchical position based on seniority, qualification and experience (knowledge in action/practice). Self-knowledge described by McAllister (1997) is central to how clinical educators experience their role. Self-knowledge, described by Eraut (1994) as control knowledge incorporates "self-awareness and sensitivity; self-knowledge about one's

strengths and weaknesses, the gap between what one says and what one does, and what one knows and does not know” (p. 81). Drawing on Eraut’s concept of control knowledge, clinical educators utilise clinical education as opportunities to address gaps in knowledge and processes which are essential to maintain their position and status within their communities. Senge (1990) believed that people with a high level of personal mastery, defined as “the discipline of continually clarifying and deepening our personal vision, of focusing our energies, of developing patience, and of seeing reality objectively” (p. 7) are in a continual learning mode. Personal mastery goes beyond competence in skills and is perceived as a special kind of proficiency, a lifelong discipline of learning; yet an awareness of one’s own weaknesses, ignorance and areas of growth (Senge, 1990). This could be extended in Bourdieusian terms, as adopting strategies of self-preservation and ensuring social and career trajectories within fields of employment and also profession. The following quotation illustrates how self and professional confidence promotes transparency and receptiveness to critical evaluation.

Mark (community based clinical educator):

*I think it’s an openness as well, that you’re actually open to being looked at yourself. You’re actually opening up your practice, is the first thing and not everybody likes to be looked at. It’s a confidence in their own work, so that’s one aspect of it. There’s the ability to teach as well, facilitate whatever and an openness to receive. I think there’s always people that, this is the way they’ve practiced for years and years and they don’t want anybody to say that there’s a different way of doing it, so they stick to what they know.*

Such valuables do not exist in isolation, but as Mark perceives, co-exist with an “ability to teach”, that is the medium to translate and share knowledge with others. Indeed, clinical educators’ teaching skills were found by Cole and Wessel (2008) as the most significant interpersonal item which contributed towards student satisfaction, yet only 13 out of the 18 clinical educators in this study alluded to some insight/expertise in learning. Teaching as discussed in Chapter Four is perceived by the majority of participants as a separate knowledge-base and skill set, rather than extension of existing knowledge/skills. This is further discussed in Chapter Seven as a tension within clinical education and between clinical educators/stakeholders.

Embedded dispositions conducive to clinical education, as illustrated to date, are brought to fields of physiotherapy and clinical education as habitus. They are also recognised in students and represent a form of self-selection, which distinguishes clinical educators from other physiotherapists, and also as a distinctive social class. Further socialisation influences were found to influence and shape personal habitus. This includes attendance at university based workshops for clinical educators (professional habitus II).

## Shaping of habitus and expectations of quality

Both Schools of Physiotherapy provide workshops/sessions clinical educators. These sessions created opportunities for physiotherapists to develop skills and knowledge relating to student learning, and also knowledge of the processes and expectations of Schools. Thirteen clinical educators attended workshops in the year preceding data collection, two had previously participated in workshops when working overseas, one clinical educator had only recently taken up the post of university based clinical educator and therefore, not yet attended any workshops and two clinical educators had previous experience teaching in Schools of Physiotherapy.

The value of these workshops was perceived differently. For example, Warren (clinical educator and clinical tutor) describes the workshops in terms of relevance, being exposed to new techniques and learning about university processes:

*The physio school does offer a one day session where x [academic staff member/clinical co-ordinator for the School of Physiotherapy] came down to xx hospital to talk to supervisors and educators and give them an idea of different techniques to use with students, and an idea of what the physio school was expecting. So that would be the main sort of education you come by as a clinical educator other than that I guess I learn via discussions with, xxx and with xxx.*

For Richard, attendance and subsequent support from School staff helped facilitate a shift in his thinking and practice:

*We had the workshop to start off with, like the one being done in the University. It gave me an idea of what sort of thing to look out for and how to deal with students, and also I got a little bit of support, from mostly from xx but in xxx (country of training), there is a different style of education, different style, so she probably knew where I was coming from. She taught me about different learning styles, and helped me out with that and a new way of learning.*

Workshops and the support that Richard described represent opportunities for new clinical educators to be socialised to the rules and values of Schools of Physiotherapy, i.e. the culture and practices of reproduction. Cultural capital, such as familiarization and understanding of the field rules, together with social capital (networks and relationships) are transformed into status as a clinical educator (symbolic capital), and albeit unknowingly, agents of the field of education. Workshops therefore, appear mutually beneficial, clinical educators gain knowledge and skills (capital) and Schools legitimise their expectations of clinical education. Doxa, as a symbolic form of power relations reproduces and legitimises the power relations and position of Schools relative to clinical educators. Learning to be a clinical educator is inherently linked with learning to meet the expectations of the School.

Evaluation of School workshops on clinical educator preparedness and effectiveness is limited. Prompted by the move from diploma to degree award and subsequent shift in paradigm and pedagogy, a needs analysis workshop of clinical educators associated with one United Kingdom School of Physiotherapy was undertaken by Cross (1992). Findings included a disjuncture between workshop models designed by the School and “the contextual variables of professional practice over which the school had little control” (Cross, p. 758). These variables included turnover of staff, different roles with other responsibilities, such as, management. Recommendations included the adoption and implementation of continuous programmes for clinical educators, responsive to professional variables, and collaborative evaluation of the programme. The impact on continuous socialisation provided by on-going education compared with annual or sessional workshops has not yet been evaluated.

Motivation to attend workshops was associated with the value of different forms of knowledge and the perceived benefit to clinical educators. Shelagh (managing director of a private practice):

*But I just thought that maybe some formal guidelines on that or maybe some touchy feely subjects for the supervisors might be a good idea. But having said that it would have to be a damn good course to make me want to go to it and think I'm already touchy feely pretty well with my patients I need to learn something here that would apply to other things as well*

Shelagh's perception of what she requires for her role illustrates an underlying tension between the types of knowledge and skills required to practice as a clinical educator. Guidelines relate to process or procedural knowledge. Described as “knowing how to conduct the various processes that contribute to professional action” (Eraut, 1994, p. 107), it excludes other forms of professional knowledge such as propositional and personal knowledge. Motivation (as habitus in action) to learn/attend is intrinsically linked to the exchangeability and transferability of capital into profit, symbolic or otherwise, i.e. patient care, and income. As a private practitioner, attendance at a workshop equates to lost patient time, and therefore, lost income.

Through primary socialisation, personal habitus has been demonstrated as significant in determining the trajectory of physiotherapists in clinical education. Whilst considered relevant secondary socialisation (physiotherapy and professional habitus), little is known as to the extent it transforms habitus. As illustrated below, geographical location impact on services and also team manager approval impacted on attendance at workshops. Dee (clinical educator and sole practitioner in a community based hospital):

*There is a lecture that we can attend at the start of a clinical year before the placements come out or they'll [School staff] come down and I've attended a*

*couple of them but my location makes that quite difficult because I have to travel a fair way and take the day off, so it's a day when no patients are seen.*

For Richard, attendance is subject to team manager approval:

*I know that, courses that do take place and I think that sometimes you find like the current workshop, say the certain component in the morning, usually geared for the new practitioner, or new clinical educator and the afternoon sessions are reserved for the experienced clinical educator. But there are some topics, and then I need to recap on these things so it just depends on your team leader if they are flexible you know to allow you to attend.*

Dominant interests of the field in which clinical educators are located influence the configuration and transferability of capital between fields of practice and clinical education. Time and patient contact (cultural and economic capital), for example, constitute greater value compared with attendance and for Richard, denied based on the value systems of his team leader. Positions of hierarchy and systems of domination are produced, maintained and protected through symbolic violence (Schubert, 2008) such as denying attendance at study days. Withholding attendance results in denying periods of socialisation (professional habitus II) but may impact on clinical educators' ability to meet the expectations of the School. Additionally, the School's opportunity to reproduce power relations is also withheld.

Limited opportunities exist as secondary socialisation periods which prepare physiotherapists for their role in clinical education. Rose, Best and McAllister (1999) identify 11 key objectives for preparing clinical educators. These include promoting self-knowledge and understanding ethical and legal requirements, and goals and processes of clinical education and assessment. Additionally, developing knowledge and skills pertaining to educational principles and promoting increased autonomy and independence in managing students, improving learning outcomes and enhancing the status of clinical education within the workplace are other objectives. Withholding such opportunities was not only determined by team leaders, but also by the value determined by the field in which the clinical educator is positioned, and how these values are transformed into priorities.

Whereas secondary socialisation has been described in terms of shaping clinical educators, for students, clinical education represented periods of socialisation (physiotherapy and professional habitus I). Individual and field habitus were reproduced not only through role modelling of ideology, behaviours and practices, but also through the provision of learning opportunities, whereby students could fulfil their own personal and professional trajectory.

## Shaping others and strategies of reproduction

Clinical education is recognised as essential for the induction of students into physiotherapy practice, the profession and healthcare environments. Professional socialisation shapes the ideology of students consistent with the profession, creates opportunities for students to understand the roles, responsibilities and codes of practice, along with clinical and generic skills of a practising physiotherapist. Cant and Higgs (1999) advocated that professional socialisation involves “a synthesis of old and newer values and attitudes, and a recombination of previously acquired skills and newly acquired skills and knowledge” (p. 48). Periods of socialisation as a student therefore, influence and transform habitus (physiotherapy habitus and physiotherapy habitus I) and as described later, have a significant impact on reproduction of ideology and practice.

Clinical educators employed overt and covert strategies to influence students, reproducing behaviours and preferences for, for example, clinical specialities. Described as sources and objects of transformation (Higgs, 2005), the importance of clinical educators and their ability to influence cannot be underestimated.

Enthusiasm, also described as passion and inspiration for clinical speciality areas were commonly described by clinical educators as influential factors in shaping students and their trajectory towards clinical areas. Whilst enthusiasm was found by 34 out of 40 clinical educators in the study by Bennett (2003) as important abilities/qualities of clinical educators, this compared with lower ratings by students and in particular academic tutors in the study by Cross (1995). As illustrated below, clinical educators sought to shape students in relation to the profession, as described by Dee:

*I suppose again we have that power it's our role to influence that, that student and inspire them a bit about their profession.*

In relation to clinical specialty, employment and career choices, as illustrated by Julia:

*You know a really positive placement within the public health system as well might influence the setting they choose to work in, so, I think we certainly can influence what they choose and what their future career choices, by a positive experience.*

In relation to the quality of future practitioners and physiotherapy practice as highlighted by Claire:

*I'm passionate about physiotherapy, I'm passionate about the fact that I want our students to come out and be the best that they can be. Well if I don't give them the opportunity to come in and help to teach, then how can I stand back and criticise them if I'm not involved. So that's why I have been involved and that's why I am passionate about it so hence where I am.*

And in relation to clinical education, as proposed by Katie:

*I'm very, very passionate about physiotherapy and I'm very passionate about being able to educate people and I guess the passion that I have I probably, I'm able to bring that through in my teaching when I've been working with students and I really, really enjoy that. That's something that's very, very important to me. And I'm not saying that my other colleagues aren't passionate, but I think I make the time to take students and I think probably maybe that other colleagues have other priorities. But for me education of young physiotherapists is very, very important.*

Katie further describes the personal reward she gains from working with students:

*I feel very, very passionate about investing the time and the energy in new physiotherapists coming through. I love the profession, I love my job and I want to see enthusiastic motivated physiotherapists coming through the ranks and if I feel as though I've been a part of that, that just makes my day. I really, I just, I like it when the light comes on and something clicks, I get so much motivation and enthusiasm from that, I really, really do.*

Described as personal reward, illusion disguises the underlying social reproduction and reconversion strategies (Bourdieu, 1979/1984) whereby various types of capital are reconfigured to maintain or enhance position within the profession, organisation and relative to students. In contrast, when ideology was not shared with students, tension existed. Shelagh:

*Because they [a student] weren't motivated and then trying to find ways to motivate them, when they just want to go diving and be a dive instructor in Thailand. It's a little bit hard. And I'm coming from the point of view of also that I really only wanted to be a physiotherapist and that's what I wanted to do and I still want to do, and I'm very happy in my choice. And so coming from a point of view, looking at the person and thinking, what a waste of three and a half years, and also how many kids has he taken the place of. From a personal point of view that was a difficult for me so I had to step back from it and look at it from that side of things and think okay well for him to pass, it's my job is to provide him with the tools to be able to.*

Incongruent values are described as source of tension for Shelagh personally and professionally. Regardless of strategies to align (motivate) the student's personal and professional habitus with field habitus, Shelagh's frustrations are evident.

There is further evidence of the impact of secondary socialisation described as role modelling behaviour drawn from experiences as students and reproduced in present or future practice. Gillian and Katie illustrate how they model aspects of clinical education, drawing on previous experiences.

Gillian:

*I just remember the educators whom I had whom I thought were good and try to do that. If you can inspire someone in anyway, then that's good. I just recall my educators who were good. And you know in a much positive, much more positive frame than some others so I like to think that that's something that I inspire in students as well.*

Katie:

*I look at one [clinical educator] in particular, and I think about what I really liked about that type of supervision. And then try and provide that as much as possible.*

Unlike Gillian and Katie, Alistair (university clinical educator) describes recent experience as a post-graduate student. His experience, maturity and reflection enable him to critically analyse teaching and learning strategies from the perspective of an adult learner and to apply successful teaching/learning strategies into his practice as a clinical educator.

Alistair:

*And having come from a teaching environment from again where I have this range of people who were teaching sound were good and others weren't and I was in the position where I could sit and think about it, why is this person so crap. As a mature student I was able to process that kind of information as well, apart from just saying oh this is not working enough of this. It's not working because and so now that I'm here [at university based clinic] I'm aware of all that, and I want to make sure I deliver, hopefully at the good end rather than the bottom end.*

Role modelling different styles of teaching/learning strategies appears to be important in shaping future practice as a clinical educator. For example, Emma (year IV student) describes reproducing strategies she perceived as beneficial to her learning:

*I know at the time of being grilled, you feel like you've missed so much or something that you're a little bit stupid but looking back on it, it's so worthwhile that even though most students might not like me at the time, because I grill them, but I think that they'd really benefit from it because I know that it really benefited me.*

Role modelling by all physiotherapists in education is highlighted by Kiera (academic staff) who acknowledges the symbiotic relationship between academic and clinical staff in shaping students' habitus (professional and physiotherapy I socialisation periods):

*They [clinical educators] are the role models for the future health physiotherapy health professionals. They are the ones I mean, I think they ideally the academics here sort of light the fire for their chosen profession, but then the clinical educators need to keep that fire lit or give it a burst and without the clinical educators we wouldn't be able to provide the clinical.*

Modelling personal and professional valuables and practice corresponds with secondary socialisation, and the ability of habitus to be shaped (rather than fundamentally altered). Being a role model was described as a key descriptor of the ideal clinical educator by 95% of clinical educators in this research. This compares with data from another study where the importance of the clinical educator as role model was rated by 70% of year I and II students and 45% of year III students (Cross, 1995). Differences

between perceptions of year I/II and year III students was attributed to professional confidence and the capacity of students to exert themselves, compared with less experienced students.

Transforming practice including attitudes towards clinical education within teams requires conversion of capital, often marketed as beneficial for development of individuals and the team. Once transformed as new practice, the misrecognised and disguised motives of individuals become embedded and clinical education becomes taken for granted (doxa). Field habitus thus is structuring and structured, and through the transformation of capital, can influence team practice, culture and attitudes. Attributes, ideology and motives as cultural capital when brought to fields (teams) evoke symbolic power that influences and re-shapes field habitus. This is facilitated by clinical educators, positioned high in social hierarchies compared with students, based on the configuration of capital (cultural, social, economic and symbolic). Evidence is provided by Mark (clinical educator) and Dan (allied health director) of how personal motives underpin social reproduction strategies.

Mark:

*I thought it was important that students were exposed to the work we do. So I talked to the powers that be and said I'd like to have students.*

He continues to talk of his motives and how practice and staff attitudes have been transformed:

*I thought well having students helps me think about what I'm doing as well, being able to justify what I'm doing, checking my own work, as well so that I was learning from them, by teaching, and also by their, hopefully newer knowledge, fresher knowledge, different ideas, so that's why I thought it was a good idea. And the staff that we have now are all very keen on students.*

From a different perspective, Dan, allied health director talks of cultivating clinical education within his organization; this was congruent with his personal ideology related to clinical education:

*But I'm certainly pretty passionate about having students and participating, it doesn't matter it may not be exactly as a clinical educator, but even if you're supporting your colleagues to take the student, participating in that total process is part of your professional role. There's lots of different ways that you can contribute to having a student and it doesn't mean that you have to be the clinical educator for people who just generally can't stand the thought of having a student.*

Methods of restructuring field habitus and transforming practice used by Dan involve reconfiguring capital, converting cultural into economic capital, through, for example, salary progression projects.

Dan:

*We were also developing our salary progression project, so we used taking students as one of the, one of the examples as staff could do. Which we actually needed to do to get things started. What we do now around that is, that's a core part of their job, but it wasn't at that time. Whereas we've been able to move to saying it's part of your role now, so taking students is no longer acceptable in terms of a salary progression objective, it has to be you're taking more students than would be expected or you're putting your hand up to take the difficult students and failing students you know, so extending people that way.*

Salary progression projects both motivate and legitimise reconfiguration of capital and as a consequence, field habitus. Once embedded as practice, rules are changed by Dan, whose position and authority within the organisation allow him to interpret and implement salary progression criteria. Doxa, as a form of symbolic power, requires physiotherapists not to question the legitimacy of the rules of the department, or those who exert them (Deer, 2008); the rules of the game are accepted and played. It is through doxa that field habitus is shaped, mediated through acceptance of physiotherapists to take on students, and shaped by motives of financial gain.

As illustrated, the structuring nature of habitus can influence and transform field habitus, and practice. Disguised personal motives embedded in personal habitus, personal and professional trajectory is realised through clinical education and the change in team practice and culture. In establishing clinical education within teams, organisations and specific discipline contexts, opportunities for secondary socialisation are established, and reproduced.

### **Other motives as reproduction and reconversion strategies**

Other motives for engagement in clinical education included developing social networks with Schools and universities, specifically related to career advancement. In this study, 3 out of 18 (17%) participants compared with 3 out of 67 (4.5%) of clinical educators in a study by Bennett (2003) identified motives for becoming clinical educators with career advancement. As described by Katie and Alistair, relationships with Schools (social capital) enabled clinical educators to reconfigure capital to access resources (cultural capital), financial support (economic capital) and enhance their position within organisations and the profession (symbolic capital).

Katie (district health board based clinical educator):

*I enjoy the link with the University. I think it's important that we continue to strengthen and foster that link because I think that it can be even more of a symbiotic relationship than it is at the moment. And personally I'm very interested in research and want to kind of pursue that in future. I think that certainly having that link with the University would be wonderful; it would be fantastic to be able to tap into those resources.*

Alistair (university clinic based educator):

*From my personal fulfillment I think it's just adding professionally, it's adding another string to my bow. It's made me a more effective communicator and facilitator I think of groups, and it's enabled me to do my postgraduate studies, obviously with a vastly reduced cost financially, still a personal cost, I think but so a vastly reduced financial cost.*

Clinical educator/School relationships were also described as mutually beneficial by stakeholders who recognised the benefits for individuals and also practice through research.

Sam (allied health director):

*... as the staff, not necessarily more senior staff, but the staff that do mentor students enjoy it. It challenges their practice. They see it as professional development and they certainly can use it as part of their own professional development when they're looking at goal setting and different things. They get opportunities more so now through the School with some of the options that that provides.*

Rebecca (professional association representative):

*So I mean again that is, finding mutual benefit out of it. And that can be in a number of ways. You can set up research groups, and you know tied to the University and say well as part of it, the University will help facilitate, or cover a research project.*

As will be discussed in Chapter Seven, forms of knowledge (and holders of such knowledge) were found to hold different value with research compared with clinical knowledge, perceived as greater value. Research by clinical staff and within the clinical setting, is therefore, beneficial to individuals, teams and organisations, and can be exchanged for clinical education services.

### **Clinical educators as a social class, and class conflict**

As previously described, distinctive valuables constitute personal habitus of clinical educators. This is recognised by stakeholders and also identifiable in student participants. Many of the valuables discussed are comparable with literature pertaining to the 'ideal' clinical educator as perceived by clinical educators in physiotherapy (Bennett, 2003), clinical educators and stakeholders in physiotherapy (Cross, 1995) and in allied health (Rose, Best, & McAllister, 1999). Personal habitus transformed individual, team and organisational practice through reconfiguration of capital, to facilitate the trajectory of physiotherapists into clinical education. In some instances, clinical education was described as a conduit to access university resources, to further enhance the position and career trajectory of clinical educators.

Whilst habitus identified clinical educators as a distinctive social class within fields of physiotherapy and organisations, participants protected such valuables by acknowledging that all physiotherapists should not be clinical educators. According to some stakeholders such as Rebecca, educational knowledge and skills are valued capital compared with personal valuables previously described as conducive to clinical education:

*I mean one issue is not everybody is cut out to be an educator. So you can't just assume that everyone should take students because some people can't teach to save themselves. To some extent but teaching a clinical skill is not necessarily the same as teaching patients. And teaching a contemporary at a high level is completely different to teaching a patient something and some people just don't work on that basis. So, if the expectation is that everyone does it, I think there is a potential that the quality is going to drop because you'd like to think that the people who are taking on students and mentoring them are people that actually are keen and interested in doing that, and because of that they develop special skills that you're relating to a different subsection of the population.*

Whilst the application of “educational principles to physiotherapy practice” is listed as competency 5 in Physiotherapy Competencies (Physiotherapy Board of New Zealand, 2009, p. 15) in relation to patients/clients, education of students is absent in terms of context and expectation. It may be assumed that knowledge and skills of education are transferable between fields of clinical practice and clinical education; however, the lack of transparency creates a gap and as illustrated by Rebecca, reinforces a separation of practice from education. Notwithstanding the Board’s competency requirements for registration, evidence provided by this research suggests that personal habitus remains a dominant determinant influencing the trajectory of clinical educators. Concerns however, were raised by Öhman et al., (2005) regarding the dilution of quality if all physiotherapists were to become clinical educators rather than those with a genuine interest in students and student learning. In the absence of personal valuables, yet the presence of demonstrable competencies relating to education of patients/clients, the impact on clinical education and student learning is unclear.

Stakeholders such as Stevie (professional association representative) and Shoba (academic staff) however, advocate that all physiotherapists have a responsibility to educate students, and to the profession.

Stevie:

*I've heard a lot of these complaints about having students, but I actually think its part of your responsibility as a professional, to actually help pass on knowledge and opportunities to the incoming, young professionals. That's how you nurture and grow your profession, with the new ideas and enthusiasm and people coming through. So I actually think it's a responsibility that we have as professionals and I don't really have a great deal of time for the complaints or concerns that people bring forward about not having students, or why they wish to not have students.*

Shoba:

*I think the issues relating to the responsibilities as a physiotherapy profession to assist with clinical education are not promoted well enough by some managers and I think that's a difficulty. I think that every physiotherapist has to have a responsibility to educate its incoming profession. And I think sometimes the people are given the choice, rather than given the responsibility.*

Clinical education is perceived by stakeholders such as Stevie and Shoba as a professional obligation and responsibility to develop the next generation of physiotherapists. The assumption or taken-for-grantedness (doxa) exists that all physiotherapists have the educational skills for clinical education irrespective of the personal qualities (personal habitus as embodied cultural capital) found by Cross (1995) in the 'ideal clinical educator'. Expertise in clinical practice does not translate to expertise in clinical education (Strohschein et al. 2002). In fact, as evidence suggests, phases of habitus formation are key to becoming and being a clinical educator, for which many stakeholders are responsible, yet take limited responsibility.

As inferred by Shoba, managers promote clinical education as an option rather than compulsory requirement. This implies that field habitus (and personal habitus of managers) plays a role in shaping clinical education as practice within organisations. Compulsory engagement of all physiotherapists in clinical education would increase the capacity of Schools, which has been inhibited due to the lack of clinical placements (Baldry Currans & Bithell, 2000; Moore et al., 2003); this infers that School motives are associated with economic gain.

Field habitus emerges as influential in shaping clinical educators and clinical education through symbolic power exerted by individuals. Distinguishing organisational attributes and motives differentiate between, for example, private and public based physiotherapy practice.

Karen (university clinic based clinical educator):

*Private practice physio bung a patient through the door.*

Mark (clinical educator):

*I think people once they've passed the rotational aspect of hospital, I think those that are in hospital, I'm generalizing, are less concerned about money, although money is always an influence. But that's less of the driving force and it's more about the work, perhaps the caring nature of physio. So I think private practice is more is about that financial side, more of the fixing-type physio as opposed to the nurturing type physio.*

As inferred by Mark, there is greater association between private practice and economics compared with hospital based physiotherapy practice. Patient throughput and

physiotherapy productivity (production of economic capital) represent dominant features of individual and field habitus. This is in contrast with the 'caring nature' and 'nurturing type physio' based within public health. Tara (year III student) talks of a common perception held amongst private practitioners, as described by a friend who is a private practitioner:

*.... that's held throughout private practice is that we [private practitioners] don't have the time, the energy, the skills, we may compromise our clients, so those types of things I think are pretty much how all physiotherapists in private practice see the responsibility [of having students/being a clinical educator].*

Barriers to clinical education are categorised into requirements of clinical education (time/energy/skills) and factors that impact on business, for example, clients and relocation of time away from patient care (and potential income). "Economic capital is at the root of all the other types of capital" (Bourdieu, 1986, p. 252) and in the context of private practice, it reflects the dominant interests and motives of physiotherapists and their apparent reluctance to distract from economic gain.

## **Transforming habitus and stakeholder responsibility**

Habitus is described as durable, shaped by periods of primary socialisation (Bourdieu, 1972/1977). However, habitus is recognised as capable of adapting to new situations such as further periods of socialisation, although it does not fundamentally alter its primary dispositions (Swartz, 1997) Primary socialisation is identified as a key determinant in the trajectory of clinical educators, with secondary socialisation having some influence, although to what extent habitus is transformed, is unclear. As a student (professional and physiotherapy habitus I), opportunities for transformation are recognised by Callum (academic staff):

*I have heard that most of the students' behaviours are moulded in the time that they're at the school of their training and so if that's the behaviour that they've learned, then that's how they're going to be.*

The role of Schools and the profession in influencing habitus of undergraduate students is uncertain, however, evidence suggests that secondary socialisation can have a transformative effect on habitus. Responsibility for clinical education appears to rest with a selected 'class' of physiotherapists, whose dominant dispositions influence their role, and when in positions of seniority, shape team practice. Implications for practice include reviewing socialisation periods as opportunities to shape habitus conducive to clinical education. This includes identifying embedded dispositions as part of undergraduate selection criteria, facilitating the transferability of educational principles across fields and providing continuous educational programmes for clinical education to sustain habitus

transformation. Additionally, recognising and valuing the 'valuables' of clinical educators in the form of, for example, a dedicated career pathway, could raise the status of clinical education comparable with clinical specialities. Although identifiable as a social class with distinctive habitus, reconfiguration of capital would also elevate clinical educators within the social hierarchies of organisations and the profession. This is further explored in Chapter Seven and Chapters Ten.

As will be demonstrated in the next chapter, the co-location of physiotherapy in different fields and under the auspices of different stakeholders is complex. This is compounded by the influences of politics and economics on physiotherapy education and practice provision, including commoditization of clinical education within the market of healthcare, and distanced from the traditional vocational roots, as described in Chapter Nine.

## **Chapter summary**

Distinctive phases of socialisation are identified within this chapter as shaping individual habitus as clinical educators, and students as potential clinical educators. Distinctive ideology (habitus) and motives (habitus in action) identified clinical educators as a unique social class/group within organisations and the profession (fields). As a social class however, there was evidence of class inequality which resulted in withholding of resources including time to attend workshops in clinical education run by Schools of Physiotherapy. Clinical educators (and students) recognised and valued personal attributes including empathy and an interest in student learning; these commonly formed the basis for self-selection as a clinical educator rather than competency in teaching and learning. Compared with discipline-specific knowledge and skills, education principles were found to hold little value within the field of physiotherapy and contributed to the low ranking of clinical educators in social hierarchies. This is discussed in the next Chapter.

## **Personal reflections**

*Reflecting on the phases of socialisation that shaped my trajectory as a clinical educator, I recognised many of the 'valuables' formed from life experience and evidenced in my career pathway towards physiotherapy. Within two years of graduating, I 'became' a clinical educator, if that means attendance at a workshop and being allocated students from Schools of Physiotherapy. Drawing on Bourdieu's concepts, I recognise that my education and learning was embedded in my personal habitus, which I brought as a student to the university and ultimately the profession. My personal motives for becoming a clinical educator echo many of those which emerge from participants of this research. I enjoyed*

*teaching and working with students, I was passionate about my clinical specialty area. I was also interested in learning and developing myself professionally and personally, learning new skills and approaches to working with different people including students. I was committed to making a contribution to the next generation of physiotherapists. This differed from the professional obligation that stakeholders in this research described. Apart from the personal and professional benefits described, at the time an allowance was paid to clinical educators in recognition of the 'additional' role compared with other physiotherapists who chose not to engage in student learning. Funding however, was a token amount, and although appreciated, when it was later withdrawn, did not impact on my role and commitment to clinical education. Admittedly, being a clinical educator also allowed me to develop networks with university staff, ultimately, facilitating my role as guest and then full-time lecturer in physiotherapy. So from Bourdieu's perspective, I exchanged my knowledge and skills (cultural capital) as a clinical educator for economic and social capital. The title of clinical educator (symbolic capital) held little value at the time. My trajectory in education on reflection appears predetermined by personal habitus, and the exchange of capital.*

*My physiotherapy and professional habitus were shaped as a student of physiotherapy at university and on placement. I cannot remember pedagogy being as visible in my learning as subjects such as anatomy, physiology and pathophysiology. So how did I learn to be and practice as a clinical educator? Trial and error epitomized my journey as I relied primarily on informal rather than formal educational frameworks. I drew from previous experiences as a student and reflected on what worked well and why, and why not. I participated in several workshops (professional habitus II) though at the time, I remember that the workshops focused more on the processes of assessment and expectations of the Schools of Physiotherapy. Little time was spent learning how to facilitate student learning and learning about educational principles. Another area that was covered was what to do with the struggling student. For example, what processes to follow, who to contact. Perhaps in hindsight, understanding how students learn and how I facilitate that learning, would have been more useful, perhaps the struggling student represented the struggling learner whose style of learning was not compatible with my style of teaching.*

*I recognised from an early stage, that understanding how people learn was key to patient learning and therefore, education principles had direct relevance to student learning as much as patient and peer learning. This prompted me to undertake postgraduate study into aspects of education (professional habitus III) including this research. I am curious as to why clinical education is so undervalued compared with other physiotherapy skills, and yet its inherent value lies in educating the next generation of physiotherapists. As will be*

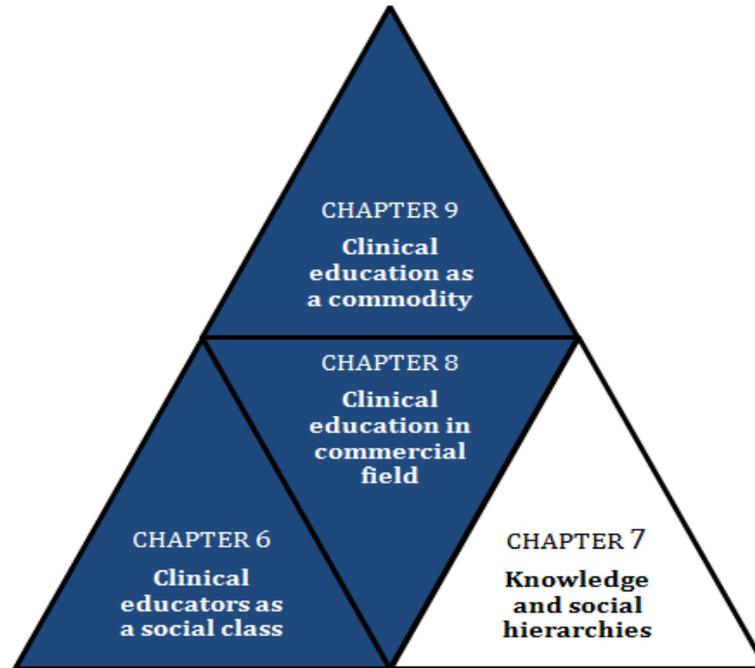
*demonstrated in subsequent findings chapters, hierarchies of knowledge were found to exist which influenced how clinical educators were valued.*

*As a senior physiotherapist and team leader, my commitment to student learning and appreciation of the value that students bring to my team, allowed me to influence team practice. Having students within the team became the 'norm'. Over time, my role moved from clinical educator of students to 'educator' of clinical educators and in effect, I became responsible for shaping team members as clinical educators. As team leader, I had the authority to implement change and shape team practice. Symbolic and cultural power determined the 'rules of the team', and clinical education became integral to 'team habitus'; although at the time, I did not have Bourdieu's framework to understand my habitus and motives as a clinical educator, team leader and now researcher.*

*As the 'valuables' emerged from the data, I was cognisant of my role as researcher. My researcher gaze (skholé) formed from personal experience, interest in the subject and familiarity with the literature, could influence the lens through which I interpreted the data. Although many of the valuables resonated, through continuous review of the data I ensured that all valuables described were captured. Additionally, I was mindful to ensure there was representation from different fields (private and public health, both Schools of Physiotherapy), stakeholders including students, and clinical educators with different levels of experience and clinical specialties. Exploration of individual and field habitus allowed me to identify homogeneities which underpin Bourdieu's field analysis and theories of symbolic power and violence (Swartz, 1997). Acknowledging the inability to truly suspend my presuppositions, declaration of my position and additional strategies including peer and supervisor review, challenged my objectivity in relation to the data and interpretations.*

## CHAPTER SEVEN

### Value of clinical education knowledge and skills – capital configuration and influence of fields



Chapter 6 Clinical educators as a social class
<b>Chapter 7 Knowledge and social hierarchies</b>
Chapter 8 Clinical education in commercial field
Chapter 9 Clinical education as a commodity

Figure 7.1 Summary of themes which emerged from this research: Chapter Seven

### Chapter overview

This chapter presents **theme two** pertaining to individual and stakeholder tension and conflict that emerges from diverse values relating to different forms of knowledge within physiotherapy, and specifically, clinical education. A hierarchy of knowledge emerges which locates 'clinical', 'education' and 'research' knowledge at different levels and locations, and by association, those who possess and impart such knowledge (social hierarchy). Whilst the value of clinical education is intrinsically linked to the practical

nature of the profession and professional registration, this research reveals that education knowledge is considered separate from physiotherapy knowledge and holds little value amongst individuals, organisations and the profession. Consequently, clinical educators have low hierarchical ranking compared with their clinical and academic peers, with clinical education perceived as additional to other clinical, managerial or business responsibilities.

Value and configuration of knowledge as capital are examined as field habitus revealed by participants, professional events, Ministerial and professional documents, and international influences. Clinical education as a unique field, represents a place of intersection between often competing field habitus (education and clinical practice), and was found to be a site of struggle and power interplay. Reconfiguration of education knowledge as cultural capital within organisational and professional fields may help address the disjuncture between different forms of physiotherapy knowledge and embed clinical education more successfully into physiotherapy and organisational cultures. Potential outcomes may include improved stakeholder relationships, increased capacity of clinical placements, growth and sustainability of the profession.

## **Components of physiotherapy knowledge, essential but unequal**

### **Physiotherapy knowledge as capital**

Different categories or components of knowledge constitute professional knowledge (Eraut, 1994) such as physiotherapy knowledge. Physiotherapy knowledge includes propositional and non-propositional knowledge, personal and reflective knowledge and encompasses learning practical physiotherapy skills. Knowledge dimensions and 'types of knowing' are derived and predominantly imparted in different locations i.e. university, clinical practice. Consequently, types of knowledge hold different value as capital and by association contribute to social hierarchies, and sources of tension between stakeholders.

Table 7.1 illustrates the origin, location and dominant delivery method of different components of knowledge as applied to physiotherapy. Whilst presented separately, knowledge is described as dynamic, continuously transformed from one form to another (Higgs et al., 2004a). For example, knowledge derived from experience can be transformed into propositional knowledge through theorisation, and reflection on and in action (Schön 1983), and double loop learning (Argyris & Schön, 1974) allows knowledge from any domain to be transformed into new knowledge. Knowledge therefore is dynamic, capable of transformation and as such, its value fluctuates.

**Table 7.1 Components of physiotherapy knowledge**

<b>Knowledge dimension</b>	<b>Types of knowing</b>	<b>Origins of knowledge</b>	<b>Dominant location of knowledge</b>	<b>Dominant delivery method</b>
Propositional	Knowing that	Research and theory	University	Lectures Applied as clinical reasoning in practical labs and on clinical placement
Non-propositional or professional craft	Knowing how	Professional experience	Clinical practice	Practical labs Applied in clinical practice experiences
<i>Procedural</i> Higgs et al (2004a, p. 62)	<i>Enables action</i>	<i>Professional experience</i>	<i>Clinical practice</i>	<i>Learned within each team/department/practice</i>
<i>Emancipatory</i> Higgs et al., (2004a, p. 62)	<i>Empowers people</i>	<i>Professional experience</i>	<i>Clinical practice</i>	<i>Theories learned in School Applied in clinical practice experiences</i>
Personal knowledge	Knowing me	Personal and life experiences	University and clinical practice	Life experiences applied in University and clinical practice
Reflective knowledge	New knowing	Propositional/non-propositional and personal knowledge	University and clinical practice	Formal skills learned in University and applied in clinical practice

(Source: Argyris & Schön, 1974, Eraut, 1994; Higgs et al., 2004a; Schön, 1983; Sim & Richardson, 2004)

Professional knowledge has been described by Higgs et al. (2004a), as “dynamic, context-bound and constructed from different ways of knowing” (p. 53). From both ontological and epistemological perspectives, they argue physiotherapy knowledge is dominated by the positivist world view evident by the focus on the medical model and values embedded in the scientific method of knowledge generation. Propositional knowledge gained primarily through quantitative research therefore holds greater value than other components of knowledge such as qualitative research with traditions of interpretivism and the social sciences. This view is supported by Gibson and Martin (2003) who found that only 4% of qualitative studies were published in four physiotherapy journals between 1996-2001, and Grypdonck (2006) who described qualitative research “at the very low end of the hierarchy”, and arguments of qualitative researchers who feel “they should be assigned a higher place in this hierarchy” (p. 1372). As findings from this research indicate, hierarchies existed based on value systems associated with different components of knowledge, where knowledge was predominantly

located and by association, who imparted such knowledge. By way of example, propositional knowledge acknowledged by Eraut (1994) as “closest to traditional academic territory” (p. 43) is primarily imparted in universities; this compares with non-propositional knowledge or professional craft knowledge learned and applied in clinical environments. Although the context and how knowledge is constructed and influenced are considered important (Higgs, 2009), all forms of knowledge as identified in Table 7.1, are essential for successful completion of undergraduate physiotherapy training and registration with the Physiotherapy Board of NZ. This is irrespective of where such knowledge is gained or transformed (i.e. fields of academia or clinical practice) into physiotherapy knowledge and practice.

As separate fields, (albeit connected by clinical education and the profession of physiotherapy), fields remain arenas of struggle in which individuals and groups compete for capital and positions of dominance and hierarchical ranking (Swartz, 1997). Additionally, each field may be subject to similar influences, such as, politics and economics, their unique field habitus shapes the value of different forms of capital.

Notwithstanding the geographical distances between organisations responsible for different components of knowledge, from a Bourdieusian perspective, horizontal and vertical spaces resulted based on two principles of differentiation. These principles influenced the positioning of individuals and groups relative to each other through the volume of capital held and the value afforded to the type of capital, as determined by each field. Consequently, between sites of ‘clinical’ and ‘education’, hierarchies emerged symbolic of different and often competing value systems embedded as field habitus in organisations and the profession. Such value systems were intrinsically influenced by historical, political and organisational factors that determined how knowledge as capital was constructed and configured, and by association, staff who possessed/imparted knowledge. Additional influences arising from the location of clinical education in the wider ‘market’ of healthcare and the commoditization of clinical education are further explored in Chapters Eight and Nine.

As illustrated in Table 7.1, foundation professional knowledge is learned in Schools of Physiotherapy. This includes propositional and non-propositional knowledge, and encompasses learning practical physiotherapy skills. In contrast, clinical practice sites provide the clinical environment and access to patients enabling students to apply knowledge and skills learned at School. However, different forms of knowledge and learning environments are inter-dependent, contributing towards effective and competent

practice. As described by participants and associated stakeholders, different components of knowledge and where they were provided, held different values.

Value of clinical experience including clinical education was described by participants in terms of the opportunity for knowledge to be assimilated and applied, and new knowledge learned unique to clinical practice. Claire (clinical educator) associates value in relation to clients and the practical nature of the profession:

*Physiotherapy is not an academic course okay, it's physical and you have to see clients. So if you do your training and only work through books and sit exams you're not going to be a good physiotherapist it's really that simple and as far as I'm concerned that practical aspect of physiotherapy is extremely important.*

In comparison, Tania (university based clinical educator) describes clinical education as essential to being a physiotherapist:

*Well I put a very high value on it [clinical education] because it's the epitome really what the students need. They can't be a physiotherapist without the clinical practice, so having their knowledge and being in the physiotherapy school is not going to make them physiotherapists.*

Jamie (year III student) described the value of clinical education as:

*Pretty high. I found just in terms of practicing techniques and clinical reasoning, I guess bringing all your knowledge in one place and applying it was all about learning, definitely.*

Other learning was recognised specific to clinical practice as described by Julia (clinical educator):

*We're a practical profession so the value is through the clinical experiences and, reflecting and building on the clinical experiences, and gaining insight in to the health system, and health information, communication, documentation, how teams work many things that they can't learn in the university.*

As illustrated, clinical practice/education as cultural capital was configured based on the practical nature of the profession and professional practice knowledge unique to the clinical environment/experience. With approximately one third of undergraduate programmes dedicated to clinical education, clinical education is a compulsory requirement for professional registration (World Confederation for Physical Therapy, 2011b); its value is therefore determined by the wider field, i.e. physiotherapy community. Availability of placements impacts on the value, with national and international shortages described in the literature (Baldry Currens, 2003; Moore et al., 2003) and within this study, as noted by Callum (academic staff):

*Clinical placements are scarce as hens teeth and we have to battle each year to get enough placements for the students.*

Although the commercial value of clinical education is examined as economic capital in Chapter Nine, as cultural capital, clinical education is configured by field and discipline habitus, including availability of placements and clinical educators. Notwithstanding the value of clinical experiences to the professional socialisation and education of student physiotherapists, the majority of clinical practice has been delegated to healthcare providers. This, according to Cross (1995) is problematic for universities as clinical education is the only part of the course where the university has little control in comparison to other components of the curriculum. This suggests that field habitus of academia and physiotherapy practice provision are unique and not always congruent. Resultant tension between two dominant providers of physiotherapy knowledge is therefore, inevitable. Historical influences have shaped the location of physiotherapy knowledge and as a consequence, stakeholder relationships.

### **Location of different forms of knowledge within fields**

Historically, the location of patients determined where clinical practice experience has taken place, with responsibility for the 'education' of students in practice retained by Schools. Tania (university based clinical educator) talks of her memories as a student (qualified 1978):

*I think we had a very close relationship with our educators [academic staff], like we were with them at school and then we were with them in the clinical setting, so we had that continuum.*

Irrespective of the location, academic staff were responsible for students and their education. The continuum described could infer a continuity of learning or responsibility which was perceived positively by Tania. As demonstrated in the quotations below however, the growth in student numbers and subsequent demand for clinical placements has impacted on all stakeholders in clinical education and created a greater geographical distance between centres of different physiotherapy knowledge.

Tania describes changes to the organisation of learning:

*More and more difficult to do that [taught a module first and then put into practice] due to the number of students. It was probably because it was just a small physiotherapy school and that was easier to do it that way and the connection was definitely there between the school and the clinic.*

Relationships between the School and stakeholders were influenced as described by Kiera (academic staff):

*From a clinical point of view it [clinical education] was running really well and you had the relationship with the organisations that you're working with, you had the relationship with the student, you knew all their names without any problems. So when you go to double the numbers, those things started to become more difficult to achieve. We achieved them, I mean, I hope we still have a relationship*

*with them but we were going further a field, we were going to more different placements. The support that we were trying to provide becomes thinner.*

Challenges of providing support in rural areas are illustrated by Savannah (placement co-ordinator):

*But these very rural towns, hospital which again we have students at so they're community placements so not one big core, neuro rehab, cardiac pulmonary, musculoskeletal placements, because we just can't provide adequate clinical tutorial support for them. Just due to the nature of being a rural placement and costs and time to get an educator out there.*

For students, placements in different areas created personal challenges as described by Emma (year IV student):

*It's hard because you don't really have time to find a place and living in a strange town if you're out of town, well it's horrible! I found out the week before I had to move to Hawke's Bay for musculo placement, so I had a week to find accommodation but I didn't know anyone there and I, well I hated it!*

Given that approximately 1,000 clinical hours are required for registration, increases in student numbers equated to a significant demand for clinical placements requiring Schools to seek placements over a wider geographical location. Kiera and Savannah as academic staff, described the impact on student numbers (economic capital) on relationships with students and stakeholders (social capital) and clinical experiences (cultural capital). Illusio disguises symbolic violence of withholding previously defined support systems to students and stakeholders, as support become 'thinner'.

In New Zealand, only two Schools of Physiotherapy exist, however, student numbers increased from 60 to 120, as described by participants. The projected shortfall in health sector workforce (World Health Organisation, 2006) highlights the influence of external/global forces on New Zealand, and legitimised the growth in student numbers. Universities gained economically through the income from increased student numbers, however, growth as demonstrated in the quotations above, directly impacted on stakeholders, including students like Emma. Student numbers also impacted on staff employed by Schools as clinical placement co-ordinators such as Savannah:

*Unfortunately it's just me. The role itself has been identified as having, needing two people, but that hasn't been changed, as of yet.*

Growth in student numbers although beneficial to Schools (economic capital), the profession (cultural capital) and health workforce, according to Savannah does not appear to be matched with relevant resources. Withholding of resources as symbolic violence impacts Savannah's ability to provide clinical placements, support to students and clinical educators, and further impacts students such as Emma, as described above.

To date, different components of knowledge and the dominant providers of that knowledge have been described in relation to spatial distances, both geographical and using Bourdieu's principles of differentiation (1994/1998). Based on the configuration of capital associated with different components of knowledge, hierarchies emerge.

### **Hierarchies of knowledge and providers of knowledge configured by field habitus**

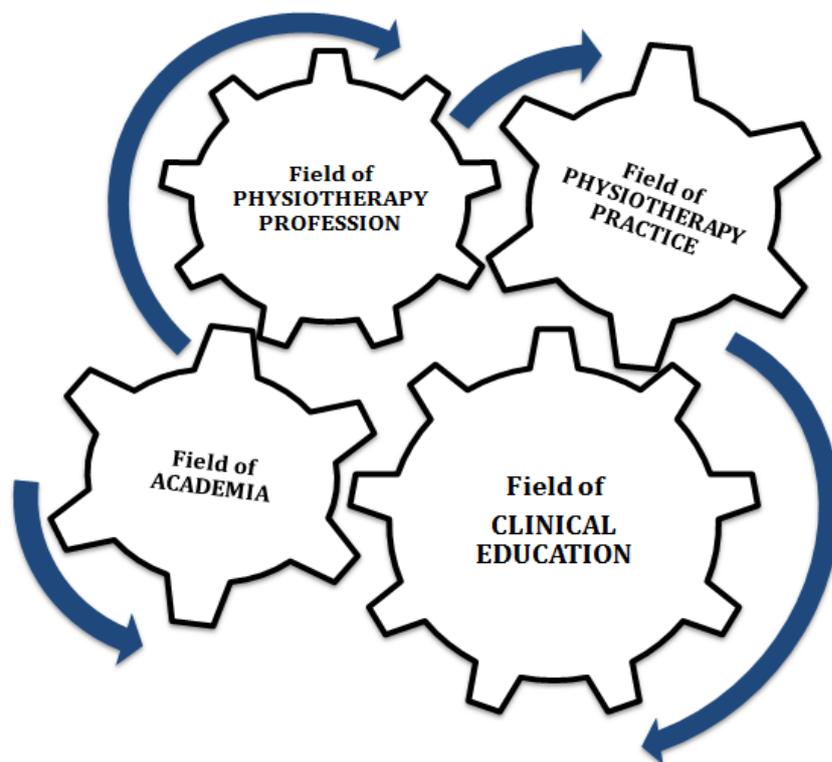
The interconnectivity of different components of knowledge and those who possess and impact such knowledge are bound by compulsory clinical hours, competency and registration requirements as determined by the Physiotherapy Board of New Zealand and the World Confederation for Physical Therapy. Kiera (academic staff) speaks of the unique contribution and value of academic and clinical staff relative to their location and contribution to student education:

*I think they ideally the academics here sort of light the fire for their chosen profession, but then the clinical educators need to keep that fire lit or give it a burst. And without the clinical educators we wouldn't be able to provide the clinical. We need that clinical experience for people who are currently doing it. It's hard for an academic to be doing everything on a regular basis so you need that clinical expertise of the clinical educator that's currently working in the clinical setting.*

Jamie (year IV student) alludes to a hierarchy of staff based on expertise and relative to the field in which staff are located:

*I think the ones at school, the lecturers, generally are really experienced and at the top of their field and I think they know a lot more about the literature and evidence base. They're very on to it in terms of the evidence behind the techniques and everything, whereas some of the physios just in the field might not be. But then in saying this, some of the lecturers who have been here, they haven't necessarily actually practiced techniques for quite a few years, they might be a little bit out of practice that way and the physios in the field are doing it every day so they're in practice.*

Whilst interconnectivity and co-dependence of academic and clinical staff (and locations) is evident, knowledge and those who possess it as cultural capital, is configured in relation to the field in which it is located (School or clinical practice). As demonstrated in Figure 7.2, clinical education represents a unique field formed by the overlap and interconnectivity of fields of education, practice and physiotherapy profession. With distinctive field boundaries described by Swartz (1997, p.122) as "contested terrain", points of overlap represent sites of tension for those who are responsible for the field, and located within. Different hierarchies can therefore, exist within each field, and between interconnecting fields.



**Figure 7.2 Field of clinical education interconnecting with other fields**

One dominant area of tension emerges from differing value systems which reveal a hierarchy based on knowledge. Configuration of different forms of knowledge is shaped not only by field values, but also historical and professional influences. Shoba (academic staff) describes the current 'field' in which knowledge is valued:

*The students are now educated for a world that is very research and evidence based and they have to have that knowledge, absolutely.*

In comparison Claire (clinical educator) values anatomy and physiology knowledge as essential and describes current student knowledge as inadequate:

*Their anatomy is poor, their physiology is poor. Your craft is anatomy and physiology, if you don't know your anatomy and physiology, how can you treat the body if you don't know what you're looking at? You do anatomy year one first semester, you do physiology year one or year two first semester, then you've finished.*

Whereas Rick (professional leader) describes his experience as a student in relation to knowledge:

*We didn't have the touchy feely stuff. You had the basics of what you needed.*

The quotations above indicate that propositional knowledge consisting of research, evidence and core sciences holds greater cultural capital and value than non-propositional knowledge which includes 'touchy feely stuff'. Wider influences of "the world" described by Shoba illustrate how physiotherapy knowledge is shaped by factors including current healthcare and consumer demands and technology. Higgs (2009) also argued that socio-cultural and historical influences have determined the evolution of physiotherapy practice, and by association, clinical education.

Dominant influences of the physiotherapy profession included the deliberate association of the physiotherapy profession with medicine (Barclay, 1994; Kell & Owen, 2008) and the adoption of the biomechanical model (Nicholls & Cheek, 2006). The latter embodied propositional knowledge, disassociated the patient from their environmental context and echoed professional legitimacy found in other professions such as medicine and surgery (Pynt, Larsen, Nicholls, & Higgs, 2009). Physiotherapy practice and practitioners according to Higgs (2009) have evolved from that of the health professional with a strong emphasis on professional socialisation and scientific theory/evidence to the current stage of the "interactional, person-centred professional" (p. 28), which embodies the patient as consumer and central to decision-making process. However, the above quotations from different stakeholders suggest that the profession and physiotherapists are still transitioning. This transitional stage represents hysteresis, described by Hardy (2008) as "dislocation of habitus" (p. 131) whereby there is a time lag before habitus adjusts to new conditions, i.e. change. Dominance of scientific knowledge (Higgs & Tichen, 2001) and experimental and quantitative research (Bury & Mead, 1998; Scalzitti, 2001) suggest that hierarchies continue to dominate; a view supported by participants including Shoba, Claire and Rick.

Notwithstanding the influence of medicine on the origins of physiotherapy (Barclay, 1994; Kell & Owen, 2008) and value of propositional knowledge, current trends value evidence based practice and scientific evidence (propositional knowledge) over professional intuition and preference (non-propositional and personal knowledge). The evidence based practice movement challenged physiotherapists to support all practice knowledge with research and the ontological basis of professional knowledge, ethic and practice (Eraut, 1994) which Sturdee (2001) argued has become so strong that it has attracted and protects powerful vested interests that inhibit discussions and debate about ideas. As illustrated by Alistair (university based clinical educator), this can result in tension between personal habitus and physiotherapy/professional habitus from the perspective of the student and also clinical educator:

*Because physio can be quite biomedical and quite scientific about things whereas one of the students in particular was into chakra healing and alternative therapies and that didn't really align with what, he was really intelligent but it didn't align with the information that he had gained from the theoretical side of things before he came on clinical. And then when he came to a clinical setting and we're trying to reinforce the whole diagnosis and hypothesis generation he basically found it better to go instinct rather than some sort of sound basis or sound clinical rationale. And I found that sort of conflicted with what I'm meant to teach as far as gathering the data and making an informed opinion.*

Doxa, that is, what is taken for granted, functions to ensure physiotherapy/professional habitus is reproduced by aligning personal habitus with physiotherapy and professional habitus with field. As illustrated by Alistair the mismatch between the student's personal and physiotherapy/professional habitus which represent phases of socialisation within the clinical education field (hysteresis) is a source of tension for the student and Alistair, whose role is to facilitate transformation of habitus within the clinical environment.

Hysteresis was also described within this study at field level, when significant events within the profession, resulted in time lag of adjustment before field and habitus aligned. This had implications for fields of the profession and Schools of Physiotherapy and centres of clinical practice, and staff located within. Examples highlighted include the move of Schools and physiotherapy programmes into universities and changes from diploma to degree qualification. The impact on individual and field habitus in terms of social positioning, and in particular, in relation to knowledge hierarchy, is explored as a source of tension and power interplay.

## **Professional influences as field habitus**

### **Relocation of physiotherapy programmes and Schools to universities**

Participants spoke of the impact of the relocation of New Zealand physiotherapy programmes and Schools into universities. This was described as a significant organisational and professional event which contributed to the geographical separation of 'education' and 'practice', altered individual and organisational relationships and changed expectations of the profession and universities of staff. As a consequence, individual and field habitus were required to adapt to new conditions, albeit a period of mismatching (hysteresis) occurred before changes became embedded.

Kiera (academic staff/clinical placement co-ordinator) spoke of the impact of the relocation of New Zealand physiotherapy programmes and Schools into universities:

*There were several things that happened at the same time as the increase in students. We also moved to become a university and then the requirements, the university changed, the organisation changed to being an expert educationalist*

*and a researcher. So the changes were two fold, so it's not just the student numbers.*

Relocation into universities mirrored physiotherapy developments internationally and specifically within the United Kingdom demonstrating the influence of wider physiotherapy activities on New Zealand. Such moves were described as essential for professional survival (Brook, 1994) and academic credibility of the profession (Hunt et al, 1998). The attainment of university and degree status in New Zealand ensured parity with international developments in physiotherapy education and legitimised access to access to post-graduate opportunities and overseas registration by New Zealand graduates (Scrymgeour, 2000).

Simultaneous changes as depicted by Kiera indicate the impact on individual and field habitus and specifically expectations of expertise in education and research (cultural and symbolic capital). Habitus transformation is inferred, not only influenced by the location of Schools within universities, but also expectations of the university as field habitus. Multi-dimensional sources of tension can be deduced symbolic of social distances (Bourdieu, 1994/1998) between distinctive yet interconnecting fields: physiotherapy, university and clinical practice and their field boundaries, interlinked by clinical education. Symptoms of tension are found within international literature including lack of communication, support and relationships between universities and clinical practice providers pertaining to clinical education (Öhman et al., 2005; Strohschein, et al., 2002) and in this study as described by Sam (allied health director).

*I think we've worked quite hard at it [communication and relationships] over the years. And I think that the School's worked hard at it as well. I think we've both worked hard at it.*

Similar sentiments are described by Dan, another allied health director, in terms of communication and influencing change:

*Where we've got an opportunity now which we haven't had in the past is via the workforce strategy group because all of the workforce strategy groups have identified issues. If you think about the supply and demand chain, where the demand is having to go to the supply end and yet there's been very poor communication with us the service providers as to what we need in the future.*

The benefits of relocating physiotherapy programmes to universities were multi-dimensional and advantageous to all stakeholders. The shared interest appeared to unify the profession, yet the outcome created tension, hierarchies and divisions between those who facilitated different components of knowledge. Communication and relationships illustrated by Sam, required effort on the part of both Schools and organisations and appear fragile. There is a sense from Dan that it is only through the workforce strategy

group (collective voice and representation) that sufficient voice is generated to influence Schools.

More recent events, specifically the development and implementation of clinical centres by one School, challenged communication and relationships with stakeholders, including clinical educators. While the clinical centres relocated responsibility, organisation and location of clinical education to district health boards, it widened the distance between education and physiotherapy practice providers. In particular, initial consultation and the change process were criticised, and created tension between education and clinical practice providers.

### **Development of clinical centres**

Development of clinical centres at the time of interviewing revealed that communication between education and clinical practice providers continued to be a source of tension as demonstrated in the quotations below. Lack of collaboration and involvement was highlighted by Dan (allied health director):

*I would have found it more helpful to have some earlier, joint conversations around the strategy. I didn't think being presented and being told what the benefits to us were going to be was particularly helpful. It wasn't how you go about winning friends and influencing people frankly.*

This Dan further highlights, contravenes formal relationships:

*I mean we do have a strategic relationship agreement that's signed with xx and I could argue that they're in danger of breaching that in terms of not talking about the strategy side of it in a collaborative way.*

In contrast, Callum (academic staff) describes elevating conversations above physiotherapy managers in order to gain 'traction' or agreement:

*It's the physiotherapy managers of the various departments, some of whom are on our advisory boards. We have a different conversation around some of that and then, depending on the amount of traction we're getting or not, it then may move up as it has done more recently into the CEO level of the DHBs to explain our current dilemma and what we'd like to try and do about it to be proactive and see, some more engagement in that area because we, essentially can't train any more students unless we have more placements and they aren't getting enough staff which creates the problem for them in terms of their workforce. So it's a very circular problem which we all have an involvement in, but that's where we're trying to keep our relationship going.*

However, from the perspective of clinical educators such as Katie (clinical educator), changes to the delivery of clinical education were imminent and inevitable, regardless of individual or collective opinion:

*And everything that I have heard and seen and read, all indicate the fact that it's [clinical centre] coming, irrespective of whether we like it or whether we don't and that's not a negative comment, that's just a general comment, a fact.*

Tensions are highlighted by each of the participants regarding communication and how change is implemented. Lack of engagement and strategic collaboration from Dan's perspective is detrimental to relationships with the School, and infers that decisions around clinical centres have been made unilaterally by the School and "presented" to stakeholders such as Dan. Indeed, even through the workforce strategy group (stakeholder collective legitimised by Ministry of Health), communication remains challenging with disconnection evident between aspects of the 'demand' and 'supply' chain as previously described by Dan. For clinical educators such as Katie, apathy is inherent in the inevitability of clinical centres and her inability to influence change.

In contrast, School motives to increase student numbers not only financially benefits the School/university (economic capital), but devolves (and segregates) significant organisational and supervisory responsibility for clinical placements to clinical practice providers. Elevating communications to chief executive officers legitimises implementation of clinical centres and effectively bypasses those responsible for implementing the centres, and accommodating additional student numbers. School motives and actions reproduce dominant interests including economic gain through symbolic violence, whereby social hierarchies and social inequalities are reproduced. Thus horizontal and vertical distances between physiotherapy knowledge providers are maintained, if not further increased, with delegation for the organisation (new responsibility) as well as clinical education to district health boards.

Further evidence of the complexity of relationships and interplay of power between Schools and clinical practice providers is provided by Shoba (academic staff) who talks about responsibility for student education:

*We have always maintained the responsibility for the students in the hospitals, a responsibility the School felt it had to ensure that we, are keeping an eye on the education which we think is an education role as opposed to a clinical role, because, we can't have students being assessed for University papers by people who are not employed by the University.*

As described by Shoba, irrespective of the model of clinical school or clinical practice implemented, including organisational responsibility, Schools retain educational responsibility for students. This further reinforces the hierarchical position of Schools relative to clinical practice providers based on cultural, social and symbolic capital.

### **Changes in qualification as capital**

Another important influence on relationships and in particular individual and field habitus, related to the change from diploma to degree, and at the time of data collection, proposed future changes from bachelors degree to doctoral qualification. Mismatching of

qualifications between clinical educators and students, and the value placed by the profession and university on the awards (symbolic and cultural capital) resulted in further gaps in the ranking of education (and those who hold different awards) on the hierarchy of knowledge. Whilst motives to change to degree qualification have previously been described, stakeholders discussed the impact of changes from their unique perspective.

Katie (clinical educator who qualified in 2001) perceives differences in qualifications being a potential barrier for staff educating students completing a bachelors degree.

*And perhaps some of our older members of staff, first of all they didn't complete a bachelors, it was a diploma. So I think that maybe makes a difference [as to their involvement with students].*

Shoba (academic staff) illustrates the importance of change reflecting the evolution of physiotherapy:

*I hope there is a change because I wouldn't like to think that graduates from the Schools these days are the same as graduates from the Schools 15 years ago. Education has moved on and knowledge has moved on and learning has moved on. So we would not be doing the appropriate thing if students were the same.*

She further describes the current climate of physiotherapy education:

*The students are now educated for a world that is very research and evidence based.*

Challenges to clinicians in terms of confidence and familiarity are perceived by Shoba:

*The evidence base is extremely important. And that might be a little bit of a threat to some clinicians if they don't feel confident to talk in the same language, but in fact they've still got the skills, I just think sometimes the education jargon's changed and so, they don't always feel up to the play with that.*

Content and focus of current physiotherapy programmes reflects the wider field of physiotherapy and healthcare education; yet creates disjuncture and tension between different forms of knowledge and those who possess different awards. For some clinicians, as perceived by Katie, the mismatch created a barrier to clinical education. For education staff, changes in field structures created a new pedagogical habitus which also required Schools staff to adjust. Kiera (academic staff) describes the impact of the degree programme on School staff:

*I think it's sort of changed when we went from diploma to degree and we became lecturers instead of tutors and with that came your reduced hours, so that you could read and research. I mean we had to write the degree and it was quite busy and, and so everybody here apart from myself, pulled out of clinical. And I think that's when we then had this division because the academics didn't go out in to*

*clinical anymore, there wasn't that sort of meeting of the brains, of the collegiality, and I think that wasn't helpful.*

Changes to the status of Schools of Physiotherapy, qualifying awards and staff titles reflect the new doxa and emphasis on research knowledge. Professional motives for academic credibility (Brook, 1994) legitimised the reconfiguration of capital, yet created disjuncture between different forms of knowledge, where knowledge was located and who possessed the knowledge. Disjuncture was represented as spatial distances within horizontal and vertical planes. Qualification status (symbolic capital) and different language (linguistic capital) enhanced the spatial distance between student and clinical educators, and in fact, as perceived by Katie, inhibited some physiotherapists from working with students. Negative effects of hysteresis are inevitable as described by Bourdieu:

*As a result of the hysteresis effect necessarily implicated in the logic of the constitution of habitus, practices are always liable to incur negative sanctions when the environment with which they are actually confronted is too distant from that in which they are objectively fitted.*

Bourdieu (1972/1977, p. 78)

Many academic stakeholders spoke of further changes towards doctoral education, again driven by international trends in physiotherapy education as illustrated by Zac (academic staff):

Impetus to change to doctoral education in United States is explained by Zac:

*I don't necessarily see that the reasons the US [United States of America] is moving to doctoral level education are immediately transferable to here [New Zealand], which by them achieving autonomous statement, as direct referral, prestigious profession.*

The impact of change on New Zealand is further described Zac in terms of developments in Australia:

*Certainly in at least two forums, there have been discussions around what is happening in the US and how it might impact on what happens here in New Zealand. Within New Zealand, there have been some discussions with the Board, the College, the Society and between [other university] and ourselves, around the probable need to move to graduate level and probably doctoral education level within a time frame of about eight years or so. Certainly in Australia, which is much closer to home, at least two of the Australian Universities are actively planning on recruiting or have deadlines set for moving to doctoral level education. If the experience in the US is anything to go by, that will start a process that will see Australia and New Zealand all probably moving to doctoral level education.*

And in relation to the wider, global context:

*It's a global market at the end of the day, and that might not necessarily be around movement of labour per se, but equally around, the state of the profession and different jurisdictions and around harmonisation to a certain extent. But what's, within the global context of physio education, once one jurisdiction moves to a certain level, it tends to be a global affect that has a ripple.*

Global and in particular education trends in Australia are recognised as impacting on New Zealand both in terms of change and also educational equity in the international market. Inherent links between New Zealand and Australia are formalised by the Trans-Tasman Mutual Agreement (TTMA) Act 1997 whereby professional registration between the two countries is reciprocal. Formal arrangements between New Zealand and Australia reflect the interconnectivity of physiotherapy fields and efforts to balance the value and distribution of capital as it is configured by both countries. This is particularly relevant given the mobility of physiotherapists between the two countries. By way of example, in 2010, 18 physiotherapists from Australia were granted registration in New Zealand under the Trans Tasman Mutual Recognition Act (Physiotherapy Board of New Zealand, 2011a).

As perceived by Shoba (academic staff) benefits clearly lie with Schools in informing clinical educators and the profession about changes, so that previous tensions are not reproduced, such as, when diploma was changed to degree qualification.

*So I think that it's not so much the degree, I think it's the ability of the individual. And I think certainly our School does try to keep the door open for all of the clinical supervisors or for instance hospital staff to actually feel that they can be educated and participate in continuing education and to know how the students are being educated, rather than perhaps the way that they were educated. And people hang on to something that they know. For instance when we brought in the suggestion that there be a degree programme, a lot of people said well why do you need that, because we've got the diploma and that's fine. And now people wouldn't ever question why we have a degree programme at the university I think it's been exactly the right move, and the next move of course is likely to be doctoral qualification. And, we have to educate the profession about that.*

Doxa and illusio disguise the benefit to Schools in updating clinical educators and hospital staff responsible for student education. Familiarity with School expectations and differences in educational programmes infers congruence with School expectations. Consequently, any mismatching (hysteresis) is minimised, as is tension which may otherwise impact on student education. Shoba's phraseology suggests that although clinical educators need to be receptive and participate in the change process, doctoral education will be implemented irrespective of their involvement. In terms of symbolic power, Schools, (in conjunction with the Physiotherapy Board of New Zealand), are key drivers of change, influencing individual and field habitus. This is expressed by Zac (academic staff):

*It's a long established School, one of the oldest Schools in the world and it's also a fact that we see our responsibility as a bit of leadership, as well as service.*

Schools as perceived by Zac, have a responsibility and leadership role in directing physiotherapy education and by association, the profession. Embedded in the socio-historical status of the School are symbolic power and the ability to configure capital (education awards, practice) resulting in transformation of individual and field habitus (physiotherapy profession and clinical practice), and social hierarchies and inequalities. The next section examines other influences which shape field habitus and the value of knowledge as cultural capital, impacting on knowledge and social hierarchies.

## **Political and economical influences shaping field habitus and value systems**

Political and economic influence exerted on fields in which different knowledge is located was also found to shape value systems and influence hierarchies. The Tertiary Education Strategy 2010-2015 makes explicit expectations of universities to contribute to the economic and social development of New Zealand (symbolic, economic and cultural capital) by acting as a source of “critical thinking and intellectual talent” (Ministry of Education, date unknown, p. 18). In contrast, Ministerial expectations of polytechnics includes the delivery of vocational education that provides employment skills, progression to “higher levels of learning” and undertaking research that supports vocational learning and technology transfer (p. 18). Whereas the contribution of university based courses is measured in terms of social change and economic development, polytechnic courses are calculated on immediate contributions to employment.

Physiotherapy education as an applied but practical degree meets the criteria of both university and polytechnic education, yet by location in universities, propositional knowledge is valued greater than non-propositional or physiotherapy craft based knowledge. Inherent tension is evident for professional practice courses such as physiotherapy based in universities, through conflicting expectations and focus on different forms of knowledge.

One dominant influence which determined the value configuration of knowledge and specifically research was the Ministry of Education’s expectations of universities in terms of performance based research funding. Given that School (and university) research outputs are not only a source of status (symbolic capital), income (economic capital) and professional knowledge (cultural capital), staff are expected to be research active. Consequently staff roles relating to different forms of knowledge emerged, with researchers ranked higher on a hierarchy of knowledge based on their contribution to professional knowledge-base, kudos and economics of the School/university. Subsequently sub-groups of physiotherapy staff (social classes) emerged within fields

(Schools) and also the wider field of physiotherapy profession. By way of example, Savannah (academic staff) compares 'professional practice fellows' with 'lecturers' in terms of School/university funding:

*None of the professional practice fellows at the moment have got their PhDs, they've got a few working towards them. Once that happens parity could occur with a lecturer, probably not senior. So that came in because of the PBRF - performance based research funding, that came in to effect in 2000 about six years ago nationally. So the research outputs of staff within University count towards the amount of money that the School gets, or the department gets.*

Savannah (academic staff) continues to explain the relevance of research in terms of job description and salary progression:

*They're professional practice fellows. So they're actually on the academic scale, so they can actually progress up the same scale as a lecturer. So they've got the capability of doing that, but obviously, in order to go past a certain point they would need their PhDs but their job description doesn't involve research. So theirs is more a clinical focus and clinical expertise.*

The overriding clinical focus was confirmed by Karen, employed as a professional practice fellow:

*My role is to take the final year students we get on the first six week placement and get them up to a point of autonomous, safe practice, building clinical skills, doing assessment, applying treatment and analysing.*

Roles such as professional practice fellows clearly define responsibility for students within the clinical setting. Location of professional practice fellows on a hierarchy of knowledge is legitimised based on the value of 'research' and 'clinical' knowledge configured by the university. This is further verified by job titles and salaries linked with research. Hierarchical positioning is also described by Alistair, a university based clinical educator:

*I don't know about my ability to influence maybe the teachings of the School if that's part of your question there. I think just for the fact that I'm I suppose right down at shop floor level and I don't really hold any status here at the university as far as having been here a long time or have a senior lecture position or anything like that. I don't feel it's maybe it's my duty to make them [academic staff] aware but I don't feel I'll have much influence.*

Given that Alistair and Karen are university employees and practice in university-based practices (minimal geographical distance), there is evidence that clinical practice knowledge/education is valued differently, and consequently, differentiates them from other staff. Research distinguishes the status and hierarchical ranking of clinical staff as described by Savannah; Alistair's perceived inability to influence change demonstrates a position of subordination and lower hierarchical ranking compared with other university staff.

Speaking in terms of the structure of the economy, Bourdieu (2005) described, “all the forms of scientific or technical capital that make for accelerated use or accumulation of knowledge represent a danger to those possessing a practical competence based on experience alone” (p. 117). Value of scientific or technical capital and scholastic capital (Bourdieu, 2005) is determined by the Ministry; such value correlates with those personnel (and organisations) who generate or contribute to the physiotherapy knowledge base and in this research, equate to a hierarchy based on knowledge.

Motives (habitus in action) of the Ministry are revealed through ensuring the symbolic status of New Zealand within the international research arena (symbolic capital) and the economy (economic capital). According to Swartz (1997) Bourdieu does not see a direct causal connection between the shaping of cultural arenas by economic structures, however, in this study a direct relationship between the motives and expectations of the Ministry and research/forms of knowledge is overtly stated in the Tertiary Education Strategy 2010-2015 (Ministry of Education, date unknown). Evidence is also provided in status, job titles and salaries of staff responsible for different types of physiotherapy knowledge. Knowledge therefore, has become an economy in its own right, a source of competitive advantage (Davidson & Voss, 2002) and as demonstrated in this research, a source of tension and power interplay to staff, Schools and the physiotherapy profession. By way of example, physiotherapy education and service delivery, with strong vocational roots is now located within a competitive, business model of healthcare and education provision. Knowledge based business models have redefined value, relationships, organisational visions and strategies (Taylor, 2002); physiotherapy education and service provision is no exception. Manifestations of two fundamentally different cultures are examined through the commoditization of clinical education as explored in Chapter Nine and how this impacts on clinical educators.

### **The value of education knowledge shaped by field habitus**

As discussed, forms of physiotherapy knowledge are valued differently, shaped by field habitus and socio-economic, historical and political influences. Research (propositional knowledge) in particular was configured as more valuable and resulted in university/School staff located higher in social hierarchies. In comparison, value of clinical or practice knowledge (non-propositional) related to registration requirements of the profession, was devolved primarily to clinical educators with university staff retaining some responsibility for formal assessments. There is little evidence in the literature acknowledging the role and value of pedagogy, i.e. knowledge and skills relating to facilitating learning in clinical education in physiotherapy. While School run clinical

educator workshops are available, there is a notable paucity of literature evaluating the structure and content of these workshops (Walker & Openshaw, 1994). Of interest, only 13 of 18 clinical educators in this research attended a workshop inferring that attendance is optional, and potentially perceived as lower priority by clinical educators, Schools and healthcare organisations. In the absence of formal pedagogy, clinical educators drew from their own role beliefs and those of their team/organisation (Kember & Gow, 1994), previous experience as students, and trial and error (Cohn & Frum, 1988; May, 1983). Although personal beliefs influence the way clinical educators approach and adapt their teaching and learning roles (Higgs & McAlister, 2007), different conceptions of learning and teaching can have completely different outcomes for students. For example, teaching compared with learning is underpinned by knowledge transmission, with an emphasis on assessment and knowledge testing. The emphasis lies with the student to demonstrate knowledge. In contrast, learning is facilitated through shared participation of learner and facilitator, drawing on a variety of methods to motivate and learn (Entwistle, 2000).

Pedagogy as cultural capital held different value within the academic field compared with clinical education and physiotherapy practice. Education knowledge and skills were highlighted as an expectation of Physiotherapy School staff when, for example, physiotherapy programmes were relocated to universities as described by Kiera (academic staff):

*So it allowed the School to actually grow and develop and develop its research strengths, and with it came the academic education knowledge as well.*

Expectations of School staff to develop knowledge and skills in education are not compulsory even for full-time School staff as illustrated by Shoba (academic staff):

*It's not laid in concrete but for most of our staff who come in, they have the opportunity to do that [formal qualification in education] and most of the new staff if they're in full time with the School are undertaking that tertiary teaching certificate.*

Unlike compulsory requirements such as the annual practising certificates for all practising physiotherapists including clinicians, academic staff and physiotherapists in research, formal training in pedagogy is optional for School Staff. Education knowledge in comparison to physiotherapy knowledge could therefore, be considered not only separate, but holding lesser value, legitimised by Schools. Non-compulsory completion of teaching certificates denies staff opportunities (symbolic violence) to develop knowledge and skills in education and the ability to adjust personal and professional habitus to new field requirements (teaching). By association, ineffective teaching and learning strategies may

have a detrimental impact on students and staff confidence and competence in their learning/teaching roles.

Exploring the experiences of new physiotherapy lecturers transitioning from clinical practice into academia, Hurst (2010) found structured strategies that specifically focused on pedagogical and research skills were recommended. Teaching qualifications and informal peer support were commonly used strategies and corresponded with transformation of habitus (professional socialisation). Some participants acknowledged a definite shift in professional role yet less clear shift in identity from physiotherapist to academic (Hurst, 2010) suggesting that dispositions relating to identity as a physiotherapist are deeply embedded, and habitus is slow to adjust to new fields. Similar findings relating to identity were identified in this study.

Academic staff such as Liam clearly identified himself based on his first order profession of physiotherapist, irrespective of where he was located:

*I'm a physiotherapist first that does education, and that happens to be ensconced in a university.*

A shared identity as a physiotherapist was perceived by Liam to negate tensions between Schools which until recently were acknowledged as tense:

*I know in the past if you're aware of the history of the two schools, they haven't always got on collaboratively, and to me you know that was just nonsense. When xx was appointed and I was appointed, I said to him what are you here for? He said I'm a physiotherapist and I said, great we're going to get on fine. And we've got a number of very, very good collaborative links that we didn't have before.*

Professional identity as a physiotherapist and physiotherapy specific knowledge appears to hold more value than education specific knowledge, or identity as a lecturer/academic staff irrespective of employment/location in universities. Whilst symbolic capital is associated with universities, owners of knowledge, 'teaching' as a profession albeit primary and secondary teaching holds lower status compared with other professions and specifically medicine (Braithwaite, 1975). Juxtaposition of practice based courses, such as, physiotherapy in universities, reveals the domination of physiotherapy specific knowledge and skills over pedagogical identity and knowledge. This however, is in contrast with nursing literature which argues that clinical practice is distinctive from academic practice (Elliott & Wall, 2008) and in fact, questions whether nurse academics should engage in clinical practice. Hurst (2010) recommended this is an area of further debate within physiotherapy.

In an Australian study into physiotherapy students' and clinical educators' perceptions of learning and teaching, clinical educators found transitioning from clinical to

education role challenging (Delany & Bragge, 2009). Lack of time to reflect on and review their experiences resulted in clinical educators relying on experiences as a student, and describing their roles in terms of knowledge provision rather than facilitation of learning. This was reflected in their educational strategies and practices. Although the study was confined to one Physiotherapy School, results echo findings in this study which identified a reliance on previous experiences and traditional teaching methods, absence of contemporary pedagogical frameworks and lack of time to reflect and transform knowledge. Evidence is provided in the quotations below.

As demonstrated by Andrew (clinical educator), lack of education knowledge, specifically School expectations (process knowledge) created tension:

*Last year, I was really had no idea what the university expected the students to come out like at the end. They don't tell us if they're just going to have one placement in this area or two and what their expectations were. And I went back to them like on a couple of occasions and said look I need to know what they should be like by week two and what you expect them to be like in week three and by week four and, they showed me that little graph about how someone learns and that doesn't help me.*

Training and time to embed new supervisory skills were described by Merrill (clinical educator) as important to her role:

*I want a, bit more training really because this supervision course has been great and I really want to put a few of these things in to a bit more practice but even some more ongoing supervision training really and progressing that would be great. Certainly the time issue, if we could have part of our role as the supervision role for students built into it, essentially our clinical roles are full time, probably with the admin plonked on top of that, and then with the students kind of plonked on top of that.*

Student perceptions verified the dominant value of physiotherapy knowledge compared with education knowledge, and also highlighted a replication of teaching practices, rather than insight into educational strategies. Emma (year IV student):

*I'm there to learn, how to assess and treat that particular patient. But then again, I'm also there, to learn about treatment options for that patient. And even, just learn about the different treatment options, even if I've done the best one for my patient. So, it is about what is best for the patient but, in the hospital, in the scheme of learning things, I'd actually need to be challenged about everything that could be relevant to that patient.*

Being 'grilled' on aspects of assessment/management replicates the style of learning that Emma found beneficial. However, the dominant focus lies in knowledge transmission and testing rather than learning through a variety of methods, including shared participation with the facilitator.

*Well learning from my placements, knowing how I want to be treated, I think I would, well do a bit better job. Like, I know at the time being grilled, but I actually*

*feel like you, I don't know, you feel like you've missed so much or something that you're a little bit stupid but looking back on it, it's so worthwhile that even though most students might not like me at the time, because I grill them but I think that they'd really benefit from it because I know what really benefited me.*

When asked if physiotherapists undertook any training to become clinical educators, Emma replied:

*I have no idea if they've done any formal training, I don't think so. I doubt it.*

For several participants, contrasting views were held in relation to whether education knowledge was transferable between different groups, i.e. patients, students. Rebecca (professional association representative) cautions against expecting all physiotherapists becoming clinical educators, perceiving clinical educators as a unique social group with distinguishable personal attributes and skills to work with students:

*I mean one issue is not everybody is cut out to be an educator. So you can't just assume that everyone should take students, because some people can't teach to save themselves. To some extent, but teaching a clinical skill is not necessarily the same as teaching patients. And teaching a contemporary at a high level is completely different to teaching a patient something and some people just don't work on that basis. So, if the expectation is that everyone does it, I think there is a potential that the quality is going to drop because you'd like to think that the people who are taking on students, and mentoring them are people that actually are keen and interested in doing that. And because of that they develop special skills that you're relating to a different subsection of the population.*

Two other participants however, perceived educating students as an extension of the role of physiotherapists:

Shoba (academic staff):

*I think that physiotherapists through practice know quite a lot about, patient management and are quite happy to teach students just as they are to teach new staff about the process of managing the ward and managing the patient and, new protocols and things like that.*

Su (community-based clinical educator):

*Because of my job as you know is teaching patients, teaching people to be better self managers and getting a better quality of life and that really is not dependent on getting an intervention from a health professional, it's them taking control of their own lives and consulting with health professional when they require it. (...) So that's my clinical role and so I don't see that there's not really any huge line between doing that and teaching a student.*

In contrast to Shoba and Su, Zac (academic staff) describes how physiotherapists associate education as separate to their physiotherapy role:

*Physios generally do not see education as part of their job, it's the university's job, it's the educator's job, it's not their job, as a physiotherapist. And, it's a culture we've got to change.*

He continues:

*There's a culture in physio which is linked to it's pragmatism. You know everything that doesn't include treating the patient is of irrelevance.*

Evidence provided by participants indicates that education knowledge whilst integral to the role of physiotherapist, is not acknowledged and valued compared with discipline-specific knowledge. Additionally, educating patients is, for some participants, different to educating students. Whilst beyond the scope of this study to explore the reasons, opportunities to develop education knowledge including workshops for clinical educators appear to have a place in transitioning physiotherapists to clinical educator in terms of identity, strategy and roles. Findings however, suggest that clinical educators valued process based knowledge (including how to assess students) more than education principles (Walker & Openshaw, 1994) and workshops were often based on what Schools presumed educators needed to know (Cross, 1992).

Non-compulsory attendance at workshops (or tertiary qualifications for School staff), and limited published literature suggests that Schools, healthcare organisations and the profession do not recognise pedagogy compared with physiotherapy knowledge and skills. Further evidence is provided by academic staff in relation to the curriculum.

Liam (academic staff) talks of training students to only 'educate' patients:

*I guess again in the past we've trained people to treat the patient, we haven't trained them or educated them to educate anyone else and it's about changing that focus a little bit.*

Embedding education knowledge within the curriculum would, along with physiotherapy practice knowledge, shape habitus transformation as will be further discussed in Chapter Ten. Recognition of education principles as integral to the role of all physiotherapists and therefore, transferable across patient/peer/student groups could enhance the value of education knowledge. Configuration of capital however, is closely aligned to field values (Bourdieu 1979/1984); physiotherapy profession, Schools and organisations therefore, would need to determine its value as cultural capital. By way of example, accreditation schemes for clinical educators have been implemented in countries such as the United States and United Kingdom. Affiliated with universities and promoted by professional bodies (i.e. Chartered Society of Physiotherapy, UK), clinical educators gain qualification, recognition and status (symbolic and cultural capital); this however, did not translate into economic gain for clinical educators. Recent evaluation of the United Kingdom based accreditation scheme of clinical educators found positive effects not only to clinical educators when working with students, but benefits were also transferable to colleagues and clients (Sellars & Clouder, 2011). The authors advocated further research

into whether accredited status (and the process therein) “really makes for a better clinical educator” (p. 344).

As recent, although scarce, international literature infers, the quality of clinical education is under review. Credentialing and accreditation schemes may provide forums to achieve standards across physiotherapy programmes and raise the profile of education knowledge; to date schemes remain optional. There is little evidence of economic gain for clinical educators (economic capital) albeit that the role and unique knowledge would gain kudos (symbolic capital). Creating education programmes and qualifications, and even development of a dedicated career pathway in physiotherapy specific to clinical education could reconfigure the value of education knowledge, but unless supported by the profession, may be limited to the field of clinical education. Until pedagogy is equitable with other discipline specific knowledge and recognised as transferable across other fields, social hierarchies may continue to exist based on the value of different and separate forms of knowledge, and specifically education knowledge. This suggests that clinical educators, compared with their peers will continue to hold less value, and as a consequence, be positioned lower on hierarchies.

## **Chapter summary**

Clinical educators represent a distinct social class and as evidenced in this chapter, rank low in social and professional hierarchies. Little evidence has been found that acknowledges or values education knowledge compared with ‘clinical’ or ‘research’ knowledge. In fact, socio-political and professional influences reinforce the value of discipline specific and propositional knowledge, for example, research/evidence based practice, and within Universities, is a source of kudos and economic gain (performance based research funding). Different values locate different components of knowledge on a hierarchy, and by association, those who possess and impart such knowledge. As demonstrated in this Chapter, education knowledge is considered separate to other forms of physiotherapy knowledge, valued less and ranked lower. The ‘optional’ nature of clinical educator workshops and qualifications in learning and teaching for academic staff, reinforce the low status of education knowledge and also clinical educators within different fields including the profession.

In order to elevate the position of clinical educators and clinical education within social hierarchies based on knowledge, reconfiguration of education knowledge as cultural capital by stakeholders is essential. Embedding education knowledge within the curriculum alongside other components of physiotherapy knowledge and promoting transferability across dimensions of physiotherapy may minimise horizontal and vertical

gaps which constitute sites of power interplay. Formal training for staff involved with students (irrespective of location) has been found useful in transitioning staff between clinical and education roles, transforming professional habitus. Benefits of valuing education knowledge differently, includes raising the status of clinical educators, standards of clinical education and education of patients. Additional outcomes may include increasing the capacity of clinical placements, moving away from traditional models of clinical education and 'teaching', towards contemporary models of shared learning and collaborative placements. To elicit change however, all stakeholders including clinical educators need to reconfigure the value of education knowledge, and the contribution of clinical educators.

The next chapter examines the field of clinical education in relation to the wider field of power (healthcare). Economics and politics, consumerism and commoditization of clinical education were found to influence value systems and are revealed as inter-stakeholder conflict, and arenas of power interplay.

## **Personal reflections**

*As I wrote about the significant changes to physiotherapy education, I remembered being in the midst of the change from diploma to degree status. As a student body, we fought for retrospective recognition and were awarded a degree even though we had enrolled on a diploma course. We had analysed the curricula and found no significant difference to justify being disadvantaged in the final qualification. Somehow we recognised that a degree held more status than a diploma, and it would have important implications for the future. In contrast, when I was given the opportunity of having my certificate of qualification reissued by the university (rather than the polytechnic), I perceived the awarding body was less relevant than the award.*

*Similarly, gaining a Masters represented a personal and professional milestone, yet as a clinician when having a Masters was not the norm, it had an isolating effect. In essence, I experienced hysteresis; my professional habitus was dislocated from the field in which I was positioned. It would take several years before Masters degrees were common amongst clinicians (transformation of field habitus), and more recently, a requirement for career progression (symbolic and economic capital). Yet, a Masters degree was one of the criteria for employment as a lecturer, inferring better congruence between habitus and field. Interestingly, expertise in my clinical specialty was also a criterion illustrating that as a lecturer in physiotherapy, both academic and clinical credentials were required, but not experience of teaching or education knowledge. What is unclear is how the value of clinical experience compared to a Masters degree in the academic field, given that they both*

*represent cultural capital. My belief is that a Masters symbolised a better congruence with the academic field as it represented a specific standard of academic achievement, unlike clinical experience which was less defined.*

*Within three months of my role as lecturer I undertook a Post-graduate Certificate in Academic Practice, which along with peer support, provided me with tools to aid my transition into teaching. Many of the tools however, I recognised and have since embedded in my clinical practice, and leadership role. As with participants in this study I retained the dominant identity of a physiotherapist who taught in a university, yet felt personally obliged to maintain a clinical caseload. This was my way of balancing my dual identities, and hysteresis.*

*As a lecturer, I also experienced the challenges of integrating a Masters degree programme with a licence to practice as a physiotherapist, alongside Bachelors degree in physiotherapy. I remember the tension for staff, clinical educators and the profession as once more, habitus and field became mismatched. Again, the academic award (Masters) was not synchronised with clinical competency, which remained the same for Bachelors and Masters students. And I anticipate with the inception of doctoral programmes, hysteresis will yet again result, except I envisage that the time lag for field habitus to transform will be much longer. Given that in New Zealand, most clinical educators hold either diploma or bachelors degrees with a minority holding Masters, doctoral awards represent a greater distance in the hierarchy of knowledge, yet their clinical competency as a student remains the same. This implies that the disparity between the value of 'clinical' and 'education' is increasing, and unless addressed, tensions surrounding the disjuncture between different forms of knowledge in physiotherapy, will amplify.*

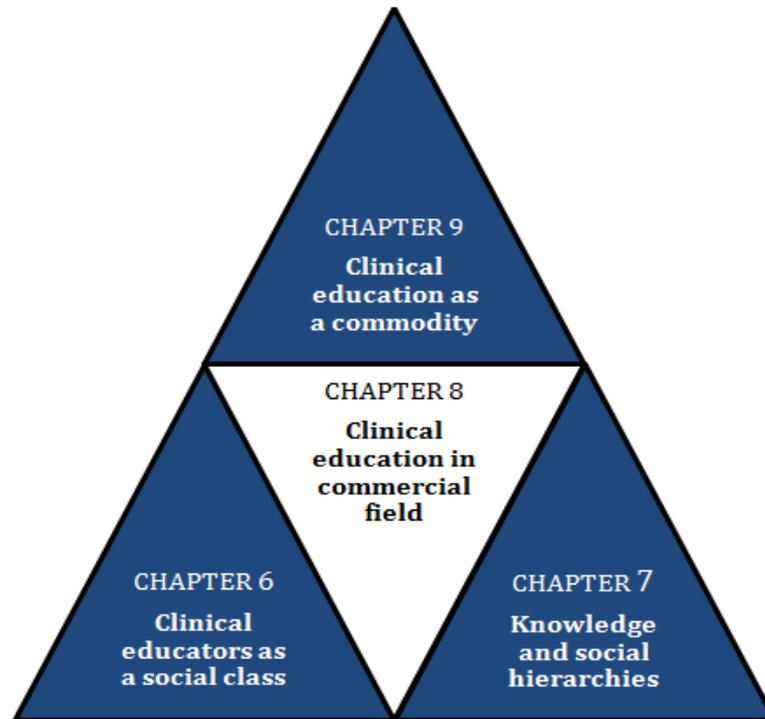
*Whilst change is inevitable, Bourdieu's concept of hysteresis acknowledges the mismatching of habitus and field, the time lag before congruence is attained. Recognising the durability and deeply embedded dispositions of habitus, I question the management of change and specifically the responsibility of the stakeholders in the transitioning process towards different qualifying awards. Imposing change such as the clinical centres, as opposed to owning change through authentic collaboration, must surely ease the tension of habitus transformation.*

*My reflexive stance has enabled me to illuminate divergent experiences from clinical practice and education and from different positions and time periods (including student, clinician and lecturer), and identify with many of the participants and the findings of this research. Mindful of the unique habitus and experiences of clinical educators and stakeholders, I endeavoured to attain different perspectives which would reveal the*

*complexity of clinical education and the tensions within. Supervisor and peer critique continued to challenge my lens of interpretation and objectivity.*

## CHAPTER EIGHT

### Juxtaposition of clinical education in different and competing markets



Chapter 6 Clinical educators as a social class
Chapter 7 Knowledge and social hierarchies
<b>Chapter 8 Clinical education in commercial field</b>
Chapter 9 Clinical education as a commodity

Figure 8.1 Summary of themes which emerged from this research: Chapter Eight

### Chapter Overview

**Theme Three** presents findings which reveal inter-stakeholder conflict arising from the juxtaposition of clinical education between different and competing markets. Clinical education is examined in relation to the wider field of power (healthcare) and specifically influences of consumerism and commercialisation. Clinical education as a commodity emerged as both a product and service to be negotiated and valued, based on market

principles of supply and demand. The commoditisation of clinical education is examined in Chapter Nine.

Both themes three and four (Chapters Eight and Nine) emerged directly from research participants who described the 'value' of clinical education relative to their own 'interests', capital accumulation, trajectory and hierarchical position in organisations. For example, clinical educators spoke of the cost of clinical education in terms of time, and funds generated from payment for placements which could be exchanged for courses. Academic staff spoke of the actual monetary cost of placements. This reflected awareness of socio-economical and political influences which shaped the field of clinical education relative to healthcare, physiotherapy education and service delivery, and also consumer expectation of quality and value for money. Bourdieu's methodological and conceptual frameworks allowed the impact and influence of economics to be further examined.

As previously described, the value of clinical educators is configured based on the practical nature of the profession, and reflected in the clinical hours and competencies which students must attain in order to gain registration. Within this following chapter, the commoditization of clinical education not only locates clinical education between two different markets (physiotherapy and education) but also between vocational and commercial worlds. As a product and service, the value of clinical education is continually contested by interested individuals and organisations, with clinical educators central to competing forces. The market concept is in stark contrast to the vocational origins of physiotherapy, as described by participants, as are the concepts of commoditization, commercialisation and consumerism. Embedded in the social structure of markets are consumers and producers, economic activities and socio-political influences which determine the configuration and value of products and services. Communication, trust and authentic collaboration considered essential for market interactions/negotiations (English, 2010), were also identified by participants as sources of tension, disguising and protecting dominant interests and in some instances, withholding resources. From a Bourdieusian perspective, trust and communication (essential for authentic collaboration) may represent components of symbolic capital which can be exploited by individuals and organisations with dominant vested interests through the practice of symbolic power.

Disparities between provider and consumer expectations manifested as inter-stakeholder conflict and tension. All stakeholders spoke of challenges relating to maintaining pace with the tempo of healthcare change. In particular new graduate readiness for work and curriculum content were perceived as incongruent, resulting in

clinical educators strategising to bridge gaps in knowledge and practice, and meet the needs of students, education and practice providers and also patients.

Patients, ultimately the consumer of both service and product, are rarely visible within the tripartite relationship of producers and consumers (Schools, healthcare providers and students) in clinical education, despite their essential role in making clinical education and physiotherapy practice 'real', and ultimately, being central in the current consumer-dominated market. Decentralisation of patients and patient care highlighted a lack of congruence and shared vision of clinical educators and stakeholders in clinical education. Consequently, conversations, actions and practices of individuals and organisations were commonly disjointed and tense. New ways of understanding practice and practice culture are proposed drawing on improved understanding of the forces of hegemony and their origins, which exist within clinical education and how, centralising patients within the field of clinical education may address some of the inter-stakeholder tension and conflict.

## **Markets and clinical education**

Clinical educators spoke of their role and value in preparing students as the next generation of physiotherapists and workforce and on occasion, in terms of the projected workforce shortages and recruitment. In this way, clinical education was defined as sites of cultural production, where through processes of professional socialisation and knowledge gained exclusively within the practice environment students were prepared as physiotherapists to work within practice environments. Central to the notion of cultural production are the social structures of the economy which influence supply and demand (market), and reveal complex patterns of determining, negotiating and exchanging clinical education (as time, knowledge and skills of clinical educators). As social structures for exchange, people, organisations and products are evaluated and "priced" (Aspers, 2006, p. 432); markets often constitute a form of production chain, orientated towards either wholesale or consumerism. Social structures are described not only in terms of position and status of producers and consumers, but also in terms of supply and demand.

Clinical education can be described as a product (service provided by clinical educators), with Schools purchasing the 'product' from practice providers. Thus, as consumers, Schools have expectations that are defined and negotiated and often formalised within documentation such as memorandums of understanding. Alternatively, physiotherapy practice providers could also be considered consumers, ultimately employing the 'end product' of education; implying that as consumers they also have rights and expectations regarding the quality of the end product, i.e. graduate/employees.

Inherent in each of these markets is a composition of unique power relations between producers and consumers. Consequently, one market is orientated towards the ‘upstream production’ of student physiotherapists through clinical education experiences (product), whilst the other market is orientated ‘downstream’ towards new graduate/employees (end product). In both scenarios, clinical educators, have a role in shaping the ‘product’ either as students or new graduates, either in private or public healthcare organisations.

Market dynamics and exchanges are also influenced by other consumers, i.e. students and patients. Students, recipients of both School and clinical based education described expectations in terms of demands on clinical educator time. In comparison, patients, consumers of both product and service (clinical education and students), are rarely visible yet unanimously, their value is intrinsically linked with student learning experiences (product and service). The complexity of relationships between stakeholders as producers and consumers is presented in Table 8.1.

**Table 8.1 Relationships between clinical educators and other stakeholders in clinical education as producers and consumers**

<b>From the perspective of the various producers</b>	<b>From the perspectives of the various consumers</b>	<b>Related product/service</b>
Practice provider (e.g. district health boards, private practice)	Schools within health faculties that provide physiotherapy education	Clinical education (service)
Schools within health faculties that provide physiotherapy education	Practice provider i.e. district health board, private practice	New graduate (product)
Education (primary) and practice provider (secondary)	Student	Education (School and clinical education)
Practice provider (primary) and Schools (secondary)	Patient	Physiotherapy practice (service and product)
Patient	Students as representatives of education and practice providers	Clinical experiences

As demonstrated in Table 8.1, each market represents a different composition of power relations; ultimately, all parties have a vested interest in clinical education. Additionally, wider influences exist from interconnections with other fields such as the registration body, ministerial bodies and funding agencies such as the Accident Compensation Corporation. From the perspectives of clinical educators however, they have a responsibility for the provision of clinical education as a service and the product (student) albeit within a specified timeframe and clinical specialty. Consequently, they are

subject not only to power relations between consumers and providers, but also expectations of individuals and organisations; these were described in terms of demands on time, tensions regarding multiple roles and an inability to influence change. The multi-dimensional dynamics of stakeholders from the perspective of producers and consumers is examined through the conversations with study participants.

## **Students as consumers**

Students described themselves as consumers in terms of their expectations of clinical educators. Jamie (year IV student) portrays his motives as a consumer:

*I know from my point of view I've got five weeks of opportunity to learn as much as I can, to get as much knowledge and get as much as I can out of the placement, because you've only got so many five week blocks before you graduate and so I want to get as much information as I can from, not just my patients but also educators and other people in the team as well. So I'm pretty constantly asking them questions, and I think students are pretty inquisitive, they want to know lots of things, when you're with a physio because they don't always get that time in school, they get the one lecturer to whole lot of students but, I think to utilise that one-on-one time, they are pretty demanding with their questions.*

Examples are provided below when, as consumers, students' expectations were not met.

Emma (year IV student) on placement in a district health board:

*From my perspective, because even if she had interesting patients, I didn't go see them with her, we didn't talk about it. She just had her own caseload and she was really, really busy and so I don't think her priority was supervising me.*

She continues:

*Well, I definitely think it [clinical education] should have taken a bigger chunk than what it did. I don't think it should have been her priority but definitely, I shouldn't have been bottom of the barrel.*

Jamie on placement in a private practice:

*Because the physio is staying to his caseload and still hasn't accommodated for you, doesn't have the time to give you so much feedback, not only are you kind of making them more money by taking a whole other caseload of more people, but you also suffer by not getting the feedback that help facilitate your learning, you're not really getting that, what you're there for I think.*

In both scenarios, dominant interests of the clinical educator and field habitus prevail, i.e. clinical caseload. Private practices are perceived as fields of economic production and gain, rather than learning environments with students, as perceived by Jamie, contributing to the economics of the practice. Yet for Emma on placement in a district health board, the clinical educator's caseload took precedence and in doing so, learning opportunities were denied. What is unclear is whether the clinical educators are meeting contractual requirements regarding time allocated to students/week, or whether what students are expecting are in excess. In a phenomenological study of 17

physiotherapy students, Morris (2007) found that students positively perceived direct hands-on experience with patients. However, “excessive or unsupported responsibility” (p. 217) for patients was perceived as negatively impacting on the clinical educator/student interaction, irrespective of the demands on clinical educators due to staff shortages. The complexity of meeting the needs of students as well as patients and other demands are highlighted by Morris, which echo findings of the current research.

From the perspectives of both students, clinical educator time represents the medium to transform different forms of knowledge into physiotherapy practice, such as, answering questions, providing feedback. Value configuration of cultural capital (knowledge) is increased based on accessibility which is in contrast to lecturing staff as noted by Jamie. The exponential growth in physiotherapy student numbers was found by McMeeken, Grant, Webb, Krause and Garnett. (2008) to impact on the ability of Australian Schools of Physiotherapy to recruit experienced academic staff; this undoubtedly has impacted on student:academic staff ratios. In contrast, despite an established body of evidence to support different models of clinical education, traditional model of clinical education (1:1 or 2:1 student/supervisor) continues to dominate. This provides the student with potentially more individualised learning opportunities compared with academic staff, however, as described by both Emma and Jamie, only when time is allocated to them by their clinical educators. In contrast, clinical educators such as Katie (DHB clinical educator) spoke of the challenges of students as consumers and their perceived demands:

*I think that students want value for money and ‘I’m paying for this so God damn it I should actually get what I paid for’ and so they want me to work my guts out for them. (...) They want a good service, whether it’s from university or whether it’s from clinical educators.*

Value was described by Savannahgh (clinical placement co-ordinator) from the perspective of students as narrow:

*They [students] want to perceive that it’s actually going to give them value and they’re going to gain from it, but I think generally it could be also that they don’t realise necessarily the other skills that they gain from it. They seem to have a narrow focus on what new techniques and things they’ve learned as opposed to actually realising what else they’ve learned.*

Bourdieu distinguishes dominant classes from subordinate classes by virtue of its advantages in total volume of valued resources. Time, in this instance, is a valued resource to students and clinical educators (and their patients). However, it is the clinical educator through symbolic and cultural power, who controls the allocation of their time (economic capital) and time with the student (cultural capital). Given that cultural capital is

subordinate to economic capital (Swartz, 1997) student learning is assigned a lesser value; field habitus (public and private practice) plays an important role in influencing how, for example, time is used and converted into different forms of capital. Patients are central to both fields, albeit that in private practices, field motives are predominantly economical compared with district health boards.

Contemporary influences on students are described by Shoba, (academic staff):

*You need to understand that they are a different generation and they are more measured. They've got bigger loans, and other things that they think are important in their lives, and they do learn differently and they do have high expectations of people who are educating them, or supervising them because they are paying good money to be educated and so all young people these days are much more demanding than they used to be. They're not a submissive group of people and sometimes we think perhaps professionally you should be submissive, and somebody's the senior and somebody's the junior.*

And Zac (academic staff):

*I think students are more challenging these days and that also students currently reflect the wider culture, social culture.*

The significance of society, and specifically economics in shaping students in terms of consumers and their expectations, is illustrated by Shoba. Wider field analysis highlights economics as an organising principle between and within fields and also functions as a key determinant in social class structure (Swartz, 1997). Consumerism in healthcare legitimises the demands of consumers such as students; this impacts on relationships previously determined by professional knowledge and respect. Traditional relationships based on hierarchies determined by cultural capital have been fundamentally altered by economics, and particularly, the position of students as consumers.

The radical transformation of physiotherapy education has reflected to some degree the rapidly changing economy of healthcare. Physiotherapists and physiotherapy as a profession (individual and field habitus) have been slow to respond to economic changes (Nicholls & Larmer, 2005; Reid & Larmer, 2007); this hysteresis effect resulting from the disruption between traditional based practices (physiotherapy habitus) and contemporary, economically determined field requirements such as healthcare delivery and service provision. Hysteresis provides opportunities for improving field positions (Hardy, 2008); the concept of consumerism legitimises the position (and expectations) of students. This was, as Shoba suggests, in stark contrast to traditional relationships between clinical educators and students whereby students were respectful and not demanding. Clinical educators must therefore, not only adjust to changing healthcare and service provision (hysteresis across a number of fields), but also the demands and

expectations of individuals therein. This includes students as well as patients as consumers.

## **Patients as consumers and the business of physiotherapy**

Economic field conditions and structures encompassing consumerism have had a significant impact on patient expectations. Within clinical education, patients are the conduit through which students transform knowledge learned at School into clinical and professional practice, and therefore, have a role as producers of the 'product' (students) whilst also being recipients (consumers) of physiotherapy services. Patient roles as consumers were emphasised more within private practice, whereby payment for professional services occurred. This was unlike district health board-based physiotherapy practice, where no economic transaction occurred. Therefore, the patient as consumer featured differently within these two distinctive fields. When asked where the patient was located in clinical education relative to the student and clinical educator Julia, a district health board based clinical educator responded:

*They (patients) get talked about a lot but they probably aren't the centre of the world. Obviously we take the responsibility for the patient. We treat that as important in that the physiotherapist would always have the ultimate responsibility, so it's not like we're handing them over to the student, we're keeping an active involvement in making sure that they're really happy having a student and whenever we change a student or the way things we work, we really try and make sure the patients are happy with the process. But I think they probably do get a bit of a raw deal being practised on for exams and mock challenges and the like. Especially in rehabilitation when they're here for a long time, they often see a number of students. Some of them really like that though, but really what do we do, they're [students] here to work with patients and, we have to find people for them to work with.*

Although patients are acknowledged as the responsibility of clinical educators such as Julia, their unique role within the student/clinical educator relationship is illustrated. Co-involvement of patients within the process of clinical education is actively undertaken, ensuring patients consent to student participation, however, clinical educators as district health board employees retain responsibility for the patient. Given the juxtaposition of clinical education between education and healthcare provision, clinical educators must balance optimal care and patient satisfaction against ensuring students provide adequate care and have sufficient clinical experiences to enhance their learning. This highlights the mediation role of clinical educators between and within two interconnecting fields, whereby both patient and student are consumers. Findings in this study echo McAllister, Higgs and Smith (2008, p. 2) who noted "the imperative to care can create tensions and dilemmas for clinical educators when the need to care for the student conflicts with the

need to ensure client care”; this illustrates the competing needs of both consumers. Mediation between two consumers has its challenges as illustrated by Julia:

*And sometimes I'll be working with a student and with a patient, and I'll get a feel that the patient's not happy, not really enjoying the situation, it's quite hard then, they've given consent and they're begrudgingly putting up with a student; to try and really ask them if they're happy and you think oh man, I just wish that I could see them because it is slower and it's sometimes a bit painful when they're very new. And you do feel for the patients who try and keep involved with them and make sure they're continuing to be happy being guinea pigs.*

Although a tripartite relationship between student, clinical educator and academic staff has been described in Chapter Four, the presence and involvement of patients within the learning relationship is almost invisible (Langford et al., 2008). Reference to patients as ‘guinea pigs’ infers status as experimental subjects within the relationship rather than collaborative stakeholders. Consent is obtained from patients, however, as described in the quote above, students’ needs appear to take precedent over the needs of patients.

Field habitus of healthcare providers such as hospitals hold established expectations for patients that as consumers, they will receive effective care provided by qualified professionals. Hospitals, recognised as teaching hospitals (field habitus) through association with education providers (symbolic capital), imply that care maybe provided by students. Sam, allied health director describes how as consumers, patients are informed of their rights:

*They [patients] know it's a teaching hospital in terms of if they're coming in to an elective situation, they are sent the information which does state that it's a teaching hospital. It doesn't say you have to have students by any means but it is a teaching hospital. (...) They most certainly can and do refuse, if they choose not too. It's the patient's choice, it's paramount but I have to say that most people that have students find the experience quite rewarding usually.*

Doxa as a symbolic form of power is embedded in the teaching status of the hospital, legitimised by formal communications with the patient and consequently, patient expectation. Patient choice whilst described as paramount by Sam, suggests that refusal to be treated by a student would represent a deviation from the ‘taken for granted’ hospital practices. Illusio however, disguises the fact that specific patients are targeted by clinical educators based on the type of experience that students may benefit from, and also how the information is marketed, as described by Julia (district health board based clinical educator):

*We usually select them [patients], usually by their condition as well, (.....). But I guess down here as well it's not just physio students that they're involved with. It's sort of the norm that there will be medical students and nursing students and OT [occupational therapy] students, it is a teaching environment, so it's not the exception that they have a student physio. And I sometimes tell the patients that it's an advantage having a student because they have a little bit more time than*

*the therapist. I do sell it to them a little bit that they will have more time then, than I do, which is realistic that they will. So I do sell it and talk the student up a bit.*

Selective provision of information relating to students, and marketing students to patients could be examined as symbolic violence whereby the patient can only make an informed decision based on the information provided rather than what is not said. 'Selling' as a concept reinforces clinical education within the market context and also that both the patient and learning experience have value.

Another clinical educator Su, compares patient care from the perspectives of experienced and student physiotherapists:

*If you get a senior clinician, they'll go in and be able to assess the problems fairly quickly and then get the job done, go straight to the point if you like. Whereas with a student they'll probably ask a lot more questions, take a lot more of the person's time. And then maybe have a discussion with another physiotherapist before actually coming round to the main point do you know what I mean. They might even do a treatment and then you might say to them well no you weren't as effective or that wasn't the right thing and then they have to go back. And I think most people don't mind, as long as they actually get in the end, they get what they need.*

Patient satisfaction with care provided by physiotherapy students is perceived by Su as different in terms of time and efficiency compared with qualified staff. Comparisons made include efficiency of processes including clinical reasoning which Su perceives are irrelevant if patients as consumers benefit. Patients appear to tolerate students as long as they receive the treatment required. This mirrors findings, by Langford et al. (2008) who found that 66 patients discharged from an outpatient physiotherapy department in Ireland were as satisfied with care provided by physiotherapy students compared with qualified physiotherapists. Irrespective of status (student/qualified physiotherapist), personal manner of the physiotherapist rated highest for patient satisfaction in their questionnaire survey.

In contrast to public health care, customer (patient) satisfaction is a priority as private practice patients represent income generating potential, and if dissatisfied, may have detrimental economical impact on business.

Shelagh, a managing director of a private practice describes the negative impact of a student on her business:

*We lost a couple of patients because he [student] had technical skills but his attitude was a problem. And, we know the patient did not come back and we had to follow up with that and reassure them. (...) We did damage control very quickly but, it also made me think do I want to put patients in this situation, do I want to put my business in this situation.*

Within the field of private practice, the patient as consumer has a more visible and dominant position compared with public health, given that customers can take their custom elsewhere. Private practices are underpinned by a business model in which each patient is a source of income. In comparison, the economic nature of public health systems is based on Governmental funding allocated to public healthcare establishments based on population demographics. Each patient therefore, in utilising healthcare services, costs the district health board. Patient dissatisfaction for Shelagh has a more immediate economical impact relative to her business. 'Damage control' was important to regain the patient's custom. This suggests that 'customer' care, as well as professional care, is intrinsically linked within the field of private practice. The combination of different forms of capital (marketing and physiotherapy skills) generates positive patient/customer experiences which self-perpetuates income for the practice. The economic trajectory of the practice is based on patient contact and payment. Dominant economic interests (capital) take precedence over clinical education (cultural capital); from a Bourdieusian perspective, economic capital/cultural capital is a familiar tension (Swartz, 1997). Students therefore, will be ranked lower than patients in social class structure within the field of private practice.

Other significant influences which have empowered patients as consumers and stakeholders in healthcare delivery include the decentralisation of health services away from public hospitals towards community based care, increased accountability for services offered and provided (Selker, 1995), and increased focus on quality, outcome of patient care and patient satisfaction. By way of example Rick (professional leader) describes recent changes to practice:

*Towards a much more patient focused approach, a patient centred approach, rather than around what staff were doing. Staff might go and see a patient because of what they thought was best for the patient and the best outcome rather than considering, what are the patient goals, what does the patient want to do and then how can we as the three therapies work together to help that patient meet that goal, to meet the patient's goals. Before we started on this, or right at the outset of this we did a customer satisfaction questionnaire.*

Government recognition of patients as stakeholders in healthcare delivery has resulted in a significant shift away from traditional paradigms of healthcare practice, dominated by, for example, centralised health services, management hierarchies and medical practitioners. Consumer orientated models of health emphasise purchaser-provider involvement, legitimising patients as stakeholders and consumers. The reconfiguration of symbolic capital (status) empowers patients and affords them a more dominant stake in healthcare including physiotherapy. Consequently the views and

satisfaction of patients as consumers and stakeholders are reflected in healthcare and physiotherapy delivery including clinical education.

The redefinition of patients as a distinctive social class, legitimised by Ministerial and international trends in healthcare, has implications for education providers and the profession. For example, included in document *Physiotherapy Competencies for Physiotherapy Practice in New Zealand* (Physiotherapy Board of New Zealand, 2009) there is a focus on quality improvement, evidence based practice, communication and patient rights. This shift in focus towards patient centred quality care is in contrast with an equal focus on cost efficiency, and in particular, health promotion and the wellness model of care. Thus new graduates are required to be competent in physiotherapy specific skills, and to enter a workforce and healthcare environment that is undergoing constant change, albeit with an increased focus on the 'business' of physiotherapy and customer care. As demonstrated in the quotations below, the business of physiotherapy is commonly neglected in School curricula.

Dan (academic staff) talks of the shift towards community-based services within the curriculum, but acknowledges students are not taught about the commercial aspect of physiotherapy services:

*So even within our bigger philosophy of embedding physiotherapy into the community, we don't actually train our students that well, to be good business people.*

For Claire (clinical educator and managing director of private practice), business acumen is essential within the current healthcare market:

*It's like with all health professionals, they're not business people. They're not business minded. I think maybe one thing in the curriculum again, is, I mean why not teach them a little bit about business sense because not enough is taught about that because it's all very well being great physiotherapist, but if you don't have any business acumen, you're not going to survive out there because it's a tough market.*

Recent changes in healthcare provision have had implications for physiotherapy services and by association, School curricula and professional competency requirements. The increased focus on quality, accountability and cost-efficiency has resulted in the location of physiotherapy within a healthcare market with patients as consumers and a disjuncture between what is taught in Schools and what is required to enter the workforce 'ready to practice'. Such tensions between education and physiotherapy practice providers will be discussed in the next section through their roles as producers and consumers in the 'market' of healthcare.

## **Education and physiotherapy practice providers as producers and consumers**

Several significant events contributed to the disjuncture between physiotherapy education and practice and created a market of producers and consumers. Global shifts in physiotherapy education away from diploma-level, hospital based training towards degree status, university based education, created a noteworthy change in relationships between education and practice providers (Brook, 1994; Potts, 1996). Physiotherapy programmes came under the jurisdiction of universities and hence Ministry of Education, whilst physiotherapy practice provision was accountable to Ministry of Health. Geographical, cultural and educational and political distances were created and transformed relationships, roles and responsibilities for students.

Several concurrent changes were also influenced by economic and social catalysts; however, Mueller and Neads (2005) argued that changes were driven largely by politics. Changes were evident in the decentralisation of health services away from hospitals towards community care, shifts towards consumerism and patient-orientated care, and a model of care that promoted wellness and holistic care.

Although Nicholls and Larmer (2005, p. 59) argued anecdotally that “change happens slowly in health care, and even slower in education”, with core curricula and healthcare education undergoing little change (Health Workforce Advisory Committee, 2002), the extent and pace of change within healthcare has been significant. By way of example, the delivery of one physiotherapy curriculum was described as “not well aligned” with the New Zealand Health Strategy and student experiences did not encompass wider clinical and health promotion activities (personal communication, Programme Leader, AUT, March, 29, 2006). Congruence of workforce demands and education provision has received little attention within physiotherapy literature and specifically New Zealand, suggesting ‘spatial’ distances between education and practice providers continues and a time lag (hysteresis) exists. Indeed the asynchronous pace of change between the two infers that unless there is significant paradigm shift, the gap will continue and tensions mount. Examples of tensions between education and practice providers are illustrated below through the mismatching of education with practice needs:

Callum (senior academic staff) acknowledges how education has focused on private practice, responding to student and also market needs, yet appreciates that the focus to date is restrictive:

*So, one of the things that's been happening in the physiotherapy school of late, there's a lot of debate about our clinical processes and, do we as a school educate*

*our students to engage with the health priorities. We've trained students to be very, very competent. Probably in private practice, for the most part. And the other areas have probably paled a little bit as a consequence of that because private practice is seen as where the money is. It's seen as probably the students' perception of what physiotherapy is, so they aspire to go there, and so our whole focus of their education has then been to make those people very good because the concern is, i.e. the private practitioners say we want these people to come in, out of your programme, and walk straight in to private practice and be able to take a case load and manage our business relatively quickly although that might take six or eight months to get up to speed. At the end of that time, we'll be thinking you've actually prepared them really well. So what the rest of us have been thinking is well that's fine, but maybe that's too narrow, maybe that's putting too many eggs in one basket in terms of our financial long term viability and it's not exposing physiotherapy, to the other areas of health in a way which is actually good for the nation.*

In contrast, Dan (allied health director) describes deficits between new graduate readiness to work in district health boards and questions the responsibility of stakeholders in aligning curricula and workforce/workplace needs:

*So then we come to the therapy group and the feedback there is that with the increasing acuity and decrease length of stay in acute environments, that the new graduates are not equipped to cope with the fast pace of decision making and, the prompt decision making, they just don't have enough experience to draw on, because they're new graduates. And so there's a strong feeling that they need more supportive placements, that's the feeling that's come through that particular group. So I'm not so sure. Because when we get in to these debates at the strategy group I say well, so what responsibility has the training institution got? My concern is, we think we've got a problem, we put a solution in place, but don't fix how the students are coming through and how they're being trained, and how they're being supported and, I wonder whether the clinical school opportunity as an example, is potentially a way to make that work better for our graduates although xx [staff member] is on this group as well and she's saying well we've got that model to put students in and we still have the same problem.*

A catalyst for review of education includes the recognition of global and national trends towards community based care and health priorities. Current educational foci, Dan admits, have been in response to student (consumers) and the private practice market which dominates New Zealand healthcare. From the district health board perspective, shortcomings of new graduate preparedness for the workforce/place are highlighted by Callum. Similar concerns regarding the deficits of new graduate preparedness for the workforce were highlighted by New Zealand physiotherapy graduates (Roe-Shaw, 2004), Australian physiotherapy graduates (Hunt, et al., 1998) and experienced practitioners (Adamson, Harris & Hunt, 1997).

In two studies of New Zealand occupational therapy graduates' preparation for practice (Nayar et al., 2011; Robertson and Griffiths, 2009), findings resonate with international literature and conclude that both education and practice providers have a

role in preparing graduates more effectively. Recommendations include education providers encouraging new graduates to evaluate potential employment opportunities on the basis of support available, and provide new graduates with skills of reconstructing knowledge, transforming knowledge into context specific practices. Practice providers should offer support processes including opportunities to observe role models and experience supervision that promotes personal and professional identity and confidence. Whereas similarities can be made between occupational therapy and physiotherapy, fundamental differences exist which means findings must be extrapolated with caution. In particular, private practitioners are dominant employment providers with a commercial focus and indeed as autonomous practitioners, new graduates may establish their own private practice. This means that support mechanisms may not be available, prioritised or valued compared with financial income. This maybe why, in one respect, Callum (academic staff) admits that a key focus has been on preparing new graduates for the private practice environment.

Calls for improved collaboration between education and practice providers are evident in Government documentation (Health Workforce Advisory Committee, 2003, 2002; Ministry of Education, date unknown; Health Workforce New Zealand, 2011). This echoes Dan's perception that responsibility for workforce readiness is shared, and not solely the responsibility of practice providers. Whilst both physiotherapy practice and education providers share similar interests including providing the workforce with competent new graduates, dominant interests of Schools prevail, for example, responding more to private practice markets rather than district health boards. Of interest, is the perceived limited influence of district health boards in influencing curriculum, compared with private practice, given that as an employer of 'end products', i.e. new graduates, district health boards are also consumers. Dominant market interests and economic viability of physiotherapy within private practice as proposed by Dan, play an important role in determining curricula content. As indicated in workforce data (Ministry of Health, 2009), more than half of physiotherapists registered as practising in New Zealand, were either self-employed or employed in private practice. Private practice is therefore, a significant employer, that is, a consumer of physiotherapists including new graduates.

Additional workforce data indicates an increase in New Zealand graduates requesting recognition under the Trans Tasman Mutual Recognition Act immediately upon registration, i.e. 3 requests in 2005, 6 in 2007 and 37 in 2009 (Physiotherapy Board of New Zealand, 2011). Proposed rationale includes the economic climate and changes to the Accident Compensation Corporation (ACC) funding of physiotherapy services, which the

Board suggest may have adversely impacted on the public's perception of cost of physiotherapy. Anecdotal evidence as noted by Skinner (2007) highlights the impact of global and economic trends (including impact of ACC funding) on recruitment of new graduates (end products) within the New Zealand market (consumers). Recruitment and distribution of graduates illustrates the interconnectivity of fields of physiotherapy education with wider fields representative of national and international markets.

As highlighted in Table 8.2, dominant employers are identified as private practices and district health boards, both of which are underpinned by different physiotherapy practices, economics and influences. Meeting the needs of both markets from the perspective of physiotherapy specific and workplace-specific knowledge could be considered a challenge for Schools, yet as demonstrated, to date, a significant focus has been on private practice. Symbolic violence disguises the disinterest in meeting the needs of district health board employers, students and patients.

**Table 8.2 Main employment setting of active physiotherapists (Ministry of Health, 2010)**

<b>Employment descriptions</b>	<b>Not reported</b>	<b>Total</b>	<b>Total %</b>
Private practice (self employed)	43	705	28.7
Hospital and health service/District health Board	30	687	28
Private practice (employed)	26	628	25.6
University/polytechnic	4	62	2.5
Schools (education service)	5	61	2.5
Private hospital or rest home	1	56	2.3
Government department/Crown agency	1	17	0.7
Commercial/industrial organisation	1	11	0.4
Voluntary agency	0	3	0.1
Other	2	43	1.8
Non reported	16	183	7.5
<b>TOTAL</b>	<b>129</b>	<b>2,456</b>	<b>100</b>

(Source: Ministry of Health, 2010)

It is, therefore, not surprising that clinical educators must develop strategies to bridge education and practice needs, and demands of consumers and providers. Examples are provided below.

Gaps in knowledge are bridged by Katie (DHB based clinical educator):

*We end up actually teaching them [students] an awful lot of even theory, which we may be would have presumed that uni would have covered in an education setting at the university.*

For Su (community based clinical educator), working in the community still required in her opinion, experience of the acutely unwell patient. She therefore, created additional learning experiences to bridge this gap:

*Because we are trying to get a model of people being more self managed. So the focus is going more to primary health. So when it comes to cardio respiratory physio, the focus is going more into the primary health which is more community based. So we have to move with those times anyway. So I suppose my placement is that, it's the assessment process, has not caught up with us. And I'm not sure how you'd go about it really. Because you still need, that in the community you still have to be acutely aware of when the person is not well.*

She continues:

*And then I said so I've been allocated this hour once a week so we can go up onto the wards and they [ward physiotherapists] can watch you doing the assessment and learn that skill.*

Both clinical educators demonstrate strategies to bridge gaps in student knowledge and practice requirements. In particular, Su recognises that gaps in experience may be detrimental to the patient (and physiotherapist) if the student/future physiotherapist is unable to recognise and manage the acutely unwell patient. Transferability of knowledge and skills across the physiotherapy and environmental continuum is therefore, important.

Aligning the curriculum with market and employer needs creates a field-habitus match, reproducing practices that are mutually beneficial to both parties. As such social agents share the 'doxa' of the field, the taken for grantedness which reinforces the interconnectivity and exclusiveness of fields and agents, often to the detriment of other fields and agents, i.e. district health boards. Individual and field habitus, as embodied dispositions according to Maton (2008, p. 59) "develops a momentum that can generate practices for some time after the original conditions which shaped it have vanished". School habitus therefore, seems unable to change at a pace (hysteresis) determined by external factors such as market needs and in the case of physiotherapy, changes in healthcare and workforce needs. These concerns are illustrated by Callum (senior academic staff) who refers to the threat to physiotherapy (and Schools) if the profession cannot avail of newly created opportunities:

*If we continue to focus and say all of our students must go to a DHB [district health board on clinical placement], and we ignore the earlier levels of health in the community, I think it will be to our peril and there are so many opportunities out there, we haven't quite figured out how we're going to engage with them, or how we're going to fund them but certainly engaging with the primary health care organisation environment is an opportunity that we shouldn't be ignoring. And so physio needs to get its head around that and that might create all sorts of different ways of doing clinical.*

As inferred by Callum, physiotherapy as a profession needs to become more responsive to changes in healthcare provision and delivery. A multi-stakeholder approach is required from all aspects of the professional continuum to accommodate and embed such a significant paradigm shift in practice (field habitus and capital). Multiple stakeholder involvement, whilst essential to represent various dimensions of the profession, brings the challenge of different and often competing interests. Further compounded by unique differences in stakeholder's objectives and influences, varying degrees of communication, collaboration and autonomy in decision making can enhance or thwart timely decision making. Issues such as goal conflict, varying beliefs and personalities, together with mis-interpretation and poor relations amongst stakeholders, can delay timely decision making and further contribute to unproductive stakeholder dynamics. Mismatching between stakeholder's dispositions and practices (habitus) and new field structures can result in stasis, potentially resulting in a time lag before a new collaborative pedagogical habitus is established. For change to occur, a shared vision and commitment is required which aligns actions (habitus in action) and ensures that benefits and gains in capital are shared rather than accumulated by the selected few.

## **Stakeholder negotiations**

Negotiating change requires authentic collaboration, trust and communication (English, 2010) between stakeholders, which was described by some participants as poor. This includes communication between Schools and practice providers including managers and professional leaders, and also between Schools and stakeholders and clinical educators. In some instances, collectives have been formed, such as, District Health Board New Zealand and workforce strategy groups at a national level, to bring about action relating to, for example, the workforce. Struggles to influence the readiness to practice of new graduates constitute symbolic struggles, which as a collective and social class, district health board New Zealand is better positioned to negotiate based on the volume of capital and also its legitimisation by the Ministry of Health.

Dan (allied health manager) highlights the interconnectivity yet tensions between both sectors, i.e. education and practice providers:

*Politics influences clinical education but not clinical educators much though; they're too far down the food chain. Where we've got an opportunity now which we haven't had in the past is via the workforce strategy group because all of the workforce strategy groups have identified issues. If you think about the supply and demand chain, where the demand is having to go to the supply end and yet there's been very poor communication with us and the service providers as to what we need in the future.*

Other examples of inter-stakeholder tension are provided in the quotations below.

Zac (academic staff) describes tensions of both Schools and Ministries of Education and Health:

*To be honest we don't have a great dialogue, as far as I can see with either of the Ministries and indeed in working together, certainly fellows at xx (other university), ourselves and the Board, are interested in opening up more dialogue.*

Liam (academic staff) explains historical tensions between both Schools of Physiotherapy impacting on collaboration:

*I know in the past if you're aware of the history of the two schools, they haven't always got on collaboratively.*

Communication is perceived by Sam (allied health director) as crucial to negotiations and relationships between her team and School of Physiotherapy:

*I think we've got a very good relationship. I think it's communication. I think there has been a real need on both sides. (...) We might need to negotiate how we do things and what will meet and suit our needs but I can't imagine why we wouldn't have a good relationship to be honest.*

Opportunity emerges from the reconfiguration of symbolic capital of individuals who have come together collectively, as a group or social class, politically sanctioned and with a shared focus – workforce. Ability to influence change and negotiate with the 'suppliers', i.e. education providers, has been greatly enhanced through symbolic capital. Dysfunctional communication between suppliers and providers as symbolic violence seems to have benefitted the educational providers, albeit resulting in an important and significant gap between supply and demand. The supply/demand chain (described by Dan) is symbolic of the interconnectivity of different aspects of the market, yet highlights a spatial gap between agents and organisations. Spatial distances as previously depicted, are sites and sources of tension in which individuals and organisations compete for capital and improved ranking in social hierarchies. Improved equality based on symbolic capital creates a more equal forum for communication to occur between the agencies responsible for the healthcare workforce, as Dan (allied health director) explains:

*But if they'd started a conversation saying we think this is a gap, or we go to them and say we've got a gap can you help, that's a much better place to be in. So, we're still talking past each other to a certain extent and one of the things that, through the central DHB establishing a better relationship with the tertiary*

*education commission so that they actually hear our sector feedback in a more planned way, rather than it being quite adhoc. So the workforce strategy groups will be quite useful in terms of being able to say well we represent nursing and midwifery workforce and the allied health workforce.*

Dysfunctional relationships compounded by or as a consequence of poor communication, serve to maintain the interests of the dominant organisation. Similarly, organisations with entrenched cultures and practices (and power relations) constrain relationships with other stakeholders, hindering development, responsiveness and change as they project all actions towards achieving and maintaining their position and social standing. In order to navigate around perceived barriers to feedback, strategic relationships are developed by Dan and colleagues with the Tertiary Education Commission. Alignment with such influential agencies reconfigures social capital held by district health boards, with the intention of influencing change.

Field habitus durability may help to understand the inability of education and practice providers to change and respond to changes in market needs. Traditions, conservatism and entrenched cultures as embodied cultural and symbolic capital (habitus) safeguard the position of institutions and practices, and in particular the position of universities relative to physiotherapy practice providers, and as demonstrated by Zac (academic staff) relative to other education providers:

*Our university would be extremely conservative and unlike the other university, we are in a completely different environment and I know people in higher education management circles talk about mission statements look exactly the same from higher education institution to higher education institution and they're going to be absolutely wonderful centres of excellence for education and international learning etc, but institutions are very different, and the difference here that we've got to recognise is that the School is an old university, and by New Zealand's standards the oldest university in New Zealand*

As professional leader, Rick highlights the challenges of practising differently and how to evoke change in the curriculum:

*I guess for it to change at undergraduate level it needs to be more than one DHB, that's practicing in this way. The programmes will be targeted for the majority. And if the majority are practicing in one way and you've got one that is, perhaps practicing differently, a bit more innovatively and a bit differently and following a differently line, then that's not necessarily going to change anything in the first instance. And the way that you do that I think is by opportunity and by getting people up maybe doing some of some actual research where there is both qualitative and quantitative stuff but having a look at what are the difference in patient care, what are the differences in the outcomes and what part do we have a play and how does that compare.*

Conservatism and dominant practices of the majority illuminate the entrenched culture of organisations (field habitus) and may provide an insight into why organisations are slow to respond/change. Paradoxically, as centres of excellence in education and

learning, universities are advocated as change agents through research. Research is also recognised by Rick as valuable for change and in particular, using research to demonstrate patient outcomes. Centralising the patient as consumer and demonstrating positive outcomes are perceived as essential to elicit change in practices. What is unclear is how research is used to transform knowledge and practice, and the time required for field habitus to adjust. Motives for change are underpinned by economics as demonstrated in Health Workforce New Zealand Annual Plan 2011/12 (Ministry of Health, 2011) which includes activities relating to “ensuring services are clinically and financially viable”, reviewing health professional activities to free up “limited and expensive clinician time” and “best value clinical training” (p. 3). In response to fiscal and budget constraints, healthcare activities are dominated by cost-effective strategies and reviews; this results in field habitus constantly undergoing adjustment, facilitated by a workforce that is flexible and responsive, i.e. “training and recruiting more health professionals with generic skills, to increase flexibility” (p. 3) and “develop closer liaison with TEC to achieve common understanding of priorities and projections of trainees required to meet workforce needs” (p. 7).

From a Bourdieusian perspective, Schools/universities as sites of intellectuals and cultural production represent specialised cultural markets (Swartz, 1997) constructed around “certain forms of symbolic capital that are relatively autonomous from economic and political capital” (p. 228). Cultural and symbolic capital is acquired and embodied over time, it could therefore, be deduced that field habitus of education providers is more durable, deeply embedded, and less able to adjust. Intellectual fields reinforce social-class relations (Bourdieu, 1994/1998; 1985); inaction or conservatism may therefore, represent strategies to preserve positions of domination, cultural production and consumption, and positions within organisational hierarchies.

## **Chapter summary**

Evident in this chapter is the visibility of economics in shaping clinical education within the wider context of consumerism and commercialisation. Tension between stakeholders is revealed through contrasting positions of providers and consumers and the ability to determine the value of clinical education. Embedded cultures and poor communication serve to protect dominant interests and inhibit constructive dialogue between stakeholders in clinical education. Education providers whilst acknowledged as contributing to professional knowledge-base and physiotherapy workforce, appear slow to adjust to the multiple demands of healthcare. Additionally, physiotherapy practice providers have been unable to influence changes in the curricula which would otherwise

shape the end product, i.e. student/new graduate. Education, physiotherapy practice providers and the profession are continuously challenged by technology, fiscal constraints and workforce shortages. These have been found to directly impact clinical educators as they strategise to meet multiple demands, including protecting their own unique habitus as previously described.

The next chapter examines clinical education as a commodity and contested resource. In particular, economics, politics and historical influences are explored to reveal inter-stakeholder conflict, and arenas of power interplay.

## **Personal reflections**

*Several of the emergent themes and tensions resonated with me as I interpreted the participant conversations. Aspects of my own practice are fraught with tensions between providing large 'quantities' of 'quality' patient-orientated physiotherapy practice, caring for patients/staff; yet mindful of cost, balancing competing demands of multiple stakeholders, providing services to meet current needs, whilst anticipating future needs. Paradoxes within healthcare delivery mirror the tension with foci on key performance indicators commonly related to patient length of stay, contrasting with patient flow and experiences projects.*

*Whilst I acknowledge the inability to truly objectify my position relative to this research, writing this chapter required me to reflect in greater depth compared with other chapters. In part because as a team leader I am living and surrounded by these tensions; whereas in previous chapters, I drew more on historical aspects of my role and career.*

*Personally there have been times when I have been paralysed by multiple demands on my time and energy. Being an expert (Benner, 1984) encompasses discipline-specific practice, but also expertise is survival strategies. Useful strategies have included conversing with managers in terms of economic consequences, i.e. effect of new equipment on patient bed days, and compartmentalising time to care for staff so that I can move the team/services forward AND have a competent team to meet current and project patient/team/service needs.*

*As a team leader, I witness the fear on student faces as they join the team/organisation and observe new graduates faltering as the 'honeymoon' period of placement/employment wears off. I observe their struggles and strategies as they cope with the pace of change, workload demands and patient complexity, expectations of themselves and those perceived by others. To accommodate the inevitable 'wobbles' of students and staff unfamiliar with district health board or New Zealand healthcare systems, support mechanisms are put in place. Responsibility for transitioning students (habitus shaping) and staff to the*

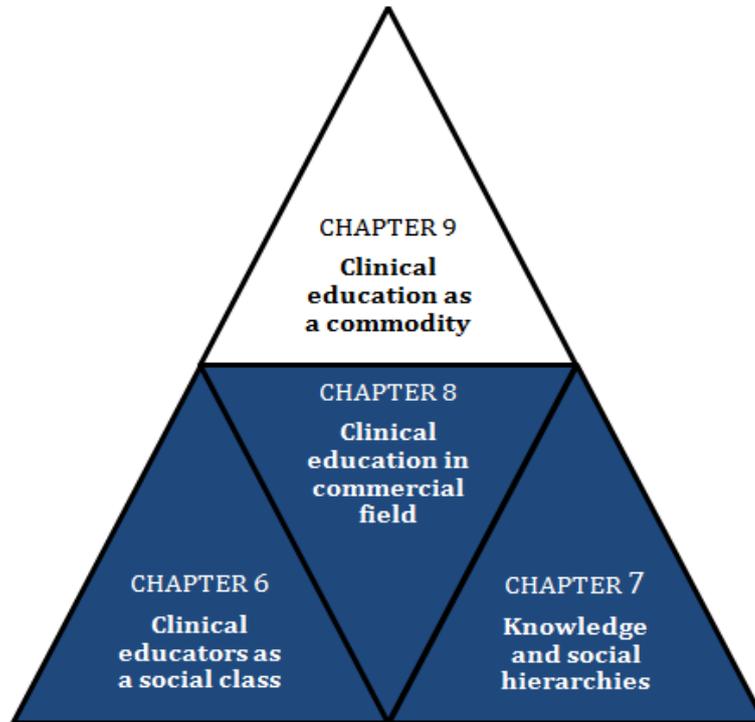
*team/workplace predominantly lies with senior staff who are competent and proficient (Benner 1984) in physiotherapy skills, and also possess advanced strategies to cope with the multiple demands faced daily. My role is to nurture and care for the senior staff and establish support processes for all concerned. However, caring takes time, albeit with students, staff, patients, and time is money (economic capital), which is constantly being measured with statistics, time-in-motion studies, and cost analysis projects. I wonder how many staff chose to abdicate from the role of expert juggler or have burnt out, unable to balance quality and quantity, or unwilling to compromise quality for quantity. Why physiotherapists leave the workforce remains invisible in the literature. So how can we better prepare students as new graduates, and staff for the growing demands on their time and skills? This question alone is worthy of future yet urgent debate given the exponential change occurring in the fields in which physiotherapists and clinical educators are located.*

*Constant changes in healthcare forces staff to develop strategies to cope, to keep up with the tempo of change, technology and fiscal constraints. It would appear that physiotherapy curricula at the time of data collection are unable to maintain pace (hysteresis) with the continuous change of healthcare delivery. It could be argued that more than a time lag results but also a lag in skills and coping strategies. Clinical centres may be one way of acclimatising students (secondary socialisation and shaping of habitus) to organisation and healthcare environments, but does this not shift responsibility to clinical educators and distance education providers? Formal evaluation of these centres is essential, yet not forthcoming from educational providers (symbolic violence). Further evidence of symbolic power and violence is evident in the profession's dominant interest in creating evidence to support physiotherapy practice rather than other aspects of physiotherapy including clinical education. This supports earlier arguments on hierarchies of knowledge, isolation of education knowledge and skills, and the limited value of clinical education to physiotherapists and the profession.*

*One impetus for undertaking this research was to find a more successful way to embed clinical education into physiotherapy practice by understanding the complexities of clinical education. Bourdieu not only provided the framework, but the framework has become a coping strategy allowing me to analyse the 'fields' and hierarchies in which I am located. My reflexive stance has not only allowed me to consider my position as a researcher and in relation to the subject under review, but also to reflect on my personal and professional strategies, including how Bourdieu's framework has become embedded in my practice.*

# CHAPTER NINE

## Clinical education as a commodity



Chapter 6 Clinical educators as a social class
Chapter 7 Knowledge and social hierarchies
Chapter 8 Clinical education in commercial field
<b>Chapter 9 Clinical education as a commodity</b>

Figure 9.1 Summary of themes which emerged from this research: Chapter Nine

### Chapter overview

This chapter explores theme four, clinical education as a commodity, a valuable service purchased by educational providers, and provided by physiotherapy practice providers and their agents, clinical educators. The economics of clinical education emerged as a significant source of tension and conflict between stakeholders in clinical education.

## Commoditization of clinical education

As will be demonstrated, many clinical educators and stakeholders spoke of clinical education as a commodity (product), with a market value negotiable between providers and consumers. Described as an economic activity, tensions and power interplay were inherent as its value as capital was negotiated across fields and between education providers and other stakeholders including clinical educators.

Economic activities are organised around three modes of governance: market, network and hierarchy (Windeler & Sydow, 2001). From a Bourdieusian perspective, all actions are motivated by dominant interests to accumulate capital, including social capital (networks) and maintain hierarchical positions. Markets represent the intersection of fields which are characterised by intensive inter-organisational interaction that shape the exchange of capital and negotiations therein. Social capital as networks, represent relationships amongst stakeholders and processes of communication which facilitate the transfer and exchange between fields. Drawing on Bourdieu's (1994/1998) principles of distinction and differentiation, capital is configured in terms of volume and value, and influences location of individuals and groups within fields and also on social hierarchies. Acknowledging that field boundaries are sites of friction (Bourdieu, 1972/1977), clinical education as a unique field yet formed from the intersection of fields of physiotherapy practice and education (and physiotherapy profession) is subject to influences exerted from all fields. It is therefore, a site of conflict in which multiple stakeholders compete to protect dominant interests, including negotiating the value of clinical education as a commodity. Table 9.1 illustrates tensions which emerged from participant conversations in this research which are the subject of further discussion.

**Table 9.1 Tensions regarding clinical education as a commodity**

Clinical educator	Schools of Physiotherapy	Physiotherapy practice providers
Limited access to funds generated from clinical education	Reluctance to provide incentives to individuals/organizations	Perceived benefit to staff recruitment, development and retention – cost benefits unknown
Exchange services for education opportunities	Demand for placements exceeds availability, limiting growth of student numbers and School	Funding models outdated
Provision of equipment in exchange for clinical education	Funding models based on 1994 economic report	Limited evaluation of impact on students on clinical educators and, for example, waiting lists

Recognition and reward for services	Different funding models and flexibility with payments based on demand
	Limited funding available to increase payment to physiotherapy practice providers
	Funding of physiotherapy courses not equitable to other healthcare courses

## Value of clinical education

Unlike non-practice based professional courses, clinical education is a valuable service purchased by educational providers, and provided by physiotherapy practice providers and their agents, clinical educators. As a commodity, its professional value (cultural capital) is associated with professional socialisation and registration. In contrast, its economic value is influenced by multiple factors including the scarcity of clinical educators and clinical placements, and perceived impact of students in the workplace. Funding models which influence the devolution of finances to and between stakeholders, as will be discussed, also determine the market value and economics of clinical education.

Scarcity of clinical educators was noted by academic staff to impact on the growth of Schools of Physiotherapy due to their inability to train more students. Callum (academic staff):

*Clinical placements are scarce as hens teeth and we have to battle each year to get enough placements for the students.*

He continues:

*Essentially can't train any more students unless we have more placements.*

Pressures to secure more clinical placements were translated onto other staff. This included clinical educators, as noted by Emma, (year IV student):

*I'd say that she did have a say in the matter but she would have been obliged and she would have been under a lot of pressure to say yes.*

And pressure was also on clinical placement co-ordinators such as Kiera, irrespective of increased resources available at Schools:

*If we took in more students, if the university provided us with the environment here, classroom space and all of that sort of thing, but we still have to provide the clinical education, of which, we currently don't have enough with our numbers.*

Dependence of Schools on physiotherapy practice providers for placements and the impact of lack of clinical placements are revealed as not only a source of frustration in that they must be continuously negotiated each year, but also as limiting the growth of Schools. The sense of going into 'battle' with stakeholders infers that Schools are dependent on physiotherapy practice providers and that growth of student numbers and the School is linked with stakeholder provision of adequate numbers of clinical placements. These tensions echo frustrations noted by Cross (1995) where Schools of Physiotherapy have little control over clinical education compared with other components of the curriculum.

There is evidence of pressure exerted on clinical placement co-ordinators from within the university to secure placements, thereby increasing student numbers. However,, from Kiera's perspective, if demand for placements exceeds availability, this may directly affect students' ability to become registered. Hence the market value of clinical placements and the services of clinical educators increase.

Kiera (academic staff) highlights the impact of placements on professional registration:

*I've just said to the university that we can't take in any more because I can't place them [students]. These students will not be able to graduate, well they can graduate with a Bachelor of Health Science in Physiotherapy, but they won't be registered.*

As a practice-based degree, the qualification represents acknowledgement of academic achievement (cultural capital) and eligibility for professional registration (symbolic capital). Division of the two components could devalue the qualification and potentially impact on the status of Schools through its failure to meet student (consumer) expectations and university standards.

To date, the market value of clinical education has been described in relation to availability, consumer expectation and service provider obligations, and value linked with professional registration. These are common factors acknowledged by Shoba (academic staff) as on-going, as the value of clinical placements is continuously contested:

*There are also other issues of course like, shortages of staff and funding issues and all those other things that are part and parcel of that [challenge of obtaining clinical placements]. And funding will be a perpetual issue, both for the University and for the placements.*

The following quotations provide evidence of negotiations occurring at both local and hierarchical levels to determine the value of clinical education.

Callum describes negotiating its value at a local level, albeit an occupational therapy placement:

*When things really go a bit pear shaped and they need some extra traction and that is most often around money because I have the sign off authority for the money. So they might say to me, this person would take a student but at \$25 a week for an OT student, we don't think that's enough, where's the negotiations. So I go well how valuable is the placement, what's the consequence if we lose that placement, can we offer these people anything else that might be helpful, and at the end of the day it's often just a dollar value they go well I'll double it and off we go.*

As described by academic staff from both Schools, to reconfigure the economic value of clinical education, negotiations with the wider field of power must occur. For example, to elicit change Kiera (academic staff) describes negotiations with the Ministry to relocate physiotherapy within a different funding bracket:

*So, the other thing of leverage is to actually go to the Ministry and put physiotherapy in a different bracket of funding, and currently we're in the lowest bracket of funding, so that's also what the School is currently doing.*

It is unclear from participant conversations how the increased funding may influence clinical educator and clinical placement capacity; however, Skinner (2007) described some challenges arising from the additional costs associated with clinically-based education. These include the potential compromise of educational standards and status of physiotherapy education internationally, reduced ability of research activities, and inability to attract academic staff and post-graduate students.

Symbolic power of the government sanctioned Ministry could be used to influence the number of placements through the relocation of funding. However, as noted by academic staff, redistribution of funding is challenging based on a culture of chronic underfunding of education and the perceived difficulty in negotiating with the Ministry. By way of example, Schools of Physiotherapy in New Zealand were found to receive 20% less funding per student compared with other students of similar practice-based courses, i.e. osteopathy (Baxter, 2006) and due to low attrition rates of physiotherapy students, the cost/student was even higher (McMeeken, 2008; McMeeken et al., 2008). Economic challenges to physiotherapy education are therefore, multi-dimensional and have relevance to all stakeholders. As described by Zac (academic staff), such concerns have prompted stakeholders to create a collective voice to improve communication with the Ministry:

*Some things are common issues like funding, for example, and the chronic underfunding of education in New Zealand. Also the fact that we're talking to the same stakeholders, whether it's the Board, or the Society etc. And it hasn't been pushed by either of the Ministries. To be honest we don't have a great dialogue, as far as I can see with either of the Ministries and indeed in working together, certainly*

*fellows at the other School, ourselves and the Board, are interested in opening up more dialogue.*

As demonstrated by Callum, (academic staff), the economic interests of other fields are also involved in the negotiations:

*The new model of funding from the tertiary education committee is an output model not an input model. What I mean by that, is the current model is bums on seats, the more bums on seats you have, the more money you get, and so you can work to that particular dictum that we can train as many as we like if we have the clinical placements. What the government is now saying is that we want to see people complete and must ensure that in the first instance. So that's a bit of a quality issue and retention issue within the course.*

Vested interests of the Tertiary Education Commission are protected through the shift from student numbers commencing courses, to numbers of students successfully completing. This has implications for Schools, and by association, clinical educators to ensure that students have positive and successful learning outcomes. The symbolic power held by the Tertiary Education Commission determines the funding model, and conditions of funding, which Schools, as taken for granted (doxa) must abide by.

## **Economics of clinical education**

Clinical education has not been exempt from economic review. The economic consequences of healthcare students' clinical training including physiotherapy on the then area health boards/crown health enterprises (public healthcare providers) was evaluated by Coopers and Lybrand (1994). The report found that the average net cost per student/clinical week was \$5.25 (degree student/year III) and \$24.07 (degree student/year IV). This compared with occupational therapy example, of \$85.00 (year I), \$192.00 (year II) and \$160 (year III). This influenced the market value of clinical education as a commodity and the economic activities as placements were negotiated.

Economic consequences of clinical education have also featured in physiotherapy literature. Increased productivity of a senior physiotherapist was found by Holland (1997) when teamed with a student in a United Kingdom outpatient setting over a 24 week period. Similar increases in staff productivity and cost benefits of Australian students on placement were found by Ladyshefsky et al. (1998), Ladyshefsky, Bird and Finney (1994) and in the United States by Bristow and Hagler (1997, 1994), Cebulski and Sojkowski (1988) and Lopopolo (1984). In an Irish study, O'Sullivan et al. (2007) found that the clinical workload of four students in both in and out-patient settings was comparable to one physiotherapist. There is consistency within international literature regarding the positive impact of students in clinical setting however, of interest is that principle authors were employed by Schools of Physiotherapy. Undertaken to dispel

assumptions regarding the negative impact of students, and actively market clinical education as having a cost effective benefit on staff and service productivity, such research may disguise School motives and dominant increases to increase the capacity of student numbers. Given that all actions are interest orientated and designed to protect and enhance dominant positions within hierarchies (Bourdieu, 1980/1990), it is interesting to note that irrespective of findings, a national and international shortage of clinical placements and educators remains. Appealing to managers in terms of economics, productivity and positive impact on waiting list management as linguistic capital would appear to hold little value with physiotherapists who represent potential and actual clinical educators.

Different perspectives regarding clinical education as a commodity are captured in the quotations below. Two different models of remuneration are employed by both Schools as described by academic staff. Funding is based on a unit cost (student) described by Savannahagh (clinical placement co-ordinator):

*No we pay per student, so it's just a small, very small amount per week. It's \$50 per week for students, so it's not a huge amount. So that's not even a contracted amount, it's like a bonus, well not a bonus but basically it's a contribution, that we pay.*

In comparison, funding was calculated on an hourly rate/week/student as indicated by Callum (academic staff):

*Physio gets paid \$20 per hour, for a couple of hours per day of contact for the clinicians in the DHBs, so they've always been remunerated at a higher rate than occupational therapy but that in itself creates another problem. Because the physios talk to the OTs and they say well how come you're getting more and it all comes back to this access issue and that's another discussion that we may be heading towards is that should we be paying at all or is it a professional responsibility issue to be having students, and that's a bit of a philosophical barrier that we come up against as well. People clearly want to be paid quite large amounts of money or they'll not even bother to have students in some cases.*

As illustrated, clinical education funding is modelled differently by both Schools of Physiotherapy and also between professional groups such as occupational therapy, which falls under the economic control of both academic staff members. It is unclear whether the economic review by Coopers and Lybrand (1994) has influenced funding; however, as described by Callum, availability of placements has more significant impact on the market value of placements (albeit occupational therapy):

*It comes back to me from those individuals when things really go a bit pear shaped and they need some extra traction and that is most often around money because I have the sign off authority for the money. So they might say to me, this person would take a student but at \$25 a week for an OT student, we don't think that's enough, where's the negotiations. So I go well how valuable is the placement, what's the consequence if we lose that placement, can we offer these*

*people anything else that might be helpful, and at the end of the day it's often just a dollar value they go well I'll double it and off we go.*

Non-academic stakeholders however, held different perceptions regarding the economic value of clinical education. Stevie (professional association representative) describes a hierarchy where funding is exchanged between organisers, yet clinical educators are distanced from such financial exchanges:

*The Schools for their part are paying the people who take students, but it's the clinical educators and supervisors who are actually not seeing anything for their efforts.*

The economic value as portrayed by Dan (allied health manager) is minimal and negotiable:

*There's not a lot of money. I negotiated a price increase when I was setting up the contract and that's been stable for the last four years. It's a token really, I mean it's a contribution towards the clinical education but it doesn't cover the cost as you know.*

Niamh (professional leader and clinical educator) reinforces token value:

*I wouldn't even think the money pays for photocopying! We don't ever see that money. It just goes in to the DHB. I think I did actually try to track that down once. I asked senior management. It goes in to the educational pot.*

Although the amount paid to physiotherapy practice providers was minimal (economic capital), a further theme emerges relating to how and if clinical educators access and exchange capital.

Savannagh (clinical placement co-ordinator):

*Predominantly the lack of funding impacts upon what we can offer clinical placements in terms of support. Ideally I would love to be able to offer educational support to supervisors particularly the clinical staff in the fourth year environment, so that they can have access to post graduate diplomas, degrees etc, coming along to higher education seminars that type of thing. And being able to pay for that time so they can take time away from clinical so they can then recruit someone else at the hospital to cover the clinical load.*

She continues:

*I don't know if money would actually change perceptions so much, but I think it would go some way to help if the amount that we could contribute to the hospital for placing students was increased.*

Funding as economic capital was described in terms of how it can be valued and exchanged for educational opportunities (cultural capital), support (economic capital) and changing staff perceptions and motives (habitus). Funding could be utilised to release clinical educators' clinical time (economic capital) in order to attend courses and enhance professional knowledge (cultural capital). Similar views on exchanging the income

generated from clinical education (economic capital) for continuous professional development activities (cultural capital) were echoed by clinical educators.

Julia (clinical educator):

*I think that's one of the benefits of this organisation is that we get to utilise that money for our ongoing professional development. And, I don't know, that in the health system money is very tight and without that, there wouldn't be really any way of rewarding the senior staff or the clinical educators. So, to me that's a resource that we use to reward our senior staff for their continuing education conferences, courses, post grad study, books etc.*

For Katie however, inaccessibility of funding generated through her role as clinical educator was a source of frustration, denying her the option of exchanging her services for continuous professional development activities:

*I do believe that there should be some sort of token gesture and even if it's not actual money that goes in to my salary package, if it's money that I can access to go on a course or it maybe pays my flight to a seminar that I want to go to, or maybe there's a book that I want, I should be able to get access to that and I feel that's unfair.*

Although time as economic capital was valued in terms of attending courses, for Merrill (clinical educator) time to prepare for students held more value:

*The money's not a big issue really. It would be nice but it's really I think appreciating more time.*

From a Bourdieusian perspective, withholding of funding generated by clinical educators or time to prepare for students represents symbolic violence. Katie's and Merrill's ability to influence resource allocation as doxa, represents the taken for grantedness embedded in team and organisational practice and culture.

From a different perspective, funding associated with clinical education was not comparable to income generated from funded treatments, as described by Stephen (clinical educator of semi-private hospital):

*It goes to the hospital, not to you directly but as a department. You've got to be aware that you only get this amount of funding, so you can't spend forever with your students because you've still got to keep the rest of the outpatients, ACC coming through financially.*

Similar views were echoed by Shelagh (clinical educator and managing director of a private practice) who describes her motives to become a clinical educator as professional rather than financial.

*The whole reason that I agreed to do the clinical supervising and the clinical educator was not, well it was definitely not for the money. I could earn three times as much going somewhere else.*

In comparison with other stakeholders, many students perceived clinical educators should receive a reward. Their views, in many ways, reproduced the sentiments of clinical educators.

Jack (year III student):

*I don't think there would be an increase in pay for taking a student on a clinical placement. Whereas if you're with the hospital or if you're at a rest home, I imagine that they would have to pay people for taking them out of what other work they're doing and I would assume that's variable between the educator and what their work is.*

Annie (year IV student):

*I think they should be encouraged to [be clinical educators] they should have some way of rewarding them.*

She continues:

*Well maybe if you could make a donation like to the gym, they could donate bits of equipment if you take on students for the next so many years. And then it's not one supervisor type of thing.*

Jamie (year IV student):

*I think it would be a good incentive for some people in terms of, it doesn't have to be that much but I think it would be a good incentive. It's another skill of having to teach someone and I think maybe, I know there are some courses I've talked about but I don't know much about them but if there were some good kind of clinical education courses and then they got paid for it, they might feel like they're a bit more confident and a bit more part of that teaching mould. Yeah I think it would be beneficial.*

Clinical education funding holds different economic value (economic capital) based on multiple influences and dominant field interests. This includes historical determinants such as economic reviews (Coopers & Lybrand's Report, 1994), district health board negotiations and policy and competing demands on time, for example, income generation from patients in private practices. Whilst academic staff described clinical education in terms of a purchased service, public health based clinical educators and clinical placement co-ordinators valued funding in terms exchangeability for educational activities (cultural capital). Value was enhanced when, for example, district health board funding was limited. In contrast, private practice based clinical educators' motives were predominantly professional (cultural capital) rather than financial given that time spent with students could be used for more lucrative activities.

Participants in this research describe clinical education and the services of clinical educators as a commodity. Clinical education is purchased as a service/product by educational organisations from public and private physiotherapy providers. The actual

cost transaction was acknowledged as minimal. It is interesting to note that no participants commented on the positive economic benefits and productivity of students within the clinical context, as supported by the literature. Bourdieusian concepts of doxa and misrecognition disguise the arbitrary economic value of clinical education which is accepted and acceptable to providers. Doxa in particular, reproduces power relations through the justification and conditions exerted by educational providers, legitimised by symbolic power embedded as an institution, and legitimised by Ministerial commissioned economic reviews. Tension between professional obligation, as advocated by the some stakeholders and economics is further examined in the next section.

## **Professional obligation versus commodity**

Another dominant influence which impacted the economics of clinical education was the tension between professional obligation of physiotherapists to take responsibility for training the next generation, and the economic/commercial context in which healthcare is currently located. Different stakeholder perspectives (and their interests) are captured in the quotations below.

Dee (clinical educator and sole practitioner in a rural based hospital):

*As a profession we tend to be a bit more vocational. And tend to try and offer that bit more, but maybe we shouldn't say perhaps we should be offered more to do that.*

Dan (allied health director) describes how the teaching status of the hospital reflects the embedded expectation of contributing to training students:

*We are a teaching hospital and we have a professional obligation to your profession and to our future workforce and we're going to need to contribute.*

The vocational nature of physiotherapy is described in terms of giving, and offering more; however, as questioned by Dee, the economic value for physiotherapy services provided should be reviewed. Characteristics typical of vocational professions are in contrast with contemporary, economic-focused physiotherapy and healthcare services. Professional obligation towards the next generation of physiotherapists draws on the responsibility and care of professionals and this is acknowledged as a tension by many participants in this study.

For Callum (academic staff), value of clinical education was intrinsically linked to the philosophy which underpinned the profession of physiotherapy. This was in contrast to economic value and need to utilise funding as an incentive:

*We discussed the philosophy of what it means to contribute to your profession. Should you put a value to it, particularly a monetary value then it's a have or have*

*not and if you were to say, to your staff, I will give you some sort of remuneration for taking a student as an incentive, then you create an incentive model rather than you should do it anyway I mean you're getting paid pretty well for what you're doing, having a student is just a normal part of your day.*

Another academic staff member highlights opposing values of clinical education, and the tension between professional and economic values.

Shoba (academic staff):

*I think that, every physiotherapist has to have a responsibility to educate its incoming profession. And I think sometimes the people are given the choice rather than given the responsibility as a health professional to do that. But that's a global view. There are also other issues of course like shortages of staff and funding issues and all those other things that are part and parcel of that. And funding will be a perpetual issue, both for the University and for the placements.*

What emerges from the quotations as presented above is the tension between competing field values including provider/consumer, vocational/commercial and value of time (clinical education versus income generating activities). Economic forces emerge as a dominant influence in shaping the 'value' of clinical education in terms of economic, cultural and social capital. Fields, i.e. clinical education, physiotherapy education and practice providers, are shaped by different and often opposing forces, such as, economic and cultural (Bourdieu, 1986), demonstrable in the quotations of different stakeholders. Fields are also not fixed, but are dynamic and responsive to external forces. As such, social tension and friction is inevitable. Dominant interests which have determined and legitimised the economic value of clinical education including economic reviews, are in contrast with the level of engagement of physiotherapists in clinical education.

Future challenges for clinical educators and associated stakeholders include potential generational differences where views of work between baby boomers (born 1946-1960) who currently dominate the workforce (Ministry of Health, 2010), and generation X (born 1961-1978) and generation Y (born after 1978) differ. Albeit in occupational therapy, 'baby boomers' views of work according to Bourdieu (2009) included the intent to make the world a better place. This compares with generation X who focus on income generation and a portable career with limited or no commitment and generation Y, who expect to build parallel careers and do more than one job at a time, to enhance position and choice. Drawing on previous quotations from Jack, Annie and Jamie (student participants), vocabulary such as 'pay' 'reward', 'donate' and 'incentive' permeates their conversations regarding how Schools should negotiate with clinical educators. The emphasis is in contrast to more established physiotherapists in the profession.

Su (clinical educator, qualified in 1979):

*Who else are the new generation physiotherapists going to be learn, learn to be physiotherapist from? It's got to be physiotherapists doesn't it?*

And Stevie (professional association representative)

*It's a responsibility that we have as professionals and I don't really have a great deal of time for complaints or concerns that people bring forward about not having students, or why they wish to not have students.*

Fundamental differences emerge from the above quotations from students and established physiotherapists. While the latter's motive to engage with clinical education is strongly associated with professional obligation, more recent generations associate the role with economics. Motives of the next generation to become clinical educators may well be in contrast to those of their predecessors, however, the next question is there a generational difference in how learning is facilitated? Unlike baby boomers, whose learning styles are described by Boudreau (2009) as interactive, both generation X and Y, are acknowledged as multi-taskers with generation X described as experiential learners and generation Y motivated to try things without hesitation. Of concern therefore, is whether latter generations will take on the role of clinical education, under similar terms and conditions, and how they will facilitate the learning of future generation of students. With the global trend of health workforce shortages, a shortage of clinical educators and potential reluctance of future generations of physiotherapists to become clinical educators, the market value of clinical education and the services provided by clinical educators will undoubtedly increase exponentially. Shaping the next generation of physiotherapists and clinical educators through phases of socialisation and habitus formation as described in Chapter Six may in some way negate these generational influences.

## **Chapter summary**

Clinical education was considered a marketable commodity, significantly influenced by economics and supply/demand. This was in stark contrast to the vocational origins of the profession, and the professional obligation espoused by many established physiotherapists including stakeholders in clinical education. In some instances, advocating professional obligation of all physiotherapists to engage in clinical education disguised dominant interests, especially academic stakeholders. Generational differences were also found to exist between students and clinical educators and stakeholders that could impact on the future of clinical education in terms of expectation and also ability to facilitate student learning.

Multiple negotiations occurred between all levels of stakeholders to influence funding flow, cost of placements and placement capacity. Pressures were translated onto clinical educators and also clinical placement co-ordinators, for example, those who were most directly connected to the field of clinical education. This compared with the ability of stakeholders collectively to influence Ministerial funding which was found to be a source of frustration, given the lack of equity compared with other practice-based courses. It was not clear how additional funding would influence the cost and capacity of clinical placements, and impact on clinical educators. While economics featured at an organisational level, for clinical educators, the value of the services they provided was calculated in terms of exchange for time and professional activities.

While clinical education was described by participants in this research as a commodity, to be valued in terms of economics and exchange opportunities, it has also become commoditised by students (future clinical educators) in terms of a service with a cost. The physiotherapy profession and by association its stakeholders, cannot afford to ignore the economic consequences of clinical education, nor the location of physiotherapy education and practice within the wider field of economics and politics.

New ways of understanding practice and practice culture are revealed within the next chapter drawing on improved understanding of the forces of hegemony and their origins that exist within clinical education. Inherent in this research is inevitability of social friction and conflict acknowledged by Bourdieu (Grenfell, 2008a), and the positive tenets which arise from the exploration of the interplay of power. Through increased awareness of influencing phases of socialisation (habitus), market conditions (field habitus) and economics (economic capital), opportunities are presented to address some of the inter-stakeholder tension and conflict described by participants in this research..

## **Personal reflections**

*The commoditisation of clinical education as illustrated in this chapter highlights the multiple tensions exerted on physiotherapy within the wider field of healthcare. In particular, I am aware of the traction created as the profession, with dominant vocational roots, being pulled into the world of commerce, economics and market negotiations. Albeit reluctantly, the profession and body of individuals has been slow, in my opinion, to embrace this new world. I believe, there is a professional arrogance that as a profession and body of highly trained individuals we can rest on our professional laurels and expect the world to circumnavigate around us. Or is it actually a naivety, where our professional identity is so closely linked with hands-on therapy that we ignore or are afraid to embrace the commercial world of healthcare? There are inevitable consequences of failing to appreciate the current*

*economic climate, failing to market physiotherapy services and expertise, and failing to value our practice in terms of economics. Whereas the next generation already demonstrate characteristics more orientated towards economics and self-interest, how then as a profession can a better balance between economics and altruism be facilitated? These are thoughts worthy of further reflection.*

*From my own perspective drawn from working over two decades in healthcare systems of UK and New Zealand, I have witnessed the transition from vocation to market, generational change and growing fiscal constraints on public healthcare and growing consumer expectations, especially within private practice. New terminology has permeated the vocabulary of physiotherapists over this time, including clients rather than patients, supply/demand, consumer expectation, commercialisation, fiscal constraints and 'value added'. Such linguistic capital as Bourdieu would describe, is identifiable with field habitus and symbolic power. In my opinion, physiotherapists cannot afford to ignore the economic climate (field habitus) and must learn the 'rules of the game', i.e. negotiate the value (cultural and symbolic capital) of our practice and profession, so that we stand a chance of success.*

*In my own world, I have become more aware of the business and economics associated with some private work. I am learning how to calculate my time in terms of dollars, ensuring paying clients and their insurance companies receive value for money, and my costs are comparable to local markets/competitors. Although the quality of my practice is equitable across both private and public practice domains, I have certainly become more commercially aware and so it seems has public based physiotherapy services. There is a growing trend towards business models, key performance indicators, outcome measures, waiting list times, patient flow experiences etc; the economics of physiotherapy and healthcare are more visible. In writing reports, business cases or evaluating services, my own vocabulary has changed, using terms and terminology not taught in my training or used in my years as a new graduate or even team leader. It seems that although patient health remains central to healthcare services, patients are described in terms of numbers, where their care is measured against 'cost-bundles' or units of cost. Clinical pathways direct the patient through the healthcare system with efficiency and standardized care, and where it appears, deviation from the pathway incurs additional and questioned cost. This greatly contrasts with current interest in the patient journey and experience as a consumer of the healthcare system. The tension between quality and quantity is evident. There is no doubt that tensions will increase with growing demands on healthcare, technology and consumer expectation, contrasted with reduced income generated from taxes on an ageing population and reduced birth rates of*

*potential tax payers. The future, undoubtedly, will be filled with tensions as governments in particular, struggle to 'balance the books'.*

*With respect to clinical education, perhaps the profession needs to acknowledge the current market impacting on clinical education and work towards negotiating with governmental bodies to secure funding equitable to other healthcare programmes. Similarly, acknowledging the professional responsibility to educate the next generation of physiotherapists may be embedded in the profession, in the current economic climate, all services will have an associated cost and value. Of interest is that clinical educators in this research readily valued the educational and CPD opportunities that funding promoted rather than additional money paid directly to them. Perhaps, as with generations past or the Kabylia society described by Bourdieu (1980/1990) in terms of "good faith economy" (p. 114), the exchange of, for example, library access, reduced fees to attend university courses could occur rather than explicit monetary exchange. While there is no doubt that clinical education and the services of clinical educators have become a commodity, perhaps what is less visible is the 'good faith' between stakeholders. This is worthy of further reflection.*

## SECTION FOUR

# **DISCUSSION OF THEMES AND RECOMMENDATIONS FOR CHANGE**

This section contains two chapters. Chapter Ten presents a discussion of the themes which emerged from Section Three together with recommendations for change. Chapter Eleven constitutes the close of the thesis and includes a critical review of the research and recommendations for future research.

## CHAPTER TEN

# Exploring emergent themes and recommendations for change

### Chapter overview

This chapter explores and expands on themes which emerged from Chapters Six, Seven, Eight and Nine, and identifies recommendations for change. Findings indicate that power interplay symbolises competing value systems held by stakeholders, organisations and the physiotherapy profession. Perpetuated by socio-economic and political influences, disjuncture between integral aspects of physiotherapy practice emerged. Value of different forms of knowledge contributed to hierarchies where clinical educators were positioned lower compared with academic and clinical peers. Moreover the value of each component was determined by wider influences including consumerism, commercialisation and contemporary 'business' of healthcare service provision and delivery.

This chapter examines how power imbalances may be addressed through reconfiguration of capital and reshaping of field habitus. Given that tension and friction are inherent in social groups, it is not the intention to achieve equilibrium of power. Such a balance is unattainable from a Bourdieusian perspective given the continuous interplay between habitus and fields, social structures and cultural practices and the constant contest for capital and positions of dominance. Recommendations are therefore, proposed to mediate the power interplay, drawing on the perceptions of clinical educators whose voices inform this research. This includes influencing phases of individual and field habitus formation (socialisation), and reconfiguring the value of education knowledge and skills, and clinical educators, taking into account the wider influences of consumerism, commoditization and contemporary healthcare issues. Implications for practice and change processes drawing on Bourdieu's concepts conclude this chapter.

### Shaping habitus

Personal, physiotherapy and professional habitus were identified in Chapter Six as phases of socialisation in which dispositions become embedded and actions are orientated towards opportunity, position and capital. Similarly, field conditions such as team and organisation expectations that shaped habitus were examined. These phases signify opportunities to reshape individual and field habitus and are described in further detail.

## **Personal habitus**

Dispositions formed through early experiences and brought by individuals as undergraduate students to Schools of Physiotherapy were identified as personal habitus. At the time of data collection, entry into Schools of Physiotherapy was based on academic achievement. Students of both Schools complete a foundation year in health sciences along with other students, and again based on academic profile, gained entry into physiotherapy programmes. Demand for places enables Schools to determine entry requirements, traditionally stating: “proven academic performance is a criterion for entry” (Skinner, 2007). Pre-entry requirements were based solely on academic profile, with little consideration of other criteria considered essential for physiotherapy practice. This includes ability to communicate well with a diverse population and health literacy, capability to transform propositional knowledge into practical craft knowledge and other characteristics conducive to interprofessional learning and practice. Similarly, flexibility and adaptability although identified as characteristics of clinical educators, could be considered essential attributes to meet the challenges of working in the current dynamic climate of physiotherapy and healthcare services. By solely focusing on academic profile, the value of propositional knowledge is reinforced and other characteristics ignored. Whilst the value of propositional knowledge embedded in entry requirements may be grounded in the historical origins of the profession, and specifically alignment with the medical profession (Pynt et al., 2009), such emphasis may inhibit recruitment of student physiotherapists to the profession who possess characteristics conducive to clinical education and physiotherapy practice.

Similarly, neither New Zealand Schools interviewed prospective students. However, in 2008 one New Zealand School instigated undergraduate medicine and health science admissions test as psychometric testing and interviews for students applying to study physiotherapy on successful completion of their foundation year in Health Sciences. Whilst details of testing, scoring system or domains considered relevant to physiotherapy are unknown, such testing does to some extent, redress the dominant bias on knowledge as a criterion for entry into Schools of Physiotherapy. Interviews also allow assessment of communication skills, and aptitude for health related courses. Notwithstanding the international dilemma of clinical educator shortages, there is no evidence to demonstrate that interviewing or psychometric testing of physiotherapy students will influence the trajectory of students to become clinical educators. This may represent an area of future evaluation. Further research is also warranted to evaluate the cost implications of additional testing and interviewing against the long-term recruitment of physiotherapists

as clinical educators, and productivity of clinical educators to work with different models of clinical education.

Given that “habitus faithfully reflects, by definition, the objective conditions under which it was initially formed” (Swartz, 1997, p. 110), the importance of personal characteristics, as well as academic profile cannot be underestimated. It may be deduced that other phases of ‘primary’ socialisation also influence students as physiotherapists and clinical educators. This contrasts with Bourdieu’s belief as previously discussed that primary socialisation represents a master set of deeply internalised dispositions which can adapt, but tends not to fundamentally alter (Swartz, 1997). Reconfiguring the entry requirements to physiotherapy programmes may in some way recruit potential physiotherapists who have the academic profile and personal characteristics that can be subsequently shaped through other periods of socialisation. This includes socialisation as students at university and on clinical placement (physiotherapy habitus) and when working within communities of practice (professional habitus). Table 10.1 presents recommendations for change based on influencing habitus formation.

**Table 10.1 Personal habitus: recommendations for change**

<b>Recommendations</b>	<b>Associated stakeholder in clinical education</b>	<b>Government as stakeholder</b>
Review and evaluate entry requirements and processes to include attributes conducive to clinical education.	Schools of Physiotherapy/universities to review entry processes and programme curricula	Support diverse entry requirements

### **Physiotherapy and professional habitus**

Described in Chapter Six as physiotherapy habitus, the time spent by students in clinical practice, that is, on clinical placement, represents a further period of socialisation in which physiotherapy and professional habitus are shaped. It is in university and specifically in the School of Physiotherapy that the student learns generic and discipline-specific knowledge and skills of physiotherapy and is assessed against competencies determined by the profession as interpreted by the School. This socialisation phase of shaping physiotherapy habitus merges with a further phase of socialisation whereby professional habitus is shaped. This relates to clinical education/practice experiences irrespective of venue, i.e. community, hospital, university based clinic, private practice.

#### *Pedagogy within the curriculum*

The value of pedagogy within the physiotherapy profession, organisations and individual physiotherapy practice was found in this research, to be ranked lower compared with

other forms of professional knowledge (Chapter Seven). Competency Five in the Physiotherapy Competencies for Physiotherapy Practice in New Zealand (Physiotherapy Board of New Zealand, 2009) relates to the application of “education principles to physiotherapy practice” (p. 6) appropriate to the patient/client. As will be discussed under reconfiguring value systems and addressing the disjuncture between different forms of knowledge later in this chapter, it is important that both the Physiotherapy Board of New Zealand and through the interpretation of Competency Five by the Schools of Physiotherapy, that pedagogy becomes more visible within the curriculum, and highlighted within student learning during theoretical and practical sessions. Students may therefore enter clinical practice with the knowledge and skills to apply to patient care, peer and student learning, and enter the workforce prepared to engage in student learning.

### *Role modelling*

Considered the most essential component of undergraduate education, clinical practice is where students consolidate and apply what was learned at School, develop new knowledge and are further socialised to the behaviours, attitudes and actions expected of a physiotherapist. It is also where students are exposed to physiotherapists and clinical educators as role models, which as demonstrated in this research, was found to influence their trajectory as clinical educators. The importance of role modelling of practice including professional behaviours is recognised by Baird and Winter (2005) as important in clinical education. Student participants in this research were also influenced by individual and organisational attitudes towards clinical educators, which were not always positive. Consequently, some students were reluctant to become involved in clinical education, seeking to prioritise their own learning and position as physiotherapists. Indeed, the role of clinical education was commonly perceived as separate and additional to clinical roles, reproducing attitudes and behaviours towards clinical education and class inequality of clinical educators as a social group. A summary of recommendations for change based on role modelling is presented in Table 10.2.

**Table 10.2 Physiotherapy and professional habitus: recommendations for change**

<b>Recommendations</b>	<b>Associated stakeholder in clinical education</b>	<b>Government as stakeholder</b>
Embed, and highlight pedagogy within curricula and throughout theoretical and practical sessions	Schools of Physiotherapy to integrate pedagogy within curricula and throughout student learning experiences	Expectation within TEC of the role and responsibility of organisations to actively promote and provide facilities, training and organisation of clinical education within physiotherapy practice environments

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Dedicate and legitimise value of time for observation and discussion	Manager and organisation review of additional time requirement within staffing formulae
Establish and promote value of role modelling within clinical education	Schools of Physiotherapy and physiotherapy practice providers to value and support non-clinical activities within clinical practice and including, clinical education.

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*Creating time to learn and reflect*

Whilst clinical educators manipulated their caseload (and in some instances patient waiting lists) to create time and opportunity for students to progressively engage in more complex patient scenarios and reflect on their practice, this was not evident in their own transition into being and practising as clinical educators. Pressures of time were found to inhibit clinical educators preparing practically for students, attending clinical educator workshops, and reflecting on their practice. Symbolic violence was evident in the denial of clinical educators both the opportunity and time to attend clinical educator workshops. Attendance should be actively promoted by managers and professional leaders, reflecting their and the organisation's commitment to learning and collaboration with education providers. The potential for these workshops to be interprofessional offers an extension and modelling of current trends in practice and creates a community of clinical educator support and learning. These workshops could be more cost effective to organisations and potentially negate concerns regarding the impact of attendance against time away from patient/service delivery. As evidence also demonstrates (Bristow & Hagler, 1997; Holland, 1997; Ladyshewsky et al., 1998; Leiken, 1983), students on clinical placement positively influence productivity of teams. Clinical educator confidence and effectiveness in facilitating student learning and working with different models of clinical education, for example, may therefore be considered an investment. Further research is warranted which evaluates the impact of clinical educator workshops/courses on clinical educator and student productivity, staff retention etc. and provides the evidence for managers to perceive the benefits in terms of patient and service requirements.

For habitus to adapt to new field conditions and dispositions to be embedded, a more systematic approach is required, drawing on principles of reflective practice and skill acquisition to promote competency and proficiency (Benner, 1984) not only in physiotherapy but also clinical education. Reflective practice, defined by the Physiotherapy Board of New Zealand (2009) as "the activity in which a person reflects on the process and outcomes of a situation with the aim of improving or affirming their professional practice" (p. 22), is integral to professional practice and considered essential

to transform different forms of learning into practice, and from practice through reflection on and in practice (Schön, 1983). Reflective practice is further supported by the work of Argyris and Schön (1978) who advocated double loop learning, suggesting learning involves the detection and correction of error, devising strategies to bridge governing variables (single loop learning). Double loop learning builds on this, challenges governing variables and creates a shift in the way strategies and consequences are framed. Whilst critical reflection of practice and experience transforms knowledge (Higgs et al., 2004b; Schön 1983) and relationships, reflexive analysis as advocated by Bourdieu, allows individuals to critique power relations, and dynamics through analysis of habitus, field and capital (Bourdieu & Wacquant, 1992), altering our perception of relations and therefore, our reaction to it. Time to reflect in terms of transforming knowledge and learning, and power relations is an essential component of relationships, practice and culture. In essence, time creates space for transformation of individual, discipline and organisational habitus to adapt to new field conditions. Withholding time as a valuable resource contravenes principles of learning, recognised as valuable in terms other than economics, such as, cultural capital. To successfully legitimise 'time' for professional development, i.e. exchange economic for cultural capital, employers would need to incorporate this time (and expectations) into staffing formulae. The investment of time in the short term however, could result in more efficient physiotherapy and clinical educator service provision, as 'novice' staff become 'expert' (Benner, 1984) and efficient practitioners. Redistribution of time is therefore, required in order to facilitate habitus transformation, ultimately towards increased confidence and productivity as physiotherapists and clinical educators.

In contrast to physiotherapy and irrespective of years of training, other healthcare professions such as pharmacy, occupational therapy, medicine and nursing, and non-health professions such as teaching, incorporate a formal transition period into both professional and employer expectations. Within this 'pre-registration' or 'internship' phase, formal support mechanisms including opportunities to reconstruct knowledge and consolidate learning over a specified timeframe could mirror other professions such as occupational therapy (Robertson & Griffiths, 2009). For such a change to be sanctioned, the Board as an agent of the Government would be responsible for the configuration of capital, and as holders of symbolic and cultural power, which employers would then be required to implement.

Redistribution of time would require a significant paradigm shift in field habitus of organisations and in particular physiotherapy practice providers, to accommodate the

transition of students to physiotherapists, and clinical educators. A change in expectation equates to the reconfiguration of cultural capital possessed by new graduates and the interconvertability of cultural to economic capital, given that time is cultural capital in disguise (Swartz, 1997). Time is perceived as the investment (socialisation phase/habitus transformation) ultimately equating to efficient physiotherapy practice (cultural capital). A summary of recommendations is provided in Table 10.3.

**Table 10.3 Creating time to learn and reflect: recommendations for change**

<b>Recommendations</b>	<b>Associated stakeholder in clinical education</b>	<b>Government as stakeholder</b>
Formalise and protect time to reflect/attend supervision workshops to promote transformation of knowledge	Actively promote and support reflection in clinical education	Funding to support additional staff time to participate in non-clinical / professional activities
Incorporate reflective practice as integral component of clinical educator workshops	Provide accessible workshops on reflective practice for physiotherapists  Promote value of reflection within practice and clinical education  Recognition of reflective practice as a professional activity within continuous professional development/professional activity log books	

### **Mentorship and support**

As noted by Baird and Winter (2005), experienced clinicians are often tasked with being a clinical educator with “very little preparation” (p. 152), or gain experience through trial and error (May, 1983). Mentorship and support was available to clinical educators, but this appeared ad hoc and dependent on time, availability of experienced colleagues and communication with university staff. Experienced clinical educators, particularly those based in large practices or district health boards provided mentorship to colleagues who were less experienced, or challenged by aspects of clinical education. For other clinical educators (rural based or sole educators in teams), there was reliance on university staff to navigate through personal and professional challenges presented by students and clinical education processes. Time pressures were also noted by academic staff (notably clinical placement co-ordinators) that inhibited communication (telephone or visits) between the university and physiotherapy practice providers. This resulted from similar multi-dimensional demands on academic staff time, including teaching requirements, negotiating clinical placements and dealing with issues. Support to some

clinical educators was provided by teleconference when academic staff were unable to visit clinical education sites due to geographical distance and time constraints.

Whilst multiple formal and informal processes existed to transition students into their role and identity of physiotherapists, similar opportunities did not consistently exist for physiotherapists as clinical educators. In some instances attending clinical educator workshops, or communicating and gaining support from academic staff were withheld (symbolic violence). This resulted in tension for clinical educators as they struggled to meet the demands of students and in particular struggling students and service requirements. As previously described, embedding education principles and practice into undergraduate curricula would make learning and teaching more visible in physiotherapy practice and integral to the habitus of student physiotherapists. Until such time that this occurs, it is important that ‘novice’ or student clinical educators have access to similar support mechanisms such as mentorship, to facilitate their transformation of education knowledge and skills into practice. Similarly, socialisation to the role requires time to attend workshops, network with peers and develop support systems both within and external to their organisations/private practices, and also time to reflect on their practice and promote transformation of knowledge. Reconfiguration of organisation expectation would legitimise time to develop support systems (social and symbolic capital) and habitus formation as well as enhancing the quality of clinical education as both a product and service. A summary of proposed recommendations is presented in Table 10.4.

**Table 10.4 Mentoring and support: recommendations for change**

<b>Recommendations</b>	<b>Associated stakeholder in clinical education</b>	<b>Government as stakeholder</b>
Establish mentorship programmes between experienced and less experienced: <ul style="list-style-type: none"> <li>• Students in School and also in clinical environments</li> <li>• Clinical educators</li> <li>• School staff and new clinical educators</li> </ul>	Schools of physiotherapy and physiotherapy practice providers to establish and support mentorship programmes and activities within undergraduate education and clinical practice  Physiotherapy Board of New Zealand and New Zealand Society of Physiotherapists’ Inc. to promote mentorship and supervision in clinical practice  Recognition of mentorship as a professional activity within continuous professional development /professional log books	Funding and grants to evaluate how new graduate physiotherapists can become better prepared for the workplace and workforce

## **Communities of learning and collaboration**

Global trends in healthcare education and practice, together with fiscal constraints driving cost efficiencies demonstrate how organisation fields are influenced. A strategy to optimise professional socialisation phases, enhance collaborative practice and learning within the market of healthcare, is the redefinition of organisations (fields) as learning organisations or communities of learning/practice.

It could be argued that productivity is a function of knowledge (practice/systems), however, to optimise productivity, knowledge should be embedded in the organisation rather than individuals. "Continuous learning for continuous improvement" (Watkins & Marsick, 1992, p. 299) is central to the concept of learning organisations. Senge (1990) described learning organisations as

*organisations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole together. (p. 3)*

Acknowledging that organisational structures and the pace of change actively promote 'adaptive learning' which limits reflection and engagement, and the ability to create for the future, Senge advocated for a shift in organisation philosophy towards enhancing creative capacity, collective learning and innovative practice. For such a shift to occur however, an organisation (and professions and professionals) would need to reconfigure the value of human resources and the contribution of staff learning (cultural and social capital) to the long term growth and sustainability (economic capital) of the organisation.

Marsick and Watkins (2003) advocated that "it is not enough to hold individuals accountable for learning continuously without also building the organisation's capacity to support, encourage, and make use of that learning" (p. 133). In essence, improved performance is linked with a culture orientated towards learning. In other occupational groups such as information technology, Egan, Yang and Bartlett (2004) found that a culture of organisational learning was associated with job satisfaction, motivation to share and transfer learning and employee retention. Enhancing and valuing learning within organisations is therefore, beneficial to all health professions across the continuum of learning, and in staff retention including clinical educators. The concept of an organisation such as district health boards instilling a culture of learning could, in some way, redress the climate of job insecurity whereby staff are reluctant to share knowledge (Marsick & Watkins, 2003) and physiotherapists, recognised as a mobile profession, could be retained.

Communities of practice (Wenger, 2006) are underpinned by three characteristics which include a shared domain of interest, relationships are built to enable reciprocal learning (community) and between practitioners. Interpreted through Bourdieu's concepts, communities of practice imply more equal distribution by stakeholders in the field (organisation). Employees as a community, engage in activities which redistribute capital in terms of professional and organisational benefit. Focus includes the practitioners and the social structures (field habitus) that enable and empower learning with and between practitioners. As such, communities develop around things that matter (Wenger, 1998) and represent connections across organisational and geographical boundaries and between practitioners such as physiotherapists, influencing theory and practice across many domains including healthcare delivery, professional practice and patient care. Successful implementation of communities of learning or practice would involve a shift in the value of individuals, their contribution and professional relations. Interprofessional education and collaborative practice as advocated by the World Health Organisation (2010) may in some way reconfigure the culture and practices of professions and organisations (field habitus), shaping and shaped by changes in health policy internationally and nationally. Driven by chronic projected workforce shortages (World Health Organisation, 2006) and impact on healthcare delivery (including physiotherapy), motives of policy makers and governments such as Health Workforce Advisory Committee of New Zealand, are shaping education and healthcare culture and practices. By way of example, the Career Framework for the Health Workforce in New Zealand (Ministry of Health and District Health Boards New Zealand Workforce Group, 2007) has relevance at a local, regional and national level in contributing towards service planning to meet the demand for health services. Through influencing workforce component at entry level and influencing structure and delivery of training programmes, a more flexible and responsive workforce is proposed, though implementation of change is acknowledged as the responsibility of Ministry of Health, education and service providers, communities and other sectors. This demonstrates the relevance of stakeholder collaboration (trust, i.e. symbolic capital and communication, social capital) and mutual respect and recognition (social and cultural capital) which may then be transformed into a shared vision (symbolic capital). The impact of wider fields of power is highlighted on the practice and culture of healthcare professions (discipline habitus), and education and practice organisations (field habitus) and ultimately individual habitus of healthcare practitioners including physiotherapists and clinical educators. The dominance of economic capital and its ability to convert more easily into cultural and social capital than vice versa (Swartz, 1997)

reconfirms that economic motives and the commercial world of healthcare are key drivers of change and practice.

Creation and location of clinical centres at district health boards may in some way, create a community of learning and practice for both students and clinical educators. With clinical centre staff employed to interface between the university and clinical sites (which encompass district health board and designated private practices), opportunities around supporting the transition of physiotherapists into the role of clinical educators is also possible. Whilst the motives and change processes involving clinical centres were initially received with suspicion, concern exists that clinical centres represent the delegation of responsibility for clinical education to physiotherapy practice providers, namely district health boards. Evaluation of clinical centres, their impact on staff, students and organisations as consumers and providers has yet to be undertaken. Recommendations for change involving learning and collaboration are presented in Table 10.5.

**Table 10.5 Communities of learning and collaboration: recommendations for change**

<b>Recommendations</b>	<b>Associated stakeholder in clinical education</b>	<b>Government as stakeholder</b>
Review impact of clinical centres on stakeholder relationships organisation of clinical education, clinical educator support and recruitment,	Schools of Physiotherapy and physiotherapy practice providers:	Continue to make explicit shared role of stakeholders
Development of interprofessional and collaborative practice within Schools and clinical practice	To engage in collaborative review of clinical centres  Review and support interprofessional and collaborative practice within curricula/classrooms and clinical practice	Provide grants/scholarships to fund innovative practice and associated research/evaluation

### **Shaping habitus through curricula, competencies and core documents**

In New Zealand, curriculum content is guided by School's interpretation of the Board's competencies, demonstrable and auditable on an annual basis (Skinner, 2007). International literature highlights that curricula are full in terms of content and skills once previously taught as post-graduate (Crosbie, et al., 2002). As discussed in Chapter Seven, propositional knowledge continues to dominate the curricula, which although historical in nature, is further reinforced by the current climate of evidence based practice and research. Added to that is the need of the profession to justify its role within healthcare and ensure practice is evidence based, efficient, measureable and cost-effective. Additionally, generation of propositional knowledge (cultural capital) in the form of

research is both a source of income through performance based research funding as economic capital and status of Schools (social and symbolic capital).

Central to physiotherapy practice are the competencies as determined by the Physiotherapy Board of New Zealand (2009), which in their written document define competence as

*The ability to consistently integrate and apply knowledge, skills, attitudes and values in an independent, timely manner to a required standard. Achievement of the standard required to be a physiotherapist in New Zealand is measured against the Physiotherapy Board's stated competencies. (p. 22)*

Interestingly, the previous competency document of 1999 'Registration Requirements: Competencies and Learning Objectives' (Physiotherapy Board of New Zealand, 1999) guided registration from 2000 to the implementation of the current document and framework (2009). It is essential that these are reviewed regularly to ensure that they reflect current and more importantly, future practice and healthcare delivery demands, and patient needs.

Another guiding document which shapes physiotherapy and professional habitus is the New Zealand Physiotherapy Code of Ethics and Professional Conduct (Physiotherapy Board of New Zealand, 2011b). Contained within this document is that physiotherapists should "willingly engage in teaching physiotherapy practice to physiotherapy students and less experienced colleagues" (p. 20). Whilst the document advocates the engagement of physiotherapists with students and less experienced staff, it is in contrast with the Physiotherapy Competencies (2009) whereby competency 5 refers to the application of educational principals to physiotherapy practice and makes no mention of specific student learning or clinical education. So whilst the ethical obligation lies with the physiotherapist, educational principles are applicable to physiotherapy practice but not explicitly to students or clinical education. Core professional values, competencies and codes of conduct are determined by the Board as the physiotherapy registration body, recognised by the Ministry of Health. Given the status of the Board (symbolic capital), core values are considered as inherently true, i.e. taken for granted by physiotherapists, yet symbolic violence conceals the explicit competency or transferability of competency in applying education principles to physiotherapy practice including clinical education. As demonstrated in this research, choice to become a clinical educator was primarily driven by self-selection processes as perceived by clinical educators. However, choice or self-selection by physiotherapists, to stakeholders in academia, limited the responsibility of physiotherapists to engage in clinical education and therefore, increase capacity of student numbers (dominant interests of Schools). Choice therefore, represents a tension between

organisational and professional expectations, with limited influence by Schools to shape organisational expectations and engagement of employees as clinical educators (interested action). Clinical education as a field represents a field of symbolic struggles and social conflict, compounded by the tension between ethical and professional obligation and personal choice.

Crosbie et al., (2002) and McMeeken (2008) argue that curricula are already overcrowded and are slow to respond to workforce and workplace needs. As previously discussed in Chapter Three, hysteresis i.e. the time lag before habitus and field re-adjust is representative of change and has been found to be a source of tension between stakeholders, and providers and consumers. Although no New Zealand physiotherapy specific data are available, other findings have relevance. For example, new graduates (health science) were found by Adamson et al. (1997) to be clinically confident, yet perceived their education inadequately prepared them to cope/manage in the workplace. A further example highlights how physiotherapy in New Zealand has been slow to respond to influences, such as, the “rapidly changing economy of healthcare” (Nicholls, Reid & Larmer, 2009, p. 105). Irrespective of significant socio-economical and political change in post-apartheid South Africa, Ramklass (2009) also found little alignment of physiotherapy curriculum responsive to contextual changes in healthcare and societal change. This highlights that irrespective of country, physiotherapy curricula are slow to respond to workforce needs and socio-economic and political change. Hysteresis, as was found in this study, can occur through multiple connections relating to change management and processes, which continue to be a source of tension (and power interplay) between stakeholders.

The interconnectivity of The Physiotherapy Board of New Zealand’s competency framework, how the framework is interpreted by Schools and the influence of national and international healthcare and physiotherapy trends is noteworthy. The timeframe for each to respond to change is unique, it is therefore, likely Board competencies and curricula lack synchronicity, contributing to hysteresis and the perception that graduates are not adequately prepared for practice. By way of example, Board competencies were reviewed in 1999 and 2009. Whilst generic and open to interpretation, they form a framework for undergraduate programmes. Minor changes to the curriculum require approval by university-specific programme committees, with significant changes approved by Committee on University Academic Programmes (Head of School, personal communication, April 02, 2012), both of which have time implications. There is also a time lag before students exposed to curriculum changes enter the workforce, with the

impact of significant curriculum changes on professional competencies and readiness for work unknown for many years (Chipchase, Dalton, Williams & Scutter, 2004). Indeed, a further time lag is evident before students as new graduates enter the profession or are in a position to influence practice or change (due to their low hierarchical ranking in teams/organisations). By way of example, one New Zealand School of Physiotherapy revised the physiotherapy curriculum, promoting an integrated approach of generic and discipline specific knowledge and skills. These changes to the curriculum were undertaken in conjunction with the establishment of clinical centres, and specifically consolidating clinical experiences into students' fourth year of training. The process of curriculum review took five years from inception through to delivery, with graduates of the new curriculum not entering the workforce until 2013 (D. Nicholls, personal communication, April 02, 2012). Although too early to evaluate whether these changes to the curriculum and timing of clinical experiences have any impact on the 'final product', that is, the new graduate, and their preparedness of the workforce, a useful consideration is the satisfaction of, for example, district health boards as consumers. Evaluation is therefore, essential.

Another development is the establishment of an Honours programme whereby a selected number of students undertake a research project. Criteria for entry into the Honours programme are based on academic achievement as determined by the School. As noted by Skinner (2012), the proposal for change have been welcomed by multiple stakeholders including students and the profession, and aligns with international programmes, Tertiary Education Commission priorities, University Charter and Health Workforce New Zealand's directions. This demonstrates the complexities of multi-stakeholder involvement and influence and time frames for consultation and change to occur. From a Bourdieusian perspective, wider socio-economic and professional factors at a national and international perspective have influenced field (and individual) habitus in producing a graduate that holds increased symbolic (status) and cultural (discipline specific knowledge) compared with other graduates. Selection of students based on academic merit to undertake Honours in Year IV, perpetuates the symbolic status of the students, and also symbolic power of the School. Symbolic power "is defined in and by a determinate relationship between those who exercise this power and those who undergo it – that is to say, in the very structure of the field in which belief is produced and reproduced" (Bourdieu, 1972/1977, p. 117). Competition for places not only increases the exclusivity (and symbolic status) but by limiting the places available to study towards Honours, denies accessibility to other students (symbolic violence). Professional field habitus is therefore, both structuring and structured through influences that shape the

curricula, physiotherapy practice competencies and relevant core documents. Table 10.6 presents how shaping habitus can influence change.

**Table 10.6 Shaping habitus through curricula, competencies and core documents: recommendations for change**

<b>Recommendations</b>	<b>Associated stakeholder in clinical education</b>	<b>Government as stakeholder</b>
Pedagogy to be more visible, valued, and integrated within curricula.	Physiotherapy Board of New Zealand to make explicit competency relating to pedagogy applicable to patients and students. Schools to embed pedagogy within curricula	
Undertake stakeholder collaboration process to ensure curriculum content and registration competencies reflect current and future practice	Promote regular reviews of curricula, professional competency and other core documents to reflect pace of change	Explicit expectation and funding to support collaborative reviews
Review documents within short timeframe to reflect dynamic state of change in healthcare	All stakeholder to collaborate and agree timeframes for review	

### **Reconfiguring value systems**

As demonstrated in Chapter Seven, Eight and Nine, the continued contestation for capital was influenced by competing value systems, resulting in power interplay between individuals and organisations. Such value systems impacted on relationships, change management, resource allocation and the ability of the profession to respond to changing and growing demands. Moreover, it is postulated that inter-stakeholder conflict has the potential to impact on the direction of the profession and patient care. Given the constant flux within healthcare in New Zealand, current trends towards collaborative and community-based services, and shift in focus towards health promotion, patient/peer/partner education is fundamental to care and marketing of physiotherapy to service providers. It is also essential that the profession is responsive to change, providing a workforce that is competent, flexible and cost effective. Similar influences of agencies such as Accident Compensation Corporation require physiotherapists to be receptive to change, innovative and commercially astute. It is therefore, both timely and important, to review how value systems may be reconfigured in order to positively influence clinical educators and clinical education, and associated stakeholders in New Zealand. Strategies are subsequently proposed to reconfigure individual and field habitus and the value of different types of capital.

In keeping with Bourdieu's three levels of analysis (Bourdieu, 1979/1984; Bourdieu & Wacquant, 1992), emergent themes are described in terms of class habitus of

individuals and fields such as clinical education, dominant and subordinate positions based on configuration of capital, and field under scrutiny, i.e. clinical education is described in relation to the wider field of power (healthcare and economics). Although described in isolation to promote clarity of discussion, themes and levels of analysis are acknowledged as interconnected, interdependent and dynamic. Similarly, recommendations for change are applicable across individual and organisation practice and culture. For example, clinical educators as a social class were identifiable by unique characteristics and a predisposition towards student learning. Different phases of socialisation were found to shape habitus, influenced by organisation and professional practice and culture. Reconfiguring the value of education knowledge and skills within the curriculum and across other phases of socialisation, could positively impact on the preparedness and productivity of physiotherapists in terms of student and patient education. Ultimately, this could enhance capacity of students and Schools towards meeting projected shortfalls in physiotherapy workforce and ensure patients continue to be provided with physiotherapy care.

### **Addressing the disjuncture between different forms of knowledge**

Other means of reconfiguring value systems lies with the value afforded to different forms of knowledge. As this research demonstrated, a hierarchy of knowledge was found to exist and influence the value of those who possessed and imparted such knowledge. In particular, disjuncture between 'clinical', 'education' and 'research' was found. Additionally, this research identified influences by, for example, the Tertiary Education Commission who has perpetuated the hierarchy of knowledge through performance based research funding. While the development of clinical centres has centralised clinical experiences within district health boards, it has also widened the geographical gap (and therefore, spatial gap which Bourdieu (1994/1998) advocates equates to tension) between what is learned at School and on clinical placement.

A significant paradigm shift is required for all types of education, irrespective of where it is provided and by whom, to be considered 'practice education'. Although each component has relevance, its value 'to practice' and 'in practice' is comparable. This would require all stakeholders to reconfigure 'education' within the profession and reshape individual and field habitus.

### *Integrating education knowledge and skills*

Concurrent with shaping phases of habitus transformation, is the reconfiguration of education knowledge and skills within fields of education, practice and the profession.

Illuminating the contribution and transferability of education knowledge and skills within the curriculum and practice, reconfigures the value as cultural and economic capital. The current trends towards health promotion and wellness models of health (Nicholls, Reid & Larmer, 2009) highlight the importance of patient and community education. Just as participants in this study valued learning styles, for example, as influencing how they facilitated student learning, patient learning styles should rightly be considered. In addition, further findings of this study and other research (Higgs & Tichen, 2001) highlight that forms of knowledge are valued differently such as propositional and non-propositional knowledge,. However if, for example, reflective practice was integrated within other subjects, and valued and embedded within the curriculum, such knowledge may not be seen and valued as separate from discipline and clinical specific knowledge. The value of education knowledge would be reconfigured on the hierarchy of knowledge relative to other forms of knowledge.

### *Simulated clinical learning*

Simulated clinical learning ('simulation based education' or 'high fidelity simulation') has been increasingly incorporated into health education both in universities and hospital environments, and more recently has been included in physiotherapy education. Simulated learning not only enables clinical skills to be applied and clinical reasoning discussed (Blackstock & Jull, 2007), but when recorded, can be used to enhance reflective practice. In this way, different forms of knowledge are transformed and applied to clinical scenarios, albeit not directly on patients. A wide variety of clinical scenarios can be produced, which may otherwise be limited in clinical practice, and repeated allowing students to confidently and competently master clinical skills and apply knowledge.

Evidence to support simulated clinical learning in physiotherapy is limited. Whilst postulated to improve the student's experiences in clinical practice, and ultimately better and more efficient standards of patient care, Jones and Sheppard (2007) found inconclusive evidence to support improved patient management in healthcare. Findings from one physiotherapy study were included in the review of 18 studies which met their criteria. Benefits included repeated practice and the ability to manage the learning environment were positively cited when learning psychomotor skills or procedural activities, however, the authors postulated that benefits to physiotherapy were limited compared with other professions in which procedural intervention dominated. Sheppard and Jones acknowledged that repeated practice by students could be more readily facilitated compared with time constraints in clinical practice, which might otherwise

impose on clinical educators. Clinical educator time, as demonstrated in this research was a source of tension and contributed to stress in meeting multi-dimensional demands.

Motives to incorporate simulated learning in healthcare education including physiotherapy have been driven primarily due to economic, ethical and organisational factors (Winslow, Dunn & Rowlands, 2005) with traditional healthcare educational models considered unsustainable. As noted by Blackstock and Jull (2007), the physiotherapy profession is “not immune to these challenges, and has stated widely that there is a ‘clinical education crisis’” (p. 3). The use of simulated clinical learning in Schools reconfigures the value as cultural capital within fields of education is traditionally biased towards propositional knowledge. Moreover, simulated learning can also be incorporated into professional development activities in district health boards including clinical education, thereby bridging learning both in Schools and the workplace. Simulated clinical learning addresses the disjuncture not only between different areas of learning and where that learning occurs, but across the learning continuum.

Additional recommendations include collaboration between education and clinical staff which would further enhance the ‘reality’ of clinical experiences, and may represent a point of shared interest and collaborative research in examining the impact of simulated learning on readiness to practice and cost-effectiveness. Indeed research into the capacity, access, cost benefits and advantages for physiotherapy training (Gough, 2011) is warranted together with guidance from registration bodies such as the Physiotherapy Board of New Zealand and World Confederation for Physical Therapy. Findings would determine the impact of simulated clinical learning in physiotherapy, within education and practice organisations, and generate much needed ‘evidence-based practice’. Recommendations for change are presented in Table 10.7.

**Table 10.7 Addressing the disjuncture between different forms of knowledge: recommendations for change**

<b>Recommendations</b>	<b>Associated stakeholder in clinical education</b>	<b>Government as stakeholder</b>
Create collaborative research links between physiotherapists/clinical educators and School staff to actively promote clinician-generated research	Schools of Physiotherapy and physiotherapy practice providers to engage in more regular collaboration and consultation processes	Continue to make explicit collaborative relationships between stakeholders
Review and evaluate simulated clinical learning experiences using practice-based scenarios (provided by clinical staff) into School-based learning	Research into role of simulated learning experiences in physiotherapy	Funding to support facilities and equipment in Schools and Physiotherapy practice

Engage students in research  
partnership with School/clinical staff

Consideration of joint positions  
between Schools and clinical practice

Shared lectures between School  
and clinical staff, accessible to  
students and also clinical staff

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## **Building bridges**

Other useful strategies to create overlap between centres of learning, is to promote clinicians to research and contribute to the profession's body of knowledge. Facilitating and valuing the contribution of clinician-based research, or collaborative research between academic and practice providers would create less diversity between two distinct yet interrelated areas of learning. This may also, in some way, create a better balance between research and practice and associated staff and organisations.

Additionally, the appointment of staff whose role bridges 'education' and 'practice', i.e. academia and clinical practice, may in some way redress the spatial, cultural and geographical gaps as described in Chapter Seven. At the time of data collection, one New Zealand School of Physiotherapy was establishing a new position whereby the staff member was jointly appointed by the university and physiotherapy practice provider. Although literature pertaining to lecturer-practitioners in physiotherapy is limited (Hargreaves & Hewison, 2002; Stevenson, Chadwick & Hunter, 2004), unpublished work by Davies (2002) found that lecturer practitioner roles in the United Kingdom predominantly represented an amalgamation of two part-time roles which contributed to unrealistic expectations of the role by both employers. Recommendations included the creation of a role underpinned by a new educational/professional/organisational philosophical shift to overlap (rather than bridge) the continuum of student learning.

### *Transforming stakeholder relationships*

In the context of this research, although personal motives were found to be the most dominant predictor of involvement with student learning, organisational culture and practice (field habitus) was also found to be influential in shaping clinical educators/clinical education in physiotherapy. This was evident through the expectations of organisations, for example, expectations were explicit in job descriptions, or implicit through unspoken expectations. However, influences were embedded in organisational expectations rather than resource allocation, with clinical educators expected to juggle clinical/management and education roles. A philosophical shift in attitude and practice of organisations towards learning would reconfigure the value of learning and staff development as economic investment and potentially result in the relocation of resources.

Cultural and symbolic capital as producers and providers of knowledge/learning would in essence be exchanged for economic capital, such as, service and practice efficiency. A culture of organisational learning combined with systems and structures which enhance and value learning should have a symbiotic relationship whereby individual learning is promoted that contributes to the learning and productivity of the organisation. In essence, individual and organisational learning are reciprocal. Clinical education through its shared location in fields of education/practice requires that Schools of Physiotherapy as stakeholders are also included in the learning vision and culture of organisations such as district health boards. Recognition of the shared meaning and benefit to stakeholders may lead to improved stakeholder engagement, improved communication and shared strategies so that students as new graduates transition from one learning organisation to another, both intrinsically representative of the continuum of learning.

### *Transforming practice*

Literature pertaining to clinical education indicates that clinical educators have been reluctant to adopt different models of clinical education (Baldry Currans, 2003; DeClute & Ladyshefsky, 1993; Ladyshefsky, 1993; Moore et al., 2003) and delegate workloads to students (Baldry Currens & Bithell, 2003). This suggests that a disjuncture between evidence and practice continues and that traditional practices continue to be representative of deeply embedded dispositions relating to practice culture. To successfully transform practice at an individual and field level, time for habitus to adjust and adapt to new conditions is essential. This requires both individuals and organisations (concurrently) reconfiguring time as economic capital, in order to influence and transform current practice and identity as clinical educators. It may also require investment of time from education providers, to assist in the transformation, given that as stakeholders, they hold a vested interest. Denial of time from the perspective of all parties, as symbolic violence, inhibits transformation of individuals, organisations and practices. Time for habitus to adjust makes change challenging and may jeopardise the capacity and growth of the profession. Table 10.8 summarises recommendations for change based on building bridges between organisations.

**Table 10.8 Building bridges: recommendations for change**

Recommendations	Associated stakeholder in clinical education	Government as stakeholder
Collaborative research to evaluate barriers to transforming evidence into practice i.e. models of clinical education	Schools of Physiotherapy and physiotherapy practice providers to develop more extensive and regular collaboration and consultation processes	Research grants to support collaborative research
School staff to work alongside clinical educators to adopt and integrate different models of clinical education		
Recreation of opportunities and forums for education and clinical staff to discuss issues.		

### **Recognising the value of clinical educators and clinical education**

Social hierarchies as discussed in Chapter Seven, were symbolic of hierarchies of different forms of knowledge. Not only were clinical educators identifiable as a distinctive social class, but were ranked lower compared with other physiotherapists. Reconfiguring the value of education knowledge, illuminating the value of this knowledge and embedding it more successfully into phases of socialisation, would to some extent elevate this knowledge within hierarchies and by association, clinical educators. However, formal recognition of clinical educators and their valuable contribution to the profession should also be acknowledged by the profession. For example in 2004, the Chartered Society of Physiotherapy (United Kingdom) in collaboration with higher education institutions, i.e. Schools of Physiotherapy, established Accreditation of Clinical Educators scheme. Designed to “give greater recognition to the important role of the clinical educator” and recognition of the “professional status of qualified CSP members who make a significant contribution to the clinical education of: qualifying physiotherapy students, qualified physiotherapists, assistants, other health professional students, social care students, other learners” (Chartered Society of Physiotherapy, 2004, p. 3). The scheme provides an example of how the value of clinical educators, clinical education and education knowledge can be transformed. Accredited status is described in terms of cultural and symbolic capital, recognised by all higher education institutes in the United Kingdom and therefore, transferable across physiotherapy practice providers. However, no reference is made in terms of economic capital, both as costs incurred by clinical educators and practice providers to either attend the taught course/module or time spent in preparation of the portfolio (profile based route). Although stakeholder motives are explicit in recognising the contribution of clinical educators, of interest is the motive to “raise the quality of physiotherapy clinical education in the UK” (Chartered Society of Physiotherapy,

2004, p. 3). The interests of Schools of Physiotherapy and also the profession are ultimately maintained, given that such schemes aim to improve the quality and standard of clinical education across Schools and nationwide. Although launched by the Chartered Society of Physiotherapy in 2004, only Sellars and Clouder (2011) have evaluated the impact of the Accreditation of Clinical Educators scheme on practice, using a purposive sample of 17 clinical educators in association with one higher education institute. Participants described making positive changes to their practice which extended beyond student education and increased confidence in their ability as clinical educators. However, as advocated by Sellars and Clouder, further research is required to evaluate the impact of accredited status and accreditation on clinical education as perceived by students (considered consumers in this study). Analysis of the uptake of Accreditation of Clinical Educators by clinical educators would also provide useful information, together with barriers to uptake and also the perceived value of the Scheme by clinical educators and stakeholders in clinical education.

Another strategy of increasing the value of clinical educators and clinical education is through the recognition of clinical teaching as a career pathway, alongside academic teaching, clinical expertise, management and research. Although drawn from nursing, Elliott and Wall (2008) questioned whether nurse academics should engage in clinical practice. Acknowledging the absence of evidence to support the benefits or detrimental impact to academics and students, they propose that if there are no perceived benefits to participating in clinical practice or career benefits, individual academics are unlikely to participate. In contrast, Hurst (2010) found that clinicians transitioning to academic roles, perceived their clinical credibility as important. The benefits of academics participating in clinical practice may not only reinforce education across the continuum of learning from Schools to practice, but ensure that subject content is relevant and up to date, and 'real/current' case scenarios are embedded in teaching practice. Similarly, inclusion of clinical educators as experienced clinicians, in practical and theoretical sessions, could promote cohesion across organisations and stakeholders in clinical education, up-to-date clinical content and continuity across places of learning. In essence, vertical hierarchies based on the volume and value of different types of knowledge would become more horizontal, as different forms of knowledge and those who possess and impart such knowledge, are valued more equally. Table 10.9 presents how reconfiguring value systems can influence change.

**Table 10.9 Recognising the value of clinical educators and clinical education: recommendations for change**

<b>Recommendations</b>	<b>Associated stakeholder in clinical education</b>	<b>Government as stakeholder</b>
Relocation and prioritization of resources including time for physiotherapists/clinical educators to attend workshops with specific education competencies and time to facilitate reflective practice	Schools of Physiotherapy and physiotherapy practice providers to make accessible and support attendance at appropriate workshops/courses in clinical education.	Scholarship schemes and funding to support post-graduate qualifications in teaching and learning
Accreditation of clinical educators through access to post-graduate papers in related subject	All stakeholders to work collaboratively to establish accreditation of career pathway	
Recognition of clinical education as a defined career pathway, equitable with paths in management, research or clinical practice.		

## **Evaluating the economic consequences of clinical education**

As described in Chapters Eight and Nine, commoditization of clinical education and the location of clinical learning within the market of healthcare and physiotherapy, has given rise to the raised awareness of the economic consequences of clinical education. This includes a focus on clinical educator time and the productivity of teams/departments with different models of clinical education. Coopers and Lybrand (1994) undertook a cost analysis of healthcare students' clinical training including physiotherapy based in the health boards/crown health enterprises, i.e. public healthcare providers. Significant restructuring and reorganisation of healthcare systems, including technology, and increased student capacity since 1994, indicate that this report is now obsolete. The review also did not take into consideration clinical educator time spent directly with struggling or failing students or indirectly, through liaison with School staff.

Unlike the Coopers and Lybrand's report, Haines et al. (2011) proposed a framework to guide the economic evaluation of decision making in clinical education, acknowledging the complex relationships and interests of stakeholders including students, in clinical education. The framework draws on established concepts such as 'quality adjusted life year' formulae in healthcare cost analysis, to include student outcomes. These include educational quality-adjusted student educated outcomes and quality-adjusted passing students educated outcomes. These two approaches seek to measure the cost analysis taking into consideration two conflicting outcomes: quantity and quality of student placements. Although not conclusive, the framework does emphasise important

factors in evaluating the cost of clinical education to multiple stakeholders and highlights the current economic interest in healthcare delivery. Given the current economic climate of healthcare delivery, it is timely that a further review of the economic benefits and costs of clinical education is undertaken. This should also incorporate an evaluation of whether students are retained as new graduates in district health boards where they have undertaken their clinical training (clinical centres) thereby saving time in orientation, or whether cost savings are only applicable during clinical education. If it is demonstrated that students are retained as graduates, stakeholders such as district health boards may be more conducive to increasing student capacity. Table 10.10 presents how change could be evoked through evaluation of economic consequences of students on services and clinical educator productivity.

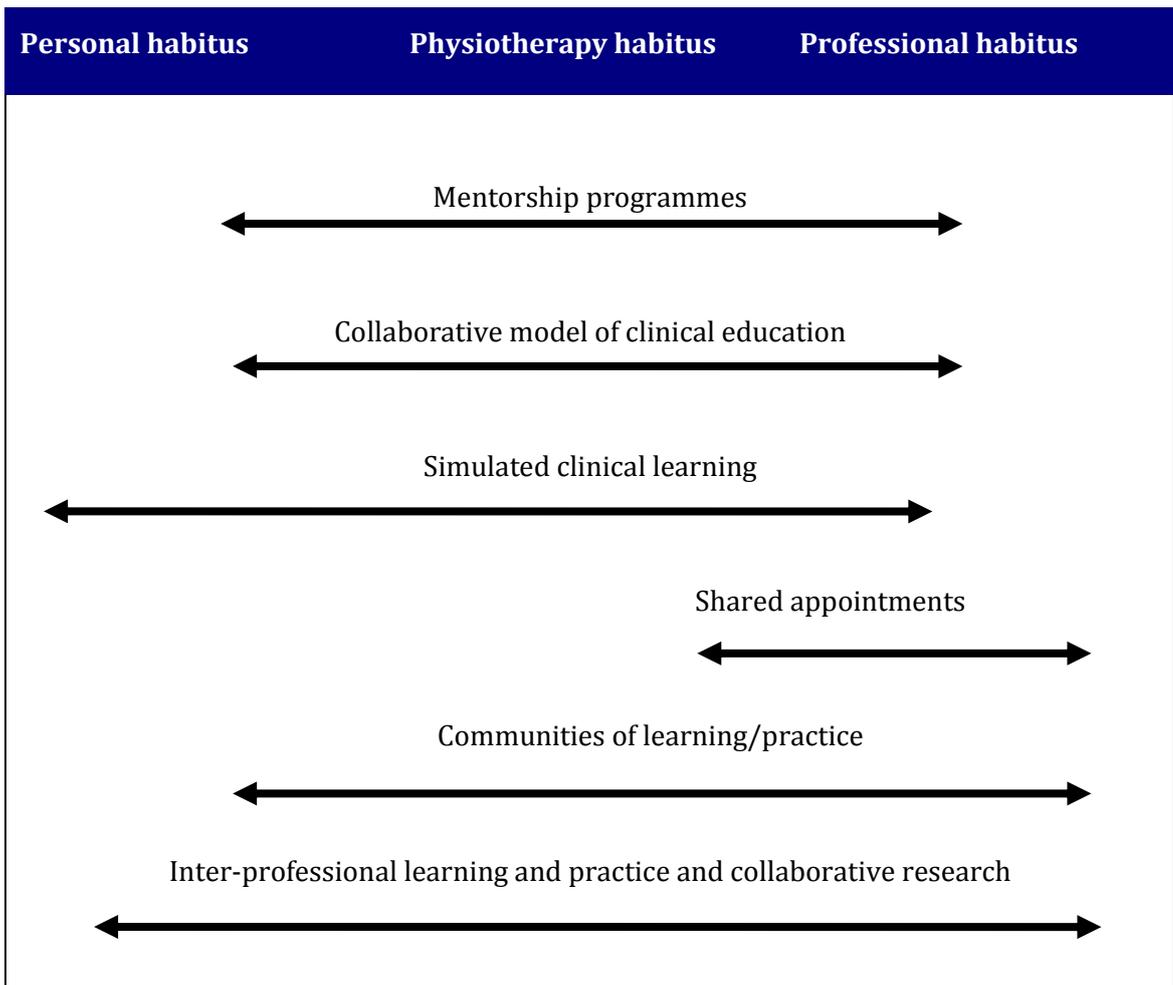
**Table 10.10 Evaluating the economic consequences of clinical education**

<b>Recommendations</b>	<b>Associated stakeholder in clinical education</b>	<b>Government as stakeholder</b>
Evaluation of economic consequences of students in clinical practice	Schools of Physiotherapy and physiotherapy practice providers to undertake collaborative research on the impact of students in clinical practice	Review workforce data collection documentation Review funding of physiotherapy courses to allow for low attrition compared with other undergraduate healthcare programmes
Review of recruitment of students as new graduates in physiotherapy practice/clinical practice providers		Revise funding framework to allow for clinical placement costs
Physiotherapy/Ministry of Health workforce data to include questions relating to students, clinical placements and new graduate employment		

## **Mediating power interplay**

Phases of individual and field habitus formation represent opportunities to influence practice through the reconfiguration of capital. A number of recommendations have been proposed which mediate the disjuncture between ‘clinical’, ‘education’ and ‘research’, and by association staff and organisations responsible for different forms of professional knowledge. Mediating power interplay in clinical education requires a paradigm shift in practice (habitus, capital and field) in all interconnecting fields of education, physiotherapy practice provision and physiotherapy profession. Recommendations fundamentally shift the responsibility away from individual organisations, where siloed learning and traditional practices occurs, towards more collaborative education and practice. By way of example, Figure 10.1 presents the

application of some recommendations described in this Chapter, applicable across phases of socialisation (habitus formation).



**Figure 10.2 Diagrammatic representation of recommendations applied across phases of socialisation (habitus formation)**

Socio-economic and political determinants are currently driving interprofessional learning and collaborative practice (World Health Organisation, 2010) which has shaped undergraduate physiotherapy programmes, but have yet to make a significant impact on physiotherapy practice providers. This is irrespective of data to support the benefits of interprofessional practice in terms of patient management. The implications of this hysteresis effect (time lag between habitus adapting to new field conditions) are discussed in the next section.

### **Implications of change**

Transformation and change are characteristics of the critical paradigm. Understanding the social reality of clinical educators through Bourdieu's concepts revealed how social forces and power imbalances impacted on clinical educators in

physiotherapy. Raising the consciousness of clinical educators (and associated stakeholders in clinical education) to the findings of this research provides a vehicle for change. Proposed recommendations for change have been explored through Bourdieu's concepts of habitus, capital and field, which collectively constitute practice (Bourdieu, 1979/1984). Change to practice such as clinical education requires reconfiguration of capital, and the value and distribution of capital within fields, as determined by habitus. As noted by Bourdieu, three potential outcomes emerge from the adaptation of habitus. When opportunities or constraints are similar to the conditions in which habitus was formed, practices are reproduced and no change occurs. Change occurs when habitus adapts to new field conditions, though a time lag results. However, when discrepancies are significant requiring immediate transformation and habitus adaptation, the potential for "social crisis" exists manifested as "resignation or revolt" (Swartz, 1997, p. 213).

Change and advancement in healthcare and physiotherapy knowledge-bases, technology and consumer expectations can be attributed to projected global shortages of healthcare staff and an ageing population. The pace and extent of change implies current traditions and practices are unsustainable. This includes current models of healthcare and physiotherapy delivery and by association, undergraduate education. Interconnectivity of fields which represent the continuum of learning and practice from student to qualified physiotherapist and clinical educator, i.e. fields of education, physiotherapy practice, physiotherapy profession, with wider fields of healthcare and politics, mean that change is inevitable. A significant responsibility lies with professional bodies and education providers to prepare new graduates for the future so that the hysteresis effect is minimised and 'social crisis' is avoided. Responsibility also lies with physiotherapy practice providers to positively influence the transition of new graduates into the workforce through mentorship and support programmes and active engagement in interprofessional learning and practice which ultimately will enhance the patient experience and improve cost effectiveness of services. As described by Jones (2000), strategies that promote 'reproduction' of practice elicit little or no change; the frustrative outcome aggravates tensions and power interplay as individuals and organisations protect their dominant interests and territorial behaviour is amplified. However, strategies to reconvert and promote habitus adaptation enhance change and project habitus towards opportunities and challenges, including integrated teams focused with a shared interest in the patient.

Within the context of this research, benefits extend to stakeholders in clinical education, and specifically, clinical educators whose position and role bridges different

fields of practice and culture. Maintaining status quo is not an option given the wider socio-economic and political influences that are shaping change and healthcare reform; “simply doing more of the same is not an option” (Health Workforce Advisory Committee, 2003, p. 21). A significant paradigm shift in the culture and practice of the physiotherapy profession across the continuum of learning is required if, as a profession, the profession is to maintain pace with change. The role and value of clinical educators in preparing new graduates for the workforce and workplace cannot be underestimated.

Reconfiguration of capital has been described within a physiotherapy-specific context; however, implications for practice and recommendations for change are applicable to other health related programmes where learning occurs across school and clinical sites. Knowledge and skills of clinical education have applicability across health disciplines and as such, can be taught, practised, and mentored inter-professionally. This is not only in keeping with current trends of inter-professional learning and practice, but could also be marketed as cost-efficient to organisations. Moreover, the patient would become central to the learning experience as a consumer of both health and clinical education. Evaluation from their perspective should therefore, be included of changes to clinical education organisation and processes.

### **Fostering not forcing change**

Recommendations arising from this research and implications of change have been presented based as the reconfiguration of capital and reshaping habitus and field. Embedded in the critical paradigm are values of participation and power sharing (Grant & Giddings, 2002). Findings will therefore be shared with participants through publication and presentation. Sharing of knowledge through relevant forums addresses to some extent, inequality of knowledge between the researcher and others including participants. Findings may be transferred to practice based on clinical educators’ and stakeholders’ ability to evaluate their significance. It is the intention of this research through dissemination of results that change is fostered rather than forced. To impose change would protect interests of dominant stakeholders, when as revealed in this research, clinical educators and stakeholders all have a vested interest in clinical education. All stakeholders can benefit collectively from utilising the opportunities that this research, new knowledge and improved understanding reveals in shaping the practice of clinical education.

## Chapter summary

The importance of shared strategic planning by stakeholders including education and practice providers, and the Board, is essential to minimise the hysteresis effect and tension found to result. Continued collaboration between education and practice providers may ensure that hysteresis is minimised and new graduates enter the workforce with versatility and skills to optimise patient care. Ultimately practitioner efficiency can be translated into economic gain/investment and capacity.

Centralising the patient as the focus for practice may result in a shift towards collaborative research, education and practice. Shared interaction and focus (patient care and physiotherapy practice) contribute to mutualistic relations and the possibilities of altering power relations. As found in this research, lack of authentic collaboration and communication amongst stakeholders negatively impacted on relationships, professional and organisational culture and practices, including power relations.

Whilst acknowledging that social tension and friction are inevitable (Bourdieu, 1972/1977) reconfiguring value including resources such as time, accreditation and status (cultural, symbolic and social capital) may well attract more clinical educators, facilitate different and more productive models of clinical education, and produce a graduate who is more ready for practice, and receptive to clinical education. Ultimately, this may positively impact on the sustainability of the profession and also patient care.

What is clear from the literature and findings of this research is that healthcare and physiotherapy delivery is in a state of constant change, and by association ever changing relationships with other stakeholders including education providers. Given that practices mediate relationships between habitus and capital within fields, and evoke actions towards opportunities to optimise position, self interest and dominance (Swartz, 1997), it is inevitable that stakeholders need to collaborate around a shared interest, so that all action albeit interest orientated (Bourdieu, 1972/1977) is directed towards patient care and sustainability of the profession. Professional or stakeholder inertia and status quo can result in hysteresis before habitus adjusts to new conditions; compromising the value of physiotherapy, physiotherapists and clinical educators in terms of missed opportunities. Individual, professional and organisational trajectory is governed by the ability of those who have effectively acquired the dispositions (habitus) to recognise symbolic capital and take advantage of opportunities, such as, newly created field positions (Hardy, 2008) which result through hysteresis. The importance of time, and in relation to this study, responsiveness to opportunity and change cannot be underestimated. Capital, field conditions and habitus are continually influenced by market value, supply and demand

and consumerism, all of which are intrinsically influenced by socio-economical, political and global influences. To ignore change would be to the detriment of the profession.

## **Personal reflections**

*As I reflected on findings and subsequent recommendations for change, I was reassured by the positive lens Bourdieu has brought to this research. Social tension and friction are inherent in social groups; therefore, attaining a perfect equilibrium is unrealistic and ideological. Proposed recommendations advocate an improved balance to address the power interplay in clinical education and maintain pace with the wider influences driving change. What is clear though is that 'traditional' practices and entrenched culture may inhibit the sustainability and growth of the physiotherapy profession by creating a significant time lag (hysteresis) whereby opportunities may be lost. Graduates, as the next generation of physiotherapists must be prepared to meet the changing demands of healthcare and physiotherapy provision, become flexible and responsive to change and possess business acumen. Similarly, supporting experienced staff to manage change, to cope with technological advances and develop commercial knowledge and skills is essential.*

*The unique position and role of clinical educators in clinical education, bridging fields of education and practice, highlights the multi-dimensional demands on their time, skills and energy. It is understandable why individuals cling to traditions and practices when innovation and change require more energy and time, albeit that time and energy will be saved as a result. Being responsive to change requires time to take notice of where change is required to reflect on deficits that could be improved, and to navigate through the processes of change. I observe staff trying to anchor in the constant sea of change in healthcare; I witness experienced staff leave organisations and even the profession burnt out and disillusioned by the cyclical nature of change. And yet, I see the enthusiasm and energy of new graduates as they enter the workforce, or staff returning to practice eager to contribute. I have come to anticipate and recognise their point of crisis, what I term, their 'professional wobble' usually at 6-8 weeks. I have created time in my day to acknowledge and support staff through this 'wobble', knowing that in giving time, time is taken from my day and increases my own pressures to meet service and clinical demands. To compensate, I stay late at work and enjoy the time free of demands and interruptions. This has become a strategy to achieve a 'work/life' balance or rather a life at work. I am rarely alone after work, with many other senior colleagues at work.*

*Life experience has provided me with the skills to juggle and prioritise multiple demands on my time. Attaining a balance represents knowing how many things to juggle, how you can delegate and working to deadlines. Experience, the slow accumulation of*

*strategy, takes time. Skill acquisition over time as advocated by Benner (1984) has relevance not only to professional competence, but also in managing change, creating a balance that is positive and progressive. Collaborative learning and practice creates the opportunity to minimise boundaries, reducing siloed and territorial practice, and promote integrated patient care and improved productivity. Clinical education already bridges organisations and the transferability of education knowledge and skills extends beyond physiotherapy profession. In theory and in practice, clinical educators already play an essential role in collaboration between stakeholders, consumers and providers; interprofessional education in clinical practice represents an extension of their role and contribution to the profession and organisations.*

## CHAPTER ELEVEN

### Thesis closure rather than conclusion

#### Chapter overview

This final chapter represents the close of the thesis; the purpose of which is to review succinctly what has been undertaken, achieved and learned. Recommendations and ideas for future research are proposed which contribute to further insights into power relations in clinical education, physiotherapy and other practice-based educational programmes. This chapter, therefore, critically examines how thesis and doctoral aims have been met, considers limitations of this thesis, and makes explicit the original contribution of this research to physiotherapy knowledge-base and scholarly communities. A reflexive statement provides an epistemological critique of knowledge construction throughout the research journey. Finally, personal reflections explore this doctoral journey, reviewing how habitus, capital and field have shaped my understanding and practice as a physiotherapist, educator and researcher.

In essence, this chapter signifies the close of this thesis rather than the conclusion of an interest into understanding dimensions of clinical education in physiotherapy. As stated in Chapter One, my personal impetus included a belief that *'things should be better'*; greater understanding generated by this thesis, reaffirms my belief that *'things can be better'*.

#### Achievement of research aims

Framed by a critical paradigm and Bourdieu's methodology, three key research aims were identified. Firstly, the research critically explored the interplay of power in clinical education as perceived by clinical educators in physiotherapy in New Zealand, contextualised by the perceptions of associated stakeholders. This was based on Bourdieu's proviso that power relations are central to social life and groups resulting in tension and conflict (Bourdieu, 1972/1977; Bourdieu & Wacquant, 1992; Grenfell, 2008a; Swartz, 1997). Clinical education and physiotherapy profession were examined to reveal the manifestations of power, and explore the interplay of power and how it shapes and influences clinical educators and clinical education in physiotherapy. The second aim of this research is to critique the applicability and relevance of Bourdieu's theoretical framework as applied to this research. The final aim included examining the implications for practice and the profession, and formulating recommendations for change to enhance the value of clinical education within organisations and also the profession of physiotherapy. How these aims have been achieved will be further discussed.

## **Power interplay in clinical education**

Power relations were found to exist within clinical education and related organisation and professional fields. Clinical educators were identified as a unique social class/group within the profession and were ranked low on social hierarchies, symbolic of different and often competing value systems. This resulted in social inequalities which included withholding of resources in terms of time to attend clinical educator workshops, prepare for students and reflect on their practice as clinical educators.

The value of clinical education was also found to be intrinsically linked to the practical nature of physiotherapy and in particular, the presence of the patient in the learning relationship. Knowledge and skills of education to facilitate student learning compared with discipline specific clinical knowledge and skills, held less value by individuals and organisations including the professional body. Student education was perceived as separate to education principles employed within the patient/physiotherapist relationship. This resulted in the role of clinical education considered 'additional' to clinical roles.

Personal attributes conducive to clinical education including an interest in sharing knowledge with the next generation of physiotherapists, were found to be dominant factors in the self-selection of physiotherapists as clinical educators. Consequently, and to the dismay of academic staff, recruiting clinical educators was challenging which limited growth of student numbers and by association, capacity of Schools of Physiotherapy.

Dominance of discipline-specific propositional knowledge by the profession influenced the location of physiotherapists on social hierarchies, and this was perpetuated by the profession and healthcare organisations expecting practice to be underpinned with evidence, i.e. research, and funding associated with research outputs. This enhanced the disjuncture and resultant tension between theory and practice, academic and clinical staff, and Schools/universities and clinical practice providers. In contrast, physiotherapy practice providers were firmly focused on service provision, cost efficiency and readiness of new graduates to practice. Tension existed between education and service providers when as consumers, their expectations were not met. This impacted on clinical educators whose role encompassed meeting service demands (service providers) and patient needs (consumers), supporting new graduates (increasing their productivity), and providing clinical education (service) to students and patients (consumers).

Different organisation philosophies were found incongruent and contributed to tensions for clinical educators, given their unique position and role in bridging both education and practice organisations. This created a significant challenge for clinical

educators as demonstrated in this research, when, for example, time to meet service needs was prioritised over attendance at annual clinical educator workshops to update knowledge and skills of clinical education, and relevant School processes. In addition, time constraints precluded clinical educators from reflecting on their practice, inherent in physiotherapy practice (Physiotherapy Board of New Zealand, 2009) and essential for professional development. Tension between professional and employer requirements is highlighted. Another example included tension between meeting professional obligations of physiotherapists to participate in clinical education as outlined by the Code of Ethics and Professional Conduct (Physiotherapy Board of New Zealand, 2011b), and having competencies to fulfil that obligation. Educational competencies are described in terms of 'physiotherapy practice' and specifically the patient/client learning relationship (Physiotherapy Board of New Zealand, 2009); the absence of the student learning relationship is noteworthy. This reinforces the perception that clinical education is an additional role which holds limited value compared with clinical skills as applied to patients.

Economic interests were inherently linked to maintaining dominant interests and trajectory towards opportunities that would further enhance economic gain. Cost efficiency of services to growing population needs and reduced healthcare funding was found to be a dominant focus of physiotherapy and healthcare providers. In comparison, Schools of Physiotherapy foci included income generation through research and Tertiary Education Commission funding and increasing student capacity. Clinical educators, whose role bridged both education and physiotherapy practice provision, were subjected to tensions and power interplay between different and competing organisation philosophies and dominant interests. Clinical educators were found to develop strategies within their sphere of control, for example, manipulating waiting lists, in an attempt to attain a balance in meeting student and service needs. Strategies however, were tested in the presence of the struggling student who required more time, which distracted from team and service provision and heightened tensions for clinical educators.

Many assumptions were found to exist arising from the absence of clear communication, authentic collaboration, trust and a transparent and shared vision between stakeholders including organisations and the profession. Education and physiotherapy practice provider motives appeared ego-centric, disjointed and slow to respond to change; the time lag for changes to be implemented was a significant source of tension for clinical educators and associated stakeholders.

## **Critique of the applicability and relevance of Bourdieu's theoretical framework to this research**

The second research aim was to critique the applicability and relevance of Bourdieu's theoretical framework as applied to this research. Clearly, power dynamics, relations and interplay were revealed in the 'practice' of clinical education supporting the applicability of Bourdieu's framework to this research both in terms of method and interpretation of data.

Key concepts of habitus, capital and field, have been effectively utilised to examine value systems which shaped the practice and culture of clinical educators, organisations and the physiotherapy profession. Analysis using habitus provided valuable insights into how clinical educators were shaped through periods of socialisation. This revealed areas of tension, and identified potential opportunities to positively influence individuals and organisations. Socio-economic, historical and political influences were revealed as influencing field habitus and the configuration of capital. This impacted on relationships, motives and actions of individuals and organisations. For example, relocation of Schools of Physiotherapy into universities increased symbolic power, yet created a gap (spatial distance in Bourdieusian terms represents a source of tension) between where different types of physiotherapy knowledge and skills were taught. The importance of economic capital in influencing relationships and determining the exchangeability for cultural capital also provided an important insight into power interplay. This was particularly relevant given current economic climate impacting on organisations including Schools of Physiotherapy, the ability of the profession to meet projected shortfalls in physiotherapists, and the growing consumer demands for healthcare.

Theories relating to symbolic power and violence, together with supporting concepts, successfully revealed how resources were allocated or withheld. This influenced clinical educators directly, i.e. time to attend workshops, and indirectly, when they relied on personal attributes and an interest in student learning, rather than explicit education knowledge and skills. Socio-economic and political factors that perpetuated symbolic power of organisations, for example, were successfully revealed, together with how such power was imposed, overtly or covertly.

Bourdieu's theories as demonstrated in this research successfully and effectively reveal and provide an effective framework to examine the interplay of power in clinical education. Moreover, his theories provide a platform from which to further examine aspects of clinical education, professional and organisational cultures. Recommendations arising from this research equate to influencing phases of socialisation (habitus),

reconfiguring resources including education knowledge and skills (capital), and expectations and facilities of organisations and the profession (field habitus).

### **Enhancing the value of New Zealand clinical educators and clinical education in physiotherapy**

The projected global shortage of healthcare workers, including physiotherapists, has increased the value of each generation of physiotherapists. The role and contribution of clinical educators cannot be underestimated. Opportunities for change are created through the reconfiguration of capital and its value and distribution as determined by organisational and professional field habitus.

Examination of how individual and organisational field habitus are shaped provides opportunities to enhance the value of clinical educators and clinical education across the continuum of physiotherapy practice. Selection processes should include the ability to assess for ideology and attitudes conducive to education (personal habitus), making education knowledge and skills more visible and valued within curricula (physiotherapy habitus) and promotion of mentoring programmes between physiotherapy students and potentially across health professions. Similarly, redefining the value and transferability of education knowledge and skills from different dimensions of physiotherapy practice, i.e. patients and student education, and within the profession through creation of accredited programmes and career structures, would recognise the contribution of clinical educators in preparing the next generation of physiotherapists.

The economic value of clinical education as a commodity was shaped by an outdated evaluation by Coopers and Lybrand (1994) into 'clinical training' in New Zealand. Significant restructuring and organisation of education and physiotherapy practice provision and healthcare delivery has since occurred. An economic evaluation of clinical education and indeed funding for Schools of Physiotherapy compared with other healthcare and undergraduate courses would provide an accurate reflection of the costs incurred and generated from clinical education. Transfer of funding between stakeholders could be negotiated and as suggested by clinical educators, supplemented with access to courses/library facilities. This would enable clinical educators to enhance their professional development in 'exchange' for services of clinical education.

Healthcare expansion due to demand, technology and consumer expectation has fundamentally altered the expectations of physiotherapy practice providers. Graduate readiness for work corresponds with productivity, the ability to problem solve and work in ever-changing dynamic and demanding environments. Reviewing the content and mode of delivery of curricula and how Board approved physiotherapy competencies are

met, would impact on the 'end product', i.e. new graduate, who has not only discipline-specific skills but also skills to meet the challenges of the healthcare climate. Although both Schools of Physiotherapy have integrated interprofessional learning into undergraduate programmes, little evidence was provided by physiotherapy practice providers, that shared learning and practice has occurred. Traditional models of clinical education (1:1 student/supervisor) reinforced siloed learning with the exception of university based clinics where students worked together. This limits the opportunity for students as peers to learn together or across professions, and equates to cost inefficiencies when many of the generic knowledge and skills are reproduced by clinical educators of different professions. The poor uptake of different models of clinical education indicates a disjuncture between research and practice, and that current clinical educator workshops are insufficient in transitioning change. If capacity of students and Schools are to grow, significant investment is required to enhance this transition towards different models of clinical education, and meeting ethical requirements of engaging with student learning, whilst concurrently raising the value of clinical educators within organisations and also the profession. From the perspective of physiotherapy practice providers, resource allocation including time is required to consolidate knowledge and skills of clinical education, and enable reflective practice to occur. A multi-stakeholder approach is required combined by a shared commitment and vision towards clinical education if the value of clinical educators is to be enhanced across the continuum of learning and practice.

## **Critical review**

### **Main findings**

This research set out to explore power interplay in New Zealand clinical education. Interpretations were made based on data collection which occurred between 2007 and 2009. Bourdieu acknowledges the dynamism of social worlds and practices, as field boundaries are constantly contested, capital reconfigured and habitus shaped. This thesis, therefore, is located in a specific timeframe, in which processes, socio-economic, political and professional influences shaped habitus, capital and field. Furthermore, several participants including stakeholders have since changed roles; others have resigned or moved locations. As demonstrated in this research, team/organisation/profession culture and practice was strongly influenced by individuals through their ideologies and hierarchical positions. Changes in personnel, hierarchies, and structure and processes of clinical education delivery alter the dynamics and interplay of power. This infers that conclusions whilst insightful may not be directly transposed to other time periods without due caution, and recommendations proposed may already be the focus of change. By way

of example, a new curriculum has been implemented by one School of Physiotherapy in New Zealand which includes improved focus on community health and health promotion.

Bourdieu's theories (practice, culture, symbolic power and violence) and methodology as applied to this research revealed that power relations existed within clinical education. Moreover, power interplay resulted from competing value systems which created hierarchies and territories, strategies to protect dominant positions and resources, and in some instances, withholding of resources. Power dynamics were exposed as symbolic of dichotomous values, i.e. commercial versus vocational influences, consumer and provider interests, professional obligation and additional role. Therefore, within the context of this study, Bourdieu's theories and methodology have relevance and value. Application to this research however was undertaken with caution given that his theories and concepts in particular relating to education were based on French culture, class and university systems which are not directly comparable to New Zealand. As noted in Chapter Three, Bourdieu has been accused of extrapolating from French society directly to other countries and cultures (Miller, 2003) yet his conceptual and methodological principles provide a useful framework to make sense of relationships between social structures and everyday practices.

By way of example, Bourdieu describes universities as fields of cultural production, class inequality and symbolic power. Entry to universities is accessible to a wide group of students, compared with traditional French universities of the time. Swartz (1997) argued that:

*It is no longer clear that the traditional importance Bourdieu assigns to the academy and its specialized cultural markets in shaping the agenda for symbolic struggle between classes continues to play the role that it once did in France or in other countries. (p. 231)*

He goes on to cite the influence of electronic media on Parisian intellectuals. Specific to this research however, is how practice-based courses such as physiotherapy within universities, technology, and consumerism have influenced the configuration of capital and altered intellectual and academic field habitus. Bourdieu's methodology and concepts are critically reviewed in the next section.

A final contribution of this research into understanding the interplay of power in clinical education is the identification of opportunities to enhance the value of clinical educators and clinical education in physiotherapy, stakeholder relationships and the capabilities of the next generation to contribute to the workforce, clinical education and the profession. Whilst specific to New Zealand, findings and recommendations have wider

relevance, including organisations as learning communities, and practice-based educational programmes and professions.

### **Methodology and method**

The critical paradigm and Bourdieu's theories of practice and culture provided an appropriate framework to examine clinical education in physiotherapy. The emancipatory intention of critical paradigm was balanced with Bourdieu's positive perspective that tension and conflict naturally exist in social worlds. This combination provided a scaffolding to understand power between individuals, groups and organisations, and importantly, to propose changes to enhance relations and specifically improve the position of clinical educators in the field of clinical education. Using research to identify change and empower clinical educators provides opportunities to build positively towards a combined field of physiotherapy education and practice, whilst acknowledging that tensions are inevitable.

Bourdieu's methodological framework as applied to this research utilised his key concepts (field, capital and habitus) and theories to reveal power interplay in the social worlds of clinical educators. The complexities and evolution of Bourdieu's thinking and those of his supporters and critics challenged the manner in which concepts and theories were applied to this research. By way of example, habitus and field emerged as dominant Bourdieusian principles. Throughout Bourdieu's work, habitus and field as concepts evolved, and also, their respective relationship to each other. Field as another core concept emerged relatively late (Grenfell, 2008d), described as a social setting in which habitus operates (Bourdieu, 1985, 1980/1990, 1972/1977). Another dimension of field interpretation is provided by Thomson (2008). Described as existing "in four semi-autonomous levels: the field of power, the broad field under consideration, the specific field, and social agents in the field as a field in themselves" (p. 79). The dynamism of field interconnectivity and complication of field boundary blurring, resulted in scholastic issues as to where the "methodological border" ends and "how to find out where the field effects stop" (Thomson, 2008, p. 78). With improved knowledge and understanding of Bourdieusian principles, field analysis in relation to this research was congruent with Thomson's interpretation of field.

Capital as a concept, irrespective of its type, is also worthy of critical review. Value and distribution are dependent on socio-economical and political influences, located in a specific era (Bourdieu, 1972/1977, 1986). In relation to this research, data collection took place between 2007 and 2009, the value of, for example, clinical education as cultural

capital was therefore determined by time-specific influences such as scarcity of placements.

Habitus, as another example, highlights the evolution of Bourdieu's thinking and interpretation by his critics. Described initially as durable (Bourdieu, 1980/1990) deeply internalised dispositions and attitudes are formed primarily through early socialisation experiences. This contrasts with further descriptors whereby habitus is recognised as being capable of adaptation (Maton, 2008), for example, under certain conditions which evoke hysteresis such as field restructuring. Specific to this research, participants, where purposively selected for their unique habitus and position with specific fields, for several participants, dual roles were held and in some instances, roles changed. This may have impacted on the volume and value of different types of capital held and influenced the way stakeholders engaged in practices including clinical education.

Purposive sampling identifies participants based on specific characteristics to facilitate comparison (Patton, 1990); however, participants selected may not be typical of the group under scrutiny, and important views may be omitted. In attempting to gain representation from variables which I believed would enhance the depth and diversity of data, such as, clinical speciality, years of experience as a clinical educator, role relative to clinical educators, extensive data were collected. Indeed Phase II interviews whilst valuable for triangulation purposes to improve clarity and detail, did not reveal any new themes.

Influences that shaped individual habitus are recognised as unique; homogenous characteristics were identified which distinguished clinical educators as a social class; individual habitus were not fully explored. It was not the intention of this research to understand tensions and power interplay specific to individual clinical educators, but to generate an understanding of power interplay through the perceptions of clinical educators in physiotherapy. Transferability of findings may occur across specialities, locations, disciplines based only on the ability of clinical educators to evaluate the significance of findings to their lives/practices.

Stakeholders were also purposively selected for their role and relationship relative to clinical educators. However, notwithstanding the array of positions represented, as many stakeholders held dual positions within physiotherapy it was unclear at times which perspective they spoke from which may have influenced how the data were interpreted. Based on small numbers of each group, e.g. professional leaders, generalisations cannot be formally made. The reader nevertheless is introduced to a different perspective which helps to contextualise clinical educators, their practices and perceptions.

A further limitation is the omission of patients as key stakeholders in this research. Their position as consumers and providers of clinical education would have provided a unique and valuable perspective. Whereas previous literature has described a tripartite relationship between academic staff/clinical educator and student (Jones et al., 1998), the relationship should be redefined to include patients based on their significant contribution to learning relationship and experience. The absence of patients as stakeholders in this research is recognised as both a limitation and an area of future research. Research into the perspectives of patients as stakeholders of clinical education both in public and private practice settings is worthy of examination. Of particular interest, is the application of Bourdieu's concepts of symbolic power and violence to explore the position of patients relative to clinical education in physiotherapy, and other health disciplines.

It is important to review the method employed. Consensus agreement from informal discussions with peers and stakeholders (colleagues excluded from the study) prior to consideration of the method, indicated a preference for semi-structured interviews, with the option of face-to-face or telephone interviews. This was confirmed by participant selection on the return of consent forms. Primary barriers to focus groups included time, limitation due to geographical location and selective access by those who had access to or were unfamiliar with teleconferencing technology. To negate these potential barriers, participants were asked to indicate a preference in the letter of invitation to participate in the study; options included face-to-face or telephone interview, participation in a focus group or no preference. Even though important data were collected through semi-structured interviews, the value of focus groups for specific participant groups remains unclear. Dialogue generated within a group setting may have revealed a greater understanding of the complexities of different viewpoints however, given that this research explores power relations in clinical education, focus groups could also have reproduced power dynamics thereby limiting voices and perceptions. One-to-one interviews allowed participants an individual voice, promoting an open and transparent dialogue, uninterrupted or dominated by others.

A paucity of literature in clinical education in physiotherapy resulted in findings being extrapolated from other countries and practice based health professions. Although useful to provide different perspectives, influences that have shaped habitus and field and configured capital, infer that such perspectives are interpreted and used within this research with caution. Similarly, findings and recommendations of this research are specific to New Zealand, through the analysis of influences that have shaped physiotherapy, stakeholder relationships and the organisation of education and

physiotherapy practice provision. Findings should therefore, be extrapolated with similar care.

### **Researcher's position and reflexive stance**

In any research, there is inevitability that aspects of the research could be improved; critical review enhances transparency of the research process and content, and insightfulness of the researcher. This section illustrates areas of development.

Patton (2002) cautioned that omission and/or commission can result in error or bias; no research is beyond critique. Within qualitative research, underlying epistemological and ontological assumptions on which research is based recognise the position of the researcher to the subject and participants under investigation, and the unavoidable bias brought by the researcher to data collection and analysis. Unconscious errors may result from researcher choice, for example, in selecting participants as a purposive sample.

Embedded in Bourdieu's work is reflexivity as a methodological concept which allows researchers to consciously and critically objectify their position relative to the research. Three principles forms of bias are acknowledged: the researcher's position in social space, *skholè* i.e. researcher's free time and interest, and the orthodoxies of the field itself (Bourdieu, 2000; Grenfell, 2008d). The same Bourdieusian principles applied to this research are utilised to examine the assumptions and knowledge I brought as a researcher to the 'field' of clinical education and also to make transparent how new knowledge was constructed.

My position within the social space and field of clinical education changed during the evolution of this research, and with it, my knowledge and understanding of the world of clinical educators. Initially, my epistemological stance was formed from my education and training as a physiotherapist, and subsequent experience as a senior physiotherapist. As an experienced physiotherapist, the expectation existed that clinical education was integral to the role of senior physiotherapists, documented in job descriptions and advocated as a responsibility by the registration body. This 'tradition' of clinical education was reproduced through *doxa*, i.e. what is taken for granted/natural beliefs that link field and habitus. Irrespective of which hospital or country I worked in, a similar field configuration existed in which the field of clinical education interconnected with other fields i.e. university, organisation, and profession. My individual habitus adjusted to field conditions by becoming a clinical educator; field conditions were therefore perpetuated and reproduced. I was 'inside being in' and therefore naive to the dominant interests of

other individuals/organisations and their role in creating the field conditions that I submitted to.

With further experience and in particular, changes to my role initially as supervisor to new clinical educators I became more aware of the complexities of clinical education. Unknowingly, I developed strategies, generated by the interaction between constraints and opportunities to develop a balance between what I valued and what was valued by the field in which I was located. I recognised how opportunities for new clinical educators to become socialised to their role were important, and attendance at workshops provided networking and support opportunities (social capital) as well as knowledge and skills (cultural capital). As team leader, this was an investment of time (economic capital) on the part of confidence/competence of new clinical educators and productivity.

A subsequent change in role removed me from direct student and clinical educator responsibility. My position changed to being 'outside looking in' and afforded me a bandstand view of the multiple demands on clinical educators and revealed the influences of stakeholders. From an ontological perspective, I began to understand how social reality was viewed and constructed. The interest and time to understand the intricacies and motivation to improve tensions and conflict for clinical educators was further enhanced through my doctoral studies and conversations with peers. Choice of the critical paradigm reflected my intention to elicit change; knowledge of the subject area revealed tensions and conflict worthy of examination.

As a researcher, I was in a privileged position (*skholè*) to pursue new knowledge and understanding of the social world of clinical educators. Knowledge of the field of clinical education and position of clinical educators was further enhanced by reviews of literature related to physiotherapy and other health related disciplines. Concurrently, knowledge and understanding of Bourdieu's theories and concepts also matured through reading of his works, and those of his supporters/critics. Confidence with interviews also grew culminating in a deeper appreciation of methodology, method and interpretation. Phases of analysis were guided by Bourdieusian principles, and revisited constantly throughout the evolution of the thesis. Supervisors and doctoral peers regularly challenged my knowledge and understanding both of the subject area and also Bourdieusian principles used to guide interpretation of literature and participant conversations. My reflexive stance therefore included strategies which represented a "common and shared effort, aiming at making explicit the "unthought" categories, perceptions, theories and structures that underpin any pre-reflexive grasp of the social world" (Deer, 2008, p. 202).

Reciprocity and power sharing underpin the critical paradigm (Grant & Giddings, 2002). New knowledge formed from this research as cultural capital, creates an imbalance between what is known by clinical educators and what is now understood through findings of this research. To redress this imbalance, research findings will be disseminated in appropriate forums, creating opportunities for participants, clinical educators and stakeholders in clinical education to reconfigure this knowledge as capital.

## **Originality and research contribution**

Clinical educator and stakeholder perceptions are evident in literature pertaining to the implementation of different models of clinical education (Baldry Currens, 2003; Baldry Currens & Bithell, 2003; DeClute & Ladyshevsky, 1993; Ladyshevsky, 1993; Moore et al., 2003); perceptions of the ideal clinical educator (Cross, 2005), and perceptions of learning and teaching in clinical education (Kell & Jones, 2007). A further body of evidence in the literature examines the economic consequences of clinical education (Bristow & Hagler, 1997; Cebulski & Sojkowski, 1988; Haines et al., 2011; Holland, 1997; Ladyshevsky et al., 1998; Leiken, 1983; Leiken et al, 1983; Lopopolo, 1984; O'Sullivan et al., 2007). Only one study explores the lived experience of five Australian clinical educators, albeit in speech and language therapy (Higgs & McAllister, 2005); this infers that within physiotherapy, little is known about being a clinical educator and power interplay in clinical education, as perceived from their distinctive position. This thesis, therefore, offers an original contribution to the understanding of clinical educators, clinical education and the interplay of power.

The absence of research by physiotherapists (not employed with Schools of Physiotherapists) and clinical educators is noteworthy, and, therefore, this research is unique. In defending intellectual freedom advocated by Bourdieu, critical inquiry is described as “a historically achieved value that can be preserved and enhanced only by struggling to free intellectual life from all economic and political constraints” (Swartz, 1997, p. 249). In aspiring to achieve intellectual freedom and unbiased interpretation of the data, strategies for researcher objectification as proposed by Bourdieu were adopted and enhanced by peer and supervisor critique.

In contrast with quantitative research which dominates physiotherapy literature, the value and contribution of qualitative research to the profession is growing (Gibson & Martin, 2003). Unfortunately, philosophical and theoretical perspectives are commonly absent, which distracts from the quality of the research within wider professional and scholarly communities. The theoretical paradigm together with the choice of philosopher to underpin this research is justified. Within the physiotherapy context, Bourdieu's key

concepts have been used to explore movement in Nepalese women (Barlindhaug, Emaus, & Foss, 2012) and the perspectives of youth/men with muscular dystrophy (Gibson, Zitzelsberger, & McKeever, 2009; Gibson, Young, Upshur, & McKeever, 2007); however, to date, no published literature relating to clinical education in physiotherapy has utilised Bourdieu's theoretical framework,

A further quality is that this research is specific to New Zealand. Unlike other research which focused on one School or region, this research drew from around New Zealand with representation from both Schools of Physiotherapy, professional associations, different geographical and service locations, and private and public physiotherapy services. Findings, therefore, are relevant nationally rather than limited to one School or locality.

### **Future research directions**

This research has examined the interplay of power in clinical education in physiotherapy. Through increased understanding of power relations, learning, organisational and professional cultures and tension management, further research is warranted.

Patient perceptions of their role and relationship in clinical education are invaluable, given that this research identified patients as key yet invisible stakeholders in clinical education. As consumers and providers of clinical experiences, their views would add a valuable dimension to the clinical education knowledge-base. Of particular interest, is how power interplay influences their consent to be treated by students, ability to withdraw consent, and satisfaction as consumers with the processes supporting clinical education. Given the elevated position of patients within consumer and healthcare hierarchies (symbolic capital and power) and as stakeholders in clinical education and physiotherapy/healthcare services, their voices and expectations are essential and should be integral to any ongoing research in clinical education.

The research drew on the only published cost analysis of clinical training to then crown health enterprises undertaken by Coopers and Lybrand (1994). Since then significant re-structuring of health and physiotherapy services has taken place, along with clinical education delivery, student numbers and placement locations. A timely economical review would provide more comprehensive data specific to New Zealand. Opportunity to view the economic consequences of clinical education could utilise recent frameworks proposed by Haines et al. (2011) which could be evaluated to ensure sensitivity to New Zealand context and organisation of clinical education. Benefits of cost

analysis includes identifying more efficient approaches to providing clinical education including interprofessional learning and practice, marketing clinical education to managers, and providing transparent data to all stakeholders including consumers and providers. An independent or collaborative review would ensure a balanced and trustworthy outcome is obtained, whereby dominant field motives have not influenced the analysis or recommendations. Clinical education after all, is a collaborative process, whereby all stakeholders have a vested and economical stake.

Findings indicated that habitus can be transformed through socialisation periods including workshops and role modelling. Of the limited literature available regarding the education needs of clinical educators, many assumptions are made and needs are met by Schools of Physiotherapy based on what clinical educators are perceived to need (Cross, 1992). Habitus transformation, as a complex process warrants further understanding in order to more successfully embed education and clinical education within the practice and culture of physiotherapists and physiotherapy. Given the evidence provided in this research of distinctive socialisation periods of habitus formation, an on-going evaluative process of identifying the needs of clinical educators, implementing a programme addressing those needs, and evaluating the outcome is required. Since courses and/or workshops do not always meet educational needs, programmes that echo education and learning strategies including mentorship, should be evaluated. This has particular relevance given the move towards doctoral programmes in physiotherapy and the potential hysteresis effect previously described in Chapter Seven.

Finally, as there is often little effective communication and consultation between producers of research and end-users (Pang et al., 2003), recommendations for future research include examining the barriers to implementing research and improving practice. Of relevance to clinical education are bodies of research which demonstrate the effectiveness of different models of clinical education and cost benefits of students. Findings of this research indicate that clinical educators continue to adopt the 1:1 model of clinical educator:student, and perceive that students negatively impact on of clinical educator productivity and waiting lists. For this research to positively impact on clinical education and stakeholders in clinical education, further research is warranted to explore how evidence can become evidence-based practice, and continually reappraised and transformed.

## **Closing words**

The research set out to examine the interplay of power as perceived by clinical educators and contextualised by stakeholders in clinical education and to contribute to the

literature on clinical education in physiotherapy. The research has shown that through gaining clinical educators' in-depth perceptions, a number of recommendations can be made to build on relationships, resources and clinical education within physiotherapy. Furthermore, the research has shown that a significant paradigm shift is required to realign education and physiotherapy practice providers in their practice and culture.

There is clear scope to evaluate initiatives such as clinical centres and joint appointments to elucidate their impact on power relations; Bourdieu's theories of practice, culture, symbolic power and violence provide a useful framework for analysis. Additionally there is scope to undertake a cost analysis of students on placement, updating previous analysis (Coopers & Lybrand, 1994) and providing contemporary evidence of the value added benefits of students and realistic impact on productivity on physiotherapy services. Finally, embedding and valuing education knowledge and skills in curriculum, organisations and the profession, promoting their transferability to patients and peers, will increase the value of clinical educators and their contribution to the profession and the next generation of physiotherapists. In today's world of fiscal constraints, evidence based practice and projected workforce shortages, responsibility lies with the profession and its stakeholders, to generate its own evidence to evaluate aspects of clinical education in physiotherapy. The unique culture and organisation of physiotherapy in New Zealand, requires that New Zealand specific research is undertaken. This research represents one step of this journey.

*"Every journey starts with one step"*

Chinese proverb

## **Personal reflections**

*This doctoral journey has been an adventure; it signifies a personal and professional milestone. It has provided the opportunity to explore two key areas of interest (and tension) 'clinical' and 'education' which have challenged me since I qualified as a physiotherapist and also became a clinical educator.*

*I remember the delight of School staff when I offered to take students, and use the 2:1 model of clinical education. I enjoyed the challenge, the learning partnership with students, and the connection with the School of Physiotherapy. Having students was fun and rewarding; it was not without its challenges. Time was continually contested with competing demands from peers, managers, patients. Time management skills were perfected and moments to reflect were precious. Even the most challenging students prompted me to learn, to reflect and in some instances, to seek support of School staff. In hindsight however, I*

*recognise that I relied on my personal attributes and interest in learning (habitus); education frameworks would have been useful and perhaps, made me a better clinical educator. Clinical educator workshops made explicit School expectations of me and the students' learning experiences, introduced me to assessment processes (and the student's right to appeal), learning styles and levels of support. How these workshops informed my practice as a clinical educator remains unknown. It was only when I completed a post-graduate qualification in academic practice, that I began to understand 'education' and how to facilitate learning. It helped to dispel many of the traditional ideology and methods I held and introduced me to a different way of thinking about learning. I saw the benefits of pedagogy beyond clinical education; it had relevance and transferability to patients and colleagues that I worked with. Even now, working with patients and staff from diverse cultures, I have used pedagogical principles to underpin my practice. For example, in empowering patients to manage their chronic respiratory diseases, I have developed educational resources to appeal to a large number of visual learners which include pictures of the lungs. For the patient who was an engineer (a theoretical learner) I developed flow diagrams and I used mind mapping concepts with the patient who was an artist. I have also simplified what I aim to achieve within sessions with patients – identifying three key aims, and repeating the same message several times, using different language and finally, at the end of the session, asking the patient to clarify their understanding of their management/action plan.*

*I have also used pedagogy in my role as a team leader, when staff conflict revealed itself through contrasting learning and communication styles. In one specific scenario, I asked two team members to complete a learning style questionnaire to identify their dominant learning styles as it was obvious to me that both staff possessed contrasting (to an extreme level) learning styles – activist and reflector. This helped to identify how their tensions and frustrations manifested, and also with this new information, how effective strategies could be negotiated. Pedagogy, therefore, in my opinion, does not exist in isolation; but has relevance and value in every facet of physiotherapy practice: management, clinical practice, and educating peers, new staff, other members of the multi-disciplinary team or the public.*

*To elicit change from the reality revealed by the participants of this research would require pedagogy to be reconfigured as capital within fields. To bridge disjuncture between different forms of knowledge and social hierarchies, a significant paradigm shift is required to value pedagogy within the profession, practice and education. However field influences are prompting change. Health promotion, interprofessional education and collaborative*

*practice, the increasing role of the consumer, are providing a catalyst for change. My hope is that the profession, and education and practice providers are responsive and embrace this change promptly and do not miss the opportunity to adjust habitus to these new field conditions.*

*Other significant global influences include the projected shortage of healthcare workers. This means that the value of students, as the future workforce, will increase as demand increases. Changing the attitude and culture towards students is essential. The responsibility for students and new graduates lies with many stakeholders, all of whom have a vested interest. That interest extends beyond economics and payment for the services of clinical educators, but represents a greater commitment in the profession and to clinical educators, whose roles are pivotal to student learning, professional socialisation and registration.*

*A recently overheard conversation from a physiotherapist (two years qualified) echoed many conversations previously heard throughout my years of experience: 'the students are coming next week' – these words are not said with enthusiasm. The 'unsaid' is that by their very presence, students create more work, take precious time away from patient contact or from new graduate learning, and challenge the thinking and practice of physiotherapists. This suggests that the culture of some teams and organisations albeit district health boards or private practices, is far from conducive to collaborative learning and practice. Indeed, working recently with a new 'clinical educator' and unpacking some of her frustrations revealed a tension between the expectations of herself to teach the student as opposed to facilitate the student's learning. We were able to discuss some simple strategies to shift her thinking away from traditional methods of 'teaching' and towards contemporary (and new to her) techniques of facilitating learning that could be applied both to students and also her patients. The sense of relief was evident when these changes were translated into time saving strategies. Just as important, she grasped the shared responsibility of the student in the learning partnership. Of interest was that this physiotherapist was qualified for approximately five years and was not only beginning to work with students for the first time, but also held some deeply embedded ideology about clinical education. How was her habitus shaped, and through which phase of socialisation? How can her habitus be positively influenced so that her current attitude and practice is not reproduced by staff (and students) with whom she works.*

*In my opinion, each phase of habitus formation (socialisation) represents an opportunity for individual, organisational and professional habitus to be positively influenced towards clinical education. From recruitment to undergraduate physiotherapy*

*programmes and time as a student, to beginning physiotherapy practitioner and on to experienced physiotherapist, there are multiple opportunities across the continuum for change. No one phase of socialisation or one stakeholder will elicit sufficient change. The responsibility lies with all stakeholders. It is hoped that this thesis, through revealing the power interplay in clinical education, can assist stakeholders in understanding not only tensions within relationships, but also identifying strategies to move forward, together.*

*Understanding how clinical education can be better remains of great interest to me. Through this research, I now know that clinical education must be better to meet future needs of the profession, workforce and patient care.*

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## APPENDICES

## Appendix A Glossary of Bourdieusian terms used in this research

Term	Definition	Source
Agency	Processes through which individuals and groups contribute to the reproduction of social structures which affect their life chances through actions and choices made.	Bourdieu (1972/1977)
Bureaucratic capital	Exists in two forms: one represents knowledge of staff for example, which is accumulated over time. The other form represents knowledge of the processes/policy that can be gained quickly.	Bourdieu (2005)
Capital	Capital represents a form of power influencing the position of individuals and groups in social space dependent on the composition and value of capital as determined by that group or field.	Bourdieu (1986, 1980/1990)
Cultural capital	A form of value associated with culturally accepted values, which shapes interactions through inclusion and exclusion from groups and underpins social/class inequality.	Bourdieu (1986)
Differentiation	Location of individuals/groups in fields or social spaces based on the type and volume of capital possessed.	Bourdieu (1994/1998)
Distinction	Describes how social space determines how different individuals or groups are placed within the space or field. Spatial distances between individuals/groups results in tension.	Bourdieu (1994/1998)
Doxa	Is characterised by a taken for grantedness which is accepted as inherently true. For example, expectations, behaviours and ideology are defined by doxa as necessary to obtain and maintain a place in the field.	Bourdieu (1972/1977)
Economic capital	Direct or indirect financial wealth which holds economic value and the ability to dominate production. For example, wealth, income and property. All other forms of capital represent disguised forms of economic capital i.e. time.	Bourdieu (1986)
Field	Field constitute a social world and represent a social setting or space in which habitus operates. They represent arenas of struggle for valued resources (capital) and positions of dominance.	Bourdieu (1985, 1980/1990; 1972/1977)
Field of power	"The relations of force that obtain between the social positions which guarantee their occupants a quantum of social force, or of capital, such that they are able to enter into the struggles over the monopoly of power, of which struggles over the definition of the legitimate form of power are a crucial dimension".	Bourdieu (1992, p. 229-230 cited by Swartz, 1997, p. 136)

Habitus	A concept in which individuals and groups become themselves through a system of deeply internalised dispositions, formed over periods of socialisation and transposable across a number of fields.	Bourdieu (1980/1990) Bourdieu & Wacquant (1992)
Illusio	A specific interest, acceptance or “tacit recognition of the value of the stakes of the game and as practical mastery of its rules”.	Bourdieu and Wacquant (1992, p. 117)
Interest	Concept conceived as an instrument for individuals and groups to make calculated choices or actions to maximize profit.	Bourdieu (1980/1990) Bourdieu & Wacquant, 1992)
Linguistic capital	Language specific to groups, recognised as unique and used to reproduce social relations and hierarchies.	Bourdieu & Passeron (1970/1977)
Meta capital	Exists in the form of accumulated capital which reinforces the position of dominance without the complicity of others.	Bourdieu & Wacquant (1992)
Misrecognition	Represents a form of social conditioning of agents within fields. Agents accept without question or challenge socially accepted ‘norms’.	Bourdieu & Wacquant (1992)
Political capital	Described in terms of political and bureaucratic fields and socially constructed problems, public policy and political struggle.	Bourdieu (2005)
Practice	“Practices occur when habitus encounters those competitive arenas called fields, and action reflects the structure of that encounter”.	Swartz 1997, p. 141)
Reflexivity	A reflexive attitude whereby a researcher objectifies their position relative to the social world under scrutiny (research) and examines how skholé and habitus may shape biases brought by the researcher to the research.	Bourdieu (1997/2000)
Scientific capital	Consists of “instruments of defense, construction, argument” which can be used against others to protect positions of dominance.	Bourdieu & Wacquant (1992, p. 183)
Skholé	The “closure onto itself of the academic world” i.e. the position and ‘free time’ of the researcher relative to the social world under scrutiny. This represents a potential for bias which requires researchers to adopt a reflexive stance.	Bourdieu and Wacquant (1992, p. 157)
Social capital	Represents social networks and connections	Bourdieu (1979/1984)
Social space	Social field in which individuals and groups are defined and located by the volume and value of possessed capita,	Bourdieu 1979/1984)
Symbolic capital	“The most powerful form of accumulation” whereby intrinsic value exists in material and non-material states recognised and	Bourdieu (1972/1977, p. 179)

	legitimised by social groups.	
Symbolic power	“Is defined in and by a determinate relationship between those who exercise this power and those who undergo it – that is to say, in the very structure of the field in which belief is produced and reproduced”	Bourdieu (1972/1977, p. 117).
Symbolic violence	“Violence which is exercised upon a social agent with his or her complicity”.  Symbolic violence may be exercised in a symbolic way i.e. withholding of resources.	Bourdieu & Wacquant (1992, p. 167).

## Other Bourdieusian terms extended and used in this research

Term	Definition	Source
Disinterestedness	“The appearance of being above and removed from areas of economic and social interest”.	Webb, Schirato & Danaher (2002, p. xi)
Field	Exist “in four semi-autonomous levels: the field of power, the broad field under consideration, the specific field, and social agents in the field as a field in themselves”.	Thomson (2008, p. 79)
Field habitus	Interrelationship between field and habitus in which both concepts are mutually structured and in which power is evoked.  Field habitus like ‘class habitus’ takes account of the internalised dispositions, created over time as embodied cultural capital, and how they integrate and adapt to fields and are transposed beyond them.  Comparative analogy is ‘theory’ and ‘practice’, commonly described as ‘theory practice’ in nursing and physiotherapy literature.	Webb, Schirato & Danaher (2002, p. 37)  Moore (2008)  Mooney (2012) Roskell, Hewison & Wildman (1998)

## Appendix B Significant dates relevant to physiotherapy in New Zealand

1913	Dunedin School of Massage (School of Physiotherapy) established providing 18 month massage course, administered by the Otago Hospital Board
1941,46, 50, 58	Unsuccessful application to Minister of Education regarding university training
1971	Transfer of responsibility of all health education from Department of Health to Department of Education
1973	School of Physiotherapy founded at Auckland Institute of Technology, offering a 3 year diploma
1976	School of Physiotherapy in Dunedin transferred under Department of Education
1989	Four year degree established (Bachelor of Physiotherapy) administered jointly by the University of Otago and Otago Polytechnic
1989	Inaugural meeting of New Zealand College of Physiotherapy
1991	Four year degree (Bachelor of Health Science [Physiotherapy]) established at Auckland Institute of Technology
1996	Otago School of Physiotherapy transferred to University of Otago
1998	Government fully funded four year physiotherapy degree programmes
1999	Auckland Institute of Technology became Auckland University of Technology
2003	Health Practitioners Competency Assurance Act (2003) passed
2006	Interprofessional placements established at Wellsford by AUT University
2007	Auckland University of Technology became AUT University
2007	Clinical hubs established by University of Otago in partnership with district health boards
2007	First clinical educator/placement co-ordinator employed by Otago School of Physiotherapy at Nelson
2008	Clinical schools established by AUT University in partnership with district health boards
2009	Inaugural meeting of special interest group: Physiotherapists in education (PEG)
2009	Akoranga Integrated Health Clinic established at AUT University
2010	New Zealand Society of Physiotherapists' Inc. rebranded as Physiotherapy New Zealand
2012	Interprofessional clinic (Tairāwhiti programme) established by University of Otago and Eastern Institute of Technology
Future plans	Interprofessional clinic to be established by University of Auckland and AUT University in Whakatane Establishment of Honours in Year 4 (Otago School of Physiotherapy)

(Source: Nicholls, (2007); Nicholls & Cheek, (2006); Pynt et al., (2009); Scrymgeour (2000); Skinner (2007); personal communication, Laura Holder, AUT University, September 04, 2012)

## Appendix C Key themes explored in Phase I interviews informed by Bourdieu's methodological framework

Bourdieu's framework	Clinical educators	Stakeholders in clinical education	Students as stakeholders in clinical education
<p><b>Analysis of the position and practice of the field in relation to the broader field of power</b></p>	<p>What is your role in CE? Who or what influences CE? What do you perceive their role to be in CE? What is your relationship to other individuals/agencies involved in CE?</p>	<p>Who else has a role in CE? What is your relationship with other stakeholders? Who is the most influential in CE? What power/influence do you have in CE? Do you perceive there to be any areas of difference/conflict between you and other stakeholders in clinical education such as students/managers/professional leaders/university staff/Physiotherapy Board members?</p>	<p>What is your experience of CE to date? Who and what influences CE? What is the relationship between clinical education, the university and placement providers? How were you prepared for CE?</p>
<p><b>Analysis of the position of clinical educators within practice and organisational hierarchies, based on the distribution and type of capital</b></p>	<p>What value do you put on CE? What stops you from being a better CE? What three things could make being a clinical educator better for you? What are the most demanding parts of your role? How do you make them less demanding? Who hears your concerns?</p>	<p>What value do you put on CE? Do you perceive there to be any areas of difference/conflict for clinical educators? As a stakeholder in CE, are there any sources of tension or conflict relating to your role? What do you/your staff need to make the role of clinical education more successful? Who hears your concerns? What forums are you involved in, to vocalise your opinions</p>	<p>What value do you put on CE? What are your stresses in relation to clinical education? What are your expectations of a clinical educator? What constitutes a good clinical educator? What constitutes a good student?</p>



## **Appendix D Ethics (AUTEK) approval forms**

This appendix contains the following AUTEK approval forms.

17.11.06	Ethics approval
26.01.07	Amendment to professional title in related documents
13.06.07	Amendment to number of participants
17.08.09	Approval for extension of time from 16 .11.09 – 30.06.10

**M E M O R A N D U M**

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To: Liz Smythe  
From: **Madeline Banda** Executive Secretary, AUTECH  
Date: 17 November 2006  
Subject: Ethics Application Number 06/177 **A critical inquiry of clinical education in physiotherapy.**

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Dear Liz

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH) at their meeting on 11 September 2006 and that as the Executive Secretary of AUTECH I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTECH's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTECH's meeting on 11 December 2006.

Your ethics application is approved for a period of three years until 16 November 2009.

I advise that as part of the ethics approval process, you are required to submit to AUTECH the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through <http://www.aut.ac.nz/research/ethics>, including when necessary a request for extension of the approval one month prior to its expiry on 16 November 2009;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/ethics>. This report is to be submitted either when the approval expires on 16 November 2009 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTECH is notified of any adverse events or if the research does not commence and that AUTECH approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTECH for approval before that change is implemented.

Please note that AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at [charles.grinter@aut.ac.nz](mailto:charles.grinter@aut.ac.nz) or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely



Madeline Banda  
**Executive Secretary**  
**Auckland University of Technology Ethics Committee**

**M E M O R A N D U M**

---

To: Liz Smythe  
From: **Madeline Banda** Executive Secretary, AUTECH  
Date: 26 January 2007  
Subject: Ethics Application Number 06/177 **A critical inquiry of clinical education in physiotherapy.**

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Dear Liz

I am pleased to advise that as the Executive Secretary of the Auckland University of Technology Ethics Committee (AUTECH) I have approved minor amendments to the Information Sheets and correspondence of your ethics application, altering the professional title. This delegated approval is made in accordance with section 5.3.2 of AUTECH's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTECH's meeting on 12 February 2007.

I remind you that as part of the ethics approval process, you are required to submit to AUTECH the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through <http://www.aut.ac.nz/research/ethics>, including when necessary a request for extension of the approval one month prior to its expiry on 16 November 2009;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/ethics>. This report is to be submitted either when the approval expires on 16 November 2009 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTECH is notified of any adverse events or if the research does not commence and that AUTECH approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.

You are also reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTECH for approval before that change is implemented.

Please note that AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at [charles.grinter@aut.ac.nz](mailto:charles.grinter@aut.ac.nz) or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely



Madeline Banda  
**Executive Secretary**  
**Auckland University of Technology Ethics Committee**

# MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

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To: Liz Smythe  
From: **Madeline Banda** Executive Secretary, AUTEC  
Date: 13 June 2007  
Subject: Ethics Application Number 06/177 **A critical inquiry of clinical education in physiotherapy.**

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Dear Liz

I am pleased to advise that on 30 May 2007, the Chair of the Auckland University of Technology Ethics Committee (AUTEC) has approved a minor amendment to your ethics application altering the number of participants. This delegated approval is made in accordance with section 5.3.2 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 9 July 2007.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through <http://www.aut.ac.nz/about/ethics>, including when necessary a request for extension of the approval one month prior to its expiry on 16 November 2009;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/about/ethics>. This report is to be submitted either when the approval expires on 16 November 2009 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTEC is notified of any adverse events or if the research does not commence and that AUTEC approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at [charles.grinter@aut.ac.nz](mailto:charles.grinter@aut.ac.nz) or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely



Madeline Banda  
**Executive Secretary**  
**Auckland University of Technology Ethics Committee**

# MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

---

To: Liz Smythe  
From: **Madeline Banda** Executive Secretary, AUTEC  
Date: 17 August 2009  
Subject: Ethics Application Number 06/177 **A critical inquiry of clinical education in physiotherapy.**

---

Dear Liz

At their meeting on 10 August 2009, the Auckland University of Technology Ethics Committee (AUTEC) received the report on your ethics application. AUTEC noted your report and asked me to thank you. AUTEC also approved the requested extension to the expiry date from 16 November 2009 to 30 June 2010.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz) or by telephone on 921 9999 at extension 8860.

On behalf of AUTEC and myself, I congratulate you on your research and look forward to reading more about it in future reports.

Yours sincerely



Madeline Banda  
**Executive Secretary**  
**Auckland University of Technology Ethics Committee**

## Appendix E Application of ethical principles to this research informed by British Educational Research Association (2004), Tolich (2001) and Tolich and Davidson (1999)

Ethical principles	What should be considered	How was this managed in this research
Overall principles	<p>Research is undertaken that is underpinned by principles that are ethically sound.</p> <p>Research would not be commenced without ethical approval.</p>	<p>AUTEC approval was obtained prior to commencement of data collection.</p>
Consideration of Maori and Te Tiriti o Waitangi	<p>The involvement of Maori within the research.</p> <p>Te tino rangatiratanga which reflects rights of self-determination and rights to make decisions regarding resources including knowledge.</p>	<p>Invitations to participate in the research were sent to all clinical educators and stakeholders. Data relating to ethnicity were not formally requested; all clinical educators including Maori were welcome to participate. A consultation process was designed should participants self-identify as Maori. Research findings would be available to Maori.</p>
Do no harm	<p>The risks and benefits to participants.</p>	<p>Risks were considered minimal. Participants were offered opportunity to voice concerns with the researcher or supervisor. Contact details together with support agency details were provided. Participants were also able to withdraw from the study at any time.</p> <p>Benefits were explicit in the information sheet and included the generation of new knowledge and recommendations to the physiotherapy knowledgebase, other health professions and professions with a practice-based component.</p>
Voluntary participation	<p>Participants must be fully informed of their role in the research, their contribution, potential benefits and requirements, i.e. time. Information provided to guide an informed decision is transparent and realistic and the researcher meets her requirements, i.e. provide a copy of the results if identified by the participant on the questionnaire. The right of participants to withdraw from the research.</p>	<p>The cover letter and information sheet provided to potential participants was explicit. Questionnaire return indicated voluntary participation in the research. Key information was provided to participants when organising a time/venue for the interview to take place, and re-iterated again prior to recording.</p>

Ethical principles	What should be considered	How was this managed in this research
Informed consent	Participants should be fully informed of the aims and protocol, and also be aware of their involvement in the research and right to withdraw from the research.	<p>A written information sheet was provided to all participants. The return of the signed consent sheet indicated their consent to be contacted and also to maintain their details on a database for future contact.</p> <p>Verbal consent was also gained at the onset of the interview; this formed part of the transcription which was returned to participants for verification.</p> <p>Consent covered the use of quotations within the thesis text and the use of transcript data for discussion and analysis with research supervisors.</p> <p>There is documented evidence of informed consent.</p>
Avoid deceit	Participants are not misled about the nature of the research and the context in which their contribution is made.	Documentation sent to potential participants was an accurate reflection of the research purpose, aims and objectives, and the role of participants, the interviews and research processes. This was reiterated again verbally when organising a time to interview participants and also prior to the interview.
Confidentiality and/or anonymity	Data Protection Act Right to privacy	<p>Throughout the research, participants were guaranteed confidentiality. Pseudonyms were allocated to participants and participant roles not disclosed or referenced within the thesis.</p> <p>A confidentiality agreement was signed by the transcriber.</p> <p>Data were stored electronically using password protected access and documentation was stored within a locked cabinet.</p> <p>On completion of the research, data will be stored and subsequently destroyed as per AUTECH policies and procedures.</p> <p>Anonymity was discussed within the information sheet and made relevant to specific stakeholders (heads of schools, programme leaders, clinical placement co-ordinators) who may be identifiable due to their unique role and also the limited number of roles within New Zealand. Quotations which may identify the</p>

		participant in their role would be sent to the participant to ensure accuracy and to gain permission for their inclusion.
Researcher safety	Personal safety.	<p>A mobile phone was carried at all times.</p> <p>Colleagues were provided with details of location (i.e. city) and informed of arrival/departure from interview.</p> <p>Interviews were undertaken in work-based areas. One interview was conducted in the participant's own home for convenience.</p> <p>Telephone interviews were conducted from the researcher's home.</p>
Quality of research	<p>Integrity of research and the research community is upheld.</p> <p>The methodology employed will accurately capture data.</p> <p>The research process will be transparent and open to review.</p>	<p>The researcher has successfully completed pre-requisites prior to undertaking research and has appropriate experience in the methods employed.</p> <p>Research supervision with supervisors took place on a regular basis.</p> <p>The methodology and methods have been scrutinized by research peers and supervisors, and presented to physiotherapy and research colleagues at relevant forums.</p> <p>Details of the research process are provided in the Appendices including, for example, how the interview schedule was informed by Bourdieu.</p>
Right to report	<p>Academic freedom.</p> <p>Anonymity of participants. Participant awareness of the relevance and value of their contribution to the research.</p>	<p>Participants were made aware that results would be reported within the final thesis. Additionally, the results would form part of presentations and publications nationally and internationally.</p> <p>The researcher adheres to publication guidelines of peer-reviewed articles and conferences, ensuring quality of writing.</p>

## Appendix F AUTECH approved participant documentation

- Documentation provided to clinical educators
  - Research pack
    - Letter of invitation
    - Participant information sheet
    - Consent forms (face-to-face interview / focus group)
    - Phase 0 data collection form returned by clinical educators
    - Letter declining participation
  
- Documentation provided to stakeholders
  - Research pack
    - Letter of invitation
    - Participant information sheet
    - Consent forms (face-to-face interview / focus group)
    - Reminder letter requesting response to letter of invitation
    - Letter declining participation
  
- Documentation to students
  - Letter to clinical placement co-ordinators requesting distribution of research packs to students
  - Research pack provided to students
    - Letter of invitation
    - Participant information sheet
    - Consent forms (face-to-face interview / focus group)
    - Letter declining participation
  
- Generic letter to participants requesting transcript verification
- Generic reminder letter

Letter of invitation (clinical educators)



Date

To: clinical educators

Dear Colleague,

....., clinical placement co-ordinator kindly agreed to send you this information pack regarding some research which I am shortly about to commence. The study title is 'A critical inquiry of clinical education in physiotherapy'. This is in partial fulfillment of a Doctor of Health Studies, with Auckland University of Technology.

The study will involve interviewing a number of clinical supervisors/educators who represent different areas, clinical settings and geographical locations. Semi-structured interviews will be used to discuss and explore perceptions and experiences of power within clinical education. In addition, interviews will be undertaken with other stakeholders in clinical education such as professional leaders, service managers, NZ Board of Physiotherapy and NZ Society of Physiotherapists' Inc. representatives. Themes which emerge from these interviews will be taken back to clinical supervisors/educators to explore further and therefore, two or more interviews may be required. Participation will involve either telephone or face-to-face interviews or focus groups, at a mutually convenient time and venue.

I would be grateful if you would take a few minutes to read through the information sheet and if you are interested in participating in the study, complete and return the questionnaire and consent form using the stamped addressed envelope.

If you have any queries, or would like to discuss the study further, please do not hesitate to contact me directly or my supervisor Associate Professor Liz Smythe (09 9219999), ext 7196.

Thank you for taking the time out of your busy day to read this letter and the information sheet. I look forward to hearing from you.

Yours sincerely,

Sarah Mooney  
Doctor of Health Science candidate with Auckland University of Technology.  
Contact details: mobile: 021 161 9653  
[Sarah.Mooney@middlemore.co.nz](mailto:Sarah.Mooney@middlemore.co.nz)  
[sarahmooney@freenet.co.nz](mailto:sarahmooney@freenet.co.nz)

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06  
AUTEK Reference number: 06/177

Enc.

## **(CLINICAL EDUCATORS)**

### **Participant Information Sheet**



Date Information Sheet Produced: 20.08.06

**Project Title: A critical inquiry of clinical education in physiotherapy.**

#### **An Invitation**

I am a senior clinician currently working in clinical practice. My role also includes the supervision and education of undergraduate students. I am interested in exploring aspects of clinical education within physiotherapy through the perceptions of clinical supervisors/educators themselves. The study involves interviewing with up to twelve clinical supervisors/educators and twelve stakeholders in clinical education. Themes which emerge from the interviews with stakeholders such as service managers and representatives of the NZ Board of Physiotherapy will be taken back to clinical educators to discuss further. This study is in partial fulfilment of a Doctor of Health Sciences with Auckland University of Technology.

You are invited to participate in the study. Your participation is voluntary and you may withdraw from the study at any point without penalty. Your contribution as a clinical supervisor/educator in clinical education is important, therefore your participation would be greatly valued and appreciated.

#### **What is the purpose of this research?**

The purpose of this research is to explore the structures and processes of clinical education. This will help the dynamics of clinical education in physiotherapy to be better understood. Findings will be published in physiotherapy journals and presented at national and international conferences.

#### **How was I chosen for this invitation?**

The clinical placement co-ordinators at Auckland University of Technology and Otago University have kindly distributed the letter of invitation and information sheet to all clinical supervisors/educators in physiotherapy who supervise students within clinical practice.

You have been chosen as a person who can contribute to the study, through your experience.

#### **What will happen in this research?**

Letters of invitation to participate in the research has been distributed to all clinical supervisors/educators who supervise students of physiotherapy from Auckland

University of Technology and Otago University. A purposive sample of up to twelve supervisors/educators will be selected to represent different areas of practice, geographical locations and physiotherapy schools. Semi-structured interviews will be undertaken by telephone, lasting up to 1 ½ hours, or by face-to-face or focus groups at a mutually convenient time and venue.

In addition, several stakeholders in physiotherapy such as service managers, representatives of the NZ Board of Physiotherapy, will also be undertaken. Themes which emerge from these interviews will be taken back to clinical supervisors/educators for further exploration and discussion. It will therefore be necessary to undertake up to three interviews.

**What are the discomforts and risks? How will these discomforts and risks be alleviated?**

You may find that issues explored and discussed are of a sensitive nature to you. There will be the opportunity to discuss these issues with the researcher or alternatively, contact details for support agencies will be made available. You will be encouraged to maintain a reflective diary to capture additional thoughts and reflections which may contribute to the study.

**What are the benefits?**

The study will promote a greater understanding of clinical education in physiotherapy through the perceptions of clinical educators.

**How will my privacy be protected?**

Your contribution will be confidential. You will be allocated a pseudonym within the final study and no reference will be made which will make you identifiable to others.

**What are the costs of participating in this research?**

There are no financial costs to participants. It is likely to take you 10 minutes to complete the initial questionnaire. The interviews may take up to a maximum of 1 and a half hours in order to gain an indepth understanding of the subject area. The interviews will take place at a mutually convenient time and venue.

**What opportunity do I have to consider this invitation?**

You have up to two weeks to return the questionnaire and consent form which indicates your interest in participating in the study. You will then be contacted by the researcher using the contact details you have provided.

**Will I receive feedback on the results of this research?**

Yes. You will need to indicate on the consent form that you would like a summary of results. These will be sent to you on completion of the research.

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:

Associate Professor Liz Smythe, Division of Health Care Practice, Auckland University of Technology. Phone: 09 9219999 ext 7196. Email: liz.smythe@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz ,09 921 9999 ext 8044.

**Whom do I contact for further information about this research?**

Researcher Contact Details: Sarah Mooney.  
sarahmooney@freenet.co.nz or Sarah.Mooney@middlemore.co.nz.  
Mobile: 021 161 9653

Project Supervisor Contact Details:

Associate Professor Liz Smythe.

[liz.smythe@aut.co.nz](mailto:liz.smythe@aut.co.nz)

Phone: 09 9219999 ext 7196

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06  
AUTEK Reference number: 06/177

Consent forms (clinical educator)



**Project title:** *A critical inquiry of clinical education in physiotherapy.*  
**Project Supervisor:** *Associate Professor Liz Smythe, Division of Health Care Practice*  
**Researcher:** *Sarah Mooney*

- I have read and understood the information provided about this research project in the Information Sheet dated .
- I have had an opportunity to ask questions and to have them answered.
- I understand that the **interview** will be audio-taped and transcribed.
- I understand that I may be required to participate in a follow-up interview to explore themes further.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a summary of the research findings of completion the study:  
(please tick one): Yes  No

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

..... Date :

.....

**Approved by the Auckland University of Technology Ethics Committee on:** *17.11.06*  
**AUTEC Reference number:** *06/177*

Consent forms (clinical educator)



**Project title:** *A critical inquiry of clinical education in physiotherapy.*  
**Project Supervisor:** *Associate Professor Liz Smythe, Division of Health Care Practice*  
**Researcher:** *Sarah Mooney*

- I have read and understood the information provided about this research project in the Information Sheet dated .
- I have had an opportunity to ask questions and to have them answered.
- I understand that the **focus group** will be audio-taped and transcribed.
- I understand that I may be required to participate in a follow-up interview to explore themes further.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a summary of the research findings of completion the study:  
(please tick one): Yes  No

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

..... Date :

.....

**Approved by the Auckland University of Technology Ethics Committee on:** *17.11.06*  
**AUTEC Reference number:** *06/177*

Phase 0 data collection form returned by clinical educators

## **EXPRESSION OF INTEREST TO PARTICIPATE IN THE STUDY**

### **A critical inquiry of clinical education.**

**Researcher:**

Sarah Mooney, candidate Doctor of Health Studies, Auckland University of Technology

**Supervisor:**

Associate Professor Liz Smythe, Division of Health Practice,  
Auckland University of Technology

I have read through the participation information sheet and understand I will be required to participate in semi-structured interviews, to be conducted at a mutually convenient time and venue.

**Contact details:**

Participant signature:

.....

Participant name: (please print)

.....

Participant contact details:

.....

.....

.....

.....

..... Email: ..... Phone:

.....

**Please tick one box unless indicated otherwise.**

**Details regarding qualification:**

I trained in New Zealand:    yes     no

If no, please specific country of training and qualification:

.....

Year of qualification:                    .....

Please indicate number of years you have been practising as a physiotherapist: .....

**Details regarding current working environment:**

At present, I work in an:

in-patient setting: (please specific area)

.....

- out-patient setting: (please specific area)  
.....
- community setting: (please specific if adults, children)  
.....
- private practice: (please specific area if appropriate)  
.....
- university-based practice: (please specific area)  
.....

My present title is:  
 Section head physiotherapist   
 Senior physiotherapist   
 Rotational physiotherapist

**Details regarding experience in clinical education:**

I have been involved in the supervision of students primarily from:

- Otago University:
- AUT
- Other  (please give details)

.....  
 .....  
 ...

Clinical education has primarily been:  
 My responsibility   
 Shared with another clinical educator   
 Shared within my team

I have worked with the following models of clinical education i.e. student:supervisor:  
 (please tick as many boxes as appropriate)

- 1:1 model  (i.e. one student to one supervisor)
- 2:1 model
- 3:1 model
- 4:1 model

Since I have become involved in clinical education, I have supervised approximately:

- 0 – 5 students
- 6-10 students
- 11-20 students
- More than 20 students

I hold a certificate in clinical teaching:   
 I am in the process of studying towards a certificate in clinical teaching:   
 I am interested in studying towards a certificate in clinical teaching:

I have attended study days/workshops on clinical education provided by the university:

- Yes  Date of when completed approximately: .....
- No

**Contact time and preference of interview format:**

The best time/means to contact me:

.....

I would be prefer to participate in: (please tick one box)

telephone interview	<input type="checkbox"/>
face to face interview	<input type="checkbox"/>
focus group	<input type="checkbox"/>
no preference	<input type="checkbox"/>

I agree for my details to be held on a data-base by the researcher for the duration of the study. Yes  No

**Additional comments:**

.....  
.....  
.....  
.....  
.....  
.....  
.....

**I would like to be contacted to discuss the study further prior to giving consent.**

Yes  No

**Please complete and sign the consent form which is on the back of this page, unless you would like to discuss the study further.**

**Thank you for completing this questionnaire.**

**Please return this questionnaire in the stamped-address envelope provided.**

**Sarah Mooney**

Doctor of Health Science candidate with Auckland University of Technology.

Contact details: mobile: 021 161 9653

[Sarah.Mooney@middlemore.co.nz](mailto:Sarah.Mooney@middlemore.co.nz)

[sarahmooney@freenet.co.nz](mailto:sarahmooney@freenet.co.nz)

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06  
AUTEK Reference number: 06177

## LETTER DECLINING PARTICIPATION



Date:

Dear .....

Thank you for offering to participate in my research: 'A critical inquiry of clinical education in physiotherapy'. This is in partial fulfillment of a Doctor of Health Studies, with Auckland University of Technology.

As previously indicated, up to 12 clinical supervisors/educators were required to participate in the study; educators who represented different areas of practice, different experiences as an educator and also geographical location.

Due to the high response rate, the 12 participants have now been recruited. Unfortunately your details were not selected. I appreciate the time and effort you undertook to complete the questionnaire and would be grateful if you would agree to allow your name and details to form part of a data-base of clinical supervisors/educators. It may be appropriate later in the study to undertake additional interviews or focus groups and your input, insight and experience of clinical education would be greatly appreciated.

If you have indicated on the questionnaire that you would like a summary of the results, this will be sent to you on completion of the research.

Thank you again for your interest and support.

Yours sincerely,

Sarah Mooney

Doctor of Health Science candidate with Auckland University of Technology.

Contact details: mobile: 021 161 9653

[Sarah.Mooney@middlemore.co.nz](mailto:Sarah.Mooney@middlemore.co.nz)

[sarahmooney@freenet.co.nz](mailto:sarahmooney@freenet.co.nz)

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06

AUTEC Reference number: 06/177

Letter of invitation (stakeholder)



Date:

To: stakeholders in clinical education

Dear .....,

I obtained your details from .... (e.g. NZ Board of Physiotherapy committee details) and am writing to ask if you would be interested in participating in a study which seeks to explore the world of clinical education. The study title is 'A critical inquiry of clinical education in physiotherapy.' This is in partial fulfilment of a Doctor of Health Studies, with Auckland University of Technology.

The study will primarily involve interviewing a number of clinical supervisors/educators who represent different areas, clinical settings and geographical locations. Semi-structured interviews will be used to discuss and explore perceptions and experiences of power within clinical education. In addition, interviews will be undertaken with other stakeholders in clinical education such as professional leaders, service managers, NZ Board of Physiotherapy and NZ Society of Physiotherapists' Inc. representatives. Themes which emerge from these interviews will be taken back to clinical supervisors/educators to explore further. You may also be required to participate in a follow-up interview. Participation will involve either telephone or face-to-face interviews at a mutually convenient time and venue.

I would be grateful if you would take a few minutes to read through the information sheet and if you are interested in participating in the study, complete and return the consent form using the stamped addressed envelope.

If you have any queries, or would like to discuss the study further, please do not hesitate to contact me directly or my supervisor Associate Professor Liz Smythe (09 9219999, ext 7196).

Thank you for taking the time to read this letter and the information sheet.

I look forward to hearing from you.

Yours sincerely,

Sarah Mooney  
Doctor of Health Science candidate with Auckland University of Technology.  
Contact details: mobile: 021 161 9653  
[Sarah.Mooney@middlemore.co.nz](mailto:Sarah.Mooney@middlemore.co.nz)  
[sarahmooney@freenet.co.nz](mailto:sarahmooney@freenet.co.nz)

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06  
AUTEK Reference number: 06/177

Enc.

(Stakeholders in clinical education)



## **Participant Information Sheet**

Date Information Sheet Produced: 20.08.06

**Project Title: A critical inquiry of clinical education in physiotherapy.**

### **An Invitation**

I am a senior clinician currently working in clinical practice. My role also includes the supervision and education of undergraduate students. I am interested in exploring aspects of clinical education within physiotherapy through the perceptions of clinical supervisors/educators themselves. The study involves interviewing up to twelve clinical supervisors/educators and twelve stakeholders in clinical education. Stakeholders may include service managers, representatives from the New Zealand Board of Physiotherapy. Themes which emerge from the interviews will be taken back to each group to discuss further. This study is in partial fulfilment of a Doctor of Health Sciences with Auckland University of Technology.

You are invited to participate in the study. Your participation is voluntary and you may withdraw from the study at any point without penalty. Your contribution as a stakeholder in clinical education is important and therefore your participation would be greatly valued and appreciated.

### **What is the purpose of this research?**

The purpose of this research is to explore the structures and processes of clinical education. This will help the dynamics of clinical education in physiotherapy to be better understood. Findings will be published in physiotherapy journals and presented at national and international conferences.

### **How was I chosen for this invitation?**

You were chosen as a person who could contribute to this study through your experience and knowledge of clinical education.

### **What will happen in this research?**

A sample of up to twelve supervisors/educators will be interviewed and asked to discuss different aspects of clinical education. They have been chosen to represent different areas of practice, geographical locations and physiotherapy schools.

The views of stakeholders in clinical education are also important. Therefore several stakeholders in physiotherapy will also be interviewed.

Semi-structured interviews will be undertaken by telephone, or by face-to-face or focus groups at a mutually convenient time and venue. Questions will be the same for each group and will include themes as they emerge from the analysis.

**What are the discomforts and risks? How will these discomforts and risks be alleviated?**

You may find that issues explored and discussed are of a sensitive nature to you. There will be the opportunity to discuss these issues with the researcher or alternatively, contact details for support agencies will be made available.

**What are the benefits?**

The study will promote a greater understanding of clinical education in physiotherapy primarily through the perceptions of clinical educators.

**How will my privacy be protected? (the appropriate section will be included; others will be deleted)**

Service managers/professional leaders/representatives of NZ Board Physiotherapy/Society of Physiotherapists Inc: Your contribution will be confidential. You will be allocated a pseudonym within the final study and no reference will be made which will make you identifiable to others.

Heads of School of Physiotherapy/clinical placement co-ordinators:

Your contribution will be confidential. Due to the limited number of heads of school/clinical placement co-ordinators, your comments may be identifiable. Quotations which may be included in the final study will be sent to you to ensure that they are accurate and you give permission for their inclusion.

**What are the costs of participating in this research?**

There are no financial costs to participants. The interviews may take up to a maximum of 1 ½ hours in order to gain an indepth understanding of the subject area. It may necessary to undertake up a follow-up interview; this will be negotiated.

**What opportunity do I have to consider this invitation?**

You have up to two weeks to return the consent form which indicates your interest in participating in the study. You will then be contacted by the researcher using the contact details you have provided.

**Will I receive feedback on the results of this research?**

Yes. You will need to indicate on the consent form that you would like a summary of results. These will be sent to you on completion of the research.

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:

Associate Professor Liz Smythe, Division of Health Care Practice, Auckland University of Technology. Phone: 09 9219999 ext 7196. Email: liz.smythe@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz ,09 921 9999 ext 8044.

**Whom do I contact for further information about this research?**

Researcher Contact Details:

Sarah Mooney.

sarahmooney@freenet.co.nz or Sarah.Mooney@middlemore.co.nz.

Mobile: 021 161 9653

Project Supervisor Contact Details:

Associate Professor Liz Smythe.

liz.smythe@aut.co.nz

Phone: 09 9219999 ext 7196

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06

AUTEC Reference number: 06/177

Consent forms (stakeholder)



**Project title:** *A critical inquiry of clinical education in physiotherapy.*  
**Project Supervisor:** *Associate Professor Liz Smythe, Division of Health Care Practice*  
**Researcher:** *Sarah Mooney*

- I have read and understood the information provided about this research project in the Information Sheet dated .
- I have had an opportunity to ask questions and to have them answered.
- I understand that the **interview** will be audio-taped and transcribed.
- I understand that I may be required to participate in a follow-up interview to explore themes further.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a summary of the research findings of completion the study:  
(please tick one): Yes  No

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

.....

.....

..... Date :

**Approved by the Auckland University of Technology Ethics Committee on:** *17.11.06*  
**AUTEC Reference number:** *06/177*

Consent forms (stakeholder)



**Project title:** *A critical inquiry of clinical education in physiotherapy.*  
**Project Supervisor:** *Associate Professor Liz Smythe, Division of Health Care Practice*  
**Researcher:** *Sarah Mooney*

- I have read and understood the information provided about this research project in the Information Sheet dated .
- I have had an opportunity to ask questions and to have them answered.
- I understand that the **focus group** will be audio-taped and transcribed.
- I understand that I may be required to participate in a follow-up interview to explore themes further.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a summary of the research findings of completion the study:  
(please tick one): Yes  No

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

..... Date :

.....

**Approved by the Auckland University of Technology Ethics Committee on:** *17.11.06*  
**AUTEC Reference number:** *06/177*

Reminder letter requesting response to letter of invitation (stakeholder)



Date:

To: stakeholders in clinical education

Dear .....

I recently sent you a letter, asking if you would be interested in participating in a study regarding clinical education in physiotherapy. Unfortunately, I have not yet received a response. I appreciate your time is valuable would greatly appreciate it if you would take a few minutes to read this letter and the accompanying information sheet.

I obtained your details from .... (e.g. NZ Board of Physiotherapy committee details) and am writing to ask if you would be interested in participating in a study which seeks to explore the world of clinical education. The study title is 'The interplay of power within clinical education as perceived by clinical supervisors/educators in physiotherapy. A critical inquiry.' This is in partial fulfilment of a Doctor of Health Studies, with Auckland University of Technology.

The study will primarily involve interviewing a number of clinical supervisors/educators who represent different areas, clinical settings and geographical locations. Semi-structured interviews will be used to discuss and explore perceptions and experiences of power within clinical education. In addition, interviews will be undertaken with other stakeholders in clinical education such as professional leaders, service managers, NZ Board of Physiotherapy and NZ Society of Physiotherapists' Inc. representatives. Themes which emerge from these interviews will be taken back to clinical supervisors/educators to explore further. Participation will involve either telephone or face-to-face interviews at a mutually convenient time and venue.

I would be grateful if you would take a few minutes to read through the information sheet and if you are interested in participating in the study, complete and return the questionnaire and consent form using the stamped addressed envelope.

If you have any queries, or would like to discuss the study further, please do not hesitate to contact me directly or my supervisor Associate Professor Liz Smythe (09 9219999, ext 7196).

Thank you for taking the time to read this letter and the information sheet.

I look forward to hearing from you.

Yours sincerely,

Sarah Mooney  
Doctor of Health Science candidate with Auckland University of Technology.  
Contact details: mobile: 021 161 9653  
[Sarah.Mooney@middlemore.co.nz](mailto:Sarah.Mooney@middlemore.co.nz)  
[sarahmooney@freenet.co.nz](mailto:sarahmooney@freenet.co.nz)

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06  
AUTEK Reference number: 06/177

Enc.

Letter declining participation (stakeholder)



Date

Dear .....

Thank you for offering to participate in my research: 'A critical inquiry of clinical education in physiotherapy'. This was in partial fulfilment of a Doctor of Health Studies, with Auckland University of Technology.

Due to the high response rate, sufficient participants have now been recruited. Unfortunately your details were not selected. I appreciate the time and effort you undertook and wish you every success.

If you have indicated on the questionnaire that you would like a summary of the research, it will be sent to you on completion of the research.

Thank you again for your interest and support.

Yours sincerely,

Sarah Mooney

Doctor of Health Science candidate with Auckland University of Technology.

Contact details: mobile: 021 161 9653

[Sarah.Mooney@middlemore.co.nz](mailto:Sarah.Mooney@middlemore.co.nz)

[sarahmooney@freenet.co.nz](mailto:sarahmooney@freenet.co.nz)

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06

AUTEC Reference number: 06/177

Letter to clinical placement co-ordinator



Date:

To: Clinical placement co-ordinator

Dear

Re: A critical inquiry of clinical education in physiotherapy.

Further to our recent conversation, please find enclosed .... envelopes which contain a letter of invitation to participate in the research outlined above, an information sheet, consent form, and a self-addressed stamped addressed envelope which respondents should return to me directly. I have enclosed a copy for your own information and interest.

I would be grateful if you would send an envelope to twenty students (ten year III and ten year IV students) who are currently studying for their degree of Physiotherapy at your university.

If you have any queries regarding the research or distribution of the information packs, please do not hesitate to contact me directly or my supervisor Associate Professor Liz Smythe, 09 9219999, ext 7196.

Thank you for your assistance and co-operation.

Yours sincerely,

Sarah Mooney

Doctor of Health Science candidate with Auckland University of Technology.

Contact details: mobile: 021 161 9653

[Sarah.Mooney@middlemore.co.nz](mailto:Sarah.Mooney@middlemore.co.nz)

[sarahmooney@freenet.co.nz](mailto:sarahmooney@freenet.co.nz)

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AUTEC Reference number: 06/177

Enc.

Letter of invitation (student)



Date

To: students of physiotherapy

Dear .....

....., clinical placement co-ordinator kindly agreed to send you this information pack regarding some research which I am shortly about to commence. I am therefore writing to ask if you would be interested in participating in a study which seeks to explore the world of clinical education. The study title is 'A critical inquiry of clinical education in physiotherapy.' This is in part fulfilment of a DHSc of Health Studies, registered at Auckland University of Technology.

The study will primarily involve interviewing a number of clinical supervisors/educators who represent different areas, clinical settings and geographical locations. Semi-structured interviews will be used to discuss and explore perceptions and experiences of power within clinical education. In addition, interviews will be undertaken with other stakeholders in clinical education such as students of physiotherapy, professional leaders, service managers, NZ Board and NZ Society representatives. Themes which emerge from these interviews will be taken back to clinical supervisors/educators to explore further. You may also be required to participate in a follow-up interview. Participation will involve either telephone/face-to-face interviews or focus groups at a mutually convenient time and venue.

I would be grateful if you would take a few minutes to read through the information sheet and if you are interested in participating in the study, complete and return the consent form using the stamped addressed envelope.

If you have any queries, or would like to discuss the study further, please do not hesitate to contact me directly or my supervisor Associate Professor Liz Smythe (09 9219999, ext 7196).

Thank you for taking the time to read this letter and the information sheet.

I look forward to hearing from you.

Yours sincerely,

Sarah Mooney

Doctor of Health Science candidate with Auckland University of Technology.

Contact details: Mobile: 021 161 9653

[Sarah.Mooney@middlemore.co.nz](mailto:Sarah.Mooney@middlemore.co.nz)

[sarahmooney@freenet.co.nz](mailto:sarahmooney@freenet.co.nz)

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Enc.

(Stakeholders of clinical education; student of physiotherapy)



## **Participant Information Sheet**

Date Information Sheet Produced: 20.08.06

**Project Title: A critical inquiry of clinical education in physiotherapy.**

### **An Invitation**

I am a senior clinician currently working in clinical practice. My role also includes the supervision and education of undergraduate students. I am interested in exploring aspects of clinical education within physiotherapy through the perceptions of clinical supervisors/educators themselves. The study involves interviewing with up to twelve clinical supervisors/educators and twelve stakeholders in clinical education. Themes which emerge from the interviews with stakeholders such as service managers, physiotherapy students and representatives of the NZ Board of Physiotherapy will be taken back to clinical supervisors/educators to discuss further.

You are invited to participate in the study. Your participation is voluntary and you may withdraw from the study at any point without penalty. Your contribution as a stakeholder in clinical education is important and therefore your participation would be greatly valued and appreciated.

This study is in partial fulfilment of a Doctor of Health Sciences with Auckland University of Technology.

### **What is the purpose of this research?**

The purpose of this research is to explore the structures and processes of clinical education. This will help the dynamics of clinical education in physiotherapy to be better understood. Findings will be published in physiotherapy journals and presented at national and international conferences.

### **How was I chosen for this invitation?**

The clinical placement co-ordinators at Auckland University of Technology and Otago University (will delete as appropriate) has kindly distributed the letter of invitation and information sheet to a convenient sample of physiotherapy students (year III and year IV).

You have been chosen as a person who could contribute to this study through your experience of clinical education.

### **What will happen in this research?**

A sample of up to twelve supervisors/educators will be interviewed and asked to discuss different aspects of clinical education. They have been chosen to represent different areas of practice, geographical locations and physiotherapy schools.

The views of stakeholders in clinical education are also important. Therefore several stakeholders in physiotherapy will also be interviewed.

Semi-structured interviews will be undertaken by telephone, or by face-to-face or focus groups at a mutually convenient time and venue. Questions will be the same for each group and will include themes as they emerge from the analysis.

**What are the discomforts and risks? How will these discomforts and risks be alleviated?**

You may find that issues explored and discussed are of a sensitive nature to you. There will be the opportunity to discuss these issues with the researcher or alternatively, contact details for support agencies will be made available.

**What are the benefits?**

The study will promote a greater understanding of clinical education in physiotherapy through the perceptions of clinical supervisors/educators. Exploration and discussion will be promoted by themes which have emerged from interviews with stakeholders in clinical education in physiotherapy.

**How will my privacy be protected?**

Your contribution will be both confidential. You will be allocated a pseudonym within the final study and no reference will be made which will make you identifiable to others.

**What are the costs of participating in this research?**

There are no financial costs. The interviews may take up to a maximum of 1 ½ hours in order to gain an indepth understanding of the subject area. It may be necessary to undertake a follow-up interview to discuss emerging themes further. This will be negotiated. The interviews will take place at a mutually convenient time and venue.

**What opportunity do I have to consider this invitation?**

You have up to two weeks to return the consent form which indicates your interest in participating in the study. You will then be contacted by the researcher using the contact details you have provided.

**Will I receive feedback on the results of this research?**

Yes. You will need to indicate on the consent form if you would like a summary of results. These will be sent to you on completion of the research.

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:

Associate Professor Liz Smythe, Division of Health Care Practice, Auckland University of Technology. Phone: 09 9219999 ext 7196. Email: liz.smythe@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz ,09 921 9999 ext 8044.

**Whom do I contact for further information about this research?**

Researcher Contact Details:

Sarah Mooney.

sarahmooney@freenet.co.nz or Sarah.Mooney@middlemore.co.nz.

Mobile: 021 161 9653

Project Supervisor Contact Details:

Associate Professor Liz Smythe.

liz.smythe@aut.co.nz Phone: 09 9219999 ext 7196

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06

AUTEK Reference number: 06/177

Consent forms (student)



**Project title:** *A critical inquiry of clinical education in physiotherapy.*  
**Project Supervisor:** *Associate Professor Liz Smythe, Division of Health Care Practice*  
**Researcher:** *Sarah Mooney*

- I have read and understood the information provided about this research project in the Information Sheet dated .
- I have had an opportunity to ask questions and to have them answered.
- I understand that the **interview** will be audio-taped and transcribed.
- I understand that I may be required to participate in a follow-up interview to explore themes further.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a summary of the research findings of completion the study:  
(please tick one): Yes                          No

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

..... Date :

.....

**Approved by the Auckland University of Technology Ethics Committee on:** *17.11.06*  
**AUTEC Reference number:** *06/177*

Consent forms (student)



**Project title:** *A critical inquiry of clinical education in physiotherapy.*  
**Project Supervisor:** *Associate Professor Liz Smythe, Division of Health Care Practice*  
**Researcher:** *Sarah Mooney*

- I have read and understood the information provided about this research project in the Information Sheet dated .
- I have had an opportunity to ask questions and to have them answered.
- I understand that the **focus group** will be audio-taped and transcribed.
- I understand that I may be required to participate in a follow-up interview to explore themes further.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a summary of the research findings of completion the study:  
(please tick one): Yes  No

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

..... Date :

.....

**Approved by the Auckland University of Technology Ethics Committee on:** 17.11.06  
**AUTEC Reference number:** 06/177

Letter declining participation (students)



Date:

Dear .....

Thank you for offering to participate in my research entitled: 'A critical inquiry of clinical education in physiotherapy'. This was in partial fulfilment of a Doctor of Health Studies, with Auckland University of Technology.

Due to the high response rate, sufficient participants have now been recruited. Unfortunately your details were not selected. I appreciate the time and effort you undertook and wish you every success in your studies.

If you have indicated on the questionnaire that you would like a summary of the research, it will be sent to you on completion of the research.

Thank you again for your interest and support.

Yours sincerely,

Sarah Mooney

Doctor of Health Science candidate with Auckland University of Technology.

Contact details: mobile: 021 161 9653

[Sarah.Mooney@middlemore.co.nz](mailto:Sarah.Mooney@middlemore.co.nz)

[sarahmooney@freenet.co.nz](mailto:sarahmooney@freenet.co.nz)

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06

AUTEC Reference number: 06/177

Generic letter to participants requesting transcript verification



Date:

Dear ,

Enclosed please find a copy of the transcript, as discussed.

I would be grateful if you would read through the transcript and if there is any part of the text which you would like to edit or delete, please indicate on the tear-off slip below and I will contact you to discuss it. Alternatively, you can make the changes on the actual transcript and return it to me using the stamped addressed envelope which I have enclosed.

Regards and thanks again for supporting my research.

Yours sincerely,

Sarah Mooney  
Mob: 021 161 9653  
[sarahmooney@freenet.co.nz](mailto:sarahmooney@freenet.co.nz)

- 
- I agree that the transcript is an accurate account of the interview which I recently participated in.
  - I have made the changes on the transcript
  - I would like you to contact me regarding changes to the transcript.

Signature: .....

Date: .....

## Generic reminder letter



Date

Address

Dear xx,

Several weeks ago, I sent you a copy of the transcript of our interview and asked that you read through it and let me know if you would like me to make any changes.

As I have finished undertaking the interviews, I am keen to start analyzing the transcripts and would therefore be grateful if you would email me to let me know if you would like me to edit the transcript in any way.

I appreciate you are busy but would ask that you contact me by the 10th September. If I do not hear from you by then, I will assume that you do not wish me to make any changes and I will start reviewing the transcripts for themes. I have attached another copy of the transcription and enclosed a reply slip/SAE for your convenience.

I look forward to hearing from you and once again, thank you for your support.

Kind regards.

Yours sincerely,

Sarah Mooney  
Mob: 021 161 9653

## Appendix G Phase I interviews: Clinical educator/participant profile

YEAR QUALIFIED	PLACE OF EMPLOYMENT	CLINICAL SPECIALTY	ROLE	TYPE OF INTERVIEW
1978	University clinic	Respiratory out-patients	Clinical educator	Face/face
1997	University clinic	Musculo-skeletal outpatients	Clinical educator	Face/face
1999	Rural hospital	In and out-patients	Clinical educator	Telephone
1985	Private Practice manager urban	Musculo-skeletal outpatients	Clinical educator	Face/face
2001	Small hospital	Musculo-skeletal / rheumatology outpatients	Clinical educator	Face/face
2001	Large DHB/Placement Co	Neurosurgical patients	Clinical educator	Face/face
1985	Large DHB	Hand therapy patients	Clinical educator	Face/face
1996	Large DHB	Care of elder patient/rehabilitation	Clinical educator	Face/face
1998	Medium DHB	Musculo-skeletal outpatients	Clinical educator	Telephone
1996	Large DHB	Paediatrics	Clinical educator	Face/face
1994	Large DHB	Orthopaedics	Clinical educator	Telephone
2004	Medium DHB	Respiratory/musculo-skeletal patients (rotational post)	Clinical educator/clinical tutor	Face/face
1981	Employed by School	Neurological rehabilitation	Clinical tutor	Face/face/ own home
1997	Large DHB	Respiratory in and outpatients	Clinical educator	Face/face
1992	University clinic	Musculo-skeletal outpatients	Clinical educator	Face/face
1990	Private practice manager rural	Musculo-skeletal outpatients	Clinical educator/clinical tutor	Telephone
1981	DHB: Community s	Community paediatrics	Clinical educator	Face/face
1979	DHB: Community	Community respiratory outpatients	Clinical educator	Telephone

<b>STUDENTS FROM SCHOOL 1 OR 2</b>	<b>CLINICAL EDUCATION EXPERIENCE ie number of students</b>	<b>MODELS OF CLINICAL EDUCATION i.e. student:educator</b>	<b>CLINICAL EDUCATOR WORKSHOP ATTENDANCE</b>	<b>INTEREST IN CERTIFICATE IN CLINICAL EDUCATION</b>
2	>20	2:1; 3:1; 4:1; 6:1 student:educator	Yes 07	Interested
2	>20	4:1; 5:1; 6:1; 7:1 student:educator	Yes 06	Interested
2	0-5	1 student:1 educator	No	Interested
2	>20	all models	Yes unsure of date	Blank
1 + 2	0-5	1 student:1 educator	Yes 2006	Blank
2	6-10	1 student:1 educator	Yes 07	Blank
2	11-20	2:1; 1 student:1 educator	No	Blank
2	>20	2:1; 1 student:1 educator	Yes annually	Undertaking
2	0-5	1 student:1 educator	Yes annually	Interested
2	11-20	1 student:1 educator	Yes annually	Blank
2	>20	4:1; 1 student:1 educator	Yes 07	Blank
1	0-5	1 student:1 educator	Yes 07	Blank
1	>20	all	No	Interested
1	11-20	1 student:1 educator	Yes 07	Interested
1	0-5	1 student:1 educator	No	Interested
1	0-5	2:1; 1 student:1 educator	Yes 07	No
1	6-10	1 student:1 educator	Yes 07	Interested
1	>20	2:1; 1 student:1 educator	No	Blank

## Appendix H Participant response profile

PHASE 0		PHASE 1			PHASE 2					
PARTICIPANTS	Number of participants surveyed	Data collection method and procedure	Approx. duration for completion	Number of responses	Number of participants recruited to Phase I	Data Collection method and procedure	Approx. duration for completion	Number of participants recruited to Phase II	Data Collection method and procedure	Approx. duration for completion
<b>CLINICAL EDUCATORS</b>	250	Questionnaire distribution/ Return of consent form in a reply paid envelope  Collation of information to inform purposive selection	20 minutes	57	18	Semi-structured telephone or face-to-face interviews Audio-taping and transcription of interviews	36 – 90 minutes	7	Semi-structured telephone or face-to-face interviews Audio-taping and transcription of interviews	36 – 90 minutes
<b>STAKEHOLDERS IN CLINICAL EDUCATION</b>	77	Return of consent form in a reply paid envelope Collation of information to inform purposive sample	15 minutes	32	18					

<b>PHASE 0</b>				<b>PHASE 1</b>			
<b>PARTICIPANTS</b>	<b>Number of participants surveyed</b>	<b>Data collection method and procedure</b>	<b>Approx. duration for completion</b>	<b>Number of responses</b>	<b>Number of participants recruited to Phase I</b>	<b>Data Collection method and procedure</b>	<b>Approx. duration for completion</b>
Academic staff	6			6	6		
Allied health directors	2			2	2		
Professional leaders and managers	36			11	3		
Committee members of Society of Physiotherapists' Inc.	7			1	1		
Committee members of the Physiotherapy Board of New Zealand	8			1	1		
Year III students	10			3	2		
Year IV students	10			3	3		

## Appendix I Phase II interviews: Clinical educator/participant profile

YEAR QUALIFIED	PLACE OF EMPLOYMENT	CLINICAL SPECIALTY	ROLE	TYPE OF INTERVIEW
1978	University clinic	Respiratory out-patients	Clinical educator	Face/face
2001	Small hospital	Musculo-skeletal / rheumatology outpatients	Clinical educator	Face/face
2001	Large DHB/Placement Co	Neurosurgical patients	Clinical educator	Face/face
2004	Medium DHB	Respiratory/musculo-skeletal patients	Clinical educator/clinical tutor	Telephone
1981	Employed by School	Neurological rehabilitation	Clinical tutor	Telephone
1997	Large DHB	Respiratory in and outpatients	Clinical educator	Telephone
1990	Private practice manager rural	Musculo-skeletal outpatients	Clinical educator/clinical tutor	Telephone

## Appendix J Key themes explored in Phase II interviews informed by Bourdieu's methodological framework

Bourdieu's framework	Clinical educators
<p><b>Analysis of the position and practice of the field in relation to the broader field of power</b></p>	<p style="text-align: center;">ORGANISATIONAL CULTURE AND EXPECTATIONS</p> <p>How has the culture of your organisation/practice/team/department influenced clinical education? What are your expectations of the university and your organisation as a clinical educator?</p>
<p><b>Analysis of the position of clinical educators within practice and organisational hierarchies, based on the distribution and type of capital</b></p>	<p style="text-align: center;">TENSION OF TIME</p> <p>Clinical educators perceived 'time' as a key tension between their roles as clinician and clinical educator; it also inhibited them from doing a better job. How could you create more time i.e. what needs to change? How do you negotiate more time?</p> <p style="text-align: center;">KNOWLEDGE AND SKILLS OF CLINICAL EDUCATION</p> <p>Clinical educators and stakeholders in clinical education perceived there to be unique knowledge and skills associated with clinical education. What do you perceive those skills to be? How do you learn to be a clinical educator?</p>
<p><b>Analysis of habitus of participants in relation to CE/other stakeholders and organisations and their influence on their social trajectory within CE and other fields</b></p>	<p style="text-align: center;">EXPECTATIONS OF STAKEHOLDERS</p> <p>Clinical educators perceived tension to exist between their expectations of clinical education and those of other stakeholders i.e. individuals such as managers, professional leaders, university staff, students and organisations i.e. DHB, private practice. Such tensions include whether clinical education should be paid for given that new graduates are then employed by organisations such as DHBs. Why are the expectations of stakeholders different to clinical educators? What can be done to align the expectations of clinical educators and stakeholders?</p>

# Appendix K Transcriber confidentiality agreement



## Confidentiality Agreement

*For someone transcribing data, e.g. audio-tapes of interviews.*

Project title: A critical inquiry of clinical education in physiotherapy.

Project Supervisor: Assoc. Prof. Liz Smythe

Researcher: Sarah Mooney

I understand that all the material I will be asked to transcribe is confidential.

I understand that the contents of the tapes or recordings can only be discussed with the researchers.

I will not keep any copies of the transcripts nor allow third parties access to them.

Transcribers' signature: .....

Transcriber's name: .....

Transcriber's Contact Details (if appropriate):

.....  
.....  
.....  
.....

Date:

Project Supervisor's Contact Details (if appropriate):

.....  
.....  
.....  
.....

Approved by the Auckland University of Technology Ethics Committee on: 17.11.06

AUtec Reference number: 06/177

## Appendix L Summary of how trustworthiness and value of data were achieved within this research

QUALITATIVE TERM AND DEFINITION	STRATEGY EMPLOYED	HOW THIS WAS ADDRESSED IN THIS RESEARCH
<p><b>CREDIBILITY AND TRUTH VALUE</b>            Participants are adequately represented within research.            Congruence exists between what was concluded from the data and the perceptions and interpretations of the participants.</p>	<p>Purposive sampling recruiting participants who were representative of key relationships with clinical educators            Methods of triangulation including participant, peer and supervisory review            Audit trail            Reflexive stance</p>	<p>Participants were recruited from both New Zealand Schools of Physiotherapy and published group and committee memberships.            Multiple participant roles were confirmed within the interview and viewpoints clarified as appropriate.            Methods of triangulation included cyclical/spiral analysis of interview data, with themes brought to the next interview and cumulatively to Phase II interviews. Theoretical triangulation was undertaken through close alignment with key research Bourdieusian principles.            Transcripts were returned to participants for verification.            Critical review and verification of interpretations by research peers and supervisors.            Presentation of key findings at New Zealand Society of Physiotherapists' Inc conference and Physiotherapy Education Group (minimum of 8 participants present at each forum).            Decision trail maintained and open to scrutiny.            Reflective notes maintained following interviews and throughout research process</p>
<p><b>DEPENDABILITY AND AUDITABILITY</b>            Stability of research design and data            Accommodation of the variability of participants and the context in which research is conducted</p>	<p>Semi-structured interview format            Audit trail            Methods of interpretative analysis</p>	<p>Flexibility and responsiveness of researcher within the interview.            Semi-structured questions were underpinned by the Bourdieusian concepts of habitus, capital and field.            Participant review and verification of interview transcripts.            Decision trail maintained and open to scrutiny.            Trail of analysis and interpretation available for scrutiny.</p>

<b>QUALITATIVE TERM AND DEFINITION</b>	<b>STRATEGY EMPLOYED</b>	<b>HOW WAS THIS ADDRESSED IN THIS RESEARCH</b>
<p><b>CONFIRMABILITY</b> Neutrality of the data and interpretations</p>	<p>Methods of triangulation including participant verification Audit trail Reflexive stance</p>	<p>Verification of transcripts by participants and the opportunity of participants to edit the transcripts. Cyclical/spiral analysis of interview data, with themes brought to the next interview and cumulatively to Phase II interviews for verification. Decision trail maintained and open to scrutiny. Trail of analysis and interpretation available for scrutiny. Reflective notes maintained following interviews and throughout research process. Critical review and verification of interpretations by research peers and supervisors.</p>