

# **Insight into the experiences of oral health therapy students on clinical placement**

## **A qualitative study**

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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 that has been previously published or written by another person or material which to a substantial extend has been accepted for the qualification of any degree or diploma of a University or other institution of higher learning, except where due acknowledgement has been made in the acknowledgment.

**Signature**..... **Date**.....

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## **Abstract**

Clinical experience is an essential component of the oral health therapy curriculum. A considerable amount of student clinical time is spent on placement; yet very little research currently exists which would provide insight into students' experiences within this context. This qualitative study addresses that void and explores the 'lived' experiences of oral health therapy students on community placement.

The research question: 'what are experiences of oral health therapy students on community clinical placement?' provided the focus of this study. Five, third year oral health students were interviewed and van Manen's thematic analysis method was used to analyse the data derived from the interviews.

Three core themes emerged from the data: relationships matter, the leap to 'real' situation is huge, and students do become confident and skilled. The findings revealed that relationships were important to student learning. The students regarded the clinical educators as their main source of learning, although peers were also identified as providing practical and emotional support as well as being a valuable source of informal learning. However not all relationships were supportive of learning and these influenced how students perceived their placement.

The move from model to 'real' patient was immense and students experienced a range of emotions during the transition. Initially students were anxious and fearful of hurting and harming the patients; but as they acquired the necessary skills and confidence, they began to see patients as people and sought to develop a relationship with the children. The students in this study were altruistic and wanted to make a difference to the lives of their patients, not just provide dental treatment. In essence they 'cared about' not just 'cared for' the children they treated.

Time, an opportunity to practise skills, support from the clinical educator and appropriate feedback, assisted students to acquire the requisite skills and knowledge of an oral health therapist. As the students became more experienced and confident

they relied less on the clinical educator for guidance and became more autonomous in their practice.

This research highlights the influence of context and relationships on clinical experience and has implications for practice, research and education for both oral health and dental therapy practice. The study calls for oral health educators to consider how they plan clinical experiences and review how they teach and support students in the clinical environment, in order to improve the quality of clinical placements.



## **Chapter One: Orientation to the Study**

### **Introduction**

The aim of the research is to gain an understanding of the experiences of being on clinical placement in community school dental clinics. This qualitative interpretive study will explore meanings within the experiences of oral health therapy students on clinical placement, through interpretation of the narratives of five third year students.

In this chapter the research question and aim of the study are outlined and my choice of methodology explained. The significance of clinical placements is described, background information on the dental therapy profession is provided and the socio political context in which oral health therapy practice exists is discussed. The relevance of the study is identified and my background and personal and professional presuppositions in relation to the study are disclosed.

### **Research Question**

What are the experiences of oral health therapy students on clinical placement in community dental training clinics?

### **Aim of Study**

To uncover the meaning of the experiences of oral health therapy students on community clinical placement.

### **The Role of Clinical Placement in Learning**

Learning in an authentic environment, within a socio-cultural context, is the central notion of a number of educational theories (Woolley & Jarvis, 2007). Educational theorists assert “that context is crucial for learning and instruction to be effective” (Woolley & Jarvis, 2007, p. 75). For a number of health care professions, student

clinical experience is an important and necessary part of education (Chesser-Smyth, 2005). It exposes students to real life experiences and provides opportunities for the transfer of theory to practice and the development of skills in an authentic context. It encourages the development of motor sensory skills (Nolan, 1998), allows problems to be placed in context, and encourages students to develop critical thinking and clinical decision making skills (Chan, 2004). Students learn the importance of effective communication and collaboration, develop empathy towards patients and internalize the language, norms and values of the profession. Clinical placement encourages teamwork, collaboration and acceptance of differences (Gerzina, McLean & Fairley, 2005), and provides opportunities to acquire the skills and knowledge not only as a result of the individual's active learning but also by vicarious learning - learning from other students' experiences (Boud, 1994).

## **Background to the Study**

It was the poor oral health of World War One recruits that highlighted the need for a public dental health service which would address the oral health needs of young New Zealanders. History credits Sir Thomas Hunter for establishing the School Dental Service (SDS) and it was upon his ideologies that the school dental service was founded in 1921. The fundamental principles which the school dental service was founded upon were: 1) dental nurses be employed only by the state and work under the supervision of a graduated dentist, 2) dental nurses should be trained in a school controlled by the Department of Health rather than be educated at a university, and 3) dental nurses be permitted to treat only pre-school and primary school aged children. These philosophies shaped the school dental service and impacted on the dental therapy profession for many decades (Brooking, 1980).

Despite opposition from members of the dental fraternity, the SDS was founded to address the high rate of dental disease present in children. To gain the dental fraternities' acceptance of the scheme, females from social middle class backgrounds, who posed no threat to their professional authority and status, were trained as school dental nurses (Brooking, 1980). The designation 'dental nurse', which later changed to dental therapist in the 1980s, was chosen to ensure that the general public regarded

these women as auxiliaries, whose skills would be applicable only to treating children (Brooking, 1980).

Institutions termed 'training schools' were set up by the Department of Health. Curricula were specifically established and conditions were specially designed to prepare the dental nurses, who were exclusively female, for the responsibilities they would be required to undertake. Access to knowledge was restricted; there was "absolute standardization of technique and rigid uniformity of instructions and directions... students were taught only service methods and procedures" (Leslie, 1971, p. 203) which were strictly adhered to. Personal judgment was discouraged or at least reduced to the barest minimum (Leslie, 1971). Lecture notes, which were exclusively written for student dental nurses, provided all the information deemed necessary for practice and individual research was discouraged. Upon graduation school dental nurses were issued with a copy of 'Standing Instructions'. According to Leslie (1971) this manual supplemented the dental nurses training and covered in depth every conceivable issue related to a dental nurses' work. It spared the dental nurse the anxiety of making choices; and thus enabled her to cope confidently with her duties.

This was the era in which I trained as a school dental nurse in the mid 1970s; a far cry from today's university based education which oral health therapists are required to undertake in order to graduate with a Bachelor of Health Science Degree in oral health. My first year had both a theoretical and practical component and subjects included general and oral anatomy, histology, physiology, general and oral pathology, conservative dentistry and dental health education. Six months was spent working on ossim<sup>1</sup> heads and considerable time was spend assisting and observing senior dental nursing students in a clinic setting. My second year was mostly spent in a large multi chair clinic treating children under the supervision of dental tutor sisters and senior dental officers. Throughout my two year course the emphasis was on experiential learning.

Oral health therapists are now educated along broader lines at universities which teach approved accredited programs. The duration of the oral health degree is three years and oral health students cover a broader range of subjects. As well as the

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<sup>1</sup> Ossim heads are polycarbonate heads with jaws which contain plastic teeth. Oral health therapists learn the technical aspects of dental therapy on these phantom heads

requisite science and dentistry papers, they attend lectures with students from other disciplines on psychology and life span development, health law and policy, ethics and research. Aspects of New Zealand's cultural heritage are also incorporated; thus an understanding of the Treaty of Waitangi and cultural diversity is acquired. Assessments are competency based and students are encouraged to analyse, critique and synthesize, in all aspects of their education. Oral health therapists begin their community clinical placements in the second year of study and now spend less time in the clinical setting.

Changes to dental therapy education began in 1990 when the last of the three Ministry of Health training schools was disestablished and dental therapy education was transferred to the Department of Education. An educational programme was established at Wellington Polytechnic. The duration of the course continued to be two years and on completion a Diploma in Dental Therapy was awarded (Coates, Kardos, Moffat & Kardos, 2009). Failure to attract students to polytechnic training, the recognition that a two year educational/training course was an inadequate time frame in which to equip graduates with the skills required to meet the professional standards associated with registration, combined with the increasing need to develop a professional work force, influenced the movement of education and training to the university environment (Coates et al., 2009).

In 1999 the University of Otago began educating dental therapists; it continued to offer a two year diploma until 2002 at which time it introduced a three year Bachelor degree. Auckland University of Technology (AUT) commenced its Bachelor of Health Science (Oral Health) degree at the beginning of 2002. By 2007 both Otago and AUT Universities had merged the hygiene and dental therapy practice curriculum and were offering a three year dual degree (Coates et al., 2009).

Dental hygiene in New Zealand is a relatively new profession and initially the New Zealand Dental Council opposed the training of dental hygienists, claiming that hygiene practice was not appropriate for the New Zealand environment. The only hygienists in New Zealand in the 1970s were those trained by the New Zealand Army, to provide oral care for its personnel. It was not until 1994 when Otago Polytechnic introduced a Certificate in Dental Hygiene that civilian hygienist training began. The University of

Otago assumed responsibility for training dental hygienists in 2001 and in 2002 the Bachelor of Health Science (endorsed in Hygiene) was introduced. This continued until 2006 when the dual degree Bachelor of Health Science (Oral Health) at AUT was instigated and in 2007 the Bachelor of Oral Health at Otago commenced (Coates et al., 2009).

To date, the most significant occurrence to impact on the dental therapy profession was the introduction of the Health Practitioners' Competence Assurance Act (HPCA) 2003. This legislation brought dentists, dental therapists, dental hygienists and dental technicians under the umbrella of the Dental Council; a self-regulatory authority responsible for coordinating and ensuring continuity in the various dental professions. It charged the Dental Council New Zealand (DCNZ) with responsibility for protecting the health and safety of the New Zealand public by ensuring that all oral health professionals were competent and fit to practice (DCNZ, 2010).

Significant changes occurred within the dental therapy profession with the introduction of the HPCA Act. Dental therapists ceased to work under the license of a dentist; they became registered, autonomous practitioners responsible for their own practice and clinical decision making. Continuing professional development became mandatory. Dental therapists now have their own scope of practice and practice in accordance to a code of practice, an agreement which describes the professional relationship that exists between dental therapist and dentist. State monopoly and control which restricted working opportunities for therapists was removed and therapists are now able to seek employment in the wider community. Dental therapists and dentists now have a consultative relationship while dental hygienists continue to practice within a team situation under the clinical guidance of a practicing dentist (DCNZ, 2010).

Although dental therapists and hygienists have different scopes of practice, they share some common knowledge and are highly complementary. Dental therapists provide a full range of preventive and restorative services to children and adolescents up to the age of 18 years (Coates et al., 2009). Most are employed within the SDS, with only a small number currently working in private practice. Although this trend seems to be gradually changing as more dental therapists are seeking employment in the private

sector. Dental hygienists' primary task is the prevention and non-surgical treatment of periodontal disease. Their role is to provide oral health education and the prevention of oral disease to promote healthy oral behaviours (DCNZ, 2010). Most are employed within the private sector and treat adults. The commencement of the dual degree was a significant educational shift for both the dental therapy and hygiene professions. The resulting qualification enables oral health graduates to register with the New Zealand Dental Council in either or both dental therapy and hygiene scopes of practice (Coates et al., 2009).

The tensions that exist within the dental therapy and hygiene professions centre on a lack of continuing education, which would enable practitioners to extend their scope of practice. The introduction of the dual degree has created a 'new oral health therapist' with a dual scope of practice. Practitioners in both disciplines have demonstrated an interest in gaining additional skills and becoming dual skilled. However, no bridging course currently exists within New Zealand that would allow either dental therapist or hygienist to extend their qualifications in order to register in both scopes of practice.

Within the additional scopes of practice, provision currently exists for dental therapists to provide dental care to adults over 18 years of age, but no accredited training programme exists in New Zealand; even though findings from a study undertaken in Australia provided evidence that dental therapists are competent to provide dental care to the adult population (Calache et al., 2009). Postgraduate papers specific to the oral health profession are not currently available within AUT University. I believe the responsibility to provide the additional qualifications that both professions are seeking lies with the education sector.

Aside from educational and legislative changes of the last decade, future changes in dental service delivery are on the horizon. The SDS is moving to a more centralized community based delivery model as called for by the New Zealand Government's 2006 Strategic Vision. Dental therapists will work in a different environment to the one that currently exists. Changes in practice, increased professionalism and teamwork will be necessary; as dental therapist, dentists, hygienists and dental assistants will be

required to work together in order to provide improved oral health care service (Ministry of Health [MoH], 2006).

A District Health Board (DHB) located in the North Island currently provides four community dental training clinics where second and third year oral health students spend time on placement. These clinics are located on school grounds or in very close proximity to a school, in various locations in a major centre. Oral health therapy students gain exposure to the realities of professional practice, with guidance, support and supervision from a clinical educator, in three or four chair community dental clinics. In clinical settings, students develop observational skills which include visual, auditory, olfactory and tactile abilities, and master procedures essential for the treatment of oral disease. It is also where students link theory to practice, develop clinical reasoning, problem solving and critical thinking skills, and acquire the ability to reflect on practice. Students learn the importance of effective communication and collaboration; they develop empathy towards patients and internalize the values and norms of the profession. These placements also provide students with the opportunity to work with different cultures and various socio-economic groups.

There are four clinical educators currently employed by the DHB in the region of the study, who work within the dual domains of professional practice and education. The clinical educators are required to be skilled practitioners, who role model sound professional practice as well as being competent teachers. They are responsible for the clinical supervision of the students on placement and take legal, ethical and moral responsibility for the students and the patients assigned to them. Clinical educators assess student learning needs and plan learning activities. They evaluate student performance and provide feedback; they manage both learning environment and student group processes. Clinical educators endeavour to balance the care of the patients with the learning needs of the students; while ensuring that all system requirements – administration, record keeping and patient safety protocols are adhered to. They have all attained their Bachelor of Health Science in dental therapy, two clinical educators graduated with this qualification and two upgraded from a Certificate and Diploma to Bachelor degree status during their employment as clinical educators. Their qualifications in teaching vary; one has a Postgraduate Diploma in

Professional Health Education, one is currently undertaking papers for her Diploma in Tertiary Teaching and two educators have no formal teaching qualifications.

Oral Health therapy is a 'hands on' practice based discipline and clinical experience is an essential component of the Bachelor of Science (Oral Health) degree. Oral health therapy students rotate between the four training clinics during their three year degree. Over a two year period students spend 900 hours in the clinical environment, 450 hours gaining dental therapy skills and 400 hours on hygiene practice. Their clinical placements begin at DHB community based training clinics in the second year of their studies. Students attend these settings one day per week during the second and third year of their degree; it is in these clinics they gain clinical experience in dental therapy practice. During the third year, students further develop their dental therapy skills at an oral health clinic on site at the university and a university community dental clinic. They gain their experience for hygiene practice at a designated community dental clinic and at the oral health clinic located at the university. These clinical placements are, however, outside the scope of this study. This research investigates the experience of students undertaking dental therapy practice on clinical placements at DHB community school dental clinics.

## **Relevance of Study**

Clinical placements shape the professional future of students (Pearcey & Draper, 2008). The clinical context has been identified as being valuable for preparing students for independent clinical practice (Edwards, Smith, Courtney, Finlayson & Chapman, 2004; Gerzina et al., 2005; Smith, Lennon, Brook, Ritucci & Robinson, 2006) and expanding their perceptions of their future professional identity (Edwards et al., 2004). Nolan (1998) affirmed that studies which provide insight into student experience on clinical placement are crucial if learning is to be made the most of in these environments.

This research will provide clinical educators, involved in teaching oral health students, with a greater understanding of the learning experiences of these students and the influence of context on the learning process. Oral health educationalists will be able to reflect on and refer to findings from this study when planning future clinical



experiences and use the data to ensure these placements are fully maximized. The study will also address the void that currently exists within the oral health educational sector and provide a body of knowledge specific to the dental therapy profession.

## **Personal Context**

My motivation for undertaking this study is to address the void in research that currently exists within the education sector of oral health therapy. For the past nine years I have been employed as a clinical educator, responsible for teaching dental therapy practice to oral health therapy students on clinical placement in community training clinics. Throughout this time, I have searched for studies in my discipline which would allow me to gain insight into the experiences of oral health therapy students on clinical placement, to assist in my teaching role, with limited success.

A significant amount of research has been undertaken on the experiences of clinical placements of students from other health care professions, and some of these are relevant to oral health therapy students. Certainly many of the teaching theories and guidelines currently in use in teaching clinical practice are very applicable to oral health therapy. But there are important differences between the clinical experiences of oral health and other health care students. Significant features of oral health therapy practice include the highly invasive nature of practice and the low student ratio per clinical educator, which results in close proximity of educator and students. The close proximity and its impact on dental student and clinical educator are confirmed in research undertaken by Schonwetter, Lavigne, Mazurat, and Nazarko (2006) who noted that high levels of rapport occur between clinical educators and dental/hygiene students as a result of the close proximity and low student ratio per clinical educators.

A small number of studies (Mofidi, Strauss, Pitner, & Sandler, 2003; Schonwetter et al., 2006; Smith et al., 2006) have been undertaken internationally on the experiences of dental and hygiene students on clinical placement and some of these findings may be applicable to student clinical placement described in this study. However, the clinical contexts in which these students practice are very different to those which New Zealand oral health therapy students encounter during their placements. To date, no

qualitative studies exist which would provide insight into the experiences of students undertaking dental therapy practice in a New Zealand community training clinic.

## **Methodology**

I chose a qualitative research approach for this study in preference to a quantitative approach because of the highly interpretive nature of my topic. A qualitative approach seemed to fit well with my research question as it provided a unique appreciation of the reality of the experience (Morse & Field, 1996). Using this approach allows the researcher to go to participants to discuss their everyday experiences and consider their interpretation (Denzin & Lincoln, 1994). To attain more depth to my study, move beyond the actual narrative of everyday clinical experiences and explore the meanings that lie behind the stories, I have drawn on the works of Gadamer [1900-2002], Heidegger [1899-1976] and van Manen.

Hermeneutic phenomenology is an interpretive approach/methodology that investigates the lived experiences of individuals in an attempt to access the life views that exist and understand the structure and meaning of human experience more fully (Morse & Field, 1996). Using this approach allowed me to stay close to the participants' experiences, as I attempted to gain insight and understanding of the experiences of oral health therapy students' experiences while on placement in community dental clinics. The four "life existential" of; lived time, lived space, lived body and lived relationship enabled me to consider the "life world" of the students from varying perspectives.

Hermeneutic phenomenology focuses on the person and the context of their existence (MacKey, 2005). Heideggerian philosophy asserts that humans cannot detach themselves from the world and their experiences are linked to social, cultural and political contexts. Within this paradigm all meanings are constructed by human beings in unique ways which are dependent on the participant's personal frames of reference and context (Lopez & Willis, 2004; Mackey, 2005). Context is an important aspect of this study and this methodological approach enabled the contextual features of the experience of clinical placement to be highlighted.

In addition to the works of the identified renowned phenomenologists, a wide range of literature has been referred to for this research, in order to place the study into a context of wider understanding. Donald Polkinghorne, whose work *'Practice and the human sciences – the case for a judgment-based practice of care'* (2004), I refer to in this study, provided me with significant insight into professional practice and the human sciences and enabled me to gain a greater understanding of the current context of professional practice.

## **Bias and Pre Understandings**

I bring to this research all my pre-understanding and prior knowledge; I am experienced in clinical teaching and I possess knowledge acquired through observation and research on how students experience clinical placement. Hermeneutic phenomenology requires I make explicit all my prejudices (value positions). Heidegger claimed that “we understand in terms of what we already know [because without that] there would be no understanding at all” (Geanellos, 1998, p. 160). Gadamer believed that it is impossible to rid the mind of historical understanding and pre-understandings are a necessary part of the researchers understanding (Geanellos, 1998).

I have been employed within the school dental service as a dental therapist for 30 years. For the last nine years my role has been that of clinical educator, teaching clinical practice to oral health students in a community dental training clinic during semester. During non student contact times I am involved in staff development, teaching and mentoring registered dental therapists, I also continue to practice dental therapy during this period.

I place a high priority on continuing education. In 2004 I gained a Certificate in Tertiary Teaching from AUT, I upgraded my certificate in dental therapy to a Bachelor of Health Science in Oral health in 2005, and in 2009 I graduated with a Diploma in Health Science in Teaching Professional Practice. ‘Knowledge is power’ and I have personally felt a sense of emancipation and empowerment through knowledge gained; it has impacted on my role both as a dental therapist and clinical educator. Teaching has allowed me to further my knowledge from a personal and professional perspective.

## **A Story from my Practice**

I graduated in the mid 1970s and, like so many of my contemporaries, I was sent to work in a rural area with high dental needs. I worked for six months in the position of second nurse and was then sent to work in a single chair clinic, as was the norm in those days. These single chair clinics were located at many of the primary schools around New Zealand and were a feature of the school dental service. Working in a sole charge clinic meant dental nurses worked in relative isolation without support from their colleagues, with only the occasional visit from the principal dental officer or dental nurse inspector. With little encouragement to study further and with limited access to any evidence based research, “standing instructions” was the main source of reference for the school dental nurse. Very little tolerance for professional judgment or deviation from guidelines existed during this era. As a young school dental nurse I recall experiencing the difficulties and the stress associated with trying to cope with situations and cases that did not fit into the ‘norm’ of practice. I was fearful of being reprimanded for stepping outside prescribed practice; even if that prescribed practice was not in the best interests of the patient.

Returning to dental therapy in the mid 1980s, after an absence of several years, I found there had been very little change within the profession. Dental therapy practice was still rule bound, with very little scope for professional judgment or clinical decision making. Many of my contemporaries found this a safe reassuring environment to work in; while others, like myself, were frustrated with the constraints that existed. Despite registration, this situation continued until late 2008.

Early in 2009 I was asked to be part of a six person team; our brief was to rewrite the service clinical practice manual. The new clinical guidelines encourage clinical decision making and professional judgment. Dental therapists are now required to take professional responsibility for clinical decision making and reasoning. They are encouraged to base their decisions on the needs of the patient, considering best practice guidelines and justify their decisions as required. The environment has now changed, some dental therapists enjoy the flexibility that the new guidelines have provided, and others feel they practice in an unsafe environment.

But, the changes are here to stay. It is the environment that new graduates encounter when they enter the workforce, an environment they must be prepared to work in. I believe my role as clinical educator is to prepare the students for this reality. I view the clinical placements as being important not only for learning the technical skills; but believe it is the environment in which students' link theory to practice, develop clinical judgment and decision making skills. Not all clinical educators place emphasis on these attributes and some believe the focus of clinical placement should be learning the practical aspects of the role. I agree it is vital for students to acquire the necessary skills, but in my view both 'doing' and 'thinking' need to occur simultaneously on clinical placement.

Midway through 2010 a new group of students arrived for placement. There is always a period of adjustment when students change clinical educator and I recall one particular student who was capable of completing the clinical tasks if directed but did not demonstrate problem solving skills or clinical reasoning. She lacked clinical awareness. Part way through her placement I sensed her frustration. She appeared to have two sets of knowledge; practical and theoretical, running parallel to each other which needed to merge. An important part of my role is to assist students to make the necessary links or provide opportunities for the links to be made between theoretical knowledge and professional practice. I used all the strategies that I had learned, while undertaking my postgraduate teaching diploma, to encourage her to make the connection, but appeared to be unsuccessful. What was happening? I questioned my teaching style which involves asking questions rather than always providing the answers and encouraging reflection. Was I asking too many questions? Was I making her nervous? Was I encouraging her to reflect enough? Was I providing enough guidance? Was I making my own thinking processes evident?

We discussed her dilemma; she also expressed concern over her lack of 'clinical thinking' and her inability to bring her 'knowledge' and 'practice' together. Acknowledging her difficulties and talking through her concerns appeared to help. Gradually I observed improvements; she began to gain understanding and started making the necessary connections. In the process her confidence soared and this further increased her ability, confidence and motivation. At the conclusion of her placement she acknowledged her increased knowledge level and I felt a sense of

satisfaction for her at the progress she had made in moving towards independent practice. It is experiences like these that motivated me to undertake this study, to gain an in-depth understanding, or perhaps a different understanding, of students' clinical experiences, from the one I possessed before embarking on this research.

## **Overview of this Thesis**

### **Chapter One: Orientation into the study**

In this first chapter I have discussed my research question and methodological approach. The study has been placed within a personal and professional context.

### **Chapter Two: Literature review**

Chapter two explores the literature of clinical placement in order to put the study into context of existing research and scholarship; although by necessity, much of it lies outside of dental therapy.

### **Chapter Three: Methodology and method**

Chapter three explains the methodology and provides a description of the research study using van Manen's (1997) hermeneutic research method. Study design, researcher conduct and ethical considerations are discussed. Recruitment of participants, data collection and data analysis are also discussed and the trustworthiness or rigour of this qualitative study is addressed.

### **Chapter Four: Relationships matter**

In this chapter data relating to students' interpersonal relationships with their peers and clinical educators is examined.

### **Chapter Five: The leap to real patient is huge**

Moving from model to patient is the main theme of this chapter, which analyses students' experiences as they move from plastic head to 'real' patient.

**Chapter Six: Learning does occur**

This third data chapter explores students' experiences as they make the transition from being unconfident and anxious, to confident, competent practitioners.

**Chapter Seven: Discussion**

The meanings that have evolved from the three data chapters will be discussed. Implications for practice and education, and recommendations for future research, will be addressed in this final chapter.

**Summary**

The research question and the aim of this study have been introduced in this chapter. Background on the SDS and the dental therapy profession has been provided, and oral health therapy has been placed in the socio political context of this period of time. The relevance of the study which examines the experiences of oral health therapy students on clinical placement in community training clinics has been addressed. My personal background and presuppositions have been outlined and an overview of the structure of this study has been provided. The need for research related to the clinical experience of oral health therapy study is clearly evident and will be re-enforced in the literature review that follows.

## **Chapter Two: Literature Review**

### **Introduction**

In this chapter, literature is reviewed to situate this study in a context of existing writing, with relevance to the study's focus: to investigate the experiences of students on clinical placement. Numerous studies have been undertaken relating to students on clinical placement within in the health care sector and in particular the nursing profession, but there is a paucity of research about the experiences of oral health practitioners on clinical placement. Many of the studies I refer to in this literature review are derived from the nursing profession, principally because of the similarities that exist between the disciplines of nursing and oral health therapy. Both disciplines are 'hands on' and practice based, and clinical placement takes place within an environment where patient care and learning occur simultaneously. The limited numbers of studies that are currently available within the dental profession are also included. Literature and research which does not pertain to student clinical placement has been cited to place this study in a wider context of learning and teaching. Most of the literature cited originates from overseas. This chapter begins with an overview of the social theory of learning.

### **The Social Theory of Learning**

Social theory of learning best supports the concept of learning on clinical placement. This theory of learning is based on the premise that learning is located in social participation and dialogue; it represents a shift from the individual cognitive processes to the belief that social relationships shape learner identities (Siebert, Mills, & Tuff, 2008). The social situated theory emphasises learning as participation rather than learning as just knowledge acquisition (Felstead, Fuller, Unwin, Ashton, Butler, & Lee, 2005). The central notion of Lave and Wenger's' (1991) social learning theory is that learning is situated and therefore cannot be considered in isolation from the social relations that shape legitimate participation. Wenger (1998) maintained that social



theory integrates the following four interconnected components: community - learning as belonging, practice – learning as doing, identity – learning as becoming, and meaning – learning as experience. According to Siebert et al., (2008) the social and cultural environment constructs the learner and learning is a social process which can occur in both formal and informal contexts.

## **Clinical Placement**

Clinical placement is regarded an integral and essential part of education (Chesser-Smyth, 2005) for a number of health care professions. Nolan (1998) described clinical experience as the “heart” of professional education. While Boud (1993) stressed that experiential learning occurs best in context. Clinical placement allows students to experience the ‘real life’ situation of providing care (Chapman & Orb, 2001) and is regarded as a more effective setting for learning than the laboratory or demonstration rooms (Chapman & Orb, 2001). It offers students their first experiences of seeing and doing and provides them with new experiences, learning situations and interesting events (Peyrovi, Yadavar-Nikraves, Oskouie, & Bertero, 2005). The clinical environment provides a context where students have the opportunity to apply the theoretical knowledge, skills and concepts learnt in the classroom, to actual patient care within an authentic environment (Chapman & Orb, 2001; Peyrovi et al., 2005). It provides students with an opportunity to develop critical thinking and clinical decision making skills (Chan, 2004).

While on placement students acquire the skills and knowledge required to meet the learning outcomes prescribed by academic institutions. They learn how to become professionals in both the clinical setting and in their professional practice (Chan 2004; Chapman & Orb, 2001). It is an environment where students are able to practice their communication skills, observe role models and learn from practice. It enables students to acquire professional values by socialising into the profession (Nolan, 1998). The opportunity to work alongside peers enables students to accept differences, while developing skills in teamwork and collaboration (Gerzina et al., 2005). Learning that occurs through activity that is authentic and involves social interaction within a socio-cultural context is pivotal to ‘situated learning’ (Brown, Collins, & Duguid, 1989) and is

the central concept in Lave's theory of communities of practice (Lave & Wenger, 1991). Both these theories assert that context is crucial for learning and instruction to be effective (Woolley & Jarvis, 2006).

Difficulties associated with initiating and sustaining an environment conducive to learning in the contemporary health care environment has been identified in research (Dunn, Ehrich, Mylonas, & Hansford, 2000; Dunn & Hansford, 1997; Field, 2004). Clinical placement can be problematic as the clinical environment is both a patient care and learning centre. It can be difficult to control, as it is constantly changing and sometimes unpredictable and stressful. Therefore, at times it is difficult to plan optimal student learning experiences (Papp, Markkanen, & von Bondorff, 2003). Clinical placements are constantly being challenged by the complex and demanding nature of the environment; this can threaten both student self esteem and patient safety and can be a potential barrier to learning (Schonwetter et al., 2006). Chan's (2004) study identified that the nature of the clinical learning environment has an impact on the outcomes of student's clinical experiences.

Research findings indicated that students can perceive clinical experience as anxiety provoking and threatening (Beck, 1993; Nolan, 1998; Sharif & Masonumi, 2005). The clinical component is identified as the most anxiety producing part of health professional education in a significant number studies (Beck, 1993; Beck & Srivastava, 1991; Sharif & Masonumi, 2005; Timmins & Kaliszer, 2002), while the initial clinical experience is perceived as the most anxiety producing aspect of the clinical experience (Beck, 1993; Kleehammer, Hart, & Keck, 1990; Sharif & Masonumi, 2005). Doubting oneself, feeling incompetent and overwhelmed, anxiety, fear and abandonment are emotions that have been identified as being experienced by students (Pagana, 1988; Sharif & Masonumi, 2005).

White (2003) believed that when students become focused on their needs, they are unable to direct their attention to the patients. Research confirmed that anxiety creates a barrier which can hinder learning (Levett-Jones & Lathlean, 2007). However sometimes stress is unavoidable due to the nature of the experience. Whitman, Spendlove and Clark (1984) asserted that not all students will see stress as a threat and some students may view it as a challenge which motivates them to learn. Student

preparation for their initial placement has been identified as being critical to students fitting into the clinical context by both Mahat (1998) and Nolan (1998).

Policinski and Davidhizar (1985) maintained that students deal with insecurities on an ongoing basis during their enculturation into the health care system. The authors believed that educators can influence students' self-perceptions; that feelings of inadequacy are related to failure, while feelings of adequacy are associated with success. They claimed that student feelings of success and adequacy are influenced more by the educator's personality characteristics than knowledge or skills and advocate stress intervention to maximize student learning and promote feelings of satisfaction.

Melia (1984) noted students often attend clinical placement on a short term basis and she asserted that rotating between too many clinics is unsupportive to learning. Nolan (1998) suggested that unfamiliarity of new settings increases anxiety and may hinder student learning; her study argued for exposing students to fewer clinical locations. White (2005) believed that while broadening students' clinical exposure may be appropriate, it may significantly influence a student's ability to function effectively in the clinical setting. Some students find it difficult to adjust to working with different educators who have different expectations and different skill levels (Elcigil & Sari, 2007). Lofmark and Wikbald (2001) reported lack of continuity in supervision as an obstructing factor for learning on clinical placement.

Feeling unsafe, being unaccepted and alienated has a detrimental effect on student learning (Nolan, 1998). Therefore, a supportive clinical environment is therefore essential in securing the required teaching and learning processes that students need in order to progress (Chan, 2004; Nash, Lemcke, & Sacre, 2009). Creating an environment where students feel safe, accepted and experience a sense of belonging enhances student learning (Levett-Jones & Lathlean, 2008; Lofmark & Wilkbald, 2001; Newton, Billet, & Ockerby, 2009).

In his book *'The Courage to Teach'*, Palmer (1998) referred to six tensions or paradoxes that need to be addressed in a learning environment. According to Palmer the learning space must be both open to remind us of possibilities, but also bound in order to maintain focus. It must be hospitable in order to be safe and trustworthy, but also

'charged' to encourage deeper investigation of things in life. Learning spaces should encourage speech, honour people's views, thoughts, feelings and experiences. It should offer solitude and community where individuals' experiences and struggles are respected; the environment must also be a place where people are supported in their endeavours. Silence through reflection and speech to enable greater understanding are also regarded as important components within a supportive learning context (Palmer, 1998).

## **Clinical Educator - Student Relationship**

The clinical environment is a complex social context which can impact on student learning (Chan, 2004; Chapman & Orb, 2001); as relationships play a central role in student learning on placement (Chan, 2004). Moos (1987) asserted that the social climate can influence an individual's behaviour, feelings and growth.

Literature identifies the clinical educator as having an influential role in student learning on clinical placement (Campbell, Larrivee, Field, Day, & Reutter, 1994; Peyrovi et al., 2005). Spouse (1998) claimed that support from clinical staff is vital and without it students find it difficult to learn. Buber (1996) stressed the importance of student-teacher connection in learning/teaching. This view is supported by Gillespie (2005) who argues the student-teacher connection is vital in supporting students learning. Gillespie, like Palmer (1989), maintained that students need a 'space', which she defined as a place of possibility, where students are affirmed; assisted to become aware of their own potential and supported in their personal and professional development by their educators. Gillespie (1997) identifies trust, knowing, respect and mutuality as important qualities which if embodied within the student-teacher connection assist in student learning and acceptance. The importance of student teacher connection is highlighted by the above author as being fundamental if students from diverse cultures are to be supported in the educational processes. Levett-Jones and Lathlean (2006) affirm that feeling accepted and valued was a motivator in student learning and if students are supported in their learning they focus less with their interpersonal relationships and more on learning.

Schonwetter et al.'s (2006) research on undergraduate dental and dental hygiene students' perceptions on effective classroom and clinical education, found that close clinical proximity and continuing communication were a significant feature of oral health education, thus it encouraged close educator student relationships in the clinical environment. Fugill's (2005) research also supports this notion. His study suggested that the one on one relationship between educator and student is a key aspect of student clinical learning in restorative dentistry.

Relationships with educators have also been identified as a significant aspect of professional socialization by Secrest, Norwood and Kealtley (2003), because students develop their professional values system through their interaction with other health professionals (Ferguson & Calder, 1993). Both Ahern (1999) and Suikkala and Leino-kilpi (2005) elaborated on this notion and suggested that clinical teachers play a significant role in role modelling clinician-patient relationships; and it is from the educator-student relationships that students develop their own professional value system.

The supervisory relationship that exists between educator and students was closely related to students' satisfaction and learning outcomes during their clinical placements (Dunn & Hansford, 1997). Cavagh and Snape's (1997) study revealed that interpersonal relationships with educators can sometimes be a source of stress for students. A positive attitude is necessary in both student and educator in creating an environment conducive to learning (Valet & Neville, 2006). Elcigil and Sari (2006) concluded that the hierarchical relationship that students perceive exists, causes many students to feel anxious about approaching the educator; they worry they will be harshly judged and be seen as lacking knowledge and skills. Hence they feel more comfortable asking questions of their peers than their educator (Campbell, et al., 1994; Christiansen & Bell, 2010). Being constantly watched and assessed by educators was regarded as a major limitation to learning and confidence (Nolan, 1998). Tiwari, Lam, Yuen, Chan Fung and Chan (2005) identified that a highly evaluative environment hindered student learning.

## Student-Peer Relationships

Cooperative learning, collaborative learning and peer coaching are all terminology used to describe peer assisted learning (Ladyshevsky, 2000). Peer learning is a concept that emerged as a strategy to reduce university attrition and promote key team working skills (Cameron, 2007). It involves students learning with and from each other in ways that are mutually beneficial through the sharing of ideas, experience and knowledge (Topping & Ehly, 2001). Ladyshevsky (2000) claimed that the pedagogic origins of peer assisted learning are found in Vygotsky who emphasised the role of social interaction in learning. Peer learning is also aligned with the theories of situated learning which highlights learning that derives from social process embedded in communities of practice (Lave & Wenger, 1991; Wenger, 1998). In communities of practice, learners learn from each other by sharing information and experiences within the group. The process provides them with an opportunity to develop both personally and professionally (Lave & Wenger, 1991).

Research findings indicate that peers play an important role in student learning and students recognized their peers as being a valuable resource; they facilitate learning and are a source of emotional and practical support in the clinical environment (Campbell et al., 1994; Christiansen & Bell, 2010). Windsor (1987) described peer support as a critical component of positive student learning experiences. Literature highlights the importance of vicarious learning, which occurs when students learn from their peers who are in the same learning context (Boud, 1994; Roberts, 2009). Vicarious learning occurs through listening to colleagues' stories of their experiences, through observation of peers and by identifying with the dialogue of other learners (Mayers, Dinnen, McKendree, & Lee, 2001).

Findings from Peyrovi et al.'s (2005) study indicated that students appreciated their colleagues more than their clinical educator; even if peers are not able to assist each other practically, the feeling of support and understanding they convey to each other makes the learning experience easier. Studies have revealed that it is important for students on placement to know that they were not alone and the fears and anxieties they felt were also experienced by their peers (Campbell et al., 1994; Wilkinson, Peters, Mitchell, Irwin, McCorrie, & MacLeod, 1998).

Peer learning is potentially beneficial to students and congruent with the educational goals of allied health education (Lincoln & McAllister's, 1993). The cited authors asserted peer learning may affirm students' self esteem, self-concept and perceptions of usefulness, and thus increase internal motivation. It may also improve co-operation and collegial relationships between peers. It may or may not increase peer competition, depending on student personalities and their prior experience and understanding of the peer learning process.

Existing literature examines the concept of student teamwork within the academic setting, although not within a workplace environment. Findings from Cartney and Rouse's (2006) study, which examined the role of small group learning in promoting social and academic integration, found working in small groups offered students opportunities for self development, interpersonal growth and support, while providing a sense of identity and belonging (Giles & Ashman, 2003). According to Cartney and Rouse, small groups can be emotionally charged and students can have both positive and negative experiences. Although groups and individual students often find ways of resolving tensions and conflicts that arise, sometimes group conflict escalates and the student's performance and emotional well-being is affected. Group process is influenced by a complex interplay between the emotional and cognitive experiences students bring to their learning (Cartney & Rouse, 2006). The cited authors emphasised the importance of fostering group cohesion and educating students in the basic concepts of team dynamics as ways to encourage student collaboration.

Students from non-Western cultures face additional challenges within the western educational system due to the different learning approaches needed to succeed and the different learning processes that exist (Samuelowicz, 1987). According to Ladysheushy (1996), international students face specific challenges within the clinical practice component of health professional programmes. His research focused primarily on Asian students and his study cited lack of knowledge of culture of host country, language, difficulties adapting to the environment, religious beliefs, Asian educational practices and high levels of stress, which originate from cultural pressures to achieve, as being central to the difficulties some Asian students encounter while studying in western countries. Chiang, Chapman and Elder's (2010) study identified cultural influences such as Confucian beliefs, fear of embarrassment, losing face and shyness or

reluctance to voice opinions, as hindering student learning. Their study elaborated on Asian cultural practices, in that children are taught to respect and obey their superiors, while teachers are highly regarded in the social hierarchy and believed to possess power and authority.

## **Student-Patient Relationships**

Student relationships with patients have also been identified as a significant aspect of clinical learning. According to Suikkal and Leino-Kilpi (2001), these relationships offer both student and patient valuable experiences of caring; but they have been identified as inherently complex as they involve aspects of both care and learning. Johnson's (1994) study affirmed that students regard the student patient relationships as important. During the early stages of clinical placement students focus on developing the required psychomotor skills and find it difficult to individualize patient care (Seed, 1994; Suikkala & Leino-Kilpi, 2001). They are more concerned about their lack of knowledge and skill development and experience difficulty communicating with patients (Seed, 1994). Students feel unprepared and unsure of what to say to patients and this can be a source of tension and anxiety especially during the initial stages of learning (Suikkal & Leino-Kilpi, 2001).

Literature suggests that as students move along the continuum of novice to competent, they come less mechanistic and begin to develop a much wider focus of seeing the patient as a person (Johnson, 1994; Seed, 1994). As students begin to acquire confidence in performing the tasks required they begin to mature both professionally and personally, and this encourages them to view people from a different perspective. Students learn to care about people as they move from 'seeing patients' to 'seeing people' and their attitudes towards patient's change as a result of personal experience (Seed, 1994). Their awareness of their own feelings appears to contribute to creating a helping relationship and professional growth (Johnson, 1994; Suikkala & Leino-Kilpi, 2001). Seed (1994) claimed that students experience different relationships with different patients; she believed that students become more emotionally involved with children than with adult patients. Factors identified in promoting good patient student relationships are contextual and, as previously



discussed, include good clinical role models, supportive supervisory relationships and positive and encouraging feedback (Suikkala & Leino-Kilpi, 2005).

Talking to patients was identified by students as creating anxiety (Mofidi et al., 2003). Findings revealed that students felt uncertain about what to say to patients and felt unprepared and lacking in this essential aspect of practice (Mofidi et al., 2003; Parkes, 1985). Communication has been identified as essential in developing a trusting relationship and a pre-requisite for gaining a child's cooperation in the provision of successful oral health care (Nash, 2006; Sarnat, Arad, Hanauer & Shohami, 2000). Yet very little information, specifically on substantive patient oral health practitioner communication skills, currently exists in paediatric dental literature (Nash, 2006).

Literature identifies two different ways of caring: first, 'caring for' which involves 'taking care of' and second, 'caring about' patients (Morse, Solberg, Neander, Bottorff, & Johnson, 1990). Nodding (1986) described the existence of two types of caring: natural caring which is spontaneous and ethical caring which requires effort and a sense of duty. Morse et al. (1990) identified five different categories of 'care' which occur in the health care environment: caring as a human trait, caring as a moral ideal, caring as an affect, caring as an interpersonal relationship and caring a therapeutic intervention. All forms of care were identified within the experiences of students on clinical placement in literature.

Caring for patients was a central theme that emerged from Mofidi et al.'s (2003) research on undergraduate dentists' clinical experiences. In this study students highlighted the importance of recognizing patients as 'real people' and caring in an empathetic way for patients. They developed awareness of the impact of socio-cultural factors on oral health; discovered how they could make a difference to patient's experiences and expressed a desire to provide quality care to all their patients. Altruism, students wanting to make a difference to the lives of patients and contribute to the greater good, was also a theme in Dunn et al.'s (2000) study.

In student patient orientated relationships students demonstrated their caring behaviour and were vigilant in avoiding harming the patients (Dunn et al., 2000). Some research exists which examines patient anxiety to dentistry but a literature search on dental practitioners experience in caring for patients experiencing pain failed to find

any results from a qualitative perspective. Lack of research in this field also extends into the nursing profession. According to Gunby (1996) a paucity of research exists in nursing literature about how student nurses care for individuals in pain. Gunby believed that students are inadequately prepared to care for patients who are in pain or suffering and need more education to prepare themselves for these experiences.

Research identifies that students, in emotionally distressing situations, are physically present but seek to distance themselves emotionally because of their vulnerability (Gunby, 1996). These findings were consistent with studies undertaken by Nagy (1998; 1999) and Madjar and Walton's (1999) research on nurses' experience of pain infliction while working in burns units. They revealed that caregivers sense something of the patients' pain when performing a clinically justified painful procedure as they try and shield themselves from it. According to Nagy (1998), practitioners have two coping strategies available to them when working with patients in pain. They can either disengage by distancing themselves or engage with the pain. Ways of engaging with the patient's pain involve preparing the patient for the painful experience, improving clinical competence, allowing patients some control over the painful events and providing emotional and physical comfort (Nagy, 1998).

## **Feedback**

Feedback is regarded as essential within the learning and teaching process (Carless, 2006; Clynes & Raftery, 2008). It is recognized in dental literature as an important component of clinical dental education (Fugill, 2005). Henzi, Davis, Jasinevacius and Hendricson (2006) claimed that dental students are rated far more frequently and in more 'fine-grain' detail than other health care students due to the procedural nature of clinical dentistry. Students in their study considered educators who provided helpful, prompt, fair feedback to be the most effective instructors.

Clynes and Raftery (2008) asserted that in the clinical environment feedback should be specific based on observation and must be an unbiased analytical reflection of what occurred. It is essential for students' growth, provides directions, boosts confidence and plays a role in motivation, self-esteem and self efficacy (Clynes & Raftery, 2008;

Fugill, 2005). According to Higgins, Hartley and Skelton (2001), the feedback process is related to issues of emotion and identity. Students with a high self esteem and have a positive attitude to feedback, are appreciative of constructive comments and understand that it relates to performance. Whereas students with low self esteem can interpret constructive comments negatively and perceive them in a personal way (Clynes & Raftery, 2008; Young, 2000).

The quality of feedback and the emotional tone of feedback are considered to be linked to student motivation and self-efficacy and is important to a student's ability to learn effectively (Hattie & Timperley, 2010). Zshar and Smith (2009) believed that "how feedback is delivered is just as important as what feedback is delivered" (p. 242) and Eraut (2006) contended that "relationships are critical for the manner in which communication of feedback is given and received" (p. 114). Fugill's (2005) study concluded that students appreciate feedback which is accurate, frequent, and comprehensive and was provided in a positive emotional environment. Higgins et al. (2001) found that students were dissatisfied with feedback that lacked specific advice on how to improve, was difficult to interpret or had a negative impact on students.

Henzi et al.'s (2006) study on North American dental students' perspectives regarding their clinical education revealed that students felt their educators experienced difficulty communicating feedback. Clynes and Raftery (2008) asserted that educators sometimes find it difficult to give constructive feedback fearing it may impact on student-educator relationships. Inadequate preparation for this role was also cited as a reason why educators find giving feedback difficult (Clynes & Raftery, 2008).

Some inherent problems exist with feedback. Feedback occurs within a complex context and the power relationships that exist between educator and student can be problematic. The conflicting dual roles the educator has in proving support, assisting and passing judgement on a student and the subjective nature of feedback can make delivery challenging (Higgins et al., 2001).

## Clinical Practice

Overall students are anxious about their performance in the clinical environment (Sharif & Masoumi, 2005). Of particular concern to students is their lack of experience and skills in the care of patients; they worry about making mistakes which might hurt or harm to patients (Spouse, 1998; Suikkala & Leino-Kilpi, 2005). Studies specific to dentistry emphasise the issues associated with working/learning on 'real' patients. Dentistry involves irreversible operative procedures which must be performed without causing patient harm (Fugill, 2006; Gerzina et al., 2005; Schonwetter et al., 2006). Therefore tensions exist in clinical practice between students learning needs and a duty of care to prevent harm to patients (Fugill, 2005). Gerzina et al.'s (2005) study revealed that strong tensions exist in dental teaching clinics regarding educator activity or inactivity in student patient care. Ahern (1999) examined the student-teacher relationship and referred to ways roles become unbalanced and unclear when educators inappropriately take over patient care from students. Doing so takes valuable learning opportunities away from the student, reduces student confidence and undermines the trust and confidence of the student-patient relationship. Ahern cited patient safety and students' unfamiliarity with procedure as two occasions when it is appropriate for educators to take over aspects of patient care. Ahern further emphasised the need for educators to retain realistic perceptions of students' performance in the "stepping back - taking the lead" scenario and acknowledged the need for educators to provide ongoing student support.

Learning emerges out of direct experience (Wilkinson et al., 1998). Dunn et al. (2000) referred to students' sense of confidence in the context of a gradual process that takes considerable energy, effort and time. During the early stages of clinical education students are very dependent of their educator (Beck, 1993). Clinical educators play a critical role in assisting students to control their anxiety (Beck, 1993), apply their knowledge and skills in the clinical environment and progress from dependent to independent practice (Hosseini, Fatemeh, Fatemeh, Katri, & Tahereh, 2009). They encourage students to develop clinical decision making skills, problem solving skills and clinical reasoning (Lofmark & Wikblad, 2001; Nolan, 1998; Papp et al., 2003).

Lofmark and Wikbladi's (2001) identified factors that facilitated learning as being given the opportunity to practice tasks, receiving feedback, allowing students to take responsibility, working independently and accepting challenging learning opportunities. Adequate time spent on practice and an committed educator who possesses a good basis of theoretical knowledge and is willing to enter into discussion were identified as being the essential requisites for moving from inexperience to competent (Field, 2004). As previously identified, the role of the clinical educator is very important in student learning (Lofmark & Wikblad, 2001).

The Dreyfus Model of skill acquisition was developed in the 1980s and has been successfully applied to numerous professions. Patricia Benner has successfully applied the concepts to the nursing profession to assess the progressive development in skill performance. The model proposes that student pass through five distinct stages of proficiency: novice, advanced beginner, competent, proficient, and expert. It is helpful in defining a desired level of competence and it supports progress in development of skills (Benner, Tanner, & Chelsea, 1992; Carlson, Crawford, & Contrades, 1989). It is used in both teaching and clinical practice and reference is made to it in numerous studies. Although not specifically designed for the oral health therapy profession, it is potentially applicable and if adopted by the profession it may prove a useful tool for assessing the development and progress of both students and therapists.

## **Summary**

Clinical placement is an important component of learning in health professional practice. The main aim of clinical education is to acquire knowledge and integrate this with the development the necessary professional skills. Clinical placement provides students the opportunity to apply knowledge, skills and concepts to actual patient care. It also assists socialisation into the profession. As discussed, there are problems associated with learning in an authentic context, mainly due to unpredictability and difficulties controlling the learning environment.

Literature highlighted clinical experience as the most stressful aspect of professional education. Feeling incompetent, abandoned, anxious and fearful have been

highlighted as emotions commonly experienced by the students while on placement and these can impact on student learning and self esteem. A supportive, safe, secure learning clinical environment is required if students are able to access the appropriate positive learning experiences for learning to occur.

Interpersonal relationships have been identified as having a critical role in student learning. The student educator relationship is regarded as essential to learning. This relationship can influence how students perceive clinical placement and can have an impact on learning outcomes. Student peer relationships also have an important role in facilitating learning and peers are argued to be as an importance source of support. Student patient relationships also play a central role in learning. The initial fear of hurting or harming patients and an inability to connect with patients were identified as major concern, over time these relationships change as students begin to see patients as people. Caring in its different modes has been described in this literature review, along with providing feedback and the complexities involved in the process. The attributes of an effective clinical educator have been discussed.

In the introduction, I loosely drew on similarities between the nursing profession and oral health therapy in order to justify why I believed it appropriate to refer to nursing literature to support my study. In conclusion I believe the oral health discipline needs its own research on the experiences of oral health therapy students on clinical placement. It cannot rely on another profession's body of knowledge because its context differs from that of other health professions. Only when research has been completed can differences and similarities between disciplines be validated.

To reiterate, the oral health therapy dual degree is a relatively new qualification and a dearth of research currently exists, locally and internationally, on education or practice within the profession. This scarcity of research extends to both dental therapy and dental hygiene practice. Oral health therapy is a very procedurally orientated profession. The treatments undertaken are irreversible and 'fine grained'; the emphasis during teaching is technical and process orientated to ensure the development of fine psycho motor skills required to perform the role. High levels of supervision are required and close, low ratio teacher student contact is a requisite of clinical placement. The current patient group for dental therapy practice ranges from

six months to 18 years of age. They are physically and emotionally diverse. Children have special characteristics and ensuring that their physical and emotional needs are attended too is an important aspect of learning. Currently the training clinics are located in the community and students are supported by only one clinical educator during this period; close relationships are an important feature of these placements.

## **Chapter Three: Research Methodology and Methods**

### **Introduction**

In this chapter I discuss the research methodology and the methods used for this study. The philosophical underpinnings of this research draw on a hermeneutic phenomenological approach associated with the work of Heidegger and Gadamer. The study was conducted using van Manen's research methods which involves turning to the lived experience, investigating the lived experiences, reflecting on the themes, writing and rewriting, while maintaining a strong orientation and moving between the parts and the whole (van Manen, 1997).

First, I will discuss qualitative research methodology and the philosophical underpinnings of hermeneutic phenomenology. Second, I will outline the research process. Ethical considerations, recruitment of participants, interviewing and data analysis will be addressed, and rigour and trustworthiness will be considered.

### **Research Methodology**

Qualitative research, the study of human phenomenon, is grounded in the social sciences (Streubert Speziale & Rinaldi Carpenter, 2003) and closely aligned to the interpretive paradigm (Burns & Grove, 2005). It is holistic in approach, as it studies and attempts to gain an understanding of the whole and give meaning to the phenomena in question (Burns & Grove, 20005; Polit, Beck, & Hungler, 2010). Within this paradigm truth is considered to be complex, dynamic and obtainable only through observation of people in their natural setting. This approach focuses on human experiences; deems that meaning is not discovered but rather constructed, and different meanings can be constructed by people according to where they are situated in relation to the phenomenon (Schneider, Elliot, Beanland, Biondo-Wood & Huber, 2003).

A number of research approaches come under the umbrella of qualitative research (Sandelowski, 2000), each possessing its own philosophical underpinnings, ontology



and epistemology, shared understandings and purpose (Guba & Lincoln, 1989). Sandelowski (2000), however, claimed that “qualitative work is produced not from any “pure” use of method but from methods that are toned, textured or hued”... and “any one qualitative approach can have the look, sound or feel of other approaches” (p. 337). For my research I was drawn to the interpretive methods of Gadamer and van Manen, which are derived from Heidegger’s phenomenology philosophy and although my study does not take on the depth of hermeneutic phenomenology ideals, it possesses tones, texture and hues of this methodology.

## **The Origins of Phenomenology**

Three different schools of phenomenology exist; these share some commonalities, but possess their own distinct features (Dowling, 2004, 2007). The first school is guided by the work of Husserl and focuses on the nature of knowledge (epistemology). It is referred to as eidetic or descriptive phenomenology and is purely descriptive. Husserl advocated that the “lifeworld” should be understood pre-reflectively and without interpretation. Husserl’s phenomenology shows a connection with the positivist paradigm as it follows Cartesian tradition by seeking distance from the experience through objectivity (Koch, 1999; Walters, 1994). To ensure scientific rigour is obtained, descriptive phenomenologists are required to ‘bracket’ or suspend all prior knowledge to prevent bias and prejudices from influencing the study in an attempt to maintain objectivity (Dowling, 2004; Mackey, 2005).

The philosophical assumptions of Heidegger and Gadamer, who are linked to the second school of phenomenology, have influenced this study. Martin Heidegger [1889-1976] is associated with interpretivism; he was a pupil, but later became a critic of Husserl. Heidegger differed from Husserl in that his primary focus was on the nature of existence and the nature of the world in which we live (ontology). His main concern was human experience and he emphasised the meaning of being (Dowling, 2004). Heidegger was responsible for developing phenomenology into hermeneutic or interpretive phenomenology. Hermeneutic phenomenology is a descriptive as well as interpretive approach. It seeks to uncover meaning in people’s experiences within their everyday lives through interpretation of text (Mackey, 2005; Dowling, 2004).

Hans-Georg Gadamer [1900-2002] continued Heidegger's work and is credited for further developing hermeneutic philosophy and positioning it at the centre of contemporary philosophical debate (Bowie, 1998, cited in Dowling, 2004). Gadamer placed stronger emphasis on language than Heidegger. He claimed that interpretation was a necessary part of understanding and all understanding was historical (Dowling, 2004). The two main tenets of Gadamerian hermeneutics are prejudice and universality, which Gadamer described as a common consciousness that exists between people and enables understanding between them to occur (Dowling, 2004, 2007).

Heidegger and Gadamer both declared that hermeneutic phenomenology was a philosophical approach not a method. The work of Canadian phenomenologist Max van Manen has therefore been utilised to guide the methods of this study. Van Manen is associated with the third discipline of phenomenology, which is guided by the Dutch school. Van Manen's phenomenology is a combination of both descriptive and interpretive phenomenology. His method involves interpretation and emphasis on the pre-reflective study of the world (Dowling, 2007). Like Heidegger, van Manen does not embrace Husserl's notion of 'bracketing' or separating oneself from the interpretation (Dowling, 2007).

## **Heideggerian Hermeneutic Phenomenology**

Heidegger's aim was to understand the meaning of 'being' (presence in the world) and being-in-the-world. He used the term 'Dasein' to refer to the way human beings exist, act or are involved in the world. Heidegger used 'lifeworld' to express the idea that individuals' realities are invariably influenced by the world in which they live. He believed that human existence is embedded in the world and thus being in the world cannot be separated from the world; therefore he maintained that all human subjective experiences are linked to social, cultural and political contexts (Flood, 2010; van Manen, 1997).

The four existential themes described by van Manen (1990) as the fundamental structure of the life world, proved to be helpful in investigating the experiences of oral health therapy students on clinical placement. By using these themes I was able to

consider the students' life worlds from a range of perspectives and explore the contextual features of their experiences on clinical placement.

**Lived space** (spatiality), is felt space which influences the way people feel; it grounds the person in a location. Van Manen (1990) described spatiality as the space in which individuals live that can assume different meanings for different experiences. In my study the clinical environment was the lived space students experienced. This context was experienced in a variety of ways. Initially the clinical context was a frightening and uncertain place, but as the students gained confidence they began to enjoy the experience of being in the clinical setting. First day in a new clinical environment provoked a wide range of emotions within Anna, she felt anxious and apprehensive but also excited at the prospect of new experiences.

*We all arrived feeling a bit flustered on our first day, and we didn't know what was going on, we didn't know anyone in the school. We were really lost that first day, but excited too. Because it a brand new clinic and a brand new school. (Anna)*

**Lived time** (temporality) describes time that individuals live through (Munhall, 2007). It is the "most fundamental structure of human existence and has been conceptualised in many forms" (Mackey, 2005, p.185). Van Manen (1990) referred to temporality as subjective time and an individual's temporal way of being in the world. Van Manen maintained that experiences of time include things which stand out from the flow of time. Past experiences can influence the present as well as the future, and perspectives of the past can be changed by influences of the future. Students' perceptions of time varied. When they administered their first local anaesthetic, many of the students talked about a heightened awareness of experiencing time very slowly. For Dee, time is measured in the number of days it takes her to become familiar and comfortable in a new environment.

*I was really nervous because I didn't know what to expect, it's slowly getting better I have worked it out. It's about three days on average before I get into the groove of things. It takes a couple of days before you settle in, finding out where everything is, getting used to the chair and the people. Then you get over it ... and get a lot more comfortable. (Dee)*

**Lived body** (corporeality) reminds us that people are always bodily in this world and in the physical presence people reveal and always conceal something about themselves (van Manen, 1990). The starting point of meaning always begins when perceptions enter the mind, while the experience itself is negotiated through both the mind and body (Munhall, 2007). In this study “lived body” was experienced by many of students through their fear and anxiety whenever they encountered a new experience. Beth described how her emotions influenced her physical “being” during her first experience of administering an injection.

*When I gave my first injection I was shaking. Fortunately my clinical educator was just beside me and she guided me in really well. I was able to push the need in without any problem. (Beth)*

**Lived human relations** (relationality) is the relationship we have with others in the interpersonal space that we share with them (van Manen, 1990). It is the way individuals relate to each other. “Being-in-the world” means being in the world with others and the ‘lived other’ can give meaning to an individual’s experiences in a social sense. For the students the significant “lived other” were the patients, their peers and the clinical educator. Relationships were recognized as being central to learning and the students strived to develop a relationship with the “lived other”. However, the findings revealed that the nature of their relationships varied. Emily stressed the importance of having a trusting relationship with the clinical educator.

*When I hear the feedback I can think back on what I did. It’s valuable ...but there has to be trust and a professional relationship to receive feedback. (Emily)*

## **Pre-understandings/Fore-structures**

The researcher’s viewpoint is integral in understanding the meaning of the phenomenon under study in hermeneutic phenomenology (Bradbury-Jones, Irvine, & Sambrook, 2010). Gadamer asserted (1998) that the researcher who is aware of his or her bias is able to recognize the uniqueness of meaning held by another. The same author believed that historic understanding and prejudices have significance in interpretations and were a necessary part of the researchers understanding. Gadamer

also maintained that pre understanding increased awareness and enabled judgements of the world to be made. Hermeneutic phenomenology requires prejudices and pre-understandings to be examined and explicated rather than 'bracketed' or set aside as proposed by Husserl (Dowling, 2004).

Gadamer's belief that researchers bring their horizon or prejudices to the research process, and the assumption that these pre-understanding enable the researcher to interpret data and constitute understanding, has guided my study. In chapter one I considered my pre-understandings and attempted to illuminate the circumstances under which my interpretations occur, making my viewpoint and position clear regarding my own learning experiences and clinical teaching. My study into the lived experiences of oral health students on clinical placement arose from my personal interest and through my role as clinical educator. Therefore, I believe it would be impossible to bracket or put aside my prejudices and prior knowledge, as they accompany me through life.

## **The Hermeneutic Circle**

The hermeneutic circle is fundamental to hermeneutic phenomenology, where understanding occurs through interpretation within a circular process (Gadamer, 1989). Crotty (1989) explained that understanding occurs through background knowledge and as a result of this comprehension further understanding is developed and illuminated, resulting in enlarged understanding. It involves the back and forth movement between partial and the more complete understanding of the whole, where the researcher moves to a position of understanding the whole in terms of detail and understanding the detail in terms of the whole, in a cycle of understanding that is constantly expanding (Crotty, 1998).

Gadamer (1989) described the hermeneutic circle as the fusion of horizons. He believed that the researcher must not remain attached to their biases and prejudices but must be receptive to the meanings held by the participants in order for a different way of understanding, not necessarily a better way of understanding, to occur. Crotty (1996) further explained, "that if we lay aside, as best we can, the prevailing

understanding of those phenomena and revisit our immediate experience of them, possibilities of new meanings emerge for use” (p. 78).

Dwelling on the data encouraged my engagement in the hermeneutic circle and expanded my sphere of understanding. The process of moving dialectically between the backgrounds of shared meanings allowed my pre understandings/prejudices to merge with the narratives of the participants creating a ‘fusion of horizons’. This comprises of a blend of my pre-understandings, my context dependent knowledge and experiences with the life views and perspectives derived from the narratives of the study participants.

## **Methods**

### **Ethical Approval**

Auckland University of Technology Ethics Committee (AUTEC) granted ethical approval (Appendix A) on the 14<sup>th</sup> May. The emergent nature of qualitative research and the trust relationship that exists between participant and researcher highlights the need for ethical consideration (Robley, 1995). Conducting research in an area in which a researcher works or is already known, raises further ethical concerns (Orb, Eisenhauer, & Wynaden, 2001; Ramcharan, 2001). Throughout my study I was conscious of the need to protect my participants and was guided by the ethical principles of informed consent, anonymity and confidentiality, non-malificence, beneficence and justice. I endeavoured to take the appropriate steps to remove or prevent harm to the participants and ensure that the benefits of the research outweighed any possible risks they may encounter. These endeavours are further discussed in this chapter.

### **Recruitment of Participants**

Potential participants were informed of the study and invited to participate using an advertisement (Appendix B) that was placed on their electronic notice board; a hard copy was also physically attached to the notice board located outside the university

dental clinic. From the onset I was conscious of the need to ensure that the participants did not feel obliged or coerced to participate in this study. Students currently on clinical placement at the training centre where I currently work were excluded from the study in order to avoid student conflict of interest. Initially only two students responded. To provide more information and encourage interest in my project, the information sheet (Appendix C) outlining the nature, intent, potential benefits and risks of the research and public outcome was later attached to the notice boards. Another three students contacted me through email and a time and venue was arranged.

I used convenience sampling for this study as it enabled participants to come forward voluntarily and state their interest in participating in the study without undue pressure. Convenience sampling allows participants to come forward and identify themselves and is regarded as an efficient sampling method (Polit & Beck, 2010). However, convenience, sometimes termed voluntary sampling, is not usually the preferred approach in qualitative research, as the main aim of qualitative studies is to extract the greatest possible amount of information from a small number of participants and convenience sampling may not provide the most information-rich sources (Polit & Beck, 2010). For my study, this was not of concern as all students possessed the experience of the research topic and were able to share their understanding by providing broad, rich and descriptive information/knowledge.

Sample size in qualitative research is usually determined by informational needs (Polit & Beck, 2010) and is a matter of judgement (Sandelowski, 1995). I had originally anticipated interviewing between five to eight students. My emphasis during the interviews was on learning about the students' experiences. After the fifth interview I began hearing repetition in the student's stories and it became apparent that I had sufficient data. At this stage I ceased attempting to recruit more participants. In phenomenological research the sample size is deliberately kept small as the intention is to obtain in-depth data to highlight the rich experiences of individuals (Baker, Wuest, & Stern, 1992). Polit and Beck (2010) claimed that "if participants are good informants who are able to reflect on their experiences and communicate effectively saturation can be achieved with a relatively small sample" (p. 321).

Due to the limited number of third years students enrolled in the oral health degree I am mindful of the need to protect the participants of this study and will supply only limited information in an order to maintain their anonymity. A brief description of their background is provided to allow their data to be placed in context. The participants were all third year undergraduate students, enrolled in a university Bachelor of Oral Health programme. Participants were in the 20-40 year age groups. Some had previous dental assistant work experience before enrolling in the programme; some did not. Three were of European origin while two were of Asian descent.

## **Protection of Participants**

### **Informed Consent**

Prior to the interview, participants were informed of their rights and encouraged to ask questions. My response to their questions was open and honest. The three crucial elements identified by Burns and Grove (2005) of informed consent: comprehension, competency and voluntary consent were present. Participants were advised that they could withdraw from the study at any time and informed that consent was an ongoing process. The participant consent form was signed prior to beginning the interview and all questions regarding consent were addressed.

### **Anonymity and Confidentiality**

The identity of the participants is known only to myself. Pseudonyms were given to participants and these were then used on the transcripts and any data related to the study. As previously mentioned, very little background information of the participants has been revealed to avoid recognition. I did all the transcribing, thus eliminating the need for a typist. This also meant I was the only one to have access to the tapes. Any data I believed might have identified the participants was removed or changed. Participants were also given the opportunity to remove any data they felt might reveal their identity when their narratives were returned to them. Returning the stories also provided the participants with an opportunity to confirm that they were happy to have



their stories told in a particular way. No changes were made and by the participants and all indicated they were happy for their stories to be told as I had transcribed them.

Tapes and transcripts were stored without any identifying features in a locked metal filing cabinet in a home office until analysis was completed; after which they were transferred to AUT and will be stored for a period of six years in accordance with AUTECH requirements.

## **Interviews**

### **Venue**

Interviews were arranged by email at a time that suited the participants and the venue chosen was a place where participants stated they would feel comfortable. Even though there was little inherent risk in this study all students were advised that counselling services at AUT were available should they feel the need to discuss issues which arose from the interview process.

### **Interviewing Process**

Participants were interviewed once, as all participants intimated that they had told me all they could by the completion of the interview. Interviews varied in length between 50 to 90 minutes. According to Orb et al., (2001) conducting research in an area in which the researcher works can be advantageous as the researcher is familiar with the situation and has the trust of the participants. On the other hand, it may limit the information participants are willing to disclose and participants may feel coerced to participate. The researcher's role according to Munhall (2007) "must be clearly known" (p. 187) and they must act accordingly. To clarify the situation I clearly identified my role and attempted to develop the trust of the participants from the onset. Beginning the session with an informal discussion and providing refreshments created a comfortable social environment in which to conduct the interviews.

Data was collected through audio taped, in-depth, face to face interviews. An interview guide which contained a list of open ended questions was used (Appendix

D); this was designed to guide my interview as a semi focused, flexible conversation. My interviews began with “can you tell me about your experiences of being on community clinical placement?” or “can you tell me about your first day at a new clinic?” Occasionally I sought clarification “can you please explain how that experience felt like for you?”

I was mindful of the need to stay close to my research question throughout the interview. Van Manen (1997) reminds researchers to stay strong and oriented to the fundamental question or notion of concern; but on occasions the participants used this venue to express their concerns regarding incidents that had occurred during time spent at the university oral health training clinic. On reflection I realised these concerns provided valuable insight into how their experiences differed between the two contexts. I was conscious of my role as researcher and attempted to limit my speech to questions, verbal and non verbal prompts and acknowledgements of having heard their stories without many additional comments. My focus throughout the interview was on encouraging the participants to share their stories so I could gain an in-depth understanding of their experiences. Kleiman (2004) states that, “it is in fact this profound readiness to listen that inspires participants to relate what presents itself to their consciousness” (p. 5). Every interview provided new insight and encouraged reflection.

All participants were positive about the interview process and felt comfortable with use of an audio tape. Several of the participants commented on how they had enjoyed the experience of discussing their time on placement as previously they had not had an opportunity to do so. All were enthusiastic about the study and continued over time to express interest in the progress and outcomes of the research. I found this encouraging and it further increased my commitment to the study as a way of shedding light on student experiences on community placement.

### **Transcribing Data**

Over a four month period, I interviewed five participants and transcribed their narratives myself. Although a time consuming process, I was pleased that I had made this decision as it enabled me to become familiar with participants narratives very

quickly. Being immersed in the data from the very beginning meant that similarities and contrasts in experiences became apparent very quickly.

### **Reflection and Analysis**

I spent considerable time reading and re-reading stories and dwelling on the data in an attempt to capture an accurate account of the phenomena. Van Manen (1997) described this process as “reflectively bringing into nearness that which tends to be obscure and that which tends to evade the intelligibility of our natural attitude to everyday life” (p. 32). However, I felt challenged and struggled with this process as I tried to remain open to new possibilities and not allow the familiarity of the phenomena to dull my senses or draw premature conclusions.

Human science involves the crafting of text (van Manen, 1997) and I referred to Caelli’s (2001) work which described the method of deriving narrative from the transcript to craft the stories out of each transcript. All material that did not pertain to the research question was deleted and stories were constructed into chronological and logical order using the participants’ words. Irrelevant and repetitive data were removed to allow the narratives to flow more freely. The themes in the narratives, are referred to by van Manen (1997) as “structures of experiences” (p. 79). Thematic analysis involved the process of uncovering the themes embodied in the meanings of the narratives. Van Manen claimed that this is not a rule bound process; rather a free act of “seeing” a process of insightful understanding, discovery and disclosure. Theme is a reduction of a notion and “no thematic analysis can completely unlock the deeper meaning of a notion and therefore cannot capture the full mystery of the experience” (van Manen, 1997, p. 88).

Many of the narratives had more than one meaning. As a consequence I experienced difficulty confining them to one section of analysis. I consistently asked myself what is this story about? What lies hidden within it? What is its significance to my research question? I reflected on the importance of the four existential themes described by van Manen (1990) and these helped me to consider the students’ life worlds from a range of perspectives and explore the contextual features of their experiences on clinical placement.

I commenced a cycle of writing, reflection, consulting with my supervisor and rewriting. As I engaged in the hermeneutic cycle the parts gave understanding to the whole and the whole gave understanding to the parts. As a result my sphere of understanding expanded and I began to grasp what it meant to be an oral health student on clinical placement.

The end result of my endeavours has been three chapters which hold the participants stories, illustrating the themes and my interpretations of the narratives. Van Manen (1997) made it clear that any interpretation is simply one interpretation of human experience and other interpretations may exist which may have richer or deeper description.

Each chapter builds on the other to reveal the experiences of oral health students on clinical placement. The process of moving dialectically between the background of shared meanings allowed my pre understandings/prejudices to merge with the narratives of the participants creating a fusion of horizons that represent a blend of perspectives; the life views and perspective of the study participants fused with my pre-understandings.

### **Trustworthiness**

Qualitative research is often criticised for lacking scientific rigour and without rigour researchers claim research is worthless (Morse, Barret, Mayan, Olsen, & Spiers, 2002). A lack of consensus exists amongst researchers as to what constitutes rigour (trustworthiness) in qualitative research (Rolfe, 2004). All agree, however, that trustworthiness is essential in qualitative studies (Koch, 1996; Morse et al., 2002; Rolfe, 2004). Some authors argued that criteria used to ensure quality in interpretive research should be consistent with the philosophical and methodological assumptions of the research and proving that rigour has been addressed within the study lies with the researcher (Koch, 1996; Koch & Harrington, 1998). In keeping with this supposition I will attempt to illustrate how trustworthiness has been addressed in my study.

### **Internal Consistency**

A number of authors claim that internal consistency can only be achieved if rigour is attended to throughout the research process with the aim of methodological coherence between research question, method and methodology (Koch & Harrington, 1998; Morse, et al., 2002). I have addressed the issue of congruence between my research question and method in chapter one. Just as the method and research question must match there is also a need for method, data and analytical procedures to be congruent (Morse et al., 2002). Earlier in this chapter I detailed how I interviewed a small number of participants in a semi structured, conversational manner, until saturation of data occurred. This fits well with qualitative research methods. I referred to the works of van Manen and Heidegger for guidance in my interpretation of data. The four life existentials of “being in this world” and “caring” helped uncover ‘what it is like to be an oral health therapy student on placement in community dental clinics’ and fit well within hermeneutic phenomenology, the philosophical approach which has coloured my study.

### **Reflexivity**

Reflexivity occupies an essential place in most forms of qualitative research (Koch, 1996; Koch & Harrington, 1998). In chapter one I disclosed my professional and personal background in order to illustrate how I am situated in this study. Being part of the research process means my prejudices and bias have accompanied me through all stages of this study, particularly in the interview process, interpretation and analysis of the narratives. Before beginning my interviews I was interviewed by my supervisor. This enabled me to reflect on my prejudice and pre-assumptions regarding the experiences of oral health students on clinical placement in community dental clinics. It allowed me articulate, acknowledge and engage with my pre-assumptions within the study and identify my position to readers of this study, so they can judge for themselves my interpretations. I am aware that the interpretations in this study are my interpretations and other interpretations may also exist. Koch (1996) suggested that the reflexive character of qualitative research causes it to be ‘non-objective’,

incomplete, and bound to context and researcher perspective. Being context bound means that in this study the participants' narratives reflected their "life worlds" in a particular time and place, which is a feature of qualitative research.

I was responsible for the interpretation and writing of this research study, although other people influenced my work in various ways. Koch and Harrington (1998) affirmed that voices, other than the researcher, should be able to be recognized in qualitative research. These include the participants, my supervisor, and other students whom I supervise, colleagues who are in a similar teaching role, and books and articles which I read throughout the study. These people and literature helped clarify and verify my thinking. Colleagues provided feedback on narratives, while students not involved in the study provided me with meanings they attributed to their own experiences. Feedback from my supervisor encouraged me to analyze in more depth and as my study progressed I sought deeper meaning in the participants' narratives. According to Tuckett (2005) academic supervisors can "add depth and breadth to an analysis" (p. 38), assist in overcoming research bias and increase rigour (Roberts & Priest, 2006).

To increase the credibility of the study I returned to each participant the stories I had derived from their transcript; thus providing them with an opportunity to verify their stories and ensure I had interpreted their narrative correctly. This gave them an opportunity to withdraw statements, correct errors or make further comment. My intention was to not to seek consensual understanding, which authors caution against (Tuckett, 2005), but rather to generate additional data or different perspectives which may have added breadth and more depth to my analysis. The stories were, however, returned without alterations.

### **Transferability**

Although qualitative research findings are not transferable, they need to be believable, accurate and useful, so that participants and readers who have had the experience to recognize and develop an understanding of the phenomenon (Sandelowski, 1993). This study contains many rich descriptive stories of students' experiences on clinical placement as documented in their own words. In chapter one I provided descriptive background information of the clinical environment and the present socio-political

climate in which clinical placements occur. Background information about the study participants has been revealed in this chapter and I believe a credible interpretation of the lived experiences of the participants has been provided in a logical and concise manner. It is, however, up to reader to determine if they are able to recognize their own experiences within this study or to determine if the findings of this study are transferable or not.

## **Summary**

In this chapter I have explained the philosophical underpinnings that I have drawn on for my study and provided some background on the origins of hermeneutic phenomenology. The need for ethical approval has been highlighted. The methods used in this research including recruitment and protection of participants, the interview process and data collection have been outlined. Analysis and interpretation of data using van Manen's method have been described. The chapter concludes with an examination of the trustworthiness of this study.

The following three chapters contain the participant's narratives and my analysis and interpretation of the themes which emerged from their stories.

## Chapter Four: Relationships Matter

The clinical educator and peers are the two main sources of learning and support for oral health therapy students on clinical placement. The interpersonal relationships that develop and exist between these people can influence and impact student clinical experiences both positively and negatively in the close confines of a clinical environment. This chapter reveals the nature of these relationships.

### Influences of Peers

#### Learning from Peers

Learning and support can occur amongst peers in the clinical environment through the sharing of knowledge, ideas, experiences and practical assistance. Many of the participants in this study talked about the social, emotional and practical support they received from their peers. Anna's story illustrated how students on this clinical placement share common experiences and provide support to each in an unfamiliar environment.

*It's really nice to have some people from class with you, especially if you are friends with them it's really, really good. It's quite nice to have people who are in the same situation, so if you feel a bit nervous about asking your educator you can ask them to see what they think and you can get a discussion going. It's quite supportive. It's nice to have someone you can talk to over your shoulder if you need to. It's really, really nice. Sometimes if we finish early we assist the next person if they are doing something big, like a pulpotomy and then you kind of learn new tricks from the way they do things that are different from the way you do things. Like with isolation or they may have a certain way of holding the hand piece and you think that looks kind of cool and you think you will try it and then you have learnt a new technique. We are always learning from each other. (Anna)*

Anna's account of being on placement with her peers reveals the nature of lived other which van Manen (1990) described as "the lived relations we maintain with others in the interpersonal space that we share with them" (p. 101). Anna found it reassuring to be surrounded by people she felt safe with and whom she knew well; she experienced a sense of fitting in and belonging. The friendship and empathy she shared with her



peers creates a 'space', an environment favourable to learning. Van Manen (1990) defined "lived space as felt space which affects the way we feel" (p. 101).

The students learn not only from their educator in the clinical environment but also from each other and, as a result of this sharing and reciprocal learning, they develop a sense of community. It is good to be able to watch a peer at work and learn different ways of doing things. Sharing ideas and learning new clinical techniques from each other through observation and discussion enabled Anna to experience new ways of doing things and experiment with different techniques. The support and help found between these students fostered an atmosphere which encouraged students to share their knowledge and engage in discussion. Sharing experiences with peers can provide much needed support and benefit in the realization that other students feel the same way (Beck, 1993; Campbell et al., 1994; Clark & Feltham, 1990). The findings from this study were consistent with Roberts' (2008) study where students believed that peers understood them more than anyone else.

Anna infers that it is safer to ask questions of a peer than the clinical educator. Fear of being judged if they reveal their lack of knowledge may be a reason the students avoid asking questions of their educator. The students may also feel intimidated by the clinical educator and may subsequently be reluctant to seek information and pose questions. Instead they seek knowledge and information firstly from their peers. It seems that the informality of peer relationships and their common shared experiences creates an environment conducive to learning, where students can engage in open communication and disclose their uncertainties, misconceptions, concerns or lack of knowledge to each without fear of being judged or feeling imitated. Roberts' (2008) study confirmed that students see each other as a valuable source of information and she suggested that an 'ask anything culture' develops between peers.

These findings are in agreement with Christensen and Bell's (2010) study which identified empathy and friendship as important qualities in peer relationships, which engendered safety and supported learning in students. These authors maintained that peer learning creates a non threatening learning environment and enhances students' knowledge. Boud and Lee (2005) suggested that interaction between peers encourages

open communication and supports students to engage more fully, creating favourable learning opportunities for them.

The learning process described in this study is aligned with contemporary theories of learning proposed by Lave and Wenger (1991) that emphasised the situated nature of learning and involves communities of practice, where groups of people socially interact and collaborate to achieve learning, by sharing ideas and strategies. The learning that occurs is often unintentional and a secondary outcome that accompanies social processes.

Emily confirmed that learning occurs between peers, but expressed some reservations:

*My relationship with my colleagues is alright. We share knowledge but to be honest I don't mind if I work by myself with the CE [Clinical Educator]. But I do feel comfortable with other students who are at the same stage or same situation so we can share our experiences about our patients like, 'how was your patient?' 'What did you do?' ...but if I have the situation where I have to work by myself with the CE I don't mind. (Emily)*

Although Emily felt at ease and related well with her contemporaries, she did not share the close personal connection that Anna shared with her peers; Emily relies less on peers for emotional and social support, "I don't mind if I work by myself with the clinical educator". The connection between Emily and her contemporaries is more the sharing of an educational journey than a close relationship.

The basis of Emily's relationship with her colleagues appears to be a mutual understanding through sharing experiences and an awareness of her contemporaries' needs. She sees her peers as similar to herself as she and her peers are in the same situation and share common experiences which enable understanding to occur. Emily finds her peers approachable and considers them to be a good source of knowledge at times, as they have something worth her learning.

Emily talked of sharing experiences with her contemporaries. It felt good to discuss patients and learn from other students' experiences. All students will have their individual stories to tell and sharing experiences with peers enables students to reflect and learn from their peers' second hand knowledge without direct engagement in the experience (Roberts, 2009). Boud (1994) referred to this as vicarious learning, which

occurs as a result of active engagement of the mind of learners with other learners' experiences, which they integrate into their being. Sharing experiences enables thinking and learning to occur together in a reciprocal relationship between Emily and her peers.

Emily states that she does not mind working solely with her clinical educator. So perhaps there are some advantages for her in a one on one situation; it may be she does not have to compete with other students for the educator's time and this could mean gaining additional clinical experience. Working with other students may be a distraction for Emily especially if they rely on her for support and assistance. Or it could be that Emily perceives herself to be more advanced in her learning, therefore not needing to lean on the learning of others.

To ask a question is to reveal one's lack of knowledge. Emily revealed why it feels safer asking questions of peers rather than the clinical educator:

*I feel a little uncomfortable talking to my clinical educator about my patients. Maybe my educator will think I'm not confident. She might make a judgement about me. She might think 'oh I thought she was confident so why is she asking me'. She might think 'oh she is not confident'. I don't want to give her the opportunity to think that. If there was no chance of failure I could ask her the questions. Her opinion would worry me because of the feedback. ...I want to pass so the feedback is quite important to me. (Emily)*

Fear of failure weighs heavy on Emily's mind and she feels reluctant to ask questions of her clinical educator. It seems Emily is concerned how she will be perceived if she asks question which might reveal her lack of knowledge or disclose her uncertainties. Poor feedback worries Emily as it might result in her failing the course and she wants to avoid this at all cost. Fear of being judged unfairly or harshly act as a barrier to learning. It is more important for Emily to be seen as 'knowing' than to reveal her lack of understanding.

All of the students interviewed for this study inferred they were concerned about being judged by their clinical educator if they revealed their incomplete knowledge. Students perceive teachers as having a more evaluative than an educative role (Sharif & Masoumi, 2005; Wilson, 1994). Clinical educators have a dual role. They support and guide student learning but also assess and evaluate and this can be conflicting as it

presents both a supportive and threatening environment for students. According to Hyland & Lio (2006) this may mean complex interpersonal interactions need to be negotiated.

Students bring with them prior experiences, history, culture and personal traits which influence their perceptions and experiences. Gadamer's hermeneutics supports the notion that tradition contributes to an individual's pre-understanding or prejudices. He advocated that self-interpretation involves understanding oneself in terms of history, culture and language (Geanellos, 1998). According to Gadamer "We have thoughts built up in history, which in turn guarantees that we already have judgements - prejudgements or prejudices – that put us in a position to reorganise common concerns with texts drawn from our history" (Lampert, 1997 p. 352).

In the following extract Emily interprets her understanding – 'lived meaning' of why she feels uncomfortable revealing her incomplete knowledge. She suggests that her culture plays an important role in determining how she reacts to her clinical educator. Emily's story continues:

*My culture may have influenced it; according to my culture we don't push our opinions with our elders or our teachers. To me the CE is my teacher so whatever she says I have to respect and I don't an opportunity to explain my opinions and I feel useless. (Emily)*

Emily's story appears to indicate a deeper concern over the evaluative role of her educator than exists for her peers. She feels intimidated and senses an imbalance of power exists within her relationship with her educator. Levy (1997) affirmed that in many Asian cultures the Confucian ethic places great importance on elders and the teaching role is linked to power, status and authority. As a consequence Asian students can be culturally influenced to regard their educators as powerful authoritative figures (Levy, 1997).

## Feeling Unsupported

Oral health students are not supported by dental assistants while on placement in community clinics. Aside from practicing two handed dentistry, students are responsible for sterilisation of instruments, setting up trays and undertaking routine cleaning up duties. Collaboration amongst the students on clinical placement is important if the clinic is to run smoothly and efficiently and if an amicable relationship between students is to be developed and maintained. Cathy described a lack of teamwork and collaboration on her placement:

*This year was a bit more difficult for me even though I knew them and liked them. In that kind of setting you find out everyone's flaws and I found that I was doing a lot more work than I should have been. Just to make the place run smoother and for us to get to lunch on time and stuff, I would do a lot of cleaning up for them which kind of never got reciprocated. But that's alright. It was just a lot of cleaning up after other people really. I always think if I can get it done on time why can't you guys? So if I wanted to go home on time or if I wanted lunch I would help the others as well. The CE told me she appreciated it. I don't mind doing stuff as long as I am being thanked, that's fine it just had to be done.*  
(Cathy)

This student experienced the lived 'other' very differently to Anna. Her experiences identify the difficulties of working alongside peers who do not work collaboratively. Working closely alongside her colleagues has revealed another side to them of which Cathy had been previously unaware. Cathy's peers expose themselves differently in different contexts. Even though she may have known them well in the classroom situation, it seems that she does not know them nearly as well in the clinical environment. Cathy uses the term "flaws" to imply imperfections and describe the 'faults' she has identified in her colleagues' characters.

Cathy appears to be an efficient, well organised student who possesses good time management and organisational skill. Therefore she finds it difficult to understand why her peers do not possess the same attributes as she demonstrates. She assumes responsibility for much of the assisting and cleaning duties. She assists her peers; but they do not reciprocate and it seems to leave her feeling disappointment and frustrated. Why is this happening? Is it because Cathy is more advanced in her learning and her peers are so focused on their own learning needs that there is insufficient time

to share in the clinic cleaning? Or is it because Cathy's peers have no concept of teamwork or collaboration? Or is it because they chose not to take responsibility for what they may perceive as menial tasks?

Even though support is not reciprocated Cathy continues to help her colleagues. She knows that she needs to support her peers if as a team they are going to accomplish the necessary tasks which will enable them to have lunch or leave clinic on time. Being recognised, acknowledged and appreciated by the clinical educator for the help she extends offers some consolation to Cathy for the assistance she extends to her colleagues.

All indications are that respect, trust, sharing, and effective communication skills, the fundamental requirements of collaboration and effective teamwork are missing in this placement. Teamwork and collaboration are essential in professional practice in the health care professions (McCallin, 2001) and encouraged on community placement. According to Henneman, Lee and Cohen (1994) group willingness and the characteristics of the individuals determine readiness to engage in collaboration. The authors asserted preparation through education, maturity, an understanding of own responsibilities, team dynamics and prior experience working in similar situations are factors that encourage collaboration. They also acknowledged that ultimately collaboration is a process which occurs between people and only the individuals involved can determine whether or not it occurs in a particular setting.

Not all placements are conducive to learning. If team work and collaboration between peers is missing, relationships between students break down. Another student described the personal and professional tensions that exist in the clinical environment when teamwork and collaboration between peers is not present:

*There is a certain person who I have been stuck with in clinic maybe two people I get stuck with in clinic and some days have been really stressful. They ask ridiculous questions that they should know by now and it stresses me out. Because they try to talk to me in the middle of when I'm operating on a child, they don't want to ask the clinical educator for whatever reason and I'm busy, they don't respect my answer anyway and they don't listen and they don't do anything around the clinic. They're lazy and it just stresses me out. I feel like I have to take on the responsibility of them. There's definite stress with colleagues. It's nice, with peers you have company; you can talk about things afterwards, go*

*over things. With those people I mentioned I wouldn't really ask them their opinions on things because they don't really have any. It's just stressful really, when I'm busy and I need things done and they don't help me, but I help them, it's just one sided. They're not really generous. (Dee)*

Our environment assumes different meaning as a result of different experiences (van Manen, 1990); the clinical placement has become a source of stress and frustration for Dee. She feels unsupported and annoyed with the situation she finds herself. Dee referred to being 'stressed' a number of times and her story suggests that she is experiencing an emotional and mental strain working alongside her peers in the clinic. There is an uneven distribution of responsibilities within this placement. Dee's colleagues are relying heavily on her for support and assistance and Dee appears to have accepted this role and talks about taking "responsibility for them". Although Dee assists the other students, they do not reciprocate and this leaves her feeling frustrated and resentful. She describes her peers as "being lazy"; it feels tiresome being left to complete most of the cleaning duties. It appears these students perceive that Dee possesses more knowledge and is more competent than they are. They not feel confident asking questions from their clinical educator rather they seek knowledge and support from Dee. Relying on Dee for their learning needs places additional pressure on her, as she is also a student and has her own learning needs to address. It appears Dee has assumed responsibility for her peers and has not addressed the lack of support she feels, with her peers? Is she concerned about offending them and losing their limited support? Or does she feel she needs to stay loyal to her peers?

There appears to be a lack of open and honest communication and conflict resolution in this group. Are these skills emphasised enough prior to placement? Is there a perception in the university that students know how to deal with conflict when it arises in the clinical environment? What is the clinical educator's role in team building, student collaboration and conflict resolution? Why has Dee shared all her clinical placements with the same peers?

There are other peers, whom Dee respects and has a better relationship; she knows that there are benefits to having good relationships with peers. Learning and sharing with peers supports student learning, but this is not happening for Dee with the students she is currently working aside. What criterion exists for clinical rotations?

What is the cost and impact of the weak and unhelpful students on other students learning?

One of the difficulties associated with peer learning is the accuracy of shared student knowledge and information. In this extract Dee makes known her lack of confidence in the knowledge levels of some of her peers:

*If there is something I really want to know and it's quite important I will go home and look it up but if it's just an average thing I will just see what everyone else thinks and I will go from there. I will ask my clinical educator before I will ask my colleagues, but maybe if it was different colleagues. (Dee)*

Dee does not perceive the people she works alongside with on placement as possessing accurate information. She appears to have very little confidence in their level of knowledge and the information she considers important to her practice she researches herself; to ensure she obtains the correct facts. She seems to know that the knowledge she acquires can impact on patient care and she wants to ensure that it is accurate. If the information she is seeking is less important then she will ask her peers, and infers she will probably consider it carefully and decide its trustworthiness.

It appears she has a lack of respect and confidence in the individuals she works alongside with on placement and acknowledges that if it were different peers, people she respected and trusted; maybe she would feel differently about seeking their opinions and advice. Asking information, seeking questions from her clinical educator, is raised as an option by Dee; even though it may be daunting, it appears to be a preferable option to asking her peers, as Dee has respect and confidence in her educator's knowledge and knows that her response will be based on expert knowledge and clinical experience. These findings are in agreement with Boud and Lee (2005) who conceded that learning interactions can create difficulties as students are learners and not subject experts and information shared is difficult to quality assure.

## **Making Comparisons**

Many of the students talked about comparing themselves to their peers to determine their position in relation to their knowledge and clinical skills. Beth told her story:



*I just knew how bad my restorative techniques were. Other people always finish way ahead of me; I always feel my peers are a good example for the way to do good clinical work. They really help me a lot. The main thing is learning from your peers really. There really isn't much competition going on, there should be, there is. But if I'm compared to them then there isn't because I'm not at the same level I am so far behind. (Beth)*

Feelings of insecurity and disillusionment are evident in Beth's story. She appears to be uncertain about her work performance and is concerned about her ability to perform the role. She believes that her peers demonstrate more advanced clinical skills and she worries she is not progressing as she should be. It appears Beth feels as though her peers have surpassed her in their clinical skills. She indicates an existence of a large expanse as she compares her progress to her peers in terms of space, "I'm not at the same level, I am so far behind". She implies the space between her peers and herself involves both height and distance and it will be difficult for her to reach their level.

Beth compares herself to her peers although she claims not to be in competition. She talks about competition between peers going on, but she excludes herself from this as she believes it is futile to try and compete. This story illustrates both positive and negative aspects of students comparing themselves. From the positive aspect it appears Beth's peers are role models, she is learning from their experiences and trying to improve the standard of her practice. But from the negative aspect making constant comparison to peers is eroding her confidence in her abilities and it may be preventing her from recognizing and gaining satisfaction from her own achievements.

In contrast other students expressed being satisfied with their achievements when comparing themselves to their colleagues:

*I compared myself to my classmates and if I said I didn't I would be a liar, I'm still doing it because I'm on the positive side, to be honest in the second year I was not on the positive side. I always considered myself to be behind my classmates so I always compared myself to other people. (Emily)*

*I don't really see it as a competition but at the same time I feel comfortable where I'm at. So I'm not really crawling up to meet them I'm already there, so for me I'm not really behind in things. I don't like being behind though. It's definitely competitive. (Cathy)*

It appears that both Cathy and Emily are competitive students who do not want to be behind their peers in their learning and skill development. They feel satisfied with their level of achievement and confident in their clinical practice but they continue to compare their progress and achievements with their peers in order to self evaluate. In her second year Emily perceived herself as being behind her peers and perhaps knowing this motivated her to work harder to progress and achieve clinical competence. While Cathy described the competitiveness that exists between the students, it appears to be important to her to know where she is in relation to her peers. She stressed that she does not like being behind her peers.

The findings from this study concur with the social comparison theory which suggests that individuals evaluate themselves against people who are similar, usually people they are competing or co-operating with, when they require objective information regarding their performance and abilities. The motivation to make comparisons reflects a desire for positive self evaluation as well as the need for evaluative information (Mumford, 1983). It may be that these students are not given adequate feedback on their progress and they need to look at their peers in order to gain reassurance on their progress. Or perhaps making comparisons is a common occurrence which motivates students to achieve.

## **Influence of Clinical Educators**

The role of the clinical educators is to prepare oral health students to graduate as competent beginning practitioners. They are responsible for creating a favourable working environment, structuring learning experiences which facilitate acquisition of clinical skills, integrating theory and practice, providing feedback and developing relationships characterized by a positive regard for the students on placement.

## **Letting Go**

The relationship between student and clinical educator has the potential to impact on learning. Dee described feeling supported towards independent practice by her clinical educator:

*She sees you do it maybe ten times and she trusts you enough to do it while she is watching another person, that kind of thing. We are monitored. She is always there. After a while you kind of see how you have grown by the way she treats you. Obviously when you first arrived she is hovering over you with everything you do, she is watching every move and then as you get better she trusts you a bit, as she gets to know your work and lets you go a little bit, she trusts you a little bit and you feel as though you have accomplished something and you are actually improving and she can trust you, she kind of lets you go a little bit and she trusts you. (Anna)*

Having the trust of her clinical educator means a lot to Anna. Initially trust did not exist in this relationship and the educator was constantly checking Anna's work to ensure all procedures were correctly performed. Over time the educator and Anna have become familiar with each other and a relationship has developed. Time has also enabled Anna to further develop her clinical expertise and earn the trust of her educator. It is important for teachers to 'know' students' and provide a space and opportunity for learning to occur (Gillespie, 2005). Teachers also need to trust that students have the ability to grow and develop (Diekelmann & McGregor, 2003). It seems that the student-teacher relationship that has developed between Anna and her clinical educator is based on mutual respect, trust and caring. It feels good to be trusted; it increases Anna's confidence and heightens her sense of self worth. Being able to look back, recognise and acknowledge the progress she has made in her clinical practice confirms to Anna that she is progressing well.

Clinical educators also experience anxiety when students initially begin treating patients or before they develop knowledge of a student's clinical skills. Anna described her educator as 'hovering over her with everything she did'; it appears that this educator is apprehensive as she anticipates possible treatment outcomes and she is ready to step in and take over care of the patient should the need arise. However if the educator takes over patient care the student misses out on valuable clinical experience and affirms to the student and patient that the educator lacks confidence in the student (Ahern, 1999).

Heidegger (1995) described two modes of concern which present two possibilities: to "leap in" and to "leap ahead". To leap in is to take care away from the 'other', which can leave the 'other' dominated and dependent. To leap ahead avoids taking care away, by going ahead of the 'other' and giving 'authentic' care back to them. Practice

can be complex and leaping in may be required sometimes, while leaping ahead may be appropriate at other times (Smythe, 2000). Clinical educators must judge when to leap in and when to leap ahead.

It appears that mostly this educator leaps ahead as Anna describes being “let go a little”. The educator knows the importance of ‘letting go’ and allows some degree of independence which helps Anna develop her skills, build confidence and prepare her for ‘life after graduation’, when she will be required to practice autonomously. By doing so the educator is affirming and motivating Anna in her learning, encouraging her to realise her professional self. Confirmation is important in a student teacher relationship. It means that the teacher is able to accept the student’s current limitations, yet remain aware of their potential while supporting them in their professional and personal growth (Gillespie, 2005).

### **Relationships Impact on Learning**

Not all student-teacher relationships are supportive to learning. Buber (1965) described two different types of relationships. The ‘I-it’ relationship, which occurs when one person objectifies the other, interacting as if relating with an object; in contrast, the ‘I-thou’ relationship represents intimacy, reciprocity and mutuality. It is a direct relationship of two beings where individuals meet each other in their authentic existence as illustrated above in Ann’s story. The following narrative illustrates an I-it relationship:

*Our educator would tell people off in the room with us, so that wasn’t very comfortable. It made us find out what level people were at which isn’t very nice, we had no choice about that. I don’t think we should know about other student’s progress and it’s embarrassing for them to get into trouble in front of us as well it’s not very nice. (Cathy)*

Cathy appears to feel ill at ease and embarrassed when her contemporaries are reprimanded and personal information regarding their progress is disclosed in her presence by the clinical educator. The bond that exists in the relationship she shares with her peers may explain why Cathy appears to share the embarrassment and distress her peers feel when humiliated through public criticism. She may also be

reflecting on how she herself would feel in the same situation. Insensitive educators, whose behaviour includes criticising students in front of peers, were identified by students as being a major source of stress (Cavanagh & Snape, 1995; Timmins & Kaliszer, 2002).

It appears that Cathy views this as a moral issue and does not condone the insensitive actions of her educator. Cathy stated she “had no choice” which infers if she was free to choose she would have removed herself from the situation, perhaps to allow her peers to maintain their self esteem. Or perhaps she feels unsafe and uncomfortable in the clinical environment where the welfare and security of students is not assured. Palmer (1998) confirmed that learning spaces need to be hospitable; inviting as well as open, safe and trustworthy, for learning is to occur.

The educator in this story is not considering her moral or legal obligations, as she fails to demonstrate respect or maintain student privacy. Noddings (1992) viewed wrongful actions as a ‘diminishment of the ethical ideal’. The educator’s primary motivation may have been a desire to correct and enhance student learning, but in the process she has not considered the student’s welfare and feelings. Noddings (1992) believed that students are more important than the subject and must be received fully and respectfully during every teacher student encounter.

It is difficult to surmise the thinking and motives of the educator but her practice raises questions. What are the educational and personal requirements for this role? Are clinical educators adequately prepared before embarking on this role? Who is responsible for providing clinical educators with continuing support and education?

Feedback on clinical performance is regarded as essential for effective student learning in oral health therapy practice and its importance is widely acknowledged amongst educators and students. Clinical educators make observations of oral health students while they are working in practice and provide feedback using both formal and informal methods. Feedback can assist students to rate their own clinical practice in a realistic way; yet as a process, it faces challenges such as time, miscommunication and emotional barriers (Carless, 2006).

In her story Emily appears to be intimidated and subsequently reluctant, to seek feedback or pose questions regarding feedback from her clinical educator.

*I'm nervous when I get feedback because everyone wants to get good feedback, but I really want to ask them if I did wrong or right. ... I want to check myself to know if I'm doing it right or not, so feedback is important. If sometimes there is something I don't understand about her comments, now days I just ask but it really depends upon the educator or whether she can accept me asking or not. As a student you are really concerned what your teacher's comments are, she is an educator but she is also human and you don't want to offend her. Sometimes I think this may be a little bit offensive and I stop. It's not good for me the results won't be good for me. (Emily)*

Feedback appears to have a strong emotional dimension in this story. Emily regards feedback as an important aspect of learning and although she wants to know how she is progressing, she feels anxious about receiving feedback. It may be that Emily is not confident in herself and has low self esteem. She appears to be concerned about her performance and fearful that perhaps the feedback will be negative. Emily may be a student who interprets feedback as judgemental and is deterred by the emotional cost of negative feedback. Feedback can impact on self esteem and some students experience shame, rejection and disappointment as a result of negative comments from educators (Young, 2001).

Although Emily considers feedback a valuable way to assess her performance and develop professionally, she is hesitant to ask for clarification if she does not understand her educator's comments. Socio-cultural factors and personality can impact on how students respond to their educator and this may be the reason students are reluctant to raise questions if they disagree with their educator or fail to ask questions if they misunderstand (Hyland & Loi, 2006).

It appears that Emily feels she needs to be careful as to how she approaches her educator and she considers how her actions will impact on her future progress. An imbalance of power is inherent in student-educator relationships (Hyland & Loi, 2006) and it appears that this disparity concerns Emily. It is acknowledged that the feedback process is problematic because of the nature of the power relationship (Carless, 2006; Higgins, Hartley, & Skelton, 2001). It seems that this is making Emily feel vulnerable especially as she does not have a trusting and open relationship with her educator.

Students possess very little, if any, formal power and have a great deal to risk if they openly differ with educators (Jamieson & Thomas, 1974). Emily appears to be very aware of this dynamic. The teacher-student connection is fraught with uncertainty and distrust and Emily senses that although this educator is 'with her' she 'not there' for her.

Emily infers that she feels more confident seeking clarification from other educators "it really depends on the educator". This suggests she has better rapport and a more trusting relationship with some educators and not others. Differences between educators can adversely affect student learning and students find some educators more difficult to communicate with than others (Eligcil & Sari, 2006).

## Summary

Relationships are a cornerstone to learning. This chapter has focused on the relationships students share with peers and their clinical educator. Van Manen (1990, p. 101) refers to this as the lived "other" the "lifeworld existential" by way of which all human beings experience the world in relation to another. Students regard relationships as an important aspect of their learning and clinical placement. Students experiences were understood based upon their individual "thrownness"- their lived experience of "being-in-the-world" (Heidegger, 1995) and this influenced the way they experienced the context.

The participants' narratives illustrate how contemporaries and clinical educators influenced their placement. Students turned to their peers in the first instance for assistance, knowledge and emotional support, and they gained reassurance in knowing that their peers' experiences were similar to their own. However not all relationships were supportive to learning and some students expressed frustration, and felt that their peers hindered their learning. For these students lived space "spatiality" assumed a different meaning; experiences do not exist alone rather they are embedded and connected (van Manen, 1990). Therefore, the clinical context became a source of frustration and stress for some students.

The lived relations between student and clinical educator also varied. Some students felt supported by their educator while others felt unsupported. Some students implied that they had better relationships with some clinical educators and not others and as a result the clinical context assumed different meaning. Some student experienced a clinic environment that felt encouraging and supportive while for others it was frightening and stressful.

This section has examined the nature of the relationships that exist within the clinical context. The next chapter examines the “lifeworld” of students as they move from model to patient.



## Chapter Five: The Leap to Real Patient is Huge

Community clinical placements expose students to patients and provide them with opportunities to experience providing patient care in real life situations. Treating real patients enables students to develop their technical know-how, enhance their interpersonal skills and develop caring relationships with patients. This chapter provides insight into the experiences of students during their transition from models to real patients.

### Feeling Unprepared

Prior to beginning community placement students have very little exposure to the clinical environment or to 'real' patients. In the university environment students gain their practical experience on plastic heads in the ossim laboratory. These bear little resemblance to actual mouths and it appears they do not adequately prepare students for the realities of practice. Anna recalls her experience of making the transition from plastic head to real people:

*Last year it felt as though I was chunked into the deep end a little bit. Because we had gone straight from theory and all of a sudden we were in a clinic and we were expected to treat real people, real children and I think would I want my children to be treated by a second year? Would I want them to do it? It's the only way you are going to learn, to be chunked into the deep end. You learn like that. We learnt really quickly in those first few months, that we were in clinic. You kind of think that maybe you should have a little introduction or something before you get trusted with a person. It is so different when you are sitting behind the patient. So even though we have access to the ossim lab where we have the plastic heads and things to practice on. I kind of feel a little more interaction with the children or something to familiarise us with the environment would be a lot less stressful on our senses. I guess there is no other way they can do it. You are going to have to learn to do it one day and it's going to be your first time picking up that drill at some point so you just have to get on with it and do it. (Anna)*

The clinical context represents the 'real world' of practice and Anna experiences it as a very different place from the classroom environment. Initially clinical placement is a

tense, demanding and uncertain time; caring for real people is a very different experience to practising on ossim heads. Anna feels apprehensive and fearful during her first encounter with patients. She is aware that there is potential to hurt or harm the children she treats and her anxiety increases when she reflects on the reality of the situation “real people, real children”. She considers the vulnerability of the children she treats and wonders if she would allow her child to be treated by students. Working on a ‘real’ patient brings with it responsibilities and it seems that Anna is reflecting on these.

What does Anna mean when she says “it is so different when you are sitting behind the patient”? Is she talking about the differences between plastic heads and real people? Is she considering the responsibilities aligned with treating patients? Or is she talking about the physical closeness that exists between the patient and herself? The physical nearness required for treatment to occur may initially feel awkward or uncomfortable for Anna. This close proximity to another, that Anna feels, is taken for granted and seldom reflected upon within the dental professions. But for Anna it may feel like an invasion of space or it may highlight her responsibilities of caring for another. Van Manen (1990) referred to the “lived other” and our relation with others within “the interpersonal space that we share with them” (p. 104). For Anna this physical closeness is a new experience which may help her define the relationship she shares with the children she treats.

Anna used the analogy being ‘thrown into the deep end’ to describe her experience, suggesting she feels abandoned - left to cope on her own, lacking in both experience and clinical skills. She stressed the importance of learning quickly in this environment; she inferred there is no other option if one is to succeed. She is aware that at some stage students have to begin practicing on patients but questions if there is something that would make the transition from model to patient easier? She wonders how the experience could be made less daunting? Perhaps spending time prior to placement in a clinical environment observing would make the experience less frightening. Or just being with children, learning to communicate with the different age groups would be helpful. But even through her fear and apprehension Anna knows that oral health therapy can only be experienced and learnt by actually doing it – through practice. She

infers that there is no other way but to get on and do it and she demonstrates the courage it takes to achieve this learning.

Heidegger described anguish as a fundamental willingness of being-in-the-world, present in every new challenging and threatening situation encountered; which causes feelings of 'strangeness' while revealing possibilities of being and enabling choices (Sadala, 1999). Although Anna initially feels anxious and apprehensive, her story also conveys a sense of excitement and achievement of having finally made the transition from plastic head to real patients. It appears that Anna's experience has opened up new possibilities, enabling her to gain experience and learn new skills.

Lack of knowledge and inadequate technical skills leaves Cathy feeling frightened and overwhelmed when she examines her first patient.

*It was pretty scary because we had never looked into a child's mouth before, just into each others. It's quite over whelming when you first get into the mouth and you see everything and you think where do I start? We had only really worked on each other for the hygiene side of things and we had only really had the plastic teeth to work on before ARDS. We didn't have any idea about exams, so we weren't very prepared. I don't really think you can be prepared because you are always going to have to jump from the plastic mouth to the real mouth sometime. (Cathy)*

Everything looks very unfamiliar to Cathy the first time she looks into a child's mouth and she feels overwhelmed when faced with the realities of practice. She is fearful of harming or hurting the child she cares for, as she has never performed a dental procedure on a 'real' patient before. She lacks confidence and feels inadequate, as she has not yet learnt the technical aspects of performing an examination. Her lack of knowledge and skills make her anxious and hesitant the very first time. Feeling unprepared and not being ready for clinical placement has been identified by students as concerns within a wide range of educational and nursing literature (Dunn et al., 1997, 2000; Johnstone, 1994).

Cathy's use of the phrase "jump from the plastic mouth to the real mouth" suggests a huge leap occurs when students move from ossim heads to the real mouth. She implies the chasm or space between the two is great, yet seems resigned to the fact

that there is no other way. As apprehensive and unprepared as she feels Cathy indicates that she is ready to make this 'leap'.

Research published by Sharif and Masoumi (2005), Beck (1993) and Kleehammer et al. (1990) identified the initial experience of being exposed to patients as being the most anxiety producing part of a student's clinical experience. Apprehensiveness, envisioning self as incompetent and feeling abandoned are the central themes in Beck's research, and were also identified in the narratives of the students in this study.

It is difficult adapting the skills learnt on a plastic head in ossim room to a 'real' mouth. Real mouths present many challenges and for students it can be difficult performing the technical aspects of a task as well as considering the emotional needs of a patient. Dee described the challenges she encountered the first time she prepared a cavity:

*It's completely different from doing anything on plastic teeth. There was a tongue that moved around and lots of saliva and the mirror kept fogging up and it was completely different than working on an ossim head. I knew that anyway, because I had been a dental assistant, so I knew the mouth wasn't easy going. I just remember thinking oh my gosh, I'm doing something on someone's actual tooth and I can't take it back once I have drilled a hole, so I was very cautious. I was really scared of hurting them. I was really cautious about how far I pulled their lips out. I just remember being really scared to even talk to them not knowing what to say. I was concentrating so much on looking that I wasn't really speaking to them. (Dee)*

Although Dee had previous dental experience as an assistant, and knew that there were many physical aspects to consider when working in a real mouth, her prior knowledge does not make the task easier and she feels challenged the first time she carries out an irreversible procedure. Observing and doing are different and Dee feels very anxious the first time she prepares a cavity ; she is aware of the vulnerability of her patient and does not want to cause pain or harm. She is tentative and performs the procedure carefully, aware of the possible consequences. The focus on the physical act of care at this early stage of learning seems to take priority. Polkinghorne (2004) described a situation where practitioners become so intent and absorbed in performing a task that they lose touch with the world around them. Dee's story seems to describe such an occurrence. She is absorbed in the technical aspects of practice, so intent on developing the mechanical skills that she overlooks the human side of

practice and does not consider the emotional needs of the child for whom she provides care. During early encounters with patients, novice students are mechanistic in their approach, more resolute on doing tasks than having a wider focus of seeing the patient as a real person (Johnson, 1994; Seed, 1994).

Dee finds it difficult to work and talk simultaneously, and even when she is able to disassociate herself from the task she finds it difficult to know what to talk about. The high levels of anxiety that Dee experiences may be creating a barrier to developing a relationship or it may be that communicating with patients has not been sufficiently covered in lectures at the university.

Fear appears to be a predominant theme in this story. Dee talks about “fear of hurting” and “fear of talking” to her patients. This emotion seems to be influencing the way Dee treats and reacts to her patient. All students interviewed for this study talked of experiencing fear when they first encountered patients and were concerned about the physical and emotional well-being of the children they cared for. Fear of hurting or harming patients is a common theme in studies which explore students’ initial experiences on clinical placement (Beck, 1993; Suikkala & Leomp-Kilpi, 2005).

## **Connecting with Patients**

Before a caring relationship can be developed, effective communication must be established. Connecting with patients and establishing a trusting relationship is an essential pre-requisite to gaining a patient’s cooperation and confidence in oral health therapy. All the students interviewed expressed a desire to establish a caring relationship with the children they treated. Children possess a wide range of physical, intellectual, emotional and social development, and are diverse in attitudes and temperaments. Dee highlighted the difficulties of caring for such a diverse age group:

*Some of them are quiet, they are all different, you just adapt to their personalities. I’m a lot more comfortable with them now, knowing what sort of language to talk to them in. When I first started I didn’t know what was appropriate to say to a five year old or an eight year old. I didn’t know what you say differently to them or what cartoons they watched or anything like that. Now I’m learning so I’m a lot more comfortable about that. (Dee)*

Dee wants to identify with the children she treats. She describes experiencing difficulties in communicating with patients when she first began placement. Her story suggests she has a genuine interest in the children and is aware of the importance of connecting with patients on a very human level in order to reduce anxiety and provide reassurance. Oral health therapy has an interpersonal and human dimension and being able to relate to children and reduce their anxiety is an important aspect of practice. It seems that even at this early stage Dee knows that caring is more than just providing dental treatment. She is aware of the importance of the relational side of practice, and its influence on the way patients experience care. Interpersonal relationships between patient and student in the clinical environment are essential to care (Sikkala & Leino-Kilpi, 2001), but findings from this study indicate that it does not occur spontaneously.

Initially it seems Dee feels very uncomfortable and unsure of 'being-with' children and she struggles to find a common connection. The different communication styles required by different age groups and personalities that Dee cares for, makes it difficult for her to determine at what level to communicate. Would more exposure to children before placement assist students in the transition from model to patient? Would more in-depth lectures on the theory of communication and development of children be beneficial? Can communication skills be taught in the classroom environment? Or is it, as Chan cited in (Benner, Brykczynski, Malone & Chan, 2010) suggested, that interpersonal skills are learnt through practical experience.

Van Manen's (1990) lived time, the temporal dimension of past, present and the future, is illustrated in Dee's story. Initially she was afraid and unable to connect with her patient, but with time she has become more advanced in her learning and wants or maybe needs to make a connection. It seems that this student's relationship with her patients has changed as she has grown more confident in her technical skills. Sikkala and Leino-Kilpi's (2001) study affirmed that as students grow professionally their relationship with patients change.

Cathy's personal circumstances meant that she had limited contact with children and she struggled to connect with them before she began her placements.

*We have had lectures on interaction with the children but that's something you can't learn in the classroom either and with me having no younger family member or anything like that. It was what I struggled with and just thinking of the differences and how to communicate with them. (Cathy)*

This student is similar to Dee in that she demonstrates self awareness and expresses a desire to connect with patients in order to establish a caring relationship. Cathy seems to recognize that communication is an important aspect of oral health therapy practice. Van Manen (1990) refers to “self” and “other” as being fundamental to human relations (p. 89) and self awareness has been identified as an important factor in creating a student-patient relationship (Suikkala & Leino-Kilpi, 2001).

Cathy expresses a genuine desire to connect with the children and feels challenged and perhaps frustrated that she is not able to communicate, not knowing the language to use and the level to gauge her communication. Heidegger believed that to be human means to be with others, orientated towards their presence, and dealing with others involves some sort of practical or emotional involvement (Van der Geest, 2002).

Research indicates that students experience difficulties relating to and communicating with patients in the early stages of clinical experience (Cook, 1996; Parkes, 1985; Suikkala & Leino-Kilpi, 2005) and Cathy's experience affirms this. Although students attend lectures on human development Cathy feels unprepared and unsure as to how to relate to the children, but senses that it is an important aspect of care. Sarnat et al.'s (2000) study emphasised the importance of effective verbal communication in achieving a pleasant and acceptable patient experience, assisting in patient cooperation and attaining a successful dental outcome.

Students have little to guide them in their communication with patients during their initial experiences. Lack of information or research on communication in paediatric dentistry has been identified in literature (Nash, 2006). The American Academy of Paediatric Dentistry emphasised the importance of assessing patients' developmental levels and comprehension skills when caring for children (Nash, 2006). Sarnat et al. (2000) proposed a model which recommended the use of three linguist approaches. First, it emphasises empathy, focusing on patient's feeling; second, it stresses the importance of establishing a rapport and personal relationship with the child through

genuine interest and open communication. Third, the model suggests that all relevant information regarding treatment be provided to the patient using non-threatening language. The “show-tell-do” method, an important feature of this approach, is regarded as helpful for acquiring patient cooperation.

## Caring Holistically

The desire to care for both the emotional and physical needs of the patients was articulated by many of the students in this study. In this story Anna expressed her concern and empathy for the children she treats:

*You're not just dealing with the cavity you're dealing with the patient. They are going to be seeing the dentist forever. So what you do now, will impact on them later. So you are kind of treating a whole person instead of making money for a company, of course we are just doing dentistry. But their experiences with you are going to impact as to whether they are going to have horror stories like their parents when they are older like "I went to the nurse and she drilled my tooth". You know the stories adults tell you. I hear that all the time. Parents come and say "I remember in my day I hated it" and I think I'm going to make it a positive experience for this little kid, this time. I can manage to do that, I haven't had one cry in my chair yet. I try and make it a fun experience. I'm a big kid myself. I bribe them with stickers and things like that. I try and make it a fun thing. It is not a fun thing, but they seem to leave smiling with their stickers. (Anna)*

Ensuring the children have positive dental experiences is very important to Anna. She knows that dental procedures can involve discomfort and sometimes pain, but she is determined to make the children's experiences as good as she possibly can, by reducing their fears and anxieties. She wants to make a difference to their lives and attitudes toward dental care and reveals her 'being-in-the-world' through the care and concern she demonstrates towards the children she treats.

Some of the parents of the children Anna treats have a very negative attitude to dentistry. She wants to change these perceptions and instil a positive attitude to oral health care. It appears to be important to Anna that the children she cares for are left with positive memories of their experiences. Van Manen (1990) talked of past experiences influencing the present and the future when he described lived time. "Whatever I have encountered in my past now sticks to me as memories or as (near)



forgotten experiences that somehow leave traces on my being” (van Manen, 1990, p. 104). Anna knows that the children’s experiences with her will remain with them and influence their decisions regarding their future oral health care.

It is the small things that can make a difference and change perceptions. Anna’s attentiveness to the children’s emotional needs and incentives for co-operative behaviour indicate that she understands children and feels both comfortable and confident interacting with them. Her story acknowledges the emotional and physical aspect of care.

Responsibilities come with active practice. Emily has a very clearly defined concept of the role and responsibilities of an oral health therapist and this notion determines the way she cares and responds to the patients. In this story Emily expressed a deep felt responsibility for the children she cares for:

*I felt so frustrated when the child cried, I worried, and I thought that I had done something wrong. I thought it is the clinician’s responsibility to comfort the child, that’s what I thought and I still think about it that way. So when the patient is not comfortable with me or is a bit anxious and eventually cries I feel sorry for them. I feel that once you start treating a patient they become your responsibility so I think I have to look after everything, their safety and their psychological needs for their future dental treatment. If they cry during the dental care in my presence it won’t leave them with a good memory. (Emily)*

Emily believes caring is an essential attribute of an oral health therapist and therefore believes she has a duty to care for the children, to ensure that their needs are attended. Emily’s view of herself as altruistic is challenged when patients she cares for become distressed. She appears to believe that as a health practitioner she is totally responsible for patients and their needs. Her story indicates a lack of confidence, especially during her early interactions with children. She does not question why the child is crying. She just assumes that she is the cause, fearing that she has hurt or harmed the child in some way. Fear of hurting and harming patients was identified earlier in this chapter as a concern amongst students.

Emily empathises with her patients and is concerned for all aspects of their welfare; she assumes a great deal of personal responsibility for ‘getting it right’. Van Manen (1998) referred to the work of Levinas (1981) when he claimed “that the ethical

experience of the other is always located in the person who experiences the other as an appeal to his or her responsibility” (p. 22). Emily experienced the lived other through altruistic beliefs that seem to guide her in the way she cares for patients.

This story is similar to Anna’s, in that Emily is aware of the importance of attending to the emotional and physical needs of the children and seems to know that she has the potential to influence the way children perceive their dental experience. She also recognizes the importance of her role in influencing patients’ attitudes to access dental care in the future.

As she nears the end of the final year of her degree this student has developed a boarder perspective on her role as a future health practitioner, as a result of a greater knowledge and understanding of the patient group she treats. Dee’s story expressed a desire to make a difference to the lives of the children she cares for:

*I want to make a difference. There are so many children out there with so much and there’s only so much you can do. I have given a few children my lunch if they haven’t had any food. It’s kind of sad. Even if it’s only one person who gives them gives them a hug or cares about them. Some of them just get abused and even if you just give them a smile and a sticker it makes their day. (Dee)*

This student has progressed to a different level of caring and the children have become more real to her. Seed (1994) believed that students need to acquire the necessary psychomotor skills before they are able to see patients as people. She described a continuum of care where students move from learning ‘to care for’ to learning ‘to care about’ people, a skill which she believes is more complex and belongs to a different order. It appears that Dee has moved from seeing patients to seeing people and, as a consequence, she has become involved with the children in an attempt to help improve their ‘life-worlds’. Heidegger described care as the essence of being human van de Geest, (2006) and ‘being-with’ as the active involvement in the ‘life-world’ of the other (Draucker, 1999). It seems Dee’s way of ‘being-with’ her patient is through her empathy, sharing of food and gestures of kindness.

Dee demonstrates humanistic qualities and attempts to live her moral viewpoint through her care. Her concern for the children’s welfare and future means she has become personally as well as professionally involved with her patients. Providing

dental care to children from different social economic groups has enabled Dee to develop awareness of the social and environmental impact on health. It has highlighted the value of her role and enabled her to glimpse into the world inhabited by her patients.

## Ethical Concerns

Emily expressed her ethical and moral concerns of learning and practicing on 'real' patients in her story:

*My hand was shaking, so shaking when I gave my first injection. I was injecting a drug into my patient's mouth with a needle. I was so anxious, so anxious even though I did it under supervision. It was different when we practised on our classmates. I was more confident with them... but the patient... I didn't tell the patient. I pretended to be a professional. But I'm not and all these thoughts are going around in my mind. Some people say this is your practice. But no, I can't think like that about my practice; because this is a living person. (Emily)*

Emily was very frightened and apprehensive when she administered her first local anaesthetic on clinical placement. She used self talk strategies in an attempt to reduce her anxiety and those of her patients. On this occasion even the presence and support of her educator did not alleviate her fear. She did not feel nearly as afraid when she practised on one of her colleagues at the university, yet when she performed the procedure on a child she felt extremely scared. Why does Emily feel more fearful administering a local anaesthetic while on placement? Is she afraid of hurting the patient? Is it because she does not disclose her inexperience? Does she feel children are more vulnerable? Do Emily's ethical beliefs not extend to her peers?

Polkinghorne (2004) believed that "practice with people always has an ethical and practical dimension to that practice" (p. 92). This may explain why Emily feels ethically responsible for her patient and accounts for her increased anxiety when treating children. Emily has been informed by others that this is how she must learn, but she rejects this notion as she knows that the patient is a 'real' person and she finds it difficult to ethically reconcile the fact that she is learning on a human being. So is it ethical for students to learn on children? Is it ethical not to disclose inexperience? Emily's story encourages reflection on ethical issues regarding student care.

## Working with Pain

Pain and anxiety have traditionally been, and continue to be, associated with dentistry, despite better local anaesthesia and treatment techniques. In the clinical context students are confronted with pain and the knowledge that sometimes they must inflict pain in order to alleviate it. According to Nagy (2998), there are difficulties inherent in this situation because the role of carer and pain alleviator is incompatible with pain inflictor. Children are also more challenging and stressful to work with than adults because they can lack the ability to cope, have little control of their fears and emotions and are not always able to comprehend the good intentions of students.

## Recognising Pain

This student described how she felt when she first attended placement and confronted pain:

*My teeth were so good I never had any dental procedures and stuff on my teeth. I just can't experience that level of pain, I just feel like a lack of sympathy in me because I have never experienced that. Even though I see people with the pain in their face it doesn't necessarily mean that that pain can be transfer to you but it makes me anxious as well and it slows me down. (Beth)*

Pain is a very private experience that can only be felt by the patient (Madjar & Walton, 1999). Pain is a new phenomenon for Beth and she acknowledges that she has no personal prior experience with it and therefore cannot comprehend the pain and suffering her patient experiences. She is not able to feel the patient's pain and can only speculate on the intensity, even though she is closely involved with the entirety of the experience. But she recognizes its cues, her work performance is affected and she becomes stressed and anxious seeing the level and severity of a child's pain. Beth may also feel a little uncomfortable, perhaps guilty, that she has not and cannot experience this sensation referred to as pain, yet she can inflict it.

Beth appears to be distanced from her patient and their experience. It may be that she is not adequately prepared for this experience and therefore does not know how to respond to the situation which involves such intensity of emotion. Or perhaps she feels powerless to alleviate the pain and anxiety associated with dentistry and is distancing

herself from it in order to protect herself. According to Polkinghorne (2004) “individuals experiences are based on unique experiences and their responses are based on their understanding of a situation” (p. 90). It appears that Beth’s lack of experience and lack of knowledge of how to respond are influencing how she experiences patients in pain and the patients pain is showing through Beth’s anxiety and slowed practice.

### **Making Pain Visible**

In contrast to Beth, Cathy acknowledges pain is sometimes experienced during dental procedures and she wants to ensure that her patients are not too overwhelmed and are able to cope during these times. In the following extract Cathy illustrated a particular kind of ‘being-there’ where she demonstrates concern by acknowledging the existence of pain and making it visible.

*I haven’t really had any kids cry through a treatment maybe just a few tears during the injections but we are both there me and the educator are there to help calm the kid down we both usually say something. ...If they are in pain then I’m going to do something about it. When the kids complain about pain I remove the rubber dam if that’s a problem. If I’m drilling then they know it’s just going to be a little bit more then I’m just going to be like “can you handle a few seconds more or do you want a local” I just give them the option. (Cathy)*

Even though Cathy is inflicting pain she is mindful of the ability of the children to cope with the experience. She cares about the children and responds to their needs. She shares control of the pain by providing choice and allows patients to make decisions regarding their care. Cathy acknowledges her patient’s vulnerability and yet appears to recognize that some pain may be inevitable; she communicates and works with her patient to ensure that pain remains manageable and is not overwhelming.

Cathy appears to be competent and in control of the situation and her clinical judgement and actions show sensitivity and skill. She listens, understands and responds to the children’s physical and emotional needs. She offers reassurance and support when they are fearful and if she senses they are not coping with the treatment, offers pain control to alleviate the pain they are experiencing. By acknowledging and engaging with the pain, and sharing the experience, Cathy is able

to prepare and support the children through treatment. Acknowledging the reality of the existence of pain enables her to structure the painful episode; knowing that she is caring for her patient appears to provide her with a sense of satisfaction. It may also be a way for her to reconcile her own self image; that being an inflictor of pain is sometimes part of being a 'carer' was a notion suggested by Nagy (1998).

### **Disengaging with Pain**

Beth continues her story and describes how she copes with inflicting pain after some experience:

*I felt stressed and under pressure when a local anaesthetic fails if the child is crying, although now when I see a child in my chair crying I don't feel as anxious. Perhaps because I have seen children cry so much, my brain is switched of so that's no good. If it happened last year I just wouldn't know what to do I would just leave my hands there holding the instruments and my brain would shut down completely. This year I have a much better way of dealing with it. The best way to deal with it is to finish the procedure as fast as possible in the best way I can.*  
(Beth)

Initially Beth felt immobilised and helpless when patients became distressed. But as she has progressed Beth has changed her approach to crying children, her reactions now worry her and she feels uneasy about her lack of emotional involvement. She does not want to become insensitive and cold to the emotions of the children but it appears that Beth has learnt to protect herself by distancing herself from the stress involved with inflicting pain. Beth does not mention offering another local anaesthetic to alleviate pain after the first injection fails and her priority is to complete the task. Perhaps her exposure to pain has made her less sensitive to the patient's need for pain relief as she suggests.

Although Beth does not like inflicting pain she no longer feels overwhelmed if a patient becomes distressed; rather she focuses solely on the physical aspects of the task rather than the emotional needs of the children. Disengaging herself from the pain appears to allow her to assume control over her emotions and the situation. She justifies her actions by focusing on the long term benefits of completing the procedure by

suggesting that she is doing her best for the patient. Distancing herself from the pain seems to be a coping strategy that she uses to avoid having to engage with the pain and acknowledge her role in the process. Disengaging and being able to complete the procedure may also provide a sense of satisfaction that she is able to provide care even under stressful conditions.

## Summary

This chapter has analysed the students' experiences during the transition from plastic model to real patients. Students identified moving from model to patient as the most anxiety producing part of clinical experience. Heidegger believed that human moods and feelings influence and partially organize human experiences (Todres & Wheeler, 2001). The students described the embodiment of their experiences in terms of fear, stress and incompetence, and as a result they felt unprepared and anxious during their initial clinical encounters with patients.

Most of the students wanted to connect with the patients and wanted to make a difference to the lives of the children through their "lived relations". They expressed a genuine concern for the patients and felt a moral responsibility to do right by them. Many of the students attempted to actualize their caring through their relationship by "being-with" the children and their narratives indicated that care was both specific and general. Caring was identified as both a feeling and behaviour; the students cared for their patients through their actions, but they also cared about their patients in a more generalised way. Caring encompassed a wide range of activities demonstrated through student behaviours and actions.

"Lived time" changed the student patient relationship. Initially students were hesitant and uncertain in the way they communicated and provided care to the children. Over time, as they gained more confidence and the necessary psychomotor skill, the nature of their relationship changed.

Pain and fear of hurting or harming patients was a predominant theme within this study. Students used different strategies to cope with the pain they sometimes inflicted on their patients. Some engaged with the patient's experience while others

disengaged and distanced themselves. Their understanding of pain and the way they reacted was based on their own “fore-structure” or previous understanding and lived experience of “being-in-the- world”.



## Chapter Six: Learning Does Occur

Clinical experience is an important aspect of oral health therapy education. The diversity of experiences encountered on clinical placement enables students to develop a multitude of skills, gain practical professional knowledge and allows for socialisation into the oral health therapy profession. Clinical experience also increases student confidence. This chapter examines the experiences of the students as they move from feeling insecure and anxious, to being confident and skilled oral health practitioners.

### Starting Simple

The clinical setting allows the theoretical aspects of the course to be put into practice and enables students to learn how procedures are carried out in a real setting. The students in this study commenced practice on patients by undertaking simple dental procedures.

*My first placement was fun, as a first time learner to do actual clinical work. We started from the very easy stuff such as fissure sealant and fissure protection and then we went on to do fissure investigations, but because the procedure was so small we just had to use the bur very minimally so that was really good. (Beth)*

It seems that Beth enjoyed her experiences on placement; she was pleased to finally be able to 'do' what she had spent many months preparing for. Placement provides her with an opportunity to perform treatments on 'real patients' rather than plastic heads. In the early stages of her placement the emphasis appears to be on skill development. Performing simple procedures, such as preventive work and fissure investigations, allows Beth to develop the fundamentals skills of tooth isolation, application of materials and hand piece use. It enables her to become comfortable working on patients, to cope with the physical challenges of working in a 'real' mouth. Developing competence in these simple procedures allows Beth to build confidence in

her abilities and prepares her for the more complex procedures which she will need to undertake in the future.

Another student, Cathy, described how relieved she felt that on placement she was able to gradually develop the skills needed for more advanced practice.

*We did exams and simple stuff for a while first, but I heard of other girls jumping into fillings and things in their second week. So that was a bit scary, but my clinical educator eased us in to it and knew what we were capable of and would then let us go onto the next thing, the harder things. If I had had to jump into a filling the first day, it would have scared the living daylights out of me. (Cathy)*

A sense of relief is expressed by Cathy that she was not required to perform complex procedures early in her clinical placement. Cathy and her peers started with the simple treatments before they moved on to more complex procedures. It appears the clinical educator on this placement was experienced and insightful; able to assess the students' abilities, knowledge levels and learning readiness, allocating patients and procedures to the students accordingly. Developing the necessary psychomotor skills makes Cathy feel competent and confident in the simple tasks before she attempts the more complex procedures. Even the simple procedures at this stage would have been difficult, but through repetition of tasks, Cathy was able to perfect her skills and develop a sense of satisfaction in her accomplishments.

Cathy infers that she feels safe knowing she is supported in her practice. She appears to appreciate her clinical educators' knowledge and judgment in assessing her capabilities and feels reassured knowing that her educator is monitoring and providing learning opportunities that suit her skill level. It also highlights the role of the clinical educator and importance of tailoring a series of interrelated activities to individual student learning needs in order to progress student learning as suggested by Spouse (1998).

Dental literature asserts that the structured learning methods associated with learning theorists, Gagne and Skinner, are suitable for teaching psychomotor skills. Structured learning methods sequence procedures from simple to complex, using step by step processes, repeating practice and gradually increase the variety of procedures (Vann, May & Shugars, 1981, 1984). Spouse (1998) further advocated that the student activity

should be planned according to their ability and readiness to learn. It appears that this educator is applying these strategies to progress the practice of the students during their initial clinical placement and providing the right learning opportunities increases Cathy's confidence.

Although the students in this study described being eased into clinical practice, starting with simple and then moving on to more complex procedures, they felt anxious and apprehensive with every unfamiliar situation they encountered. Cathy described being cautious the first few occasions she administered a local anaesthetic:

*The first few times I was cautious not wanting to hurt the patient, I was shaky. The educator was there and watching us and helping us and guiding my hand because that was what it was like the first couple of times. Just not confident in yourself and so you need someone else there. I started breathing again when I finally had injected the solution. I could relax and rest my finger and things like that. But after getting into that position and getting the needle into position it was fine, I could breathe again. (Cathy)*

Administering a local anaesthetic is a new and frightening experience, and Cathy feels unconfident and extremely nervous the first few times she performs this procedure. She feels responsible for the child she treats and her main concern appears to be the patient's safety and welfare. She infers that she does not want to provide inadequate care and wants to avoid harming or causing unnecessary pain. She may also feel that this infliction of pain is an abuse of trust and violation of another human being. All of these scenarios, or perhaps some of these scenarios, cause her to become tense and the anxiety she feels impacts on her physically. Munhall (2007) describes the connectedness of embodiment with experience and claimed individuals negotiate experience through the unity of mind and body. Cathy's story indicates that she lives the fear she feels through her body and behaviour. Once Cathy starts injecting the solution she begins to relax and once again assumes control of herself and the situation. Her body relaxes knowing the safety of the patient is assured and she is successfully injecting the solution.

It seems that Cathy is dependent on the support and reassurance of the clinical educator to administer the injection at this early stage of learning. The educator's close proximity enables her to physically guide Cathy's hand to the correct site of

infiltration and talk her through the procedure. This educator cares for her student and demonstrates the “leaping in/leaping ahead” modes of concern referred to by Smythe (2000). Even though this student is nervous, the educator does not “leap in” and dominate by taking the care of the patient away from Cathy. Rather, she assists her to administer the injection. This educator knows that there are times she must “leap ahead”, as it is important that Cathy learns to perform these clinical procedures herself if she is to progress. The first few times student’s administer a local anaesthetic are always frightening and stressful; for Cathy knowing she has the educators support and encouragement provides her with the confidence to achieve the task.

Anna experiences mixed emotions when she prepared her first cavity; she was excited, nervous and frightened all at once.

*Cutting my first cavity was really, really scary, so scary. It was just a little class 1. It was really, really scary. I double checked with my clinical educator if I had the right tooth. If this was the decay here, just making sure I had everything right before I started cutting, so scary but fun when you finished it. I gave a local an infiltration. It was the longest two minutes of my life. Just getting the local into the patient was good, so that was alright, the patient didn’t cry or anything, it went well. It worked. I didn’t have to redo it. It worked, but it was quite scary. Your first time is very scary. (Anna)*

This story illustrates the mixed emotions that students feel when they begin placement. Anna initially delays starting the procedure and she seems reluctant to begin treatment. She feels unconfident, insecure and apprehensive the first time she performs an invasive treatment. She wants to ensure she is doing everything correctly; she seeks advice and reassurance from her clinical educator. It seems that Anna is guided by principles and rules at this early stage of learning. She needs “everything to be right” before she begins the procedure. Benner, Tanner and Chelsa (1992) claimed novices are very reliant on rules to help them perform and asserted that novices lack “life experience” in the application of rules and hence they need to be directed and guided in practice. Anna’s actions seem to be congruent with Benner et al.’s description of a novice practitioner; she is dependent on the educator for support and guidance as she carries out the procedure.

People live through a concept called time (Munhall, 2005). When Anna administers the local anaesthetic her perception of time changes as it takes on a new significance and

has a different meaning. She describes it as being “the longest two minutes of my life”. Her experience stands out from the flow of time as she develops an acute awareness of both her actions and the environment during what seemed like a very long anxious period of time.

Fear of new experiences seems to be a predominant theme in this story but there is also a sense that Anna now knows that she can overcome her fear; she did not injure or hurt the child. She succeeded in providing the necessary care and next time it will be less stressful, less threatening and less frightening.

## Learning Happens

Developing confidence and competence arose out of a myriad of experiences, both positive and negative, for the students in this study. Dee’s story illustrated how learning occurs from experience:

*Now I’m really confident giving injections. There were just a few times I have had things that have happened that I got a little bit scared about. I did an infiltration on the lower tooth and there was a lump there right next to where I had given an injection and I thought oh my gosh, what have I done. But apparently it’s really normal, if you just push on it disperses. I didn’t know what it was and I thought I had seriously done something wrong and I was really panicking. That was quite scary. ...I actually quite like doing them now. (Dee)*

Dee describes her experience of giving an injection when she encounters an unfamiliar situation which she cannot explain. She has the practical ability to give an injection; she has the theories, principles and rules of administering a local anaesthetic. But she lacks prior experience which she can call on to help her develop understanding and meaning of the procedure. This causes her to become fearful and concerned; she blames herself and questions her actions. It is worrying not knowing what caused the lump. She feels uncertain and inadequate not knowing the cause. This episode has tested Dee’s knowledge and experience and she has learnt that she cannot rely entirely on guidelines and rules when confronted with practice.

Dee’s story reveals what has been a valuable learning experience. She has learnt through an actual clinical situation and this experience has contributed to building a

repertoire of experiences which appears to take her from nervous and hesitant to confident and skilled. Successfully administering local anaesthetics has influenced her attitude and her ability to perform this procedure.

Clinical placement provides students with opportunities to extend what they have learned at university. They are able to practice challenging and complex procedures instead of being restricted to routine tasks in which they can achieve proficiently. Knowing that support and guidance are readily available, enables students to take on more difficult procedures and further increases their confidence and competence.

*I remember the day my clinical educator gave me my first pulpotomy and crown. She had one and she said I'm going to give it to you and I was like oh well, okay. I was scared but excited at the same time. As I set up I went through the knowledge I had been taught in class and I went through the steps. It was hard because I had never gone into the pulp before and it was such a long way down, but I just knew she was there and I could call her over if I needed her and it was fine. I'm going to miss her when we are out on our own. It's always scary and exciting at the same time and it's always cool afterwards. It only felt like a short period to complete the procedure and the educator complimented me on my time management as well. (Cathy)*

Cathy experiences mixed emotions when she is chosen by the clinical educator to carry out a pulpotomy for the first time over the other students in her group. She feels pleased that the educator has confidence in her and it helps her shape her attitudes and belief in herself that she is capable. She is excited at the prospect of undertaking a task which is beyond her demonstrated level of skill. At the same time she feels apprehensive at the thought of 'doing' this advanced procedure for the very first time. It is usually only after extensive practice and proven performance that students are allowed to undertake pulpotomy treatments. Mentally Cathy goes through each stage of the procedure thinking aloud. Spouse (1998) claimed this intrapersonal speech helps novices become familiar with new procedures.

Having the clinical educator present in the room provided Cathy with the confidence and reassurance she still appears to need. Having made considerable progress, she is now able to accept new challenges and relies less on her clinical educator. She has developed her skill level, has gained more knowledge and confidence in her abilities and will only call the educator over when she requires advice and guidance or

encounters something unexpected. At this stage Cathy relies continues to rely on rules and steps to guide her in her practice. She is still dependent but becoming more independent. She wonders what it will be like when she graduates and has no one to call on for support; this frightens her a little. She worries about how she will cope without the reassurance and support.

Having completed the treatment, Cathy feels a sense of achievement, excitement and a high level of satisfaction. It is affirmation to her that she is making progress and working towards independent practice. Having these sentiments endorsed by the educator further confirms her beliefs.

Clinical educators play a critical role in student learning; however over time as students develop more skills and require less supervision, the nature of the relationship changes. Dee's story illustrated the changed relationship and the impact of these changes on student confidence:

*You can earn trust with your clinical educator and they're not stopping you every step of the way and they trust you and after a while you can actually do a local anaesthetic without them watching you. It makes you feel really good oh my gosh. They actually think I'm okay. It is so cool. It is just nice because you can actually put the local anaesthetic in and then they discuss with them what you are going to do. (Dee)*

Dee is not longer being constantly watched and monitored; she has proven that she is capable and she now feels accepted and respected by her clinical educator. She enjoys the autonomy and independence in her practice that she now encounters on placement. Dee's interaction with her educator affirms her feelings of self worth, self satisfaction and self efficacy, the belief in herself that she can perform the procedures required. Being listened to and consulted increases her confidence and self esteem. Research indicates that being allowed to take responsibility and work independently increases student confidence in clinical practice (Lofmark & Wilblad, 2001). Dee begins to believe that she is competent and feels like a professional making a worthwhile contribution to the dental care of the patient. Letting go and encouraging independence is preparing Dee for the future when she will need to make her own clinical decisions.

In contrast, Cathy believes that more supervision and guidance while on placement would be beneficial to her learning and skill development.

*I put the high speed in and the mirror gets wet straight away and I think 'ah'. Just little techniques would help. When I see the clinical educator sit down and pry the mouth open with the mirror so the kid doesn't close, I just learnt that through her checking my work but we didn't get told about it. Just being told about little things would make life easier. It's natural to you guys but we have no idea about it. So if we are doing things and there is something that can be improved on we should get told about it instead of them just checking our finished work or in the middle of our work. Getting stood over is not something people like but if it's going to help us and if the clinical educator is nice about it then I think it would be really helpful. It would be scary at the time but the same time it is going to be good. (Cathy)*

Cathy experiences the limitations of her technical knowledge and skills and watching the clinical educator using her 'craft knowledge' makes Cathy aware of the knowledge embedded in practice, which she does not possess at this stage. She considers that just having her work checked at the various stages is not enough and believes that more direct supervision, guidance and feedback from her educator would assist her to develop in practice. It seems that observational learning is not enough for Cathy; she wants the implicit knowledge in practice articulated.

A number of reasons exist as to why this procedural knowledge has not been highlighted earlier to Cathy. Spouse (1998) suggested there is a lack of literature to assist educators on how to transmit professional knowledge in practice, with a tendency to rely on learning theories associated with classroom or laboratory teaching. Do the educators appreciate their role in student learning? Was there an assumption that Cathy already knew these techniques? Are the educators aware of the complexity of learning in practice? Is some procedural knowledge so implicit that educators do not reflect on its existence? Benner et al. (1996) suggested that experienced practitioners have difficulty identifying the complex nature of their daily practice and find it difficult to articulate their actions. Polanyi (1962) cited in Polkinghorne (2004) believed that language only conveys part of what individuals perceive and know, and that tacit knowledge, rooted in the body functions out of awareness, develops through personal interaction with the world, without awareness or intention. Therefore is this "know how" Cathy refers to tacit knowledge?



Knowledge which maybe the educator is unaware exists but needs to be learnt through observation and interaction?

Although Cathy experienced direct intense clinical supervision in her second year, she still expressed fear and apprehension of experiencing close scrutiny again in her third year. She inferred that the educator's attitude determines how she experiences direct supervision and feedback. Literature suggests that how feedback is delivered is equally as important as what feedback is delivered (Eraut, 2006; Zsohar & Smith, 2009).

Another student agreed that direct supervision is beneficial to learning.

*I would rather someone watched me and caught me doing something wrong on the spot, rather than someone find me doing it wrong sometime later and I realised I have been doing it wrong for all this time. I think that's really good, I like it. It gets a bit nerve wracking sometimes when they are checking your work and stuff but that's good. I think it is helpful. (Anna)*

Anna wants to learn. She is aware that she is working on real people and wants to ensure she performs procedures correctly. She recognises that receiving on the spot feedback will assist with her learning. Eraut (2005) confirmed that immediate comment given at the time is a valuable in the learning process as takes into account situational factors. Even though she experiences feedback as stressful Anna wants confirmation of her performance.

The findings in this study contrast with other studies where students felt that being watched increased their levels of self-consciousness and reduced their ability to perform procedures (Nolan, 1998). Although most students in this study agreed that they felt nervous and anxious when working under close scrutiny; their desire to learn took priority and all felt it was important to learn to carry out dental procedures correctly.

Feedback is given to students as immediate comment on aspects of task or role as already described. It can be formal or informal and can be formative or summative feedback. The main aim of feedback given by the educators is to improve the learning experience. Cathy described how she feels when she receives positive feedback from the clinical educator.

*I have a lot of satisfaction a lot of the time just when I have done something well and the kids have responded well and I have got feedback. Of course everyone likes hearing that from the educator they say a good job. If you have done something really well they tell you. (Cathy)*

Cathy feels pleased when her efforts are acknowledged and she is praised by her clinical educator. It appears Cathy respects her educator's knowledge and skills; therefore when she receives positive feedback it increases both her motivation and self esteem. Receiving positive feedback provides her with an opportunity to reflect on her progress, contributes to her development and increases her self confidence.

Dee wants honest, specific feedback which will provide her with direction and professional growth:

*The feedback is really generalised and my clinical educator didn't pinpoint exact things, she was very general and she just wrote things like good and nothing else. Like every day she just wrote excellent day and it didn't give you much to go by. Specific feedback lets you know what you're doing wrong and what you're doing right, and what you need to improve on. If they say your time management is not too good, then I know I need to focus on time management and if your day is just good, well then you ask does that mean I need to improve or I don't. (Dee)*

Dee appears to be a mature, confident student with high self esteem and a positive attitude, who wants guidance on her knowledge and performance in order to improve her clinical skills and grow professionally. Dee wants specific feedback and does not seem concerned that her educator's perspective may be different to her own. Eraut (2006) claimed that the type of feedback received plays an important role in shaping a student's learning future. Students with high self esteem have a positive attitude to receiving feedback (Young, 2000). They appreciate constructive comments and understand that information relates to performance (Clynes & Raftery, 2008). Even if Dee gets a little anxious about the quality of feedback, she does not appear to complain. This may be because she is willing to trade off long term information gain for the immediate emotional deficit of precise feedback.

It seems Dee regards her educator as the subject expert. Seeking feedback from her educator illustrates the respect Dee has for her educator's knowledge and skills. She wants to know what she is doing right, what she is doing wrong and what

improvements she needs to make. When feedback is offered it appears to be vague and generalised and this is not helping; Dee wants more feedback that will assist her to rate her clinical progress in a realistic way. These findings align with research which indicates that students are often dissatisfied with the feedback they receive if it lacks specific advice on how to improve (Higgins, Hartley, & Skelton, 2001).

Specific feedback has been identified as an essential component of learning (Clynes & Raftery, 2008; Higgins et al., 2001). It is the clinical educator's role to provide feedback and this educator needs to be more explicit if the feedback is going to help Dee progress. The clinical educator's ability to give feedback may be impeded by a lack of skills; she may not be aware of how to provide constructive feedback; perhaps she has not received formal training on this aspect of her role. Perhaps her unwillingness to be specific in her comments may be because she wants to maintain a positive relationship with Dee and is afraid that Dee may become upset if she is honest. The existence of a close student-educator relationship may be creating an obstacle. Or it could be there is little to say because Dee is such a proficient student.

Students experience four clinical placements over the second and third year of their degree. These changes provide students with an opportunity to experience different role models and different ways of 'doing' things within a very similar context. Anna described her experiences working with different clinical educators:

*The clinical educators are all very different, each educator has their own way of doing things and you better do it that way or you are not going to go far. The way they show you how to do things are different and some of their standards are also quite different. I don't think it's a bad thing. The more you get exposed to differences the more you learn. They are not better or worse than each other, it just that they have a different way of doing things. The more I can see that they are a bit different, the more comfortable I can feel with myself. Just because I don't do something exactly the way my educator tells me or can't do it the same as my educator, but I can do it the other way. It's not wrong as long as it's achieving the outcome you want. It just shows you will develop your own way of doing things and that's alright. It was difficult to get used to it initially because I like to work on something and get it right. But when you go to a different clinic and you have perfected it this way and you find out that you are not doing it nicely, then they want you to do it a different way. You have to start doing it, sort of perfecting it again. (Anna)*

Initially this student found change difficult. Different educators want things done their particular way and Anna infers that there is no choice but to comply. If students want to progress they need to do things according to the wishes of the educator. It seems that Anna experienced some difficulty with this; perhaps it was due to her personal learning style as she suggests or it may have been a consequence of her novice status at that time. Benner et al. (1992) suggested that novice behaviour is governed by rules and is extremely limited and inflexible. It is possible that Anna found it difficult to accept that learning is more about best practice rather than about a specific way of doing things; things can be done differently and still be right.

However, as Anna has progressed she has become more receptive and accepting of differences. It seems she now enjoys working with different clinical educators and is aware of the learning opportunities associated with it. Through experience she has learned that clinical educators are different, have different ways of doing things and different standards. It appears working with a range of educators has allowed Anna to evaluate their practice, discriminate between good and bad practices and enabled her to form ideas about what it means to be a good oral health therapist. She has developed confidence in her own practice and learned new skills, and this has enabled her to reflect on what her standards will be in her future practice. Anna has learned that there is more than one way to do things and it seems she has developed an awareness of the importance of remaining receptive to new ideas and techniques which will assist her in her future practice. She now seems to rely less on rules and guidelines to guide her in her practice. She has learned that she no longer has to do things the way prescribed by the educator and she seems to be developing her own individual way of doing things. Polkinghorne (2004) confirmed that “practitioners will always reflect their individuality and differ from other individuals to some extent when they perform a task” (p. 89).

These findings were not consistent with the results from other studies where students found it difficult learning to adjust to working with a variety of educators and felt the different expectations of the educators adversely affected their learning (Elcigil & Sari, 2006). In contrast, all the students in this study stated that over time they enjoyed the opportunity of working with different educators and felt they benefited from the experience.

## Becoming Competent

Dee is mid way through her final clinical placement, and her story reflects the role experience plays in becoming a competent and confident oral health therapist:

*I always try to be nice to them and make them feel comfortable and not scare them and I talk to them all the time. I try not to give them injections all the time as well. I have got this thing now if it's not very big I will have a go with the round bur and usually its fine, they're fine. I have never really had one that's had pain from it and I think that's cool because they don't always associate having to get something done with an injection, so they don't fear it as much. (Dee)*

Dee cares about, and shows concern for, the patients to whom she provides treatment. She is aware that patients associate injections with pain and she wants to change their perceptions by not always administering local anaesthetics when drilling a cavity. She wants to make a difference to how they experience dentistry using her practical skills, knowledge and experience. She is no longer working or thinking like a novice; she is no longer guided by rules and guidelines alone. She has reflected and analysed the needs and fears of the children. She does not want them to constantly associate dental treatment with pain, fear and discomfort. She provides care for her patients using the professional knowledge and skills she has acquired through her clinical experiences. Through her actions she is assuming responsibility for patient care and justifying her actions. Her story reflects clinical progress, growing independence, professionalism, competence and confidence.

Another student evaluates her personal progress:

*I did an extraction I was really proud of, of course other students must have done better extractions than me but that is the best one I have done. I extracted a 74 without guidance from my clinical educator I did the local anaesthetic myself, and fortunately the patient didn't feel any pain. I extracted the tooth without asking the clinical educator to come and have a look, I became excited, that was the happiest day for my placement. I felt that I was confident with my stuff and I got good results as well. This really made me feel good. (Beth)*

Beth describes a time when she becomes so absorbed in doing an extraction that she omits to ask her educator to observe her performing the procedure. What was the reason Beth did not remember to ask the educator to come and observe her extracting a tooth when this is required of her? Does Beth no longer feel dependent or reliant on her clinical educator to coach her through the procedure? Or is it that she became so absorbed in the flow of the procedure, things around her cease to have meaning as

she becomes caught up in carrying the task out successfully? Polkinghorne (2004) referred to the writings of Csikszentmihalyi (1990) and described a state where practitioners become so absorbed and focused on what they are doing they stop being aware of themselves separate from the action. Could this explain the situation Beth finds herself as she performs this procedure?

Time has changed Beth's perspective of herself. Van Manen (1990) asserted that "the past changes under the pressures and influences of the present. As I make something of myself I may re interpret who I once was or who I now am now" (p. 104). No longer does Beth judge her performance against others, she is more focused on her own performance and abilities than those of her colleagues. She is pleased with her own accomplishments and expresses pride in her achievement. She feels as though she has made real progress. This has been an uplifting experience and Beth feels confident, more like a professional than a student.

## **Summary**

This chapter has examined students' experiences as they made the transition from being insecure and anxious to confident and skilled. Learning emerged directly out of lived experience within practice for the students in this study. They had a desire to learn and succeed and were prepared to accept the challenges that clinical practice presented.

Effective learning occurred with structured guidance from the educator. Students began with tasks that were small and simple and then progressed to more complex and challenging procedures. Progress occurred as students built on their repeated experience. Time, an individual's temporal way of being in the world (van Manen, 1990), allowed learning to occur and was therefore an important part of the process. Feedback was highlighted as essential to learning and the content of feedback and the manner in which it was presented had the potential to impact students' learning.

The clinical educator was identified as the critical person to student learning, within the clinical context, and the educator-student relationship was pivotal as students moved from hesitant and unskilled to confident and competent. The educator's role

was to provide guidance and support and to help students make sense of their learning. The students' narratives illustrated Heidegger's mode of concern (Smythe, 2000) where educators did not "leap in" and take patient care away from the students, but rather "leapt ahead" to free the students to practise their own way, also watching closely in case they needed to "leap in".

Initially students felt anxious and unsure and were very dependent on the educator, but as they progressed to skilled and confident the nature of the relationship between educator and student changed. Students referred less to the educator and their self perception grew as they became more confident and self assured within their practice.

## Chapter Seven: Discussion

### Introduction

To gain deeper understanding of what it means to be an oral health therapy student on clinical placement in a community training clinic, I have explored the experiences of five oral health dental therapy students. In the previous three chapters I have presented data from the participants and offered my interpretation of their experiences.

During my analysis three themes presented themselves; 'relationships matter', 'the leap to 'real patient' is huge' and 'learning does occur'. They are interconnected and represent the experiences of students on placement

In this chapter I illustrate how these themes revealed themselves and assisted me to reach an understanding of the central findings of this study. The implications for practice, research and education will also be addressed in this chapter.

### Relationships Matter

A predominant theme of this study was 'interpersonal relationships'. The students in this study identified relationships as being a significant aspect of their clinical placements. Van Manen (1990) referred to "self" and "others" as fundamental to human relations (p. 89). The "self" in this study were the students and the significant "others" were their peers, patients and the clinical educator with whom they had a relationship. The clinical educator was identified as an important source of learning and support for the students in this study. However it was evident from the narratives that peers were also a valuable source of informal learning and assistance, which included both practical and emotional support. The students appreciated their peers and felt a sense of familiarity and belonging in their company, knowing that they were on the same educational journey. These findings were in agreement with Christiansen and Bell's (2010) study, which found that student relationships provided protection



against social isolation and provided emotional support during times of adversity. Friendship, empathy and understanding were aspects of the students' relationships and it was important for the students to know that their fears and anxieties were shared by their peers. Chapman and Orb (2001) asserted that students believe that only their peers really understand their experiences. The non hierarchal relationship that existed within the group meant students felt less anxious about revealing their uncertainties and asking questions, as illustrated by Anna: *"so if you feel nervous about asking your educator you can ask them [peers]"*. Having peers created an environment conducive to learning, which encouraged sharing and openness. These findings concurred with Campbell et al.'s, (1994) study which indicated that optimum learning occurred when students felt supported by their peers and educators.

Strong bonds of friendship were not essential for learning; vicarious learning occurred between peers even though these were not present.

*My relationship with my colleagues is alright. We share knowledge but to be honest I don't mind if I work by myself with the clinical educator. But I do feel comfortable with other students who are at the same stage or same situation so we can share our experience. (Emily)*

Emily's relationship with her peers is one where reciprocal learning occurs as a result of shared experiences, stories, practice and a desire to learn. This is congruent with Lave and Wengers (1994) theory of communities of practice. Wenger (2000) claims that participating in 'communities of practice' is essential for learning to occur and asserts that relationships within these communities are dependent on the connectivity between people. This connectivity involves the brokering of relationships between people which is dependent on their needs.

A number of students experienced frustration and resentment when their peers did not assist with cleaning up duties or support was not reciprocated. A sentiment expressed by Cathy: *"in this kind of setting you find out everyone's flaws and I found I was doing a lot more work than I should have been"*. Emily felt stressed and pressured by the peers she had shared her placement with, as they relied heavily on her for support and knowledge and this placed her under additional pressure, as she had her own learning needs to consider, *"there's definitely stress with colleagues"* (Emily). Some groups of students rotated together through clinical placement and if issues

existed, it seems they remained unresolved. Emily however does acknowledge that issues only existed with some colleagues and she appreciated the support and companionship she shared with other contemporaries: *“it’s nice, with peers you have company and talk things afterwards”*.

Literature exists on student collaboration in the classroom environment, yet peer conflict during clinical placement seems to be a relatively under researched field. This is somewhat surprising as Spalding et al.’s, (1999) study, which focused on the academic setting, found that learning was enhanced if students work in a cohesive group. Oral health student placements maybe different to other clinical placements due to the high degree of interaction and teamwork required within these settings. Or it may be student collaboration in the clinical environment is a relatively under researched area. Spalding et al claimed that group cohesion can be difficult to attain and, as a way of addressing this problem, suggested that changing group composition during the course to allow less socially cohesive groups to reform.

Teamwork and collaboration are important pre requisites for professional practice in oral health therapy. Upon graduation oral health students are required to work collaboratively within teams and with other health care professionals. With the move to a more centralized community based delivery model, called for by the New Zealand Government’s Strategic Vision, this will become more apparent. Hilton and Morris (2001) suggested that the clinical context is an ideal environment for the development of skills conducive to collaborative practice. They asserted that teamwork can be nurtured during clinical education, by establishing a clinical environment conducive to team skill development.

Many of the students talked about comparing their performance to their peers in order to gauge their progress and ranking. *“I don’t really see it as a competition, but at the same time I feel comfortable where I’m at”* (Cathy). Sometimes comparing progress against peers resulted in students feeling a sense of achievement and satisfaction. For others it resulted in feeling demoralized and failing to recognize their own individual achievements, as was Beth’s experience: *“there really isn’t much competition going on... but if I’m compared to them there isn’t, because I’m not at the level. I’m so far behind”*. It is evident that constantly making comparisons was eroding Beth’s self

confidence and therefore not beneficial to her learning. The social comparison theory asserts that individuals evaluate their opinions and abilities against similar others if objective information regarding their performance is not available (Festinger, 1954). It may be that the students who participated in the study felt that the feedback they received about their performance was inadequate and therefore they resorted to making their own evaluation against their peers.

This research identified the clinical educator as having an influential role in student learning on clinical placement; which is verified in the findings of other studies (Campbell et al., 1994; Peyrovi et al., 2005). Results from this research suggest that students develop a close rapport with their clinical educator. Dental literature indicates that the close proximity, low student educator ratio and continuing communication intensify relationships between student and educator (Schonwetter et al., 2005). My own personal experience, and those of my colleagues, supports this view.

The students considered the clinical educator a valuable source of learning and support within the clinical environment. Their narratives identified ways in which educators influenced student learning. *"You can see how you have grown by the way she treats you... she lets you go a bit, she trusts you a bit and you feel you have accomplished something and you are actually improving"* (Anna). Demonstrating trust in students and providing them with opportunities to practice were ways the educators encouraged student confidence. These findings concurred with Gillespie (2005) who believed that teachers need to 'know' students and provide opportunities for learning to occur.

Smythe (2000) referred to Heidegger's two modes of concern: "leaping in" and "leaping ahead"; either mode can be correct depending on the situation. "Leaping ahead" was illustrated by the clinical educator in Anna's story. As Anna treated a patient the clinical educator anticipated possible treatment outcomes, remained in close proximity in order to support and provided assistance if required. The educator feels anxious but resists taking patient care away, because she 'believes in' and 'trusts' Anna has the ability and skills to complete the treatment. In this situation the educator was correct in her judgement to "leap ahead". Doing so provided Anna with an

opportunity to further develop her skills and the educator provided affirmation that she had confidence in Anna and supported her learning. Nash et al. (2008) referred to a similar scenario which they name “stepping back - taking the lead”, where the student provides the required care and the educator provides ongoing support to the student. In oral health therapy this scenario can create additional tensions because many of the procedures performed are irreversible and educators need to balance the needs of the patients with the learning needs of the student.

Cavagh and Snape’s (1997) study revealed that interpersonal relationships with educators can sometimes be a source of stress for students. These findings were also evident in this study. Cathy’s story illustrated how insensitive actions by a clinical educator left her feeling ill at ease: *“Our educator would tell people off in the room with us, so that wasn’t very comfortable... it wasn’t very nice we had not choice about it”*. This narrative seems to indicate that students feel unsafe and uncomfortable in a clinical environment where their safety and welfare is not assured. Emily experienced different relationships with different educators and indicated that she related better to some educators than others: *“now days I just ask but it really depends upon the educator or whether she can accept me asking or not”*. Pollicinski and Davidhizar’s (1984) study maintained that students are influenced by an educator’s personality characteristics; suggesting that individual personalities attribute to student-educator relationships and these have the potential to impact learning.

The hierarchical relationship that students perceive caused many students to feel anxious about approaching the educator. *“I feel a little uncomfortable talking to my educator... Maybe my educator will think I’m not confident. She might make a judgement about me... If there was no chance of failure I could ask her questions”* (Emily). Emily, like many of the students in the study, expressed reluctance to ask questions of her educator fearing she would show her lack of knowledge, be harshly judged or receive a poor evaluation. Students’ reluctance to ask questions of the educator from fear of appearing ignorant was also highlighted by Campbell et al. (1994).

Another factor which Emily acknowledged influenced her relationship with her clinical educator is her cultural background: *“my culture may have influenced it; according to*

*my culture we don't push our opinions with our elders or our teachers".* Chaing et al. (2010) confirmed that cultural influences, such as the Confucian philosophy and high levels of stress which stem from cultural pressures to achieve, can impact on how students regard their teachers (Ladyshevsky, 1996). Emily's story illustrated the influences of background beliefs on learning.

## **The Leap to 'Real' Patients is Huge**

Fear and anxiety, predominant themes throughout this study, were the meanings that students attributed to the 'lived space' of the clinical environment. Munhall (2007) asserted that experience does not exist alone; it is always embedded and connected. The students indicated that anxiety and fear were embodied within themselves and as a consequence they experienced the 'lived space' of the clinic as frightening and overwhelming. The initial clinical placement where students had their first exposure to patients was very stressful and demanding and the students felt uncertain and anxious. They encountered new experiences and it was their first opportunity to work with 'real patients'. This view is consistent with Beck's (1993) study which found that the clinical component was the most anxiety producing aspect of health professional education and the initial clinical experience identified as the most anxiety producing aspect to clinical experience.

The students in this study felt overwhelmed, anxious, incompetent and abandoned: *"it felt like we had been chunked into the deep end"* (Anna) and *"unprepared for the experience we didn't have any idea about exams so we weren't prepared"* (Cathy). Yet all students accepted that this was going to be the only way they would learn the skills required to become an oral health therapists and their stories indicate they were ready to accept the challenge that clinical placement presented.

A common theme in Suikkala and Leino-Kilpi's (2005) study, students' fear of hurting and harming, is also evident in this study. Dee expressed her concern for the patient the first time she cuts cavity: *"I'm doing something on someone's tooth and I can't take it back once I have drilled a hole, so I was very cautious. I was really scared of hurting them"* (Dee). Fear of hurting and harming the patients was a major concern for the

students. They acknowledged the vulnerability of the children for whom they cared and worried about making mistakes which might hurt or harm the patient. In this study students also acknowledged that many of the procedures they performed were invasive and irreversible and this further compounded their fears.

Initially the students were so focused on the task that they failed to see patients as people. As they gained more confidence, they wanted to identify and connect with the patients they provided dental care to. These findings are consistent with Johnson's (1994) research which concluded that students regard student patient relationships as important. However most of the students experienced difficulty in communicating with the children; they felt uncertain about what was appropriate communication. Cathy had limited experience with children prior to entering the programme and struggled with interpersonal aspects of patient care: *"It was what I struggled with and just thinking of the differences and how to communicate with them"* (Cathy). These findings are not exclusive to oral health therapy students; studies of other health care professions have also highlighted this problem during the initial stages of clinical placement (Cooke, 1996; Suikkala & Leino-Kilpi, 2005). Oral health students have little to guide them in their practice as literature on effective communication in paediatric dentistry is scarce. However literature on substantive content and ways on talking to children is available outside the domain of dentistry.

As students gained experience and became more confident they moved to a different level of care, which involved not only 'providing treatment' but 'caring about' patients. This theme was acknowledged by Mofidi et al. (2003). In this study undergraduate dentists highlighted the importance of recognizing patients as 'real people' and caring for patients in an empathetic way. Heidegger described our fundamental way of being in this world through care and maintained that our contact with others involved some degree of practical and emotional involvement (van der Geest, 2002).

Dunn et al.'s (2000) research on student nurses and teachers on placement found that students derived satisfaction from making a difference to the lives of the people they cared for and wanted to contribute to the greater good. Students in this study confirmed this finding. Different placements allowed students to provide care to children from various social economic groups and as a result students came to

understand how social and environmental factors impacted on health. Dee's story illustrates her growing awareness: *"I want to make a difference. ...there is so much you can do. I have given a few children my lunch if they haven't had any food it's kind of sad"*. This was consistent with Mofidi et al.'s (2003) study, where students developed awareness of the impact of socio-cultural factors on oral health.

Both Anna and Emily recognized the importance of their role in determining their patients' attitudes to future dental care. *"Their experiences with you are going to impact as to whether they have horror stories like their parents... I'm going to make it a positive experience"* (Anna). *"If they cry during the dental care in my presence it won't leave them with a good memory"* (Emily). This finding is consistent with the stance maintained by the American Academy of Paediatric Dentistry which suggested that prior dental experiences may influence a child's future attitudes to dentistry (Nash, 2006).

Qualitative studies undertaken on clinicians' attitudes to pain are not available in the dental professions; perhaps because traditionally dentistry has always aligned itself with quantitative research. The perception exists in dentistry that all pain can be alleviated; therefore, research focuses on investigating how to minimise or eliminate pain rather than how to work with it. The students in this study recognized the pain experienced by patients. Beth initially became stressed and anxious when she first encountered a child in pain. Her limited experience with this phenomenon meant she found it difficult to comprehend it and this influenced the way she initially reacted to the pain. *"If it happened last year I just wouldn't know what to do I would just leave my hands there holding the instruments and my brain would shut down completely"* (Beth). With experience Beth developed a way of dealing with pain, which involved disengaging herself from the patient's experience: *"this year I have a much better way of dealing with it. The best way of deal with it is to finish the procedure as fast as possible in the best way I can"* (Beth). In contrast Cathy deals with her patients' pain by making it visible and working with it. *"If they are in pain then I'm going to do something about it... 'can you handle a few more seconds or do you want a local?' I give them an option"* (Cathy).

Both strategies of dealing with pain are used by clinicians. Nagy (1999) acknowledged all types of coping strategies have their advantage, yet she suggested that a combination of strategies may be the most effective way of dealing with a patient's pain. Madjar and Walton's (1999) study supported the concept of a clinician patient relationship to manage pain, where the patient retains some sense of control of the situation and the clinician achieves a sense of satisfaction and achievement in their work. In the school dental service the word 'pain' has become 'taboo' when working with patients amongst some groups of dental therapists. In their efforts to avoid associating dentistry with pain, therapists are encouraged to use euphemisms to avoid making direct reference to the term. This may be appropriate in some situations, but doing so, seems to deny its existence. With the scarcity of research in dentistry on the subject of pain and how it should be managed, there is little to guide students in their practice in this area.

## **Learning does Occur**

The concept of time was significant throughout this study. It took time and experience for the students to develop from nervous and hesitant to confident and skilled. This notion was in accord with Wilkinson et al. (1998) who found that learning emerges out of direct experience. Many of the students suggested that there was a 'before' and a 'now' when they discussed their experiences. Dee discussed how she feels now and how she felt when she gave a local anaesthetic which caused a swelling in a child's mouth, she described herself as panicking thinking that she may have done something seriously wrong: *"now I'm really confident giving injections... that was quite scary... I actually like doing them now"* (Dee). Dee's story infers there is a past and there is the present and within this concept called time she has become more experienced and confident. Dunn et al.'s (2000) study referred to students' sense of confidence in the context of a gradual process that takes considerable energy, effort and time.

Students experienced time differently from clock time. Sometimes time went quickly, sometimes slowly and sometimes students wanted to delay time. Anna described asking the clinical educator to check all aspects of her work several times, in order to delay time as she felt hesitant starting the procedure. When she administered her first injection she was apprehensive and recalled it as being the: *"longest two minutes of*



*my life*" (Anna). Munhall (2007) maintained that perceptions of time vary in incredible ways with experiences and are very meaningful.

In this study the students initially relied heavily on the clinical educator to guide and support them in their practice. These findings were also evident in Beck (1993). Students appreciated starting with the simple procedures and then moving to the more complex treatments. Cathy recalled her first placement: *"we did exams and simple stuff for a while first... if I had to jump into a filling the first day, it would have scared the living daylights out of me"* (Cathy). She expressed confidence in the clinical educator assessing her capabilities, *"she knows what we were capable of and eased us into it"* (Cathy). The educator's presence and guidance provided them with much needed support during the initial stages.

The relationship with the clinical educator changed as the students became more experienced and confident. The clinical educator no longer monitored their every aspect of their work or checked every stage of every procedure and this further increased confidence in the students. Dee described how the changing relationship impacted her: *"It makes you feel really good oh my gosh. They [clinical educator] actually think I'm okay. It is so cool"*. White's (2003) study identified increased responsibility, working independently and accepting challenging learning opportunities as factors that facilitated learning. As a result the students began to believe in their own abilities, became more confident and relied less on their educators.

Students in Nolan's (1998) study felt that being watched and assessed by their educator was a major limitation to their learning and confidence; while Tiwari et al. (2005) identified that a highly evaluative environment hindered student learning. The findings in this study differed as the students indicated that they did not mind direct supervision by the clinical educator. All students wanted to learn to perform procedures correctly. *"I would rather someone watched me and caught me doing something wrong on the spot... I think it's really good I like it... I think it's helpful"* (Anna). The very procedural nature of dentistry may mean students realise that the process is important. Or perhaps the students felt less intimidated by the clinical educator due to the trusting and supportive relationship that shared.

Changing clinical educators was viewed as an opportunity for further learning. It allowed students to learn different techniques, to evaluate standards, accept differences and establish their own standards of practice. These findings were in contrast to Lofmark and Wikbald's (2001) study which reported lack of continuity in supervision as an obstructing factor detrimental to learning on clinical placement. While Elcigil and Sari (2005) maintained that students find it difficult to adjust to working with different educators who have different expectations and different skill levels.

Feedback was regarded as important to learning: *"I want to check for myself to know if I'm doing it right or not, so feedback is important"* (Emily). All students appreciated positive feedback, as this increased both their motivation and self esteem. However not all students were happy with the feedback they received. Anna expressed frustration when her clinical educator was vague in her feedback, *"the feedback is really generalised and my clinical educator didn't pinpoint exact things she was very general... specific feedback lets you know what you are doing wrong and what you're doing right, and what you need to improve on"* (Anna). Students wanted accurate, specific, constructive feedback in order to progress. The importance of feedback has been highlighted in numerous studies (Hattie & Timperley, 2007; Lofmark & Wikbald, 2000; Mofidi et al., 2003); while, lack of feedback was identified by Lofmark and Wikbald (2000) as hindering student learning. Fugill's (2005) study highlighted the emotional tone of feedback and its relationship to student self esteem, which were consistent with the findings from this study.

## **Limitations of the Study**

Qualitative studies are highly subjective and contextualised and the findings of this study are a product of the context in which they are situated. This study is located in unique, specific community based clinics. The clinical educators are employees of a DHB and solely responsible for patient care and student learning at the various training clinics. In the main, a student is exposed to only one educator during each placement. Elsewhere oral health therapy students gain most of their clinical experience in multi chair training facilities on site at a university and are exposed to a number of onsite

educators. Therefore, the findings may not be replicable to students at other dental training facilities. The purpose of this study was to gain deeper understanding of the experiences of oral health therapy students on clinical placement; it was not the intent to generalise findings to other contexts. Never the less, the findings may well resonate with other people's experiences in other services.

Five participants were interviewed for this study. This number is not large but in the context of qualitative research it is appropriate and the data and findings indicate the rich descriptive data obtained was suffice. I conducted all the interviews, therefore my role as a clinical educator may have influenced the participants in the types of stories they told and their candour. Additionally, my own experience and role as clinical educator has influenced my interpretation of data and the research process, as is the nature of hermeneutic phenomenological research.

I acknowledge that some areas of this study are under developed as the volume and richness of the data has not been fully analysed due to the limitations of a master's research thesis. However I have made every effort to conduct a credible study adhering to methodology and method of a qualitative study with a hermeneutical phenomenological hue.

## **Implications for Practice**

The findings of this study show how oral health therapy students experience clinical placement. The results may be insightful for oral health educators and assist them in planning clinical experiences. They may also be helpful for those involved in teaching practice in the clinical context. The findings from this study lead me to make the following recommendations:

- Oral health educators need to reflect on the study findings to improve the quality of clinical experience and review how they teach and support students in the clinical environment.
- Peer learning in the clinical environment needs to be acknowledged and encouraged for its contribution to student learning.

- The development of team cohesion needs to be fostered and the concepts of teamwork and collaboration emphasized and encouraged.
- Educators need to attain a greater understanding of students' cultural beliefs and their impact on student learning in the clinical environment.
- Student groups need to change at each rotation to encourage teambuilding skills and address the problem of un-cohesive groups.
- Clinical educators need to acquire in-depth understanding of complexities of teaching a professional practice.
- Clinical educators need to recognize the importance of feedback, its role in learning/teaching process and the inherent difficulties associated with it.

## **Implications for Education**

Many of the above recommendations warrant inclusion into the undergraduate oral health education programme. It would also be beneficial if the academic institution worked closely with the dental service to ensure that educators responsible for teaching clinical practice to students are conversant with underlying principles of teaching a professional practice.

- Educators should ensure that students are adequately prepared for clinical placement to reduce the high levels of anxiety associated with the initial clinical experience. This could be addressed by sharing these findings with second year students and ensuring that students acquire the fundamental clinical skills before they begin clinical placement.
- Clinical educators should try and alleviate the anxiety students feel by creating an environment conducive to learning; by welcoming students into the clinical environment and encouraging a student-educator relationship that has both personal and professional dimensions and is egalitarian, supportive and affirming.
- The concepts of teamwork, team dynamics and collaboration need be taught to encourage group cohesion.
- The curriculum needs to include principles associated with child communication and offer students an opportunity to practice these skills.

- The curriculum needs to include the physical and psychological aspects associated with pain and its management.

## **Implications for Research**

Very little qualitative or quantitative research currently exists within the oral health disciplines of dental therapy and hygiene practise. This study will hopefully inspire further studies which will benefit both professional practice and education. This study has however identified voids in both education and practice.

- Further research on the management of pain in children in order to help guide students in their practice.
- Further research on communication in pediatric dentistry to assist students in their practice.
- Further research on what constitutes best practice in teaching oral health therapy within the clinical environment.

## **Conclusions**

This study identified social interaction as central to student learning and findings indicated that both the clinical educator and peers influence student experiences on placement. Clinical educators were identified as a valuable source of support; their skills and knowledge in both teaching and professional practice were important to student learning. The most influential educators were those who believed in the students, showed respect, supported their learning and instilled self confidence. Students also learnt vicariously through their peers' experiences. Contemporaries were viewed as a source of emotional support and the empathetic understanding that existed between students created a favourable learning environment. However not all placements were conducive to learning and on some clinical placements lack of peer support left students feeling stressed and disillusioned with their peers.

The students experienced a range of emotions on clinical placement. Initially the clinical environment was perceived as frightening and stressful; the students were

anxious about their performance and felt unprepared and incompetent. Their main concern was the safety and welfare of the patient. As they became more competent their attitudes changed and they wanted to connect with the patients. Connecting enabled the students to move from seeing patients, to seeing people, and they began to care about the children rather than just perform a dental procedure. The desire to make a difference to the lives of the children was expressed by all of the participants.

Confidence and competence developed over time, as a result of a myriad of experiences and through the continued support of the clinical educator. Feedback was regarded as valuable to learning and contributed to student progress and self confidence; however there were inherent difficulties associated with it. As students became experienced the relationship with their clinical educators changed; they relied less on them for support and assumed more responsibility for their practice.

This study sought to understand the experiences of oral health therapy students within a specific context. As the students narrated their experiences of “being” it was evident that they brought with them their previous history and personal experiences, acquired from the social and cultural environment they inhabit. Their way of “being” on clinical placement was profoundly influenced by the way they experienced the clinical environment, the emotional content of the experiences and the meanings which they attributed to them.

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## Appendix A: Ethics Approval



# MEMORANDUM

## Auckland University of Technology Ethics Committee (AUTEC)

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To: Liz Smythe

From: **Madeline Banda** Executive Secretary, AUTEC

Date: 14 May 2010

Subject: Ethics Application Number 10/39 **Insight into the experiences of oral health therapy students on clinical placement - a hermeneutic phenomenology study.**

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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 (AUTEC) at their meeting on 12 April 2010 and that I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's Applying for Ethics Approval: Guidelines and Procedures and is subject to endorsement at AUTEC's meeting on 14 June 2010.

Your ethics application is approved for a period of three years until 13 May 2013.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 13 May 2013;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics>. This report is to be submitted either when the approval expires on 13 May 2013 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You



are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

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. Also, if your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

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 the AUTECH 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**

Cc: Agnes Smith [agnes.smith@xtra.co.nz](mailto:agnes.smith@xtra.co.nz)

## Appendix B: Invitation to Participate



### **3<sup>rd</sup> Year Auckland University of Technology Oral Health students**

My name is Agnes Smith and I am a clinical educator working at Northcote Intermediate training clinic. I am currently carrying out some research and I am looking for volunteers to interview. My aim is to investigate the experiences of third year Oral Health Therapy student while on clinical placement at Auckland Regional Dental Service community clinics.

I am looking for participants who are currently on placement at Royal Oak Intermediate, Buckland Road or Finlayson Park School Dental Clinics. If you are happy to share your stories and discuss your experiences at length, then please consider becoming a participant.

The interviews will involve you talking about your experiences while on clinical placement and will take approximately 60 – 90 minutes. The interviews will be audio taped, but your names will not be used and your privacy will be protected if you decide to participate.

If you are interested in becoming a participant in this research or would like further information about the study please email [agnes.smith@xtra.co.nz](mailto:agnes.smith@xtra.co.nz)

## Appendix C: Participant Information Sheet

# ***Participant Information Sheet***



**Date Information Sheet Produced: 10/02/2010**

### **Project Title**

Insight into the experiences of Oral Health Therapy students on clinical placement – a qualitative study

### **An Invitation**

I am a clinical educator employed to teach oral health students on clinical placement in an Auckland Regional Dental Service community training clinic. I am currently enrolled in the Master of Health Science programme and my thesis will involve researching the experiences of undergraduate oral health students while on clinical placement in these clinics. I would like to extend an invitation to third year students to participate in this research project. Participation is voluntary and you can decide at any time during the study to withdraw from the project.

### **What is the purpose of this research?**

The purpose of this study is to enable oral health educationalists to gain a better understanding on how students experience clinical placement and examine how context influences learning; the findings will be used when planning and implementing future clinical placement experiences. The results from this study will be presented at the New Zealand Dental Therapy Conference and submitted for publication in the NZDTA Journal and Australian Dental and Oral Health Therapists Association Journal.

### **How was I chosen for this invitation?**

You were chosen because you are a third year student currently on placement at Royal Oak Intermediate, Buckland Road or Finlayson Park School Dental Clinics. I believe the stories you could share with me about your clinical placement will help me to gain an in-depth understanding of what it is like to be an oral health student on placement in a community dental clinic. If you agree to participate please contact me by return email. Students who are currently on placement at Northcote Intermediate will be excluded from the study to avoid role conflict, as I will be both researcher and clinical educator

### **What will happen in this research?**

This study will involve 60-90 minute interviews with participants, where you will be asked to talk about your experiences while on clinical placement in community dental clinics. The interview will focus around your experiences and a series of questions such as tell me about your first day on clinical placement. Tell me about the first time you treated a patient. What do you enjoy most about your placement? What do you enjoy the least about your placement? Tell me about your first time you took the hand piece into your hand and started drilling? How did you feel?

### **What are the discomforts and risks?**

Sometimes clinical experiences can produce anxiety and you may feel uncomfortable about talking about these experiences.

### **How will these discomforts and risks be alleviated?**

You do not have to talk about experiences where you felt anxious or uncomfortable. You can withdraw from the interview or study at any time and you can access AUT Counselling Services to discuss any concerns you may have experienced during or after the interview. If do decide to do withdraw all your data and interviews tapes will be destroyed.

### **What are the benefits?**

Although taking part will probably not provide you with any immediate benefit this study will help oral health educationalist better understand the way students experience clinical placement and has the potential to assist future oral health degree students. Some people enjoy talking about their experiences.

### **How will my privacy be protected?**

My supervisor will have access to all audio tapes and transcripts, but the identity of the participants will only be known to the researcher. No identifying features will be included within the research reports or publications and participants will have the opportunity to withdraw identifying statements during the interview. You will also be able to read the stories crafted from the transcripts and withdraw or clarify statements.

### **What are the costs of participating in this research?**

The only cost for participating in this research will be your time. It is envisaged interviews will take between 60-90 minutes. The interview will take place at the time and place that is convenient for you.

### **What opportunity do I have to consider this invitation?**

You have a fortnight to consider if you would like to participate in this study or not.

### **How do I agree to participate in this research?**

Please email me direct and I will make contact in order to enable you to sign a consent form and to ensure that you are aware of your rights while participating in this study.

### **Will I receive feedback on the results of this research?**

Yes, I will contact you twice, firstly when tentative findings are available and secondly when the report is completed. If you would like access to these I will email them to you.

### **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 Dr Liz Smythe.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz , 921 9999 ext 8044.

### **Whom do I contact for further information about this research?**

*Researcher Contact Details:*

*Agnes Smith – agnes.smith@xtra.co.nz*

*Project Supervisor Contact Details:*

*Dr Liz Smythe – [liz.smythe@aut.ac.nz](mailto:liz.smythe@aut.ac.nz) 921 9999 ext 7196*

*Approved by the Auckland University of Technology Ethics Committee on 14<sup>th</sup> May 2010 AUTECH*

*Reference number 10/29*

## **Appendix D: Interview Questions**

Tell me about your first day at clinic. What was that like? How did you feel?

Tell me about the first time you treated a patient?

Tell me about your first time you took the hand piece into your hand and started drilling? How did you feel?

Tell me about the time you gave your first injection?

Tell me what you enjoy most about your clinical placement? Can you tell me about a specific experience/time

Tell what you enjoyed the least about your placement?

Tell me about your relationship with your colleagues on placement?

Tell me your experiences of changing clinical placement?

Tell me about a time you felt really supported/unsupported and what made you feel that way?

Tell me what it feels like to when your clinical educator is watching you working?

Tell me about a typical day

When you mentioned... what did you mean?

What did you feel?

Tell more about....

## Appendix E: Consent Form

### Consent Form



**Project title:** Insight into the experiences of oral health therapy students on clinical placement – a qualitative study

**Project Supervisor:** Dr Liz Smythe

**Researcher:** Agnes Smith

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated / /2010
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ 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 copy of the report from the research (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 14<sup>th</sup> May 2010. AUTECH  
 Reference number 10/39**

**Note:** The Participant should retain a copy of this form.