

**Experiences of Practice Educators  
Supporting Disabled Physiotherapy  
Students: a Critical Exploration**

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**'I, Karen Ann Atkinson confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.'**

## Personal statement

I began the EdD in September 2007; I feel that I am now a very different person, both personally and professionally. On commencing the programme I intended to finish within five years, taking the shortest time possible to gain the qualification. As is often the case, however, life events meant that this was not possible. I had not originally intended to undertake doctoral level study but as my experience in higher education increased I realised that this was crucial in order to widen my thinking and to develop criticality in my areas of interest. This has enabled more effective application of my work in practice and progression in the academic setting.

I had little experience of research other than undertaking a small study as part of my MSc many years previously. Initially I lacked confidence in my abilities in this regard and looked forward to both the Institution Focused Study and the thesis with trepidation. The four modules studied in the taught part of the programme did, however, effectively prepare me for these tasks, being challenging and fascinating in equal measure. Having always worked in higher education, it was valuable to gain insights into education taking place in a wider range of settings as I entered into discussion with my student colleagues regarding issues of professionalism, methods of enquiry and psychoanalytic perspectives on education. I believe that my contribution was valued and that I was able to provide insights and perhaps, at times, an alternative lens through which colleagues could view their own disabled students.

The EdD programme was a steep learning curve particularly in relation to the sociological approaches addressed. I have found these extremely illuminating, however, and essential in developing my own understanding of the positioning and relationships of disabled students and the academic and clinical staff who support them. Foundations of Professionalism in Education began the process of considering professional identity and how this is developed and internalised. I noted with interest that colleagues within higher education found construction of their professional identities problematic and generally defaulted to their allied health identities rather than that of academics. This provided a background for the consideration of physiotherapy 'identity work' and the context driven nature of identity development in relation to professional socialisation and fields of practice. From the perspective of my thesis this also enabled an examination of the ways in which disability might impact upon physiotherapy professional development.

Methods of Enquiry 1 engaged me specifically with the issues regarding theoretical approaches and research methodologies. This enabled a formulation of ideas regarding the research that I subsequently carried out. The feedback from both my supervisor and the assignment enabled my thinking to develop and become more focussed as I moved on. Methods of Enquiry 2 enabled me to continue to develop my area of research interest through further exploration of my epistemological and theoretical approaches and of the literature. I developed and carried out a small piece of research: proposal, ethics approval (in both my own institution and at the Institute), design of a questionnaire, semi structured interviews and the transcription of these, analysis of the data and report writing. I was introduced to the statistical package SPSS, using it at a basic level to look at my data. In my novice researcher position, the most important factor in relation to these modules was that they enabled me to overcome the mystique of 'doing' research which I realised had been a barrier for me. Being based in a School of Health and Bioscience at that time, most of the research I saw was quantitative and laboratory based which was distant from my qualitative interests. Exploring different theoretical and practical approaches through the EdD, I discovered my niche and became more confident about the type of work that I wanted to undertake within my role as an academic, supporting disabled students, in higher education.

Studying the specialist course 'Using Psychoanalytic Perspectives to Make Sense of Education and Educational Research' was fascinating; providing another lens through which to consider my approach to research. I think that its major contribution to my more recent thinking was in exploration of the historical background and dominant social discourses which provide context for the positioning and interactions of disabled and non disabled groups in society.

The Institution Focussed Study helped to consolidate the work carried out in earlier modules. This year of the EdD was different with less contact with my cohort and more expectations with regard to self-directed work. The research process was both interesting yet challenging. I carried out semi structured interviews, transcribed these by hand and analysed them using an Interpretative Phenomenological Approach (IPA) which fitted very well with the nature of the data that I was collecting. The IPA community was extremely supportive of researchers new to the field which was an excellent formative experience for me in both attending and presenting at their conferences.

Early in 2010 my father died which affected my ability to engage with the work. This, in addition to a very hectic time at work, including renegotiation of contracts and production of major publications, altered my timetable and meant that I was unable to progress as far as I had intended. I was, however, able to present my work in progress at the IOE Summer Conference and I used some of the results to contribute to a presentation at an Equality, Diversity and Inclusion Conference in Vienna which helped me to realise that I was moving on and enabled me to maintain my enthusiasm for the work.

I did hand in my IFS on time which was a great achievement for me and I was very pleased with the work, getting excellent feedback which boosted my confidence. The following year, however, brought other challenges which I realise, on reflection, put a great deal of pressure upon my ability to move forward. My mother died during my planning for the thesis and I was now onto my 3<sup>rd</sup> supervisor which was unsettling. The transition to this situation was slow and delayed the start of my data collection. My work environment was turbulent and unsettled with Olympic teams using our campuses necessitating a 2 week shift in our academic year. Along with a greater teaching load (due to staff redundancies), this led to a stressful year. We were also informed that NHS London would no longer be funding Physiotherapy at our university as from September 2012. This had far reaching effects on all staff and students. These stresses continued going forward into the next period as staff left and the remainder had to work harder to support the students in years 2 and 3 as they completed their programme of study. This provides context for reflections on my development throughout my studies.

I completed the first phase of data collection for my thesis comprising an electronic questionnaire distributed to practice-based physiotherapy educators in London and the south-east, carried out analysis of the data and moved on to follow up interviews. I used information gained from this work, as well the results of my IFS to feed into service enhancement and development in my role as part of the Allied Health Professions Support Service team. I continued to incorporate the work into my own practice and approach to clients. I was fortunate to be able to share this work with a range of groups through disability awareness training sessions, presentations at meetings and conferences.

Life continued to be challenging – finding out that my 3<sup>rd</sup> supervisor was retiring was a blow. She had provided excellent and sensitive support when needed – but I had not really been in a place to be able to produce much work on which she could comment which I felt

was very negative and I felt despondent. My work environment continued to be very turbulent and in October 2012 we were informed that NHS London would no longer fund our disability service. This required much of my attention in winding up the service and decommissioning our Resource Centre along with dealing with potential redundancy and greater teaching and administration loads. My position was extremely unclear for about 6 months resulting in feelings of uncertainty and disempowerment. The stress of the closure of our service had both physical and psychological effects with which I had to contend whilst keeping up with day to day activities.

Throughout this time, however, I carried out my follow up interviews and completed the first in depth analysis of the transcripts, collated the results and started to consider emergent themes. I had intended to incorporate the work into practice through our disability service. As a result of the closure, however, I needed to consider the outcomes of the research more generically across the Physiotherapy profession which seemed a viable alternative and valuable way forward.

In 2013-14 I met and started working with my new supervisor and began to feel that I could look forward more positively. Work continued to be extremely busy with mass revalidation of all programmes in our university due to changes in the Academic framework with the consequent extra workload. This was followed by another tranche of redundancies.

I completed the major analysis of my interview transcripts and as with all qualitative exploration, new insights and viewpoints continued to emerge. Meetings with my supervisor were absolutely invaluable, helping to focus my thoughts, providing really useful feedback on my writing and reining in my enthusiasm as necessary! I found that constructing my theoretical framework was very challenging and our discussions helped to channel and refine my thinking in this regard. This along with other external influences has enabled me to feel confident in my work and to alter my approach to a more critical appreciation of physiotherapy practice.

I fully acknowledge that completion of the EdD, and particularly the thesis, has taken much longer than I anticipated. I strongly believe, however, that it would not be the piece of work that it is, had it been completed in the original timeframe. I have developed both personally and professionally during this time and I have learned a great deal about myself and my areas of research and professional interest. As a result of undertaking this

programme, along with many years of experience working in the disability field, I felt empowered to apply for Principal Fellowship of the Higher Education Academy. I based my application on my part in the development of mainstreaming physiotherapy education for disabled students; this had both national and international influence. I achieved this in 2013.

I was a founding member of a new international Critical Physiotherapy Network which was launched in 2015. Through interaction and publishing with this group I am developing my thinking with regard to a critical approach to physiotherapy identity. I presented elements of my work at an international 'In Sickness and in Health' conference in 2015. I was also successful in my application for a Principal Lecturer Professional Lead post at the University of Hertfordshire involving a move into management. I am now responsible for a team of fourteen members of staff. Based on my disability work I have been asked by the university to apply for a National Teaching Fellowship and I have recently obtained a mentor under the Athena Swan framework. The aim of this is develop and extend my research following my doctorate.

I continually integrate my work and the findings from my studies into teaching and apply it during programme and curriculum development activities. I am also called upon by our physiotherapy professional body for advice and guidance on equality and diversity issues with a particular focus on disability. This is at the core of my professional practice. Professionally, undertaking the doctorate has changed my day to day practice and enabled me to feel confident in defending my work and in interacting with colleagues within the university and in outside organisations. There is no doubt that it has been a major contribution to my professional development and career progression.

## Abstract

Disabled physiotherapists have been part of the profession for over one hundred years, nevertheless, the greatest influences physiotherapy has in relation to disability are the therapeutic alliances with clients; which have often been managed through a largely reductionist biomedical approach. This can lead to dissonance when a disabled person is in a professional rather than a client role.

Practice educators aim to enable students to assume often standard patterns of physiotherapy 'ways of being'. Findings from previous research suggest that while disabled students often tend to be viewed through a deficit lens, few studies have specifically sought to identify the concerns of practice educators when working with them. The aim of this thesis was to explore the experiences and understandings of practice educators and the influences that the presence of disability has on the educational process in the clinical setting.

This qualitative study involved eight physiotherapy practice educators from London and the South-East and explored their experiences of supporting disabled students.

Through an interpretive, ideographic approach which drew upon Bourdieu's sociology of practice and critical hermeneutics key themes identified were Pressures and placements; educator needs and perceived lack of support; perceived student challenges; disclosure-communication and honesty; understandings of disability and; educator responsibility. Participants rarely explicitly discussed their understandings of disability; yet they had specific requirements for students to 'disclose' their impairments. Participants' accounts were related to the professional doxa and habitus of physiotherapy that impacted upon understandings of disability and practice. Consequently, a 'practice gap' was identified in relation to the support of disabled students.

Tensions were identified regarding the content and competence-based focus of education in contrast to possibilities offered by reconceptualising physiotherapy from traditionally biomedical definitions of disability to a more critical understanding of it. It is concluded that opportunities are needed within curricula, research and network groups to explore professionalism and psychosocial aspects of health, through critical thinking and professional reflection.



## Impact Statement

As was seen from the abstract this work explored practice educators' experiences of supporting disabled students in the clinical setting. In my 35 years of supporting disabled students it became clear that physiotherapists generally believe that this is a demanding and difficult situation. My aim in this work was to explore and subsequently challenge some of the underlying attitudes and behaviours that led to these beliefs.

In the light of the EdD being embedded within practice I have identified my key findings as:

- evidence of embodied notions of disability and disabled people and naturalised and unquestioned practices relating to the client as disabled and the therapist as non-disabled resulting in educators focussing on 'normalising' the situation/student to fit the habitus and doxa of the setting
- assumptions that supporting disabled students would be a negative experience particularly in relation to them falling short of required professional standards. There was limited evidence of critical reflection related to these issues which might have offered a counter-narrative of acceptance of difference and consideration of the potential of all students on a continuum
- participants' accounts indicated that the disabled students they encountered, being immersed in the well-established, largely normative biomedical field, largely accepted their position in the non-disabled educator/disabled student dyad and did not step back and challenge these issues, if indeed they were aware of them at all

I have presented this work locally at Learning and Teaching conferences in my own workplace, nationally at the British Sociological Association Medical Sociology Conference (Glasgow) and internationally at the In Sickness and in Health conference (Mallorca) and the World Confederation for Physical Therapy Congress (Cape Town).

When presenting this work, it has stimulated lively debate and I have had direct feedback from physiotherapists and other health care professionals that my interpretation is challenging but thought provoking, providing a fresh perspective on the ways in which disability is viewed. By surfacing these issues with regard to the possible underlying attitudes and beliefs that lead to 'a sense of one's place' and the 'sense of the place of others' (Bourdieu 1989), some colleagues are already starting to re-examine their own

approaches to difference in the teaching and learning environment and to think about how these ideas can be considered in more depth in the curriculum.

This has led to my starting to write a journal article for Disability in Society and considering another for the International Journal of Inclusive Education. This will continue to raise consciousness about these important issues. I am stimulating debate and offering colleagues an invitation to enter into dialogue and to reflect. This offers the opportunity to begin the process of moving habitus in a direction that could affect some transformation through changes in thinking and practice. As a result, practitioners may be encouraged to take a more critical stance in relation to established physiotherapy educational practice and physiotherapy 'ways of being'.

## Research questions

**The overarching questions guiding the research were:**

1. What is already known about the experiences of practice educators in supporting disabled students on clinical placement?
2. What are the experiences of educators in supporting disabled physiotherapy students on placement?
3. What are the implications of these findings for future practice?

## Acknowledgements

There are many people who I need to acknowledge and thank, who have supported me throughout the journey of my EdD and without whom I would not have reached this stage. First and foremost, my manager (retired) and good friend Jane Owen Hutchinson who shared her experiences and taught me so much, both about disability and about myself. I would not have taken the first step without her unfailing help, friendship and her faith in my ability to undertake doctoral level work.

Second, my good friends and colleagues at the University of East London where I worked for 22 years in my academic and disability support role. Particularly Dr Jane Culpan – we started to explore critical ideas about physiotherapy together and still continue to debate these whenever we meet.

Third, the colleagues I met in my cohort at the Institute of Education where we undertook the early part of the EdD – their support and interest, along with the enthusiasm of the academic staff enabled me to build the foundations for this work. Not least, in the latter part of my studies, my supervisor Dr Ian Warwick, whose advice and support has been absolutely invaluable in helping me to shape this final piece. Our meetings have been immensely enjoyable, exploring a wide range of ideas and enabling me to refine my thinking in relation to my research and recognising my passion for, and interest in, supporting disabled physiotherapy students.

Fourth, all of my students and particularly, the disabled students who I supported whilst part of RNIB's Allied Health Professions' Support Service, who helped me learn so much.

Last, and most importantly, my family and friends, who again have been unfailingly interested and supportive of my work, especially my husband John and my daughter Emily who have been there throughout the whole experience and lived it with me.

I would like to express my gratitude to everyone who has been part of my journey.

My lovely mum and dad, who are no longer with us, both passed on during my work on the IFS and thesis. They were always there through all of my educational and career developments and were fully behind me in everything I did in my life. I would like to dedicate this thesis to them, with love.

## Glossary

AGCAS - Association of Graduate Career Advisory Services

AHPs – Allied Health Professions or Professionals

CPD – Continuing Professional Development

CSP – Chartered Society of Physiotherapy

DH – Department of Health

GP – General Practitioner

HCPC – Health and Care Professions Council

HE – Higher education

HEE – Health Education England

HEI - Higher education institution

ICF – International Classification of Functioning, Disability and Health

NHS – National Health Service

NUS – National Union of Students

QAA – Quality Assurance Agency

RCN – Royal College of Nursing

RCT – randomised controlled trial

RNIB – Royal National Institute of Blind People

UMHAN – University Mental Health Advisers' Network

VI – visually impaired

WHO – World Health Organisation

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## Chapter 1 Introduction

This study arose because of convergence of a number of elements of my work and research interests. First, my role supporting disabled physiotherapy students over a twenty-year career as part of the RNIB's Allied Health Professions Support Service, also comprising UK-wide work with academic and practice staff, aiming to enable improvement of support for disabled students in university and clinical settings. During this period there were apparent increases in the number of disabled students successfully completing degrees: between 2002 and 2010 declared numbers rose from 6.1% to 9.6% (AGCAS 2013) climbing to 11.3% in 2014 (AGCAS 2016). Within physiotherapy there was an increase from 7.68% of 1<sup>st</sup> year students declaring a disability in 2011 to a high of 12.42% in 2013. Latterly the picture is less clear with a decline to 8.99% in 2015, climbing back to 12.11% in 2016. It is debatable as to whether these were 'real' increases due to positive change in underlying attitudes and approaches to disabled students or whether 'disclosure' of disability has increased due to a range of legislative changes beginning with the Disability Discrimination Act (1999). Approximately 60% of these physiotherapy students are classified as having learning difficulties (CSP 2016).

Second, my interest in challenges that both disabled students and the staff members with whom they work, experience or perceive in the physiotherapy learning and teaching environments in which they interact. This interest evolved during my Doctoral studies and experiences of practice educators provide the focus for this work. Meekosha et al (2013) note that in early disability studies the social model of disability emerged largely to contest the hegemony of medical and allied health professionals. In this work I begin to explore some of the apparent problems of speaking, thinking and feeling about the Other (students referred to as 'disabled') and the 'extraordinary' Other, the 'Able' (Campbell 2009,3). I aim to offer an invitation to physiotherapists and others to shift their gaze from the focus on disability and to consider other subtler ideas related to ableism. This may offer a different perspective from which to view the practices and production of disablism and *"to examine attitudes and barriers that contribute to the subordination of disabled people in liberal society"* (Campbell 2009,4). There is also an opportunity to examine whether and how these attitudes and barriers translate into the NHS setting.

A third factor in the development of this work was the findings of my Institution Focused Study (IFS). In the IFS, qualified visually impaired (VI) physiotherapists shared their

experiences of transition from university into work in the NHS. Interesting and valuable insights were revealed, one of the key features that emerged was the importance of student relationships with practice educators during clinical placements. Accounts of the disabled physiotherapists indicated the major role that educators had played and in some cases, educators were instrumental in their decisions as to whether physiotherapy was in fact the right profession for them. As a result of this exploration of the experiences of VI physiotherapists (Atkinson and Owen Hutchinson 2013) I felt it important to add another piece to the picture by exploring the experiences and perspectives of the practice educators.

My fourth reason was a growing interest in the construction of contemporary physiotherapy and its conjunction, or otherwise, with evolving models of disability. This construction of the profession has historically taken place, in most cases, within the largely ableist discourses of the NHS where disability is often viewed in medical terms by the dominant hegemony. This has led to the positioning of physiotherapy as a profession whose focus is the body and yet in which the body is under-theorised. The body defines physiotherapy practice and yet physiotherapists in education and clinical practice have a largely biomedical approach. There is little attention given to the body as a philosophical or theoretical construct (Nicholls and Gibson 2010). I believe this influences the ways that physiotherapists view disability as a concept, and consequently, the ways that they view disabled people; whether clients, students or colleagues. Viewing this through a Bourdieusian lens, dominant discourses within the NHS, and the development of the professions therein, contribute to an emergent reality, the structures of which are not necessarily self-evident or directly observable. Intentionally constructed social structures such as the NHS often have unintended effects that are not evident to the 'social actors' themselves (Gorski 2013).

Last my growing conviction that when disabled students (and disabled qualified physiotherapists) enter this milieu, they disrupt the expected relations between the different actors, so influencing the pedagogical processes and behaviours of those actors.

## **1.1 Context**

Physiotherapy evolves in response to external drivers and because of physiotherapists challenging boundaries and embracing new knowledge and skills (Kell and Owen 2008). More autonomous professionals have moved into primary care settings due to the rise in

the ageing population, increasing complexity of healthcare needs and escalating constraints on time and resources in the NHS (Oliver et al 2014, Age UK 2017). This shift in focus obliged physiotherapists to modify their approach and to consider alternative methods of interacting with clients, necessitating examination and adaptation of the physiotherapy undergraduate curriculum (Ward and Gracey 2006, Alexanders and Douglas 2016). Physiotherapy education is enmeshed within this changing health and social care field which, arguably, contributes to the challenges with which all physiotherapy students and their educators must contend, both academically and in practice.

Physiotherapy has an established history of enabling disabled individuals to join the profession: beginning with VI soldiers after the World Wars. This initiative was unique within health professions, largely due to a specific historical situation and the work of a few individuals who influenced thinking regarding rehabilitation and the return of blind servicemen to gainful employment (Way 1994).

Employment rates for disabled people are consistently lower than those for non-disabled people; since 2008 the average employment gap has been 31.1% (Pfefer 2015). The graduate situation is most positive with 52.8% of disabled graduates in full-time employment in 2014 compared with 58.1% of non-disabled graduates (AGCAS 2016). Statistics suggest that higher levels of skills and qualifications equate with improved life chances and a higher probability of employment. It is axiomatic, therefore, that if a disabled person successfully completes a professional degree such as physiotherapy, his/her employment prospects will be enhanced.

Over the last 25 years I have encountered a wide range of disabled people successfully working as physiotherapists and, as evidenced by the CSP figures, people from this group continue to enter physiotherapy education. With the move from segregated to inclusive physiotherapy education, more staff have worked with, and participated in training with regard to supporting, disabled students. Given the continuing challenges that disabled individuals reportedly experience in physiotherapy education and the workplace (Atkinson and Owen Hutchinson 2013), I believe that more work is necessary to provide opportunities for physiotherapists to explore their understandings of disability in relation to therapeutic alliances with disabled clients and educational relationships with disabled students.

## 1.2 Physiotherapy in contemporary health and social care settings

Physiotherapy enables improvement or maintenance of movement, function and wellbeing in those individuals affected by injury, illness or impairment (CSP 2014a). Physiotherapists work in a range of settings such as hospitals, GP clinics, day centres, sports clinics, schools and other community establishments or in clients' homes. They also have roles in public health, health promotion and ergonomics.

Physiotherapy aims to facilitate clients' recovery or to enable individuals to manage long-term conditions to remain independent for as long as possible in activities of daily living and in turn, to improve wellbeing. The focus is on the client (and family/carers) participating in the care process, taking responsibility for self-management to become independent (CSP 2014a). Health professionals are expected to be able to manage clients within the context of their own lives (Corben and Rosen 2005). Moving clients out of the acute setting into the community has been a UK-wide priority for over a decade in response to pressure on resources. There is, however, limited evidence of appropriate investment in community services (RCN 2014). Client management is largely addressed through the provision of education, guidance and awareness-raising. Physiotherapists are well placed to provide these services as part of the multidisciplinary team.

### 1.2.1 Scope of practice

The UK definition of physiotherapy scope of practice is generic and flexible encompassing 'any activity' carried out by physiotherapists. It is based on the 'four pillars' granted to the profession by the Royal Charter in 1920 (massage, exercise, electrotherapy and kindred forms of treatment) (CSP 2013a). The focus is on movement and function supplemented with principles of evaluation, maintenance, improvement and independence.

Physiotherapy practice continues to evolve reflecting changes in clinical procedures, client/population needs, an emerging evidence base and developments in career progression. This is tempered by changes in service design and delivery as well as responses to policy development and political drivers (CSP 2013a).

Fields of clinical practice still seen by some as core to physiotherapy are expanding to wider ranges of client groups and health/social care settings. The London Olympics (2012) highlighted the role of physiotherapists in elite sport for both non-disabled and



Paralympian athletes, continuing in the Special Olympics in Bath (2013) and the Commonwealth Games in Glasgow (2014). Physiotherapists work in women's health, palliative care, mental health, cardiopulmonary rehabilitation, bariatrics, ergonomics, health promotion and occupational health. These less traditional areas of practice are likely to increase given the ageing population, long-term conditions, work capability assessments for disabled people and healthcare issues associated with modern lifestyles (CSP 2014c; Waterfield 2008).

Physiotherapists are autonomous; making decisions and taking actions independently in a professional context and being accountable and responsible for these (CSP 2014b). They must practice within the minimum proficiency standards laid down by the Health and Care Professions Council (HCPC 2017). Recently there have been changes in the design, delivery and funding of healthcare with initiatives such as Personal Health Budgets, Choose and Book, GP fund-holders, commissioning and the instigation of health and wellness communities (Health Unlocked 2014; NHS.UK 2015; The Kings Fund 2015). Consequently, physiotherapists' career structures are now less predictable with opportunities emerging in different fields leading to new roles. Alongside these opportunities, however, austerity and welfare reform in the UK has resulted in significant reductions in public spending, largely through budget cuts (BMA 2016), impacting on healthcare professions by posts being frozen, down-banded, or transferred to alternative providers (Owen 2012). Because of this, physiotherapists need to argue the business case for their services and to be flexible and forward thinking in their practice. This is reflected in the already overstretched curricula of educational programmes needing to assimilate service improvement, innovation and entrepreneurship. This places pressure on all physiotherapists which must be considered when exploring the roles of those who take on extra responsibilities involved in practice education.

This chapter has provided a rationale for undertaking this work in relation to my experiences of supporting both disabled students and the staff groups with whom they interact during their education, as well as linking to my previous research. It also provides context with a brief background of the physiotherapy profession in the UK, highlighting some of the drivers and pressures with which practice educators contend. The next chapter takes a more critical approach to facilitate later exploration of physiotherapy as a profession and approaches to disability.

## Chapter 2 Physiotherapy: a critical examination of the profession

This chapter reviews some recent work that critically examines the theory and practice of physiotherapy, resulting in the emergence of “*a complex, multifaceted professional identity*” (Nicholls and Gibson 2010,497). The first section considers elements of the development of professional identity, largely relying on literature emanating from the medical profession and applying this to physiotherapy. I then examine some of the influences and drivers underpinning the profession and its positioning in current practice.

### 2.1 Professional identity

Physiotherapy education is as much about the development of professional identity as it is about gaining knowledge and skills (Monrouxe 2010). In their work with medical students Vivekananda-Schmidt et al (2015,1) note that professional identity is an “*appropriate state of mind*” involving realignment of characteristics, norms and values that result in the individual “*becoming*” a doctor and “*internalising the doctor identity*” (Burford 2012,145). Education is part of this process and the clinical setting is the most influential element for any healthcare profession, with its communities of practice<sup>1</sup> where students experience professional socialisation<sup>2</sup>. Here group identity is the most available to students i.e. the professional category of ‘physiotherapist’ is more accessible in a clinical workplace than in other educational experiences (Burford 2012) so this may be where the process of recognition of ‘becoming’ physiotherapists takes place. Arguably it is part of the educators’ task to enable students to form, integrate and include this professional self into their multiple identities (Vivekananda-Schmidt et al 2015) by facilitating their participation in appropriate activities and recognition by others in the workplace.

Limited literature addresses professional identity formation of physiotherapists. Bartlett et al (2009) depict an identity for physiotherapy students which comprises what I would

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<sup>1</sup> Groups of people who share a concern about a topic and deepen understanding and knowledge of the topic by interacting on an ongoing basis, sharing information, insight and advice. They develop a unique perspective on their topic as well as a body of common knowledge and established ways of interacting and may develop a common sense of identity (Wenger et al 2002)

<sup>2</sup> Processes through which individuals learn the attitudes, values and beliefs of their profession and develop a commitment to a professional career (Bartlett et al 2009)

describe as mechanistic elements of 'what physiotherapists do', rather than 'what physiotherapists are' or 'what it is like to think, feel and act as a physiotherapist'. As noted, the expectation is that students integrate physiotherapy professional identity into their personal identity. When interpreted in a traditional sense this relates to "*something acquired as a fixed asset by novices in their early physiotherapy training*" (Hammond et al 2016,72). Increasingly a critical and philosophical turn is emerging, focussing on physiotherapy identity as more fluid and co-constructed; able to change within different contexts (e.g. Hammond et al 2016; Nicholls and Gibson 2010). Physiotherapists make sense and (re)interpret their professional self-concept influenced by clients, workplace and institutional discourses, boundaries and hierarchies (Hammond et al 2016). As noted the clinical placement and educators are key in influencing students' identity formation. Students experience professional inclusivity when they are treated as future healthcare professionals by clients and qualified staff (Weaver et al 2011). Over time they become 'similar to' other physiotherapists (professional inclusivity) and consequently 'different from' other students/professionals (social exclusivity), however, these competing discourses of standardisation and diversity, which occur in all professional groups, can cause tensions (Vivekananda-Schmidt et al 2015). Students' participation involves not only professional socialisation but also reconstruction of self (Hughes et al 2007). Each individual negotiates this differently depending on their unique social identity (Vivekananda-Schmidt et al 2015). The challenge for us, as educators, is how to most effectively facilitate this process given the wide range of students' individual differences and learning requirements.

Anecdotally 'professionalism', incorporating elements of role, image, behaviour and ethics, is implicit i.e. we all describe ourselves as 'professional' and expect that students and colleagues will exhibit similar behaviours. Identity dissonance can occur, however, if professional values and orientations that students are expected to integrate, differ from their own (Monrouxe 2010). Both students and qualified physiotherapists must negotiate dilemmas that arise because of this dissonance, developing strategies to enact their physiotherapy role. This has led to a notion of 'identity work' (Hammond et al 2016). Arguably the presence of disability, or other protected characteristic, may amplify this dissonance, consequently increasing the amount of identity work and reconstruction of self that needs to be undertaken. Stresses experienced by disabled students in this situation might be exacerbated if impairment has only recently been recognised/diagnosed. Practice

educators may also find it more challenging to provide the support necessary to facilitate the processes of professional identity formation with these groups of students.

## 2.2 Influences underpinning physiotherapy practice

### 2.2.1 Biomedical drivers

Physiotherapy takes a whole person approach to health and wellbeing (CSP 2014d), however, the 'four pillars' upon which physiotherapy rests focus on physical modalities and their application to the body. Arguably this indicates a greater emphasis on 'normal' bodily functioning than on psychosocial issues. Nicholls and Gibson (2010,497) note that the body is central to the identity of the physiotherapy profession being:

*“the site upon which much of our therapeutic work takes place...the socio-political focus through which physiotherapists compete with other professions to assert our unique identity...”*

Similarly to other health professionals, the ways that physiotherapists learn/are taught about bodies are largely aligned to medicine; mechanistic in nature-the body as a machine. Divided into systems, normal structure and function is addressed followed by consideration of trauma and diseases that can affect these systems. Much of the focus is on diagnosis and dysfunction, systems or regions which go wrong and consequently need 'fixing' (Eisenberg 2012).

Management of movement dysfunction has become a focus for physiotherapists; we specialise in the application of objectivity, logic and reason, using these to define elements of clients' function that are normal or abnormal. This focus on defining abnormality empowers physiotherapists to provide alleviation, relief or 'cure', and some would argue that this has become a basis for professional status (Nicholls and Gibson 2010); enabling us to *“defend and demarcate the territory of physiotherapy as a valued profession in contemporary healthcare”* (Shaw and DeForge 2012,420). It is thought by some that physiotherapists have become comfortable in their assertion that they are the preferred providers of rehabilitation services to those with physical impairments (Nicholls 2008).

Much research undertaken by physiotherapists has reinforced this approach; being carried out within an almost exclusive biomedical milieu underpinned by a positivist paradigm focusing on the effects of physical physiotherapy interventions (Wikström-Grotell and Eriksson 2012). In 2005 Bithell posited that physiotherapy was a relatively 'young' profession in academic and research terms, largely lacking in a theoretical basis and I would

argue that this is still the case relative to professions such as medicine. While the scope of physiotherapy research has begun to widen, I would contend that a large proportion of it, thus far, appears to support a conscious biomedical socio-political positioning of the profession. It is important to note, therefore, that this type of research often neglects important psychosocial aspects of client care which takes place in the wider context of the health and social care arena.

### 2.2.2 Alternative paradigms

As noted, physiotherapy views the whole person in relation to health and wellbeing. In my experience, physiotherapy programmes do introduce students to the concept of biopsychosocial approaches to healthcare including client-centred care and self-management/the expert client. Students also start to consider ethical issues in healthcare including the concept of personhood.

Engel (1977) introduced the concept of a biopsychosocial approach which effected the beginning of a paradigmatic shift in medical science, both clinically and in research (Adler 2009, Schubert 2010). This posited that it was impossible to consider or fully understand aspects of human nature at cellular and molecular levels without considering higher and more complex levels such as psychosocial aspects (Schubert 2010).

This is a crucial aspect of practice for physiotherapy students to appreciate given the research that has been carried out showing the impact of psychophysiological factors on health and/or response to treatment (e.g. Moseley 2004 on low back pain, Davis et al 2015 mindfulness in the treatment of chronic pain, Matcham et al 2016 depression and symptoms of rheumatoid arthritis). An overly biomedical approach to education could increase students' negative beliefs and attitudes about clients and their symptoms so influencing their interventions and information/advice provided for clients. There is evidence to suggest that biopsychosocial input can positively influence physiotherapy students' approach to client management (Domenech et al 2011). Smith et al (2010) note, however, that there is less use of the biopsychosocial approach in education, clinical settings and research than would be expected given its positive effects.

As in a range of other professional programmes, physiotherapy academic teams involve expert clients in admissions, teaching and assessment processes to expand students' awareness of these wider issues. There are also expert client groups such as [www.patientvoices.org.uk](http://www.patientvoices.org.uk) that are keen to encourage this and to support academic teams.

Research suggests that the learning encouraged by these initiatives is positive (see Ottewill et al 2006, Pickering 2001, Bazin et al 2016), but their efficacy is not universal. Utilised most commonly in social care and non-psychiatric mental health education, most appear to be *“single educational experiences for a specific group of learners which are often isolated examples within the broader curriculum”* (Health Foundation 2011,4). The above examples from physiotherapy show that rather than being embedded seamlessly into the curriculum, these learning experiences take a great deal of time and resources to organise. There is some evidence to show that while these initiatives enhance learning in relation to the subjective aspects of living with long-term conditions, they can, rather paradoxically, sometimes reinforce the biomedical paradigms they are designed to dismantle (Wilson et al 2007).

### **2.2.3 Professional positioning and research**

Since the mid-1990s initiatives for nursing and AHPs in the UK, have focussed on research capacity building, supporting Government schemes to improve health outcomes and experiences of healthcare (DH 2012; Pager et al 2012). It is recognised that these professions are ‘research emergent’, lacking a traditional research base for practice. Identified barriers to research initiatives include lack of time, skills and resources as well as differing opinions regarding the relative value of qualitative and quantitative research (Pager et al 2012). Participation of nurses and AHPs in competitive research training schemes lags behind that of doctors, dentists and clinical scientists (DH 2012). There are tensions for AHPs when undertaking biomedical scientific research because their research paradigms are different: complex and multidisciplinary, often community based and holistic in nature (Pickstone, Nancarrow, Cook et al 2008).

Possibly physiotherapists feel they need to ‘prove’ the worth of the profession by utilizing research methods such as RCTs; widely recognised as the ‘gold standard’ from specific epistemological standpoints. The type of research more suited to a holistic physiotherapy paradigm does not tend to attract large grants which are often associated with predetermined areas of study (Alderson 2013); consequently, it is often unrecognised and unsupported so potentially erecting a barrier to participation. Arguably then, the smaller, less visible professions must strive to make their case, both clinically and in business terms, through a more biomedical approach to be acknowledged as important elements of client care within what could still be considered a largely hegemonic medical framework.

## 2.3 Re-imagining healthcare

Traditionally healthcare practitioners have adopted a patriarchal model of practice that acts in the client's 'best interests' (Owen 2013). The effect of this can be limiting when trying to re-imagine physiotherapy identity and practice (Nicholls and Gibson 2010; Shaw and DeForge 2012). It may narrow the focus to a range of assumptions regarding appropriate goals and what, following intervention, constitutes a 'good' outcome. These tacit understandings often determine policy and practice (Gibson and Teachman 2012) and underpin many of the standardised measures of health status used in healthcare. This may have the effect of reinforcing unequal power relations in the relationships between professionals and clients resulting in a lack of critical reflection regarding these measures and assumptions about what might constitute a 'better' quality of life for a client. This may unintentionally devalue or mask alternative understandings and perspectives of physiotherapy practice that could usefully be applied in client care (Shaw and DeForge 2012).

One commonly held assumption is that reduction in impairment will necessarily lead to improvement in quality of life. The gap in the picture can be the relative lack of attention to clients' beliefs and values and how they might perceive success or failure. The risk is that this type of mainstream healthcare discourse can marginalise clients or depersonalise interactions so undermining the purported aim of providing client-centred care (Trede 2012).

Having said this, there is no doubt that all healthcare professions have person-centred care as a focus. The intention is not to portray physiotherapists as biomedically driven professionals who only recognize the body 'absent mindedly' as their focus for practice. It is interesting to note, however, that the body is rarely acknowledged in theoretical terms in physiotherapy literature (Nicholls and Gibson 2010; Wikström-Grotell and Eriksson 2012). The CSP requires educational programmes to take a person-centred approach (CSP 2010). This is often overshadowed by the plethora of biomedical information with which students have to grapple. In an overfull curriculum there is little time available to help them consider wider discourses or to begin to introduce more challenging ideas such as emancipatory practice.

There are wider concerns about these issues in general in relation to addressing health and wellbeing in the whole population, evidenced in the NHS Five Year Forward View (NHS

England 2014) and Next Steps (NHS England 2017). Also, initiatives such as the publication of AHPs into Action (Chief Allied Health Professions Officer 2017) and Empowering AHPs in public health (collaborative work between regulatory/professional bodies, NHS England, Public Health England, Health Education England and the Council of Deans for Health) aim to empower AHPs to combat and solve the challenges. Because of this work a new public health curriculum was released in September 2017, designed to be mapped across and embedded within all healthcare programmes (Hindle 2017). The Primary Care Home initiative has also been launched to address the priorities of local populations involving personalised care and integrated multidisciplinary teams (National Association of Primary Care 2017). Arguably, these major policy directives indicate that the past and current incorporation of biopsychosocial issues within undergraduate education, and indeed in the practice of qualified healthcare professionals, has not been sufficient to enable practitioners to engage with, and effectively apply, these more holistic approaches. It is to be hoped that these proposed changes in ways of working will facilitate an increased awareness of biopsychosocial issues leading to a re-imagining of healthcare, and of the professions themselves, to the benefit of all.

## **2.4 Power relationships**

Wherever social relations exist, various forms of domination, subjection and asymmetrical balance of forces operate (Lukes 2005). Within organisations all individuals are embedded within wider patterns of normative control and believe that they are rationally assessing situations and coming to their own conclusions, free of power. Power is exercised non-coercively by educating workers in such a way that they accept their role in the existing 'order of things', so accepting the authority of the organisation (Hughes et al 2007). It may be the case that that 'the way things are' is seen as natural and unchangeable resulting in a situation where it is difficult to imagine an alternative (Lukes 2005).

### **2.4.1 Professional socialisation and communities of practice**

In the social relations relevant to this study, power imbalances can exist between physiotherapists and clients, institution and employees, institution and clients, educator and student and non-disabled and disabled individuals (disability may be applicable in most of these dyads). In physiotherapy, patterns of behaviour signifying the way things are done (Monrouxe 2010) are taken for granted and accepted. Students are immersed in, and taught to emulate, traits and patterns of behaviour considered desirable during their



professional socialisation, interacting with significant others enabling them take on the normative behaviour that is the desired outcome (Eisenberg 2012).

Drawing on ideas from work on communities of practice, this situated learning environment has advantages, facilitating students' learning through active social participation so gradually incorporating them into the 'webs' of experts (Hughes et al 2007). More critically, these 'webs' can be viewed as being constituted in an environment in which the construction of individual knowledge and identity aligns individual aspirations with organisational goals (Garrick and Usher 2000). As physiotherapists develop expertise in the workplace they are empowered on the one hand and yet 'seduced into submission' on the other. The implication here is that they 'submit' to a specific way of being, thinking and doing (Hughes et al 2007) that in this situation, equates with recognised physiotherapy identity.

Students in the clinical environment are expected to integrate physiotherapy identity into their personal identity irrespective of pre-existing notions of 'self'. Professions are acknowledged as being adept at regulating selection of newcomers, policing boundaries and disciplining practice to manage conflicts and struggles (Hughes et al 2007). This could constitute part of the role of practice educators who are in a position of power when interacting with students.

Because of these asymmetrical power relations, issues of inequality and control may be foregrounded and could be exaggerated as a result of students attending placements for relatively short periods. Practice educators will tend to view them as 'outsiders' because placements differ from traditional communities of practice where membership is established and comparatively unchanging (Owen-Pugh 2007). Arguably, as students move through the programme and undertake further placements, they are seen to be more adept at assuming standard patterns of behaviour, involving recognition of themselves as professionals and being recognised as such by others (Vivekananda-Schmidt et al 2015) who begin to accept them as more established members of the community. In my experience, however, if students fall outside the expected patterns of behaviour and norms for any reason including disability, practice educators can express anxiety and may perceive that it is more challenging to support them in the clinical setting.

### 2.4.2 Clients, powerful professionals and disabled students

Clients experience the 'order of things' in healthcare situations. Medicine purports to be underpinned by scientific method which can foster the idea of body as machine and client as object; focussing on general principles rather than individual circumstances. Scientific method has adopted a positivist approach in which *"what is 'true' and what is contingent was constructed as stable, permanent and objective"* (Eisenberg 2012,440). Arguably this approach plays a large part in underpinning contemporary healthcare practice in relation to the ways that clients may be reduced to malfunctioning machines that need fixing. This also permeates many areas of physiotherapy practice.

If there is a focus on dysfunction, this can undermine engagement with clients' and therapists' experiential knowledge with physical diagnosis being incongruent with clients' experience of illness or trauma (Eisenberg 2012). They can feel well, applying no label of illness or disability to themselves. On entering the healthcare environment, however, they may experience a shift in their pre-existing identities which is unexpected and possibly unwelcome. Physiotherapists can promulgate this objectification of the client by referring to 'the knee in cubicle three' or 'the chest in bed ten'. Clients can be depersonalised by physiotherapists' use of specialised language imposed upon their own experience (Frank 2013). It may be the case that these fundamental ways of understanding disabled clients are to the fore in physiotherapists' understandings of disability which may carry over into their dealings with disabled students.

### 2.4.3 Physiotherapists 'in the web'

I am not suggesting that physiotherapists, either individually or collectively, approach their day filled with 'predispositions' of power which they simply execute. They are social actors subject to social relations which *"constitute structures of choices within which people perceive, evaluate and act"* (Lukes 2005,9). Most physiotherapists work in institutions where they are subject to power relations to which they largely consent, complying with the dominant behavioural characteristics of the organisation. For those who are subjected (or potentially subjected) to power, there could be an element of fear that there will be repercussions if they do not behave in certain ways. There is a sense in which therapists could be perceived as becoming entrenched or entrapped; not self-entrapped but put into that position by the organisational behaviour and power structures of the NHS. Arguably people are where they are because of context rather than as a result of active intent; but this will influence practice.

While alternative paradigms are considered important theoretically as discussed, I would argue that current work pressures and stresses experienced by healthcare practitioners may act as barriers to them engaging effectively with biopsychosocial issues in relation to education and practice. The Kings Fund (2016) reported that nearly 40% of NHS staff report feeling unwell because of stress, resulting in poorer quality client care and lower levels of client satisfaction. It also effects the ability of staff to pay close attention to clients and to respond empathically. While physiotherapists can appreciate critiques of the biomedical approach to the body, work pressures to move clients quickly through the system to discharge may cause them to fall back on mechanistic and reductionist approaches to care so again reinforcing unequal power relations. It is interesting that the public health initiatives discussed earlier have no focus on the application of biopsychosocial principles to relationships with colleagues/students. This absence, plus practitioners' understandings of disability being largely influenced by therapeutic alliances with clients, may have some bearing on educators' attitudes towards, and ability to support, disabled students.

Having briefly examined the theory and practice of physiotherapy in relation to professional identity and power, the next chapter considers disability as a concept and the ways that this may influence the approach of physiotherapists to disabled people. This provides context for chapter 4 which explores the process of 'becoming' a physiotherapist and issues relating to disabled students.

## Chapter 3 – Critical approaches to disability

This chapter provides context for later discussions regarding disability and takes a brief, critical look, at how models of disability are evolving. While these models are continually developing through the work of activists and critical disability scholars, my experience and reading of the literature indicates that the ways in which they are enacted in practice, are not necessarily mirroring more current thinking. First, I provide a brief commentary on some of the research in relation to people from minority backgrounds and the gap in the literature that this current work may go some way to filling.

I go on to introduce, and briefly examine, the International Classification of Functioning, Disability and Health (ICF) given that this instrument is widely used in healthcare settings and is a familiar way for physiotherapists to consider people's impairments. Second, I address some of the current political drivers changing the ways in which healthcare professionals and clients interact in relation to health and wellbeing. More emphasis is placed upon clients accessing services they need, providing opportunities, but with some unwelcome outcomes especially for minority groups including disabled people. The rest of the chapter focuses on approaches to, and models of, disability and takes a critical look at how this may influence physiotherapists' attitudes, beliefs and behaviour in relation to disabled clients, students and colleagues.

### 3.1 The gap in the picture?

In my reading of a range of literature regarding HE, health and health education, there is a significant focus on the experiences and performance of both staff and students, and care of clients from minority backgrounds. This is commonly related to ethnicity and underperformance, or poorer engagement with healthcare; although other areas are considered such as LGBT+, feminist and disability issues (e.g. National Union of Students 2014, Long 2015, Zubair and Norris 2015, Phiri 2014/15). There is much reporting upon, and theorising about, these staff/students' or clients' experiences and/or level of attainment in contrast to those groups comprising the hegemonic (or ableist) norm (e.g. Williams et al 2015, Esmail 2015, Vaughan et al 2014, Phiri 2014/15).

For those 'othered' individuals who might be considered essentially invisible, there is a focus on encouraging them to be 'out' or to 'disclose' (e.g. Harris 2011) without necessarily acknowledging the difficulties this may cause (Nash 2014, Somerville 2015). In the case of

more obvious difference, the recommendations encourage institutional change and increased cultural competence in both staff and students in relation to curricula, education and practice (e.g. Mikkonen et al 2015).

The difficulties, stereotyping and prejudice that individuals face are well documented and much of the literature explores societal issues affecting attitudes, beliefs and behaviours related to diversity and social justice (e.g. Ralph 2013, Foster and Scott 2015). Many examples show that using innovative and imaginative approaches can lead to success for minority groups in education and employment (e.g. Bates et al 2017, University of Kent 2016), yet these do not seem to be uniformly applied in practice. Indeed, some recent work in medical education has shown that even when intercultural competence is actively embedded in the curriculum, if there is a lack of self-reflexivity on dominant exclusionary norms and cultural prejudice, then polarisation can be increased even though the intention is to create a safe educational space for discussion of these issues (Leyerzapf and Abma 2107).

Although aware of the problems associated with individuals from minority groups, in my experience many academics and clinicians do not appear to engage with research that could provide ways to manage these issues. Accessing university websites in the UK shows a plethora of resources and attention given to improving the achievement of minority groups, in particular students from BME backgrounds. However, not all academics hold to liberal views regarding prohibition of discrimination, inclusivity and positive action (Ridell and Weedon 2014) even though equality and diversity and unconscious bias training are mandatory in many institutions.

The gap that I see, therefore, is exploration of the underlying attitudes, beliefs and behaviours of those individuals in relative positions of power in educational and healthcare settings. It may be the case that these underlying matters, along with other issues discussed relating to work pressures and stress, may be acting as barriers to engagement with, and application of, these ideas to modify and improve practice. To date relatively little literature is available relating specifically to physiotherapists. Consequently, this work starts to explore some of these attitudes, beliefs and behaviours in relation to physiotherapists and disability, with the intention of raising awareness and enabling discussion.

## 3.2 International Classification of Functioning, Disability and Health (ICF)

In considering critical approaches to disability it is useful to introduce the ICF; the model used by many health professionals when addressing 'dysfunction'. In relation to the discussion in the previous chapter, this is based upon biopsychosocial principles, purporting to be a compromise between social and medical models of disability (Goodley 2014). It focuses on problems with human functioning with three interconnected themes: impairments (problems in function or alterations in body structure), activity limitations (difficulties in executing activities) and participation restriction (problems with involvement in areas of life) (WHO 2002). I would argue that it essentially measures and classifies people using the language of 'dis'ability. The WHO Disability Assessment Scale 2 (WHODAS2), a *"practical instrument designed to measure general levels of health and disability based on ICF"* is a generic assessment which can be administered in five to twenty minutes (WHO 2014).

Many physiotherapists use the ICF which addresses the effect of environment, recognising relationships between daily life and health and acknowledging macro as well as micro influences such as social policies and structural organisation. These elements have some links with the views of the disability rights movement (Hemmingsson and Jonsson 2005). There is an absence here, however, in that the subjective experience of clients regarding participation is not noted. Using the WHODAS to assess an individual in such a short time, using normative perceptions of the body arguably privileges biomedical knowledge, positioning the therapist as the powerful expert and the client as the passive recipient of 'management'. This hierarchical and non-equitable relationship could be considered as compartmentalising the actors involved (Eisenberg 2012). Effectively disregarding client perception, emotions and feelings and objectifying the body or disability in this way, makes it more concrete and consequently easier to 'deal with' (Titchkosky 2002). This is a 'solution focus' which links to the discussion in chapter 2 concerning work pressures and stress. This instrument could be perceived as a quick and easy way to assess clients to move them through the system. Arguably, regular use of the ICF could be contributing to a biopsychosocial gap in physiotherapy practice if the role of client perceptions and feelings is neglected. If this becomes the lens through which physiotherapists view disabled clients,

it could effect their beliefs, attitudes and understandings of disability so influencing their relationships with disabled colleagues and students.

### 3.3 Neoliberalism, healthcare and education

Neoliberalisation of the voluntary sector and civil society, in which individuals pick up where the state withdraws, has been a focus for successive UK governments (Goodley 2014). Tapping into this discourse the rhetoric of the Health and Social Care Bill (2012) and the Care Act (DH 2014) indicates a shift in the power base of health professionals with clients being expected to take more control of the services that they access. The purported aim is to improve health and wellbeing by enhancing the quality of relationships; achieving outcomes that matter most to people, with elements of developing better connections with communities.

While the focus on making the most of a community's assets and skills to improve healthcare is laudable, there is a tendency for these collaborative approaches to be described through the dominant discourses regarding client–health professional relationships (Entwistle and Cribb 2013). Co-production projects are a consequence of neoliberal healthcare policies involving active participation of clients in self-management and shared decision making, taking responsibility for their own health. Arguably these are politically and financially driven changes which appear to be a given in shaping current health and social care.

At best these changes could provide critical physiotherapy proponents with a vehicle through which to explore ideas underpinning connectivity and emancipatory practice. It might be possible to rework or re-imagine 'normalised' values and judgements emerging from regulatory governmental frameworks to open up alternative philosophies of care (Goodley 2014). This could help in a move towards an acceptance of individuals as they are, concentrating on inter-dependence and self-determination: development of communities that *"support individuals as they navigate and occupy their place in the universe"* (Hutcheon and Wolbring 2013).

Alternatively, these policies have arisen due to the rapid globalisation of capitalist economies (Martinez and Garcia 2001) and are considered to undermine the basic principles of social solidarity central to the ethics of fairness and equity (Janes et al 2006). The concept of 'the public good' or 'community' has been replaced with that of individual

responsibility where generally the poorest sectors of society are expected to find their own solutions to lack of healthcare and are blamed if they fail (Martinez and Garcia, 2001).

In parallel with these processes, the corporatisation of universities over recent decades involving *“funding cuts, increased workloads, casualisation, job insecurity, and neoliberal managerial techniques”* (Wanggren and Milatovic 2014/15,v) has changed the face of HE. Students are positioned as customers and, arguably, educators as passive service providers. There is a drive for HEIs to be making a profit and for students to be ‘employable’. Issues regarding the undermining of the idea of education as a space for enacting critical thinking and social change are clearly discussed by Wanggren and Milatovic (2014/15) and others in the same volume. While not a focus of this study, I would argue that these debates offer ideas that could go some way to explaining why educators may not be able to function as politically engaged and active subjects. The opportunities to think critically about practice, to enter into dialogue and to think about learning as a form of social transformation may be limited within this constrained system.

It is to be hoped, however, that the recent initiatives discussed in section 2.3, regarding changing paradigms and educational drivers, might go some way to enabling education and health professionals to bring more holistic approaches into focus more effectively in their teaching and clinical practice.

Having provided some critical analysis of current practice the next section will briefly address the importance of language/discourse before going on to introduce the key areas of disability that may impact upon physiotherapists’ approaches to disabled people. I acknowledge that whilst this study focuses upon disability, many of the issues and concepts discussed regarding language, oppression, prejudice, stereotyping and stigma are mirrored in other areas concerning marginalised groups and mainstream theorising. It is not enough that ‘difference’ is acknowledged and celebrated, it is crucial to be alert to the kind of difference that is acknowledged. The ‘heroic’ stories that are often celebrated do not offset the embedded invisibility and negative stereotypes that abound (Mirza 2014/15).

## **3.4 The importance of language**

### **3.4.1 A note on discourse**

Language and discourse are closely linked. Discourse is how we communicate and think about people, objects and societal organisation and the relationships between these



elements. Discourse emerges out of social institutions that have particular ideological stances providing structure and order to language, and consequently, structure and order to society. Ideology, simply defined as 'worldview', reflecting a socio-economic position in society, can in turn, influence the formation of institutions and the discourses they create and disseminate. In a cyclic manner, therefore, ideology shapes discourse which spreads, and is infused into society, so influencing ideology.

This views discourse as a culturally constructed representation of reality; constructing knowledge and governing through the production of categories such as those related to ethnicity, the elderly, disability or professions. This can result in the creation of meaning systems in which some categories of thinking or doing gain status and the currency of truth; consequently, other categories can become marginalised and stigmatised being considered as other, lesser or even dangerous. These dominant, often historical, discourses can affect how we behave and how we define and organise ourselves in relation to identity and practice.

Individuals can be constructed through the language used to describe them (Johnson 2010). It is important to consider what it is like to be positioned as 'elderly', 'black', 'disabled' or as 'professional' and the experiences and actions that are compatible with such a positioning (Willig 2008). These positionings, and the language associated with them, can cause us to perceive and describe others in fixed and mutually exclusive ways. Consideration of concepts such as intersectionality are helpful in engaging with the differences that impact upon individuals' lives in our society, where identity is constantly evolving and sometimes fragmented. As noted by Bhopal and Preston (2012,1) *"intersectionality helps us to engage with understanding outsiders and what it means to be a 'stranger' in modern society"*.

These ideas and concepts can provide a useful lens through which to consider issues concerning disability and physiotherapy in relation to positioning and identity, and the language that might contribute to this.

### **3.4.2 Language**

Language is powerful, being critically linked to knowledge, forms of which are privileged (Valentine 2002). It can create belief, constructing 'truth' and influencing decisions about matters that define humanity and affect people in general. Human sciences define human beings at the same time as describing them and work together with institutions (hospitals,

schools, prisons and so on) to have specific and serious effects on people (Goodley 2014). Naming and classification is a crucial part of this process and this kind of knowledge specifies who people are by what they do or fail to do: *“doing becomes being”* (Valentine 2002,215). While systems of classification can have value they generally ignore the individual. Arguably, therefore, practice educators might classify and define black or female or disabled students, making *a priori* assumptions about their competence and what they will or will not be able to do. As noted by Goodley and Rapley (2002,136):

*“...professionals approach the task of support with epistemological assumptions that promote deficit thinking”.*

In relation to this link between language and attitudinal issues, disabled activists and their allies have focused on the development and provision of a different language regarding disability.

### **3.5 Approaches to disability**

Most research concerning disabled people is quantitative in nature; carried out by professionals for whom *“the medical story has pride of place”* (Frank 2013,7). There is an inherent imbalance in power structuring all professional practice which Oliver (2015) terms the social relation of research production.

Disability studies is an interdisciplinary field bringing together elements of the humanities, social science and science. In the humanities much of the focus has been upon social construction of disability through a range of discourses (legal, medical, popular, literary and so on) (Barton 2001). As a result of these hegemonic discourses disabled people, in the same way as other marginalised groups, experience injustice, marginalisation and exclusion.

Disabled people are said to be stigmatised. While much work has been undertaken by disability activists to combat this, there is an enduring association between disability and medicine (Goodley 2014). Culture is based on the taken-for-granted notion that everyone is physically, mentally and emotionally ‘able’. While difference is recognised as important, it can result in inequality if it acts as a basis for access to privilege for those groups associated with social norms. This is often the case when those norms are *“assumed to be available to everybody, but in practice are not available to marginalised or disadvantaged social groups”* (Adams et al 2013,xxvi).

Disability is a problem normatively understood through the medical gaze, often via reductive biomedical approaches and discourse (Goodley 2014). In 1990 Oliver argued:

*“The problem is that doctors are socialised by their own training into believing that they are 'experts' and accorded that role by society. When confronted with the social problems of disability as experts, they cannot admit that they don't know what to do...they feel threatened and fall back on their medical skills and training, inappropriate as they are, and impose them on disabled people...Further, the medical profession, because of its power and dominance, has spawned a whole range of pseudo-professions in its own image; each one geared to the same aim-the restoration of normality...each one of these pseudo-professions develops its own knowledge base and set of skills to facilitate this”.*

(Oliver 1990,4-5)

It is axiomatic that one of the ‘pseudo-professions’ to which Oliver alluded was physiotherapy and in a blog on the Critical Physiotherapy Network in 2015 he indicated that his views regarding these issues have changed little in the ensuing period (Oliver 2015). He acknowledged, however, that this situation results from medical professionals being ‘trapped’ in a set of social relations over which they have little individual control. The quote illustrates the ways in which some disabled people, particularly those with physical disabilities, think about those professionals directly involved with them through the healthcare system. This is not, however, the only way that disability issues are considered. This section provides a context for the current positioning and interactions of disabled and non-disabled groups, particularly in educational and healthcare settings, by briefly reviewing the historical background and dominant social discourses concerning disability.

### **3.5.1 Medical model of disability**

Disability has been identified through the deployment of the medical model and is often viewed and treated in pathological and deficit terms associated with the label (Renshaw et al 2014). It is important to note that the use of the term ‘medical’ in this instance does not mean that all medical professionals necessarily hold to this approach but refers instead to the ways in which the medical profession was instrumental in the development of this model and its way of considering disability. This approach is alternatively referred to as the ‘individual’ or ‘tragedy’ model indicating the ways in which responsibility is placed on the person who has the impairment; having the ontological subtext of normal versus the pathological where disability is linked to deficit or a flawed existence (Hughes 2007). This relates to the ‘tragedy’ model resulting in the perception that disabled people have no enjoyment in life and are a burden to society (Swain and French 2008).

Every culture recognises 'difference' but this is not necessarily identified in the same way and the terminology used to describe it is variable. Valentine (2002,213) noted that *"difference is at the core of characterisations of postmodern identity...[it] is seen as multiple and fluid"*. From the seventeenth to the twentieth century the ways that difference was accounted for changed markedly; moving from ideas of demonic possession or divine punishment for imagined wrongdoings to medical notions (Rogers and Pilgrim 2010). Initially no societal group was identified as 'disabled'; various definitions were used such as the 'sick and infirm', 'defective' and those diagnosed as 'mad' and confined to institutions. Similarly to other marginalised groups, there are many historical examples of *"cruel and extraordinary attitudes and practices"* being applied to disabled people (Barnes and Mercer 2010,15) but ideas gradually emerged concerning the evaluation of what constitutes an impairment and the identification of disabled people as a distinct social group.

Through this process the reductive biomedical notion of 'body as machine' which can break down and need repair, came to the fore. The medical model was established by the end of the nineteenth century and in many areas, remains dominant (Barnes and Mercer 2010; French 2001). Life became *"processed through the reductive use of medical discourse"* (Goodley 2014,4) the body was impaired and 'other'. According to Campbell (2009,98) the power of biomedicalism to explain disability has generally been accepted because:

*"medical epistemologies appear not only to be 'common sense'...but also gain credibility from the prestige of being connected to scientific-techno-medical apparatuses and corresponding notions of scientific objectivity"*.

Consequently, disabled people have been seen as medical 'objects' considered unable to engage in normal activities (Blackman 2001; Thomas 2004), variously regarded as objects of pity, a menace, sick and incompetent and/or psychological and economic threats to society (Marini 2013). In terms of the medical model, as noted, responsibility for dealing with 'the problem' is placed on the person who has the impairment.

From the medical model viewpoint, the commonly held assumption is that impairment is the 'cause' of disability and the solution is medical intervention. The environment is considered neutral with little attention given to the impact of social policy or legislation. Disabled people have the responsibility to 'disclose' or 'declare' information. Arguably this terminology, indicating something they may not wish to reveal or at least something that is difficult to articulate, can compound the fear that disabled people might have in needing to

prove their right to support or adjustments (Nash 2014). Disclosure has a confessional tone and there is a sense in which disabled people who choose not to 'disclose' are somehow dishonest. Following disclosure, the individual is expected to make adjustments and develop 'coping strategies' often under the gaze of one or more professionals (Barnes and Mercer 2010). Charmaz (1995,658) identified that negative social definitions can arise if people with impairments "*failed to reveal "correct" feelings or to take the "right" stance*". Not engaging with these processes of 'adjustment' puts disabled people at risk of being seen as 'in denial', having 'not accepted' their situation and needing support and guidance. Michalko (2002,30) notes:

*"What shall we do now you are disabled?  
We shall cure you  
How shall you live when our cure fails and you are now permanently disabled?  
You shall adjust."*

This theorisation of disability prompted the creation of specific identities – the paraplegic, the dyslexic, the sufferer, the victim. Because of this type of discourse, disabled people may internalise these identities and consider disability as something negative and undesirable possibly leading to them narrating a sense of self which minimises the significance of impairment and disability in their lives (Shah and Priestley 2011).

### **3.5.2 Social model of disability**

Critical disability studies literature widely reports the role of medicine in promulgating disabling social relations, although it is not suggested that all medicine is inherently negative. The main issues relate to notions of medical power being applied in inappropriate ways to social situations (Shah and Priestley 2011) so leading to an individualised medical model.

Proponents of the social model of disability provided the most well recognised critical voice in their rebuttal of the reductive biomedical model. They challenged the fact that modern society did not recognise or accommodate human diversity associated with impairment (Oliver 1983). As the movement developed it introduced a different vocabulary and mobilised thinking about disability which subsequently began to be recognised as a political category rather than just a distinct social category. This politicisation of disability challenged the oppressive social relations superimposed on impairment (Campbell 2010).

The social model purports that it is the barriers within society that disable people who have impairments:

*“...disability is the active and purposive social exclusion and disadvantaging of people with impairment...disability becomes a product and oppressive quality of social relationships that exist between people who are socially marked as having impairment and those who are marked as...‘normal’”*

(Thomas and Corker 2002,18)

Emphasis shifted from the individual; the ‘problem’ was relocated within social attitudes, systems and practices which act as barriers to participation resulting in structural exclusion of people with impairment from mainstream activities. It was posited that the barriers must be identified, challenged and removed (Shakespeare 2006). The distinction between impairment and disability was the fundamental difference between medical and social models in that the focus on the ‘defective’ individual whose deficiencies cause social disadvantage (Finkelstein 2001) altered to one in which the person with impairment is disabled by social relations. The social model introduced the idea that having an impaired body did not equate with disability (Goodley 2013). Impairment was not ignored or denied but the emphasis was on the ways in which:

*“society restricts opportunities to engage in mainstream economic and social activities and renders people with impairments more or less dependent”*

(Barnes and Mercer 2011,30).

The link between the body and the social situation was broken and the cause of disability attributed to discrimination and prejudice. The aim was to move away from ‘how awful it is to be disabled’ to ways of changing conditions of life (UPIAS 1976).

### **3.5.3 Critique of the social model**

The social model was important in providing alternative understandings of the experience and reality of disability, acting as a basis on which disabled people could build to challenge their situation. It was, however, a simplification of a complex social reality largely due to the separation of impairment and disability (Barnes and Mercer 2011) and, as such only went so far in addressing the issues experienced by disabled people.

Many institutions claim to enact the social model although practical engagement with its principles and its subsequent impact has been patchy at best. It is viewed as if it is an explanation, definition or theory and tends to be used in a rather sterile formulaic way

(Finkelstein 2001). It runs counter to the dominant social discourse, particularly within the NHS: that of individual difference equating with being problematic. The social model has, however, remained static for a considerable period. Few developments or revisions evolved in response to criticism and changing circumstances (Shakespeare 2006) and literature indicates that this lack of development was seen by many as a weakness. Recent work focuses on the separation of disability and impairment and the model's tendency to diminish the importance of impairment and individuals' experiences of this. Disabled feminists and some critical realists have made strong arguments to bring impairment back into the sociological discussion of disability (Goodley 2013).

Criticism of the social model relating to the disability/impairment dichotomy led to the emergence of modified versions and alternative approaches. Certain scholars reject the distinction between disability and impairment arguing that biology and culture inevitably impinge upon each other (Goodley 2013). Swain and French (2008,85) described the affirmative model of disability as a theoretical construct focussed on disability on equal terms: *"being different and thinking differently about being different"*. Blackman (2001,9) used the term 'embodiment' which takes a number of factors into account exploring *"the ways in which we live out our bodies' psychology and biology through the social"*. Use of these more flexible concepts enables the consideration of disability from a number of perspectives.

#### **3.5.4 Disablism and ableism**

Within disability studies, there has been a shift from disability as an individual problem to disablism as a socio-political entity. This must, however, be considered within the context of complex identity politics; debating ethics of care and the significance of the body within an economic climate that is constantly reformulating what *"counts as disability"* (Goodley 2013,632).

Disablism and ableism are emergent labels used to describe disability discrimination. Campbell (2008a) uses the term 'ableism' to shift the gaze away from 'disablism'. Disablism is defined as a form of social oppression involving assumptions, conscious or unconscious, and practices which impose restrictions of activity and promote the unequal treatment of people because of disabilities; actual or presumed. This can have the effect of undermining psycho-emotional wellbeing (Goodley 2013) with theories of personal tragedy permeating discourses around medical research and disability. There is an embedded negative ontology

about disability in which nothing good can be said about it, contributing to unquestioned ableist assumptions (Campbell 2009).

Proponents of ableism promote a change in emphasis from the problems of disablism (the marginalised 'Other') to the problems of ableism (the 'same' or 'dominant'). Beliefs and practices involved in ableism produce:

*“a particular kind of self and body (the corporeal standard) that is projected as the perfect, species typical and therefore essential and fully human. Disability then, is cast as a diminished state of being human”.* (Campbell 2008a,2)

Ableism is part of everyday life; the unspoken assumption being that everyone agrees that able-bodied identities and perspectives are preferable and should be aspired to (McRuer 2013). Campbell (2009) argues that this normative individual of contemporary society is a myth and the 'normal' body a social construct: an ableist ideal, impossible to reach.

Nonetheless there is a compulsion to strive towards a perfectible body. Consequently, when disabled bodies are judged and fail to match the 'fantastical' ideal, this is key in the oppression of disabled people (Goodley 2013).

Ableism comprises a preference for certain abilities and individuals judge both themselves and others, in part, in relation to the abilities or values that are exhibited. If we accept that disability is not linked to a particular body or mind but is a socially constructed binary, it is not possible to claim that one half of the binary (the disabled) is socially constructed while the other (the normal) is a natural position which is in some way superior. That is, disability only ever makes sense in relation to ability (Goodley 2014).

Arguably the ableist view is deeply embedded in the individualised, medical culture of the NHS. The illusory notion of a corporeal standard, the perfectible body is something against which healthcare professionals may measure their clients and certainly their colleagues and students. It is suggested by Campbell (2008b) that any falling away from 'ableness' is disability and that a person's abilities or characteristics will be determined by that disability; disabled people are inferior to non-disabled people. Within this culture of compulsory ableness, therefore, perhaps it is almost inevitable that a disabled student's abilities will be determined by that disability. It may be time for health professionals to consider different views, accepting the variability of bodies, instead examining and critiquing the environment, context and/or dominant discourses.



### 3.5.5 Stigma, internalised ableism and passing

Established members of communities in most settings are likely to have *a priori* assumptions of compulsory ableness in relation to any new individuals arriving in that environment. A disabled person could, therefore, experience uncomfortable tensions; being concerned about fitting in, not causing colleagues any discomfort and not causing any problems.

#### **Stigma**

Stigma is a broad and complex concept. It is important to address it, however, as elements of stigmatisation are related to internalised ableism. Dovidio et al (2003) describe stigma as a powerful phenomenon linked to the value placed on varying social identities. It is a social construction involving departure from a standard or recognition of difference (Goffman 1968). It designates the bearer as 'spoiled' and consequently of less value than 'normal' people so challenging, or calling into question, an individual's humanity.

Stigma is often related to social and physical contexts where particular cultures and subcultures define which characteristics are stigmatizing (Stangor and Crandall 2003). In Bourdieusian terms (see Chapter 5) the particular 'field' of the NHS and the culture (involving 'habitus' and 'capital') of its incumbents may lead to stigma when a disabled person, or indeed any person of 'difference', enters it. Stereotypical conceptions can lead to prejudice resulting in inferences and assumptions being made about a person's character and behaviour.

Prejudice and stigma can play out for those receiving care in the NHS and for those providing it. For any practitioner who is observed to be part of a marginalized group, this can be a complex situation. As a result of my experience, I would argue that there is a further layer of complexity for many disabled practitioners. These individuals have emerged from, or are embedded within, a largely biomedical educational system and may have internalized these understandings both about themselves and others, in relation to disability. Particularly for those practitioners whose impairments are invisible, they may actively or subconsciously decide to 'pass' (see below), to assimilate into the environment rather than to share information about their impairments to avoid stigma and prejudice. If their personal strategies are effective this can be successful. If performance is deemed to be below that expected, however, extra stress may result, as they then need to consider

and negotiate adjustments with colleagues who may now view them differently because of their lack of 'disclosure', possibly exacerbating stereotypical and prejudicial responses.

### *Internalised ableism*

Individuals described as chronically stigmatised are thought to have internalised aspects of that stigmatisation, consequently developing strategies in order to manage on a daily basis (Dovidio et al 2003). Campbell (2009) describes this as internalised ableism: the effect of accumulative, residual and reoccurring experiences in daily life. The *a priori* assumption of compulsory ableness could result in disabled people participating in the process of denying disability, emulating ableist norms of ablebodiedness or at least passing (Campbell 2008b).

### *Passing*

The term 'passing', concerns minimisation of difference to avoid stigma: almost all persons who are in a position to pass will do so intentionally (Goffman 1968). This can be a difficult conundrum with which disabled professionals have to contend particularly in the complex field of the NHS where most disabled people encountered are clients who may be viewed through a medical lens. Disabled professionals may avoid sharing disability information for fear of stigma and discrimination. This fear could outweigh the importance of any benefits that they might access if they talked to their colleagues about their impairment or learning requirements.

As with members of other marginalised groups, disabled people may already have memories of discrimination, fear, negative self-image and low expectations. If the idea of internalised ableism is accepted, it is possible that disabled physiotherapists may prefer to avoid 'disclosure' as they fear discrimination before they arrive in a new clinical environment. Once there, they may assume an identity other than their own, bordering on a fabrication of 'who they are' to conform to what they believe is expected of them, adding to identity work and dissonance. In this sense they are performing ableism and become complicit in reinforcing the negative ontology of disability. In effect, awareness of disability is reduced and can essentially be ignored, resulting in no change in attitudes or behaviour.

This section has provided some critical commentary on the concept of disability and the discourses related to this. It has also considered some of the ways in which these discourses may effect the approach of physiotherapists to disabled clients. The argument has been developed to reflect upon how this could influence attitudes to, and relationships with, disabled students and colleagues.

The following chapter goes on to explore the place of physiotherapy students, disabled students and their practice-based educators in the overall picture.

## **Chapter 4 – Physiotherapy, education and disability**

This chapter brings physiotherapists into the picture again. Academics and their roles will be mentioned to add to the overall view, but emphasis will be placed on practice education and the educators who are the focus of this work. Challenges of placements are explored noting the various pressures and tensions experienced by educators who are primarily practitioners and only educators in a secondary role (Trede and Smith 2014, Pront et al 2016). In relation to this, physiotherapy students and especially those who identify themselves, or are identified by educators, as ‘other’ or ‘different’ are discussed. Context is provided, exploring some of the elements involved in becoming a physiotherapist including reference to the roles of HEIs, practice educators and students, and these points are addressed in relation to disability.

It is important to note that little of the research referred to in this section directly relates to physiotherapy, mostly emanating from other healthcare professions. Arguably this indicates a lack of attention to these issues within physiotherapy so suggesting a gap in both abstract thinking and practical approaches to difference.

### **4.1 Student to autonomous practitioner**

Physiotherapy students are not autonomous practitioners; they work under supervision usually provided by a qualified physiotherapist. Educational opportunities aim to enable students to develop the attributes necessary to assume the responsibilities of professional autonomy. However, they must only undertake physiotherapy activity within the limits of their scope of practice as demanded by professional and regulatory frameworks. On graduation they are considered to be safe, competent novice practitioners who continue to build knowledge and skills as part of their career development. The Department of Health (DH) asserts that reasonable steps must be taken to ensure that new workers are appropriately supported, thereby enabling them to deliver care and treatment to clients safely and to an appropriate standard (DH 2009). Healthcare students who have undertaken placements should be confident, have a good knowledge of real world working, be fit for purpose and committed to lifelong learning (Quality Assurance Agency 2007).

## 4.2 Practice-based education

While the practice placement itself is not the focus of this work, it is the medium through which the participants experienced disabled students, and as such, it is important to touch on some of the complex issues surrounding this educational activity.

As with all healthcare professions, practice-based education in physiotherapy is an essential element of the programme and of the students' professional development; it is embedded within the CSP's Core Standards (CSP 2014b). Clinical experiences and the practice educator are crucial in the education, registration and professional socialisation of students (Mooney et al 2008; Thomson et al 2014). Placements comprise approximately a third of the educational programme, constituting a major component of the pre-qualifying learning experience (Kell and Jones 2007). They are the medium through which students develop the skills, knowledge, attitudes, professional behaviours and competence to become physiotherapists, including the abilities to think critically and to clinically reason. Students need to develop the ability to be collaborative, flexible and adaptable enough to be able to manage complex situations in a variety of contexts (Bartlett et al 2009, Delaney and Bragge 2009). Immersion in this setting provides experience that cannot effectively be simulated in any other way (Sevenhuysen and Haines 2011). Students learn through engaging with practice in the workplace environment with supervision from qualified physiotherapists.

### 4.2.1 Challenges

Due to its significance, practice education is a highly valued element of students' learning; however, it is also problematic. Evolving contexts, changes in student demographics, increasing numbers of students and trends in HE and healthcare present constant challenges to practice educators, students and academic staff (McAllister et al 2010, Pront and Gillham 2017) and can lead to a lack of uniformity. Educators report that taking students can be burdensome, increasing stress in the workplace; students report anxiety and variable learning experiences (Sevenhuysen et al 2015). There are questions about the quality of supervision that is provided for students and concerns that it varies considerably from location to location (Snowdon et al 2015). Much of the research in this area is small scale and qualitative in nature and so has not provided a clear overall picture of what comprises a 'good' clinical learning experience (Pront et al 2016).

All programmes have to evidence the training provided for their educators (HCPC 2017) and most access placements in a wide range of health and social care settings, using large numbers of practice educators who, over time, often rotate to other specialisms or move to new jobs. This affects continuity, requiring HEIs to have a continuous rolling programme of training available. Consequently, the preparation and support provided to clinicians to enable their development as practice educators is variable and often involves bringing new educators 'up-to speed' with the procedures rather than necessarily having the opportunity to discuss pedagogical issues in any depth. In my experience much of this training focuses upon the assessment forms used to document student performance. There is evidence to suggest that educators 'pick up' their skills through learning in the workplace with support from more experienced colleagues, essentially being socialised into the assessment culture (Trede and Smith 2014).

Using detailed standardised criteria, usually disseminated by the HEI, educators implement competence-based assessment of students and yet rarely have input into their development. It is important to note, however, that teaching and learning in the clinical setting is very different to that in academia, being situated in a complex social setting involving both formal and informal learning opportunities many of which may be unplanned and relatively unstructured (Thomson et al 2014). Uncritical and automatic use of these criteria can result in the assessment reflecting *"fragmented competencies rather than the complex nature of practice"* even though the assessment practice of the educators is very important to all stakeholders because it leads to evaluation of student learning and eventually accreditation of fitness to practice on qualification (Trede and Smith 2014,154).

Other challenges present themselves for example the organisational context in which the educational relationship takes place. Practice educators may have to justify to their managers how their role in education enables a department or service to meet organisational targets and demands (CSP 2013b). Additionally, they are working in a constantly changing environment; needing to balance provision of effective healthcare with supporting the students which will variously depend on the speciality, workload, client needs, resources available and possible financial constraints (Pront et al 2016). Consequently, the provision of opportunities for students is sometimes considered to be diverting services away from clients (Stiller et al 2004).

This role is multidimensional and is embedded with the complex setting of clinical and educational practice.

#### **4.2.2 The complex role of practice educators**

As noted practice educators have wide ranging responsibilities: balancing the needs of clients with those of the students within a pressured clinical environment as well as acting as role models and carrying out associated administrative tasks: these are well documented (e.g. Delaney and Bragge 2009). They take on both facilitatory and evaluative roles with students; facing the challenges of taking the responsibility for teaching students in an environment where education is not their key objective.

When physiotherapy became an all degree profession a change was required in clinicians' approach to students; from supervision to active teaching (Kell and Jones 2007). Given the relatively short timeframe and the numbers of students and physiotherapists involved, this transition occurred with little training or educational support. As physiotherapists assumed this educational responsibility within the framework of individual, organisational, regulatory and sociocultural expectations, the complex role of practice educator emerged to address some of these issues (Cross 1994).

Given that practice based education has complex goals, theoretically there has been a shift in approach from the aim of transmitting curriculum based knowledge and the knowledge of the teacher to a more overarching stance. The educator does help the student to acquire knowledge but alongside this, enables development and change in students' conceptions of knowledge and learning which occurs through participation in the professional community (Kell and Jones 2008, Delaney and Bragge 2009). Even though there is recognition of the complexity involved in facilitating the personal growth of students to be actively engaged in the learning process and to enable them to become self-directed, active and independent learners, there is limited research considering the ways in which educators and students conceptualise their roles. Some qualitative studies have been undertaken which suggest that educators may still work from a more traditional model of knowledge transmission, providing information incrementally to build students' knowledge which was found to be rather at odds with the students' conception of education as more dynamic and adaptive (Delaney and Bragge 2009, Sevenhuysen et al 2015). Much of this work emanates from outside of the UK and is small scale, however, these countries have similar models of physiotherapy education and the findings do resonate with UK experiences.

Given the relatively short timeframe noted, the acknowledged complexities of practice education and the inconsistent nature of the training available to educators, it is perhaps not surprising that they do not have the opportunity to engage with more critical and emancipatory approaches to teaching and learning and tend to focus largely on competence and methods based styles of assessment.

### Gatekeeping

Gatekeeping takes place on a number of levels in healthcare professions: at initial access to the learning environment and throughout the degree programme, to spaces and levels of practice and to qualification as a recognised professional (Currer and Atherton 2008). The specific benchmarks set by regulatory and professional bodies, against which healthcare professionals are judged, are designed to bar 'unsuitable' people from working in roles that involve extensive contact with the public (Riddell and Weedon 2014). Some would argue that it is not the role of practice educators to be gatekeepers to the profession as there are regulatory procedures that deal with 'fitness to practise', however, the literature (e.g. Lo et al 2017) (and my professional experience) indicates that this is a given for many clinicians, that is, they do feel that gatekeeping is at least partly their responsibility.

There is a tendency to like and feel more comfortable with others who are similar to us (Marini 2013); difference can be challenging and anxiety provoking as is evident from much of the work on intergroup threat, prejudice and the emotions elicited by different groups (e.g. Cottrell and Neuberg 2005, Stangor and Crandall 2003, Tapias et al 2007). It may be the case that questions could arise as to whether certain 'different' individuals should be allowed to become members of a healthcare profession (for example, the work of Ryan and Struhs (2007)), however, this only goes so far in considering the issue. There is evidence to suggest that there is less confidence in disabled students and qualified staff in relation to competence and fitness to practice (Dearnley et al 2010, Griffiths et al 2010, Lo et al 2017, Snashall 2009). Arguably this could impact on decisions as to whether disabled people should be accepted onto educational programmes or enabled to be registered as health professionals. These issues are succinctly summarised by Clouder et al (2016,13) "*risk, fitness to practice and competence are brought together to contrive to introduce an element of doubt to defy even the keenest aspirations of admissions tutors or of potential students*".



Given the challenges discussed earlier, practice educators may have contradictory perceptions of their role. Inconsistent guidance, differing experiences of socialisation into the assessment role and competing demands in the educational environment may account for these perceptions. Arguably this could lead to decision making being partly based on personal beliefs (Carey 2012). Simpson and Murr (2013,119), for example, go so far as to characterise the passing or failing of a student as a political act which occurs due to the *“powers and privileges conferred by society on people attaining professional status”*. There is a notion that students who fail may do so as a result of factors other than incompetent practice.

### **The challenges of taking on students**

Professional experience and the literature confirm that, on balance, practice educators value the presence of students in the workplace, although as noted it can be seen as a conflicting priority. The educator role is not necessarily considered prestigious and may be assumed as a professional responsibility (Baldry Currens and Bithell 2000; Bennett 2003a; Öhman et al 2005; Sevenhuysen and Haines 2011; Stiller et al 2004;) rather than being valued as personal and professional development. Some physiotherapists may believe the role to be important; others could consider it to be solely an expectation initiated by the job description; another standard to be achieved (Cross 2013; Sevenhuysen and Haines 2011). Clinicians may experience conflict if they perceive that their organisations do not value or appreciate the demands of the educator role, leading to work-related stress and dissatisfaction (Öhman et al 2005).

Ambivalent opinions and beliefs about taking on the educator role persist despite pronouncements by Health Education England (HEE) that role models should be developed for education and training and that being a trainer should be seen as a ‘badge of honour’ (HEE 2013). There is tension between the roles of educator and practitioner and anxiety may result if practice educators do not know which has the greater perceived value or priority. Competing value systems present challenges to professionals who wish to practice authentically in all of the roles expected (Cross 2013).

Supporting students can be seen as an extra burden making it more difficult for clinicians to fulfil their other responsibilities (Bennett 2003a, Sevenhuysen et al 2014), they often feel they are juggling the demands of clinical duties within externally dictated timeframes (Sevenhuysen and Haines 2011). There are personal pressures such as the requirement to

establish intense relationships and rapport with students within a limited period, having little choice about which students they supervise. Taking students can be problematic due to staff shortages, inadequate financial resources and time diverted from client care (Bennett 2003b). Concern about these challenges is unsurprising when viewed through the lens of increasing uncertainty and unpredictability, the unstable job market and the focus on threats to client safety (Cross 2013).

Practice educators have consistently identified the educator role as complex, stressful and time consuming (Sevenhuysen and Haines 2011, Sevenhuysen et al 2014). Varying responsibilities of the role for example mentoring and assessment and how to manage this in practice may be confusing (Finch and Taylor 2013). Difficulties are sometimes experienced in conflating the pastoral elements of mentorship such as acting as a support and advisor with the more evaluative and critical elements of assessment involving passing or failing students (Bray and Nettleton 2007; Drake and Irurita 1997; Hirneth and Mackenzie 2004).

Little of the literature considers the perceptions of practice educators even though they are crucial in developing the physiotherapy workforce of the future. As noted there appears to be a focus on 'competence', situational contributions to learning and methods based assessment. Most of the assessment is interpreted on the assessor's terms with little negotiation with students and claims to objectivity are noted by some commentators to align more with defensibility (Trede and Smith 2014). On the other hand, Billet (2006,234) noted that students' professional relationships are negotiated, unequal and contested and as such, the relational interdependencies in work-based learning involve students' unique socially shaped histories (including desire, age, experience, disability) so making up "*part of their cognitive experience and shape ...[their] engagement with what is experienced*". When educators' views are explored, while they are aware of some of the challenges and tensions involved in this complex learning environment, there is reluctance to think critically about their practice and to move towards more emancipatory action which might relieve some of these tensions (Trede and Smith 2014).

The issues discussed present some context for the complex environments within which practice education takes place. They also provide some insight into the powerful, multidimensional influences, pressures and tensions with which physiotherapists have to contend when positioning themselves as practice educators.

## 4.2 HEI role

HEIs organise placements with varying numbers of healthcare providers in their region. This takes much organisation and is a complex process involving communication with many practice educators throughout the academic year. HEIs provide training which often comprises a combination of educator days at the university and training for clinical teams in situ. As noted there is no countrywide system in place to ensure that all educators supervising students have attended appropriate training sessions.

When students are on placement academic staff support both students and educators. This may involve tutor visits or telephone/email communication or a combination of both and these processes vary across the UK. In my experience of supporting many students over the last 30 years, both disabled and non-disabled, the support provided to them and to practice educators by HEIs is variable.

Practice educators are in a unique position with regard to stakeholders in physiotherapy including universities, therapy service managers, clients and students; balancing demands of providing a physiotherapy service with those of providing a supportive learning experience for students (Kenyon and Peckover 2008; Mooney et al 2008). Given the pressures experienced by this group, the provision of effective support from universities is considered to be crucial (Tee and Cowen 2012). One area of concern is that support is sometimes inadequate in relation to preparation, updates and the amount of formal feedback provided by universities including the views of students (Quality Assurance Agency 2007). There is some consensus that practice educators across a range of healthcare professions do not feel well prepared to take students (Kenyon and Peckover 2008; Walker and Grosjean 2011).

## 4.3 Student issues

### 4.3.1 Student stress

It is reported that students on health-related, vocational courses experience higher levels of stress than students on other programmes (Nerdrum et al 2009; Robotham 2008). The transition, or translation (Thomson et al 2014) from the academic to clinical setting can be one of the most challenging experiences with which they have to contend. This may result in psychological morbidity having a negative effect on emotional wellbeing subsequently impacting on academic and clinical performance. There is a wide range of evidence

indicating that the most challenging stressors related to this study are those linked to academic pressures and clinical placements (Jacob et al 2012; Sabih et al 2013; Singh et al 2011; Tryssenaar and Perkins 2001; Tucker et al 2006; Tyrell and Smith 1996; Walsh et al 2010). This literature emanates from a range of countries and relates to a range of professions but physiotherapy students and those in the UK are referred to sufficiently to indicate that this is an important issue that practice educators may find to be a significant factor when taking students on placement.

### **4.3.2 Student perceptions of placement and educators**

It has been reported that physiotherapy students do not always feel prepared to manage key areas of clinical practice such as communication, clinical reasoning, goal setting and record keeping (Thomson et al 2014). Some healthcare students perceive that educators are too busy and not able to appreciate or to respond to their anxieties (Brown et al 2005) meaning that when they move from university to placement, they can feel abandoned. The provision of a visiting lecturer by the HEI can help to ameliorate this even if visits are infrequent, helping the student to regain a sense of belonging (Brown et al 2005). This highlights the importance of the role of HEIs in co-ordinating the preparation and training of both practice educators and students.

There is scant evidence in the literature of the attributes of practice educators valued by physiotherapy students; more is available in nursing and other AHP fields. Educators are central in influencing students' confidence and self-esteem and supportive relationships enhance the quality of the placement and the effectiveness of learning (Hughes and Fraser 2011). A successful clinical experience does not occur automatically but requires contact with positive role models (Tryssenaar and Perkins 2001) who are caring and confident and demonstrate professionalism and organisational skills. Students appreciate the provision of 'useful' feedback as well as feeling accepted, respected and having their previous experiences valued (Gray and Smith 2000; Kelly 2007; Walker and Grosjean 2010). Confidence building is important for all students but there is evidence to suggest, perhaps not surprisingly, that experiences differ depending on multiple factors. For those who are identified as 'other', instances of bias and discrimination are commonly encountered and even though educators support the abstract idea of cultural diversity and inclusion, the reality is often somewhat different (Sedgwick and Oosterbroek 2015).

It is interesting to note that most practice educator attributes reported by students as being particularly valued, relate to the quality of interpersonal relationships rather than professional knowledge and skills.

### **4.3.3 Learning support**

Students report fewer positive experiences when there is a mechanistic focus on fitting in, getting the work done and learning rules which can be detrimental for their learning and professional development. In order to support students effectively, therefore, attention should be given to strategies that improve a sense of belongingness and social wellbeing (Levett-Jones and Lathlean 2008, Sedgwick and Oosterbroek 2015). This requires an emphasis on learning as a transformative process of becoming rather than learning as product. These ideas are challenging given the pressures experienced by practice educators. As noted in Chapter 3, however, given that there is an apparent lack of engagement with literature relating to pedagogy and diversity/difference; it is perhaps not surprising that there is inconsistent application of the types of innovative and imaginative approaches that have been shown to facilitate successful outcomes for all students, but particularly those from minority groups.

The concept of learners as 'product' utilises a restricted image, the implication of which is that they are perceived as deficient or incompetent (Cross 2013). On placement, students continually encounter new and challenging learning environments which inevitably expose these issues when they are assessed against the competency frameworks and pre-identified learning outcomes discussed in section 4.2.1 (Hargreaves and Walker 2014, Trede and Smith 2014). Errors or perceived errors can lead to feelings of shame, guilt and behaviours that educators need to recognise to mitigate consequent negative coping mechanisms (Lindstrom et al 2011). Being empathic, avoiding humiliating behaviour and providing sensitive feedback can produce a more shame-resilient approach to learning, guiding students towards constructive responses (Bynum and Goodie 2014, LeBlanc 2009, McKenna et al 2016), so encouraging reflective practice, enabling students to move towards being autonomous professionals. If this type of 'nourishing' relationship can be engendered, the focus can be shifted from being one of rectification of 'deficit' to one of learning as process, encompassing positive and negative experiences, considering the whole person and enabling more effective construction of professional identity (Cross 2013; Bynum and Goodie 2014). It is worth emphasising the evidence that suggests that

there is a gap between educators' appreciation of the abstract notions of transformative educational approaches and their practice.

#### **4.3.4 Disabled students**

The number of students from all minority backgrounds entering HE is increasing for example, a 34% increase in home domiciled black and minority ethnic (BME) students since 2010-11 (HEFCE 2017). As noted in Chapter 1 the numbers of students in HE with declared disabilities also continues to rise and has doubled over the last decade (AGCAS 2016). Almost half of these students have a specific learning difference and the number of students with declared mental health issues has increased by 220% since 2010 (HEFCE 2017).

Since beginning this study there has been some growth in the literature about the experiences of disabled students in HE. Wherever research is carried out, it seems the general consensus internationally is that while there has been an increase in awareness and some improvement in practice, there is room for further development. It is disappointing to note that since a small scale qualitative study by Holloway (2010) identified positive approaches for disabled students along with aspects of HE involving discriminatory practice, marginalisation and proposed ways of managing these issues, practice appears to have changed little in the intervening period (at least with regard to the published literature). In a larger study Fuller et al (2004) found variability in practice across departments and individual staff members; little change was found in the HE landscape by Vickermann and Blundell (2010) with a continuing need for institution-wide approaches including development of accessible curricula. Similarly, Redpath et al (2013) found variability along with lack of communication and awareness and the need for increased training for academic staff particularly in relation to mental health issues.

The QAA expects HEIs to be proactive in ensuring that all students are able to participate fully in university life and identified work-based placements as a key area for action for disabled students (QAA 2010). There is evidence to suggest that some disabled students on vocationally based programmes such as physiotherapy, experience specific disability related barriers when involved in off-campus learning (Botham and Nicholson 2014).

To receive assistance disabled students must register with disability support services. For a variety of reasons, some choose not to and consequently, a percentage of them may wait until problems arise before they mention their requirements to staff (Dearnley et al 2010).

It is of concern that only 42% are in receipt of the Disabled Students' Allowance (HEFCE 2017). It is acknowledged that not all disabled students need to access extra funding but arguably factors such as lack of awareness or anxiety in relation to 'disclosure' may contribute to this low percentage. As of 2016/17 the government made wide-ranging changes to the DSA (Johnson 2015) which disproportionately affect students with dyslexia and dyspraxia who make up the largest proportion of disabled students (NUS 2015). Fear of experiences and consequences of stigma may be one of the reasons for students not being open about their impairment and failing to seek support (Eisenberg et al 2009). For example, Demery et al (2012) in their work with students with a mood disorder found that up to two-thirds would conceal their impairment. This type of coping mechanism may mean that in some cases, practice educators are the first to realise, or to be made aware of, these differences which could have an impact on a student's ability to practice.

#### **4.3.5 Disability identity**

When students enter university, there are many aspects of identity which they are developing and exploring; disability is but one of these. Disabled students may approach their relationship with the construct of disability differently in different contexts: the university and the workplace (Riddell and Weedon 2014). Students with fluctuating or invisible impairments may have an element of choice as to whether or not they include disability as a permanent or transient feature of identity, however this can bring with it further challenges as they have a varying impact on students' day-to-day activities (Boyd 2014). Low levels of awareness and understanding of the issues may cause a lack of communication from students resulting in educators feeling resentment and lack of respect for the student and increased stress levels for all concerned (Hirneth and Mackenzie 2004). This may impact on the effectiveness of the learning experience.

#### **Issues of difference**

Becoming a student can be an emotional period and a challenging time (Demery et al 2012; Hopkins 2011). There is evidence to attest that in addition to this, all students who undertake placements perceive these as stressful (Jacob et al 2012; Sabih et al 2013; Singh et al 2011; Tucker et al 2006; Tyrell and Smith 1996). It is likely to be the case therefore that disabled students, as part of the general student body will experience these same emotions, challenges and stress levels. As noted earlier, however, they may also have to contend with a range of issues, over and above those experienced by most non-disabled students possibly including the decision whether or not to 'disclose' their disability.

Arguably this could lead to more challenges (Clouder et al 2016) and associated increased levels of anxiety which may have a greater impact on their ability to engage effectively with the clinical environment. It is important to acknowledge that there are other groups of students who may experience extra stress on placement for various reasons. For example, there is much evidence relating to BME students having to contend with bias and discrimination on placement, sometimes linked to lower levels of social capital (e.g. Esmail 2013, Mikkonen 2015, Sedgwick and Oosterbroek 2015, Vaughan et al 2014, Williams et al 2015). Students who 'come out' as LGBT may experience homophobic behaviour which can cause increased anxiety so impacting on their ability to perform in the clinical setting (Harris 2011, Newman et al 2009, Somerville 2015).

All of these instances will affect the practice educators involved and in turn may cause particular challenges for them as they work to find ways to manage these situations.

### **Extra effort**

'Successful' disabled students develop strategies to minimise the impact of impairment within the educational setting and subsequently build upon these to manage in the clinical environment. Student narratives indicate that they have to work harder and develop more alternative strategies than their non-disabled peers to overcome a range of barriers in academic and work based settings (Hopkins 2011). Extra effort may be required to complete activities such as travel arrangements, negotiating new environments (particularly challenging for VI people and those with some types of neurodiversity) and becoming familiar with new staff teams and systems on each placement. In my experience of supporting disabled students, depending on the impairment, they may have to carry out a range of tasks that non-disabled students never have to consider. Some examples of these are pre-placement visits, practicing the route to work ensuring there is appropriate public transport (especially VI students), making arrangements for assistive technology to be uploaded or specialist equipment to be housed, used and securely stored, organising support workers, negotiating modified working hours or other reasonable adjustments and/or organising for an assistance dog to be accommodated (extra issues arise here if the student is accessing hospital accommodation).

Professional tasks such as carrying out client assessments, development of treatment plans and record keeping are stressful for all students (Thomson et al 2014) but due to the impact of specific impairments, such as dyslexia, VI and mental health issues these



activities can take disabled students longer and require greater levels of concentration than that expended by most non-disabled students. Consequently, they may have to contend with negative attitudes from staff and peers as well as inconsistency of approach and practice when moving from one placement or area to another (Hopkins 2011). There is some evidence to suggest that disabled students need more input than non-disabled students (Tee et al 2010) which would again increase the pressure on practice educators in supporting them.

In my experience, practice-based educational experiences can be variable for all students but for disabled students, some receive comprehensive support and are able to engage effectively whilst others struggle to survive in a system which takes little account of their requirements (Fuller 2004, Redpath et al 2013, Vickerman and Blundell 2010). This may be exacerbated further if students conceal their impairments because of anxiety about a discriminatory culture within healthcare in which exists a notion that disabled practitioners are a danger to patient safety (Griffiths et al 2010). As noted, there are specific issues relating to placement education that need to be addressed for all students, academics and educators but when disabled students are involved these may be perceived as more challenging (Hirneth and Mackenzie 2004).

#### **4.3.6 Barriers to sharing information**

Bessant (2012) explored situations in HE in which some disabled students successfully negotiated reasonable adjustments with staff whilst others found this challenging. Positive outcomes related to students who had physically identifiable impairments, self-identified as 'disabled', understood their rights and entitlements and had insight into how organisations worked, or not, in relation to disabled people. Adjustments were agreed with students and staff working as allies. This could be seen as positive and yet it requires disabled students to be assertive, almost becoming 'extra visible'. There are parallels here with some feminist and BME research where the subject in question is seen as a 'space invader' i.e. a body out of place, not representing the somatic norm (Mirza 2014/15) and yet has to become the expert on their own condition (e.g. black woman, Muslim medical student, and in the current work – disabled person) to enlighten others. The subject is, however, seen as less capable of being in authority (Mirza 2014/15, Leyerzapf and Adma 2017) and is constantly required to prove his/her competences (Mikkonen 2016).

This involves emotional work. Disabled students may feel that they are a nuisance and do not want to have attention drawn to any impairments (Hopkins 2011). It would seem to be crucial for practice educators to be aware of the potentially increased stress and barriers that may be experienced by disabled students on placement. There is a tendency to focus on physical issues which conflates the approach to disability with the concrete and visible. This may cause educators to overlook more complex and challenging barriers to social inclusion (Hall et al 2004).

Those students who had invisible impairments and a less secure sense of a disabled identity were reluctant to discuss their requirements, not wishing to be singled out (Hopkins 2011). Some staff did not 'believe' in their disabilities (Bessant 2012) and in some cases, adjustments were not negotiated until students had representation from an advocate. Staff often responded negatively to these 'non-conforming' students feeling that they were causing unnecessary work, manipulating the system and putting standards at risk. There were also suggestions that these students were 'failures, 'untrustworthy' or 'putting it on' (Bessant 2012) reflecting the sense in the literature of an undercurrent of "*grudging compliance*" (Clouder et al 2016,12). While students from other minority backgrounds undoubtedly experience challenges due to bias and discrimination as a result of their protected characteristics, whether they would have to contend with the issue of being disbelieved or being manipulative in this way is perhaps somewhat open to question and in need of further enquiry.

It may be the case that practice educators expect/want students to be 'normal' and fail to ask about difference. Alternatively, they may not hold these beliefs but disabled students, as a result of their assumptions about how they will be treated, could erect internal barriers which inevitably exert pressure to 'be normal', particularly in the clinical setting. It is also important to note that due to the reactive nature of disability disclosure policies, pressure is placed upon disabled students "*to define and categorise themselves as inherently "different" at a time when "fitting in" is perceived by young people as crucial to positive experiences in the educational domain*" (Bryne 2014,131). In order to avoid discrimination and stigma, therefore, there may be a compulsion towards passing and assimilation: to emulate the norm through internalisation of ableism (Campbell 2009; Riddell and Weedon 2014).

There are valid reasons why students decide not to share their personal information (Bargerhuff et al 2012, Bryne 2014). Evidence suggests, however, that individuals who do share information about their impairments are afforded more positive responses than those who do not (Hebl and Kleck 2003). Given earlier points regarding *a priori* doubts in relation to disabled students' competence and fitness to practice, it may be the case that concerns about this could influence their decisions about whether or not to talk about their requirements in the clinical setting. Disabled students on vocational programmes may inform their university about impairment as an administrative convenience to access funding and equipment (Hopkins 2001; Stanley et al 2011) although it appears that many do not, or more recently are not eligible to do so, as noted earlier. This is an example of disabled people adopting the label of disablement strategically to access social benefits but not necessarily holding to a belief that they 'are' disabled (Campbell 2009).

Some students who share information with academic staff assume that the information is appropriately edited and disseminated to others who 'need to know' (Demery et al 2012). This is not always the case and misunderstandings about the Data Protection Act mean that staff are not aware that they are able to pass information on with the student's permission (UMHAN 2015).

This provides some context for the complex situations in which educators and disabled students find themselves in a clinical setting. Attitudes of staff towards disability and disabled students are clearly critical in the process of sharing personal information and there is a need for more training and awareness raising in this area. Inclusivity needs to be internalised as a general guiding principle rather than being 'tagged on' in a dis/ableist culture in response to an excluded student. While this work focuses on disability there are, as noted, at least some commonalities with students from other minority backgrounds.

#### **4.4 Practice educators and disabled students**

Physiotherapists are perceived as compassionate individuals, skilled in adapting environments and working with disabled clients to enable optimum function. As such it might be expected that they would be enthusiastic in their support of disabled students (Hirneth and Mackenzie 2004). There is evidence, however, that health professionals often have negative attitudes and may perceive disabled people as having a 'medical disease' that makes them unfit for practice (Dale and Aiken 2007). Anecdotal evidence exists that

disabled employees regularly encounter prejudice and discrimination in the NHS (as suggested by the accounts of participants in my previous research (Atkinson 2010)).

Stanley et al (2011) found that in teaching, nursing and social work, fitness to practice standards discriminated against disabled people and led to individuals concealing their impairments and in some cases leaving their profession. There is also evidence that some professional prerequisites (inherent requirements, competencies, technical standards) required for entry to healthcare professions have been developed with little or no acknowledgement of disability so erecting more, generally unnecessary, barriers which particularly affect disabled students who may need a more flexible approach to be successful (Griffiths et al 2010, Johnston et al 2016, Matt et al 2015).

There is little evidence of research directly considering physiotherapy practice educators' experiences of supporting disabled students. Opie and Taylor (2008) noted that lack of awareness and inexperience regarding disability led to feelings of vulnerability in educators, so erecting barriers to disabled students' full participation in the placement. It is suggested that more support and training for the staff involved could ameliorate these feelings to some degree (Botham and Nicholson 2014). It is perhaps doubtful that this type of support could be consistently enacted, however, given the general situation in relation to training of practice educators as noted earlier and the apparently infrequent appearance of disabled students in the practice education setting.

In nursing some practitioners express concern about disabled students undertaking programmes, assuming negative effects concerning competence and client safety (Ryan and Struhs 2007). In certain vocational fields, questions continue to be raised as to whether disabled individuals can ever be considered as fit for practice (Griffiths et al 2010, Riddell and Weedon 2014). Professional and regulatory bodies have benchmarks against which individuals in all health-related professions are measured in relation to competence. This can generate tension for practice educators as to whether, in their educational roles, they are expected to meet the needs of the student or those of the profession (Carey 2012). Further complications arise when considering the requirements of other stakeholders including HEIs and employers. Practice educators work within what could be considered a contested terrain comprising different expectations and demands and yet still need to provide a relevant and quality educational experience (Bessant 2012).

A third of physiotherapy students' education occurs in the workplace and yet limited guidance is provided for practice educators regarding their support. Appraisal of student performance often includes subjective elements which may not be 'bona fide' occupational requirements but rather social interpretations of desirable attributes (Williams-Whitt and Taras 2010). Generally disabled students report feeling more supported in academic settings than in the practice environment (Carey 2012) although there is evidence that academic staff may perceive disabled students as *"an added drain on precious time and resources, someone they efficiently and kindly (if not always equitably) deal with"* (Bargerhuff et al 2012,186).

#### 4.4.1 Views about disabled students

Given earlier discussions on ableism, it is perhaps not surprising that educators tend to view disabled students through the deficit model. Medical discourse positions them as intrinsically problematic, 'other', the main concern being 'what they can't do'; typically passively constructed as 'acted upon' rather than 'acting' (Adams and Brown 2006, Ryan and Struhs 2007, Renshaw et al 2014). Resistance, negative attitudes and lack of awareness of disability issues are factors that need to be addressed (Seale 2006) as they often lead to disabled students and employees being managed through the medical model.

Physiotherapy is influenced by notions of able-bodiedness; disability being viewed as needing remediation. This normative ontology and hegemony of ableness can result in a 'one size fits all' approach so perpetuating unequal or oppressive social relations (Ryan and Struhs 2007) which can act as significant barriers to inclusion in practice placements. Titchkosky (2007,106) notes that an unchallenged medicalised approach to sense-making leads to the following conclusion:

*".... disability easily becomes meaningful as a type of problem a community would be better off not to have in its midst"*

Research in nursing identified considerable hostility to the idea of disabled people entering the profession (Ryan and Struhs 2007); disability was considered by some as incompatible with a career as a nurse. Nothing of this nature has been identified in physiotherapy literature (although in my professional experience, some individuals hold similar views). There is evidence to suggest that disabled employees are rated more harshly even when working at the same level as their non-disabled peers. Arguably this indicates that employers may have particular beliefs about disabled individuals based on negative stereotypes resulting in discriminatory practice (Williams-Whitt and Taras 2010). Again,

these beliefs and behaviours are mirrored in the feminist, BME and LGBT literature (e.g. Harris 2014, Mirza 2014/15, Somerville 2015) in relation to individuals from other minority groups.

Sometimes adjustments for disabled students are ignored or refused; possibly due to a lack of knowledge or understanding about particular disabilities, or alternatively, related to prejudicial views. When adjustments are provided, queries may arise as to whether these compromise professional standards (Hirneth and Mackenzie 2004). Non-disabled individuals may talk about a disabled person looking 'normal' and noting that 'there is nothing wrong with him/her'. Assumptions may therefore be made that disabled students are wasting time or not engaging with learning and their impairments may not be considered legitimate.

Shier et al (2009) noted that individuals who share information about their disabilities experience discrimination and labelling by employers involving negation or disregard of ability, skills and training, having a significant impact on self-esteem. Differing experiences were reported in teaching, nursing and social work, with regard to 'declaration' of disability, ranging from positive and supportive to stigmatising and unhelpful (Stanley et al 2011). In the light of this it is perhaps not surprising that many disabled students may be reluctant to talk about disability with their practice educators. Legislation has resulted in significant constitutional protection and institutional support for disabled students and those moving into employment. Given that legal definitions of disability are based on the medical model (Bargerhuff et al 2012), however, much of the work that has been carried out in this area is based on compliance with the law rather than on engagement with the socio-political and emancipatory issues relating to disability.

To conclude, it is clear that this is a complex picture involving the fields of both education and healthcare. Academic and practice-based staff are embedded within, and to an extent across, these fields and must balance their different roles and requirements at the same time as providing an effective learning experience. The roles explored are complicated, but in relation to students, arguably it is that of practice educators that is most challenging given the stakeholders to whom they are accountable and for whom they are responsible. The presence of impairment brings another layer of complexity into the picture which may be variably managed depending upon the knowledge, awareness, experience and resources of the educators and their disabled students, and the support available to them.

## 4.5 Summary

One way of assessing the effectiveness of learning is in relation to how well the intent and learning objectives match the outcomes. This is not straightforward and in the clinical situation it is important to acknowledge the causal flow of social rules that shape how individuals act in relation to the possibly conflicting needs to maintain standards and yet to promote equality of opportunity. It cannot be assumed that educators supporting students on placement are necessarily experienced, reflective decision makers, fully aware of their preferences who know all the relevant facts pertaining to those students and their circumstances before they act. Bessant (2012) contends that individuals do not necessarily act rationally and intentionally in the disorderly, variable and unexpected situations encountered in everyday life. This may be particularly pertinent if the educators must manage unexpected difference over and above the usual challenges of supporting students.

HEIs and the NHS espouse the principles of diversity and inclusion as being inherent in their vision and mission. A wide range of sociological literature clearly indicates however, that emancipatory and anti-oppressive approaches have failed to permeate educational and healthcare practice in any meaningful way. Both within the literature and in my professional experience there is a significant gap between the 'symbolic' commitment to diversity and the experiences of those who embody that diversity. Diversity has become institutionalised and 'non-performative' in that it does not necessarily bring about what it names. Ahmed (2012,72) notes that "*diversity provides a positive, shiny image of the organisation that allows inequalities to be concealed and thus reproduced*". The apparent lack of attention to these issues in physiotherapy and this gap between the abstract notions of inclusion and actual practice requires studies such as this to provide opportunities to invigorate academic debate, raise awareness and to stimulate discussion which might begin, at least, to narrow a practice/theory divide.

The following chapter outlines the conceptual framework, which was developed through drawing on ideas from Bourdieu and critical disability studies. This has provided a lens through which to begin an exploration of the possible nature of the causal flows and social rules in the practice education setting. This is then used to inform the discussion of the findings of this study and to frame possibilities for changes in professional practice.

## Chapter 5 – Theoretical considerations

This chapter provides some background to the approach taken to my research and deploys Bourdieu's conception of the body as a bearer of value in society, as noted by Shilling (2013,134) "*a possessor of power, status and distinctive symbolic forms integral to the accumulation of various resources*". As noted the body is central to physiotherapy practice, however, I would argue that physiotherapists' approach to the body (and that of other healthcare workers), embedded within the largely reductionist, biomedical milieu of the NHS, has played some role in the development of cultural processes and deeper social structures that have marginalised disabled people (Byrne 2014) within this setting.

Bourdieu's (1977) social theory of practice provides a lens through which to begin to examine and understand the interrelationships between disabled people's bodily functions and broader sociocultural values and practices (Edwards and Imrie 2003) and enables an exploration of some of the practices of domination and oppression that may impact upon the relationships between physiotherapists and disabled individuals.

In my extensive experience of working with disabled students, in my research and reading of the literature relating to disability and more specifically disabled people within educational settings, it has become clear from both recurrent and emergent themes, that it is crucial to recognise the dialectic relationship between structure, culture and agency when considering the ways in which practices of widening participation, inclusion and support are operationalised and normalised by institutions such as universities and the NHS. This is the only way in which we might begin to challenge approaches "*grounded in the rules of a non-disabled arbitrary for whom the phrase "Welcome to my world" is intransigent*" (Byrne 2014,131 original emphasis). Bourdieu's social theory of practice can perhaps enable me, through this study, to provide a small contribution to this endeavour.

### A note on development of my theoretical framework

As I moved from data collection, through analysis to writing up, my understanding of which theoretical framework to use also advanced. Having initially felt that Bourdieu's ideas might be helpful, this conceptual framework did not directly inform or shape the work in the early stages of the study. As I carried out the analysis, however, gradually making sense of my participants' accounts and as my thinking evolved, Bourdieu's social theory of practice kept returning to my thoughts. Over time, I realised that this provided a suitable framework and an appropriate means through which to consider my participants' accounts.



## 5.1 Approach to the study

This is a qualitative study in that its purpose is to gain insight into, and understanding of, the ways in which people perceive, interpret and explain their world (Stenner et al 2017), in this case practice educators with a focus on disability and their experiences of supporting disabled students. It takes an interpretive, largely phenomenological approach both in the overall aim and the research questions. It is also responsive to the themes emerging from the participants' accounts which enabled the determination of the theoretical perspective taken. The questions and the research aim made use of distinct rhetorical markers and identifiers relating to the experiences of the participants so reflecting the interpretive theoretical perspective. The three questions were interconnected in a temporal fashion so linking past and present practice and experience, with possible suggestions for future development (Koro-Ljungberg et al 2009).

The research was framed by phenomenology in that it aims to provide some description of participants' 'life worlds' and as such, interviews were used as an appropriate way to access these (Koro-Ljungberg et al 2009). Phenomenological approaches offer insights into the nature of how participants' experiences are understood from the perspective of a particular person in a particular context (Langdridge 2007) especially as participants' concerns heavily influenced the conversations. This approach had at its core the description of things "*in their appearing*" (Finlay 2009,6), focussing on lived experience (Gee 2011). This position was concerned with participants' relationships with the field in which they worked and their attempts to make meanings of their experiences (Langdridge 2007; Smith, Flowers and Larkin 2009) with a focus on disability and their interactions with disabled individuals in this setting.

During the analysis, a hermeneutic approach was taken in that, while trying to understand the phenomena that emerged, interpretation of practice also took place (Koro-Ljungberg et al 2009), as noted by Stenner et al (2017,331) "*phenomenology...becomes hermeneutical when its method is taken to be interpretive*". A double hermeneutic exists in which the researcher interprets a participant's perception or interpretation of their experience and this iterative approach can offer different perspectives on the meanings within the data (Smith et al 2009). It is important to note that in taking a hermeneutic interpretive approach, that all interpretation is situated; it is a 'view from somewhere', so

acknowledging the active role of the interpreter. This was summed up by Gardiner (1999,63):

*"The hermeneutic approach stresses the creative interpretation of words...the active role played by the knower. The goal is not objective explanation or neutral description, but rather a sympathetic engagement with the...action and the wider socio-cultural context within which these phenomena occur"*

While this is not a philosophical discussion of hermeneutics, interesting ideas are suggested by Kearney (2003) and Kinsella (2006,7) who introduce the notion of taking a critical stance *"a middle space...somewhere between the "congenial communion of fused horizons" (romantic hermeneutics) and the "apocalyptic rupture of non-communion" (radical hermeneutics)"*. Insights offered by critical perspectives in relation to phenomena such as power, the potential misuse of language and an acknowledgment of 'the fix we are in' can inform hermeneutic inquiry (Kinsella 2006) and are helpful in a study of this kind. This approach *"aims for respect and openness toward the perspective of the "Other"...a willingness to suspend one's own position in order to achieve understanding"* (Kinsella 2006,7). It is acknowledged, however, that both the researcher and participants are knowledge producers in this dynamic (Koro-Ljungberg et al 2009), the researcher reflexively interacts with the data during the conduct of the research and the researcher's 'self' is central to understanding and interpretation (Stenner et al 2017). A notion of *"vigilant subjectivity"* as outlined by DeLuca (2000,19) is useful here combining vigilance towards the other with a development of *"an understanding of subjectivity as an ability of one to temporarily let go of preoccupation with self"* so ensuring that interpretation is grounded in human experience (DeLuca 2000).

I am interested to consider 'the fix we are in' in relation to the relatively unchanging picture over time (as discussed) of the position of disabled individuals in health education. Also, given the active role I have taken in this arena over the years, I admit to feelings of frustration and disappointment regarding the apparent lack of progress. In speaking to participants, I wanted to explore and try to understand the factors that might be contributing to, and perpetuating this state of affairs in relation to disability and their relationships with disabled students. As well as understanding, however, I also wish to challenge the apparent status quo because practice needs to move on and I believe that the only way to do this is to take a critical stance in relation to the stories that my

participants tell. As Grumet (1992,50) pointed out *“the scrutiny of what is ordinary requires a critical approach to the social and political environment, for the 'ordinary' is a social concept and an unquestioned assumption”*.

A critic of this study may claim that phenomenology and critical theory cannot co-exist in a singular methodology and possibly that this situation mixes methodologies and incorporates too many philosophical perspectives. I would argue however, that there is a difference between multiplism and conceptual confusion. I acknowledge the influence of critical disability theory and hermeneutic phenomenology in the interpretive methodology embraced by this research. I would suggest that it is perhaps the acknowledgment of such approaches that effect the rigour of this study which aims to encourage and invigorate debate about emergent issues, to attempt to disrupt the taken for granted assumptions of participants and inform the development of professional practice.

## 5.2 Criticality

In the light of trying to understand factors contributing to, what I would argue as being, the almost static position of disabled students in healthcare education, during the analysis, I approached participants' accounts critically to focus on the (re)production of dominance and the exercise of social power by institutions and groups that can result in social inequality (van Dijk 1993). This led me to think about pedagogical interactions being influenced by embedded notions of 'client as disabled' and 'therapist as non-disabled', this being unconsciously believed and practiced because of habit and culture.

Within the NHS and HEIs there are pre-existing hierarchies and structures; the processes and discourses associated with these will influence people's conceptions and experience. Critical disability theory, which has emancipation as 'its cornerstone', views society as basically unjust and disabled people as undervalued and discriminated against, so revealing a need to expose the power dynamics involved in these types of hierarchical social relations (Meekosha and Shuttleworth 2009). Arguably, in relation to this study, there are important elements that lead to a pattern of situated physiotherapy professional practices with regard to disabled students. Societal practices concerning disability that continue to be structured around an able-bodied framework (Meekosha, Shuttleworth and Soldatic 2013), the medicalised context of the NHS, often reductive biomedical physiotherapy practice (Eisenberg 2012, Nicholls and Gibson 2010) plus the relatively powerless position of the student (Baird, Bracken and Grierson 2016, van der Zwet, de la Croix, de Jonge et al

2014) with or without disability. Individuals often inhabit relatively different positions which may be unequal; this inequality is socially constructed within specific historical conditions.

Extensive literature relates to students in HE studying vocational programmes and some focuses on disabled students generally. Little attention has been given, however, to the ways in which being immersed in a biomedical healthcare educational setting might influence the behaviour of, and relationships between, medical educators and their disabled students in the clinical environment. The situation is universally regarded, however, as one of difficulty, anxiety and stress for both educators and students (Adams and Brown 2006; Carey 2012; Opie and Taylor 2008; Ryan and Struhs 2007).

### **5.2.1 Absence**

Absence is a concept in which everything is in part defined by what is not; arguably information and policy will be skewed by this absence. Along with other marginalized groups the voices of disabled people are absent in much of the research that relates to them, and yet they are crucially involved (Alderson 2013). Recognising this and understanding disability as a diverse social construct and set of beliefs and behaviours, opens up possibilities for exploration. It is important to acknowledge the significance of disability in expanding the boundaries in critical sociological thought that continue to be structured around an able-bodied framework (Meekosha et al 2013).

### **5.2.2 Emancipatory?**

While not emancipatory in the sense of including disabled people within the research itself (an absence that is noted) it is intended that this work may 'disrupt' some of thinking of practitioners in clinical settings in relation to working with disabled students. It may enable them to begin to be differently informed and provide possibilities to think in other ways in relation to their practice. If a better understanding of the social processes of disability knowledge can be articulated this could lead to critical reflection on the application of theory to practice aimed at emancipatory courses of action (Gable 2013). This could change or inform physiotherapy professional practice.

### **Considering the educators**

Another notion of emancipation that can be deployed here is that of the position of practice educators themselves. As noted they are embedded within pre-existing hierarchies and structures which may effect their conceptions, experience and 'ways of being'. As

discussed in section 2.4.3 they must also contend with wide ranging pressures and could be perceived as entrapped within the interrelations, organisational behaviour and power structures of the NHS. It may be the case that problematisation of consequent taken for granted assumptions (here, relating to disability/disabled students) could pose them as a challenge to consider, allowing new viewpoints and ideas for possible action to emerge. This process might enable recognition of the existence of these issues, encouraging educators and disabled students to enter into dialogue about these assumptions and ways of being.

### 5.2.3 Using ideas from Bourdieu as a lens

Bourdieu was interested in ways in which society is reproduced and how dominant groups maintain their positions. He examined the intricate interrelations between agency, structure and culture in many of his works exploring how *“subjective and objective structural and cultural resources, processes and institutions maintain individuals and groups in competitive and self-perpetuating hierarchies of domination and oppression”* (Byrne 2014,121). His work has been deployed in disability theory to move beyond the reductive conceptions of the medical and social models of disability to consider how the concept of habitus might offer a way *“of bringing an analysis of the body to bear upon an understanding of the social inequalities which are core to the lives of disabled people”* (Edwards and Imrie 2003,241).

The following section briefly introduces the elements of Bourdieu’s (1977) social theory of practice and explores how these ideas might be useful in viewing, understanding and challenging the world of educators and their relationships with disabled students in the placement setting. These ideas proved of value in coming to understand participants’ accounts regarding the broader contexts of their professional practice.

## 5.3 Field, capital, habitus and doxa

Bourdieu’s concepts of field, capital, habitus, and doxa are useful as a means of exploring cultural habits and practices in a range of contexts. This theory of practice is central in any exploration of the dialectic between the individual and society (Bourdieu 1977). For Bourdieu action is not a mechanical response to objective structures *“but is mediated by the habitus, the field and the availability of forms of capital”* (Byrne 2014,121). The following section is not a sociological discussion, but makes use of Bourdieusian concepts, applying and extending them in trying to understand the field of the practice placement.

### 5.3.1 Field

*Field* can be thought of as a social arena in which individuals act which can involve dominance differences within or between professional groups. Each field is a relational space, dedicated to a specific type of activity: a relatively autonomous domain that responds to rules of functioning and institutions that are specific to it and which define the relations among the agents. It is not an entity but a system of relations (Bourdieu 1977, Bourdieu 2000, Hilgers and Mangez 2015).

Field exists where groups with some autonomy have something in common, providing a way of thinking about an overarching context. Relationships within these social spaces have their own structure and forces (Morberg, Lagerstrom and Dellve 2011). As a domain becomes more autonomous, relationships are transformed between individuals linked to the activities in question. Practices become increasingly evaluated by the domain's internal criteria, the field is produced by, and produces, a specialised elite, agents who have mastery and possess specific competence and practices who become less affected by external influences; so indicating increasing autonomy (Bourdieu 2000; Hilgers and Mangez 2015). During the genesis of a field, *capital* (see below) and competence becomes more specific, increasing the closure effects of the field (Bourdieu 2000); agents within the field become the “*guardians of legitimate knowledge*”, rationalising and constituting specific knowledge and developing authority. Knowledge is autonomised and becomes the minimum ‘entry tariff’ for new entrants (Hilgers and Manguéz 2015,7). As this autonomy develops it generates the *doxa* (see later), the belief of the agents of the field, presuppositions about what constitutes adherence to the domain of specific activities and implicitly defines the conditions of membership (Bourdieu 1977). As noted by Hilgers and Manguéz (2015,7):

*“The autonomization of the criteria (aesthetic, religious, scientific, etc.) that govern production, and the importance of these criteria in building a structure of relations specific to a domain of activity, leads the agents who are active within it to perceive the real on the basis of the principles shared in this field. The agents of the field then tend to perceive the world-inside and outside the field-through a prism constructed within the field”.*

This conception seems to me to be a lens through which to view my area of interest at a number of levels: first more globally, the way in which healthcare is organised within the field of the NHS and the development of the field of physiotherapy in which increasing professional autonomy is a major focus and specialist scope of practice has evolved over

time. Physiotherapy scope of practice is contested within areas of specialisation and across other professions: Bourdieu (1996,225) talks about boundaries in relation to field as *“always being fought over”* so by defining and defending the boundaries and controlling entry into the field *“is to defend the established order in the field”*. These ideas resonate with the sense that physiotherapists are guardians of their body of knowledge and skills, the tariffs for entry and conditions of membership. This also links to physiotherapy education and, for the purposes of this work, the field of the practice placement and the consequent interrelationships of educators and students; what might constitute the position or ‘sense of place’ of disabled individuals when viewed through the ‘prism’ of disability constructed within this field.

Arguably, understandings that physiotherapists have about ‘ways of being/doing’ in dealing with disabled clients and the related social divisions become ‘naturalised’ and enable this familiar world or ‘cultural arbitrary’ to be taken for granted (Bourdieu 1990a) in this case projecting these ‘ways of being’ into educators’ dealings with disabled students. I now go on to introduce the concept of *capital*: within each field agents have different types and amounts of capital.

### 5.3.2 Capital

Field can be thought of as *“a structure of relative positions within which...actors and groups think, act and take positions. These relative positions are defined by the volume and structure of their capital”* (Hilgers and Mangez 2015,10).

*Capital* refers to resources that individuals possess or develop in relation to a field in which that capital is used. The forms of capital described by Bourdieu (1989) are economic, cultural, social and symbolic. Capital takes time to accumulate and the *“structure of the distribution of the different types and subtypes of capital at a given moment in time represents the immanent structure of the social world...which govern its functioning in a durable way, determining the chances of success for practices”* (Bourdieu 1986,46).

Different forms and amounts of capital are resources that can be drawn upon and used to maintain/enhance position in the social order and emerge as power or privilege used to control individuals or institutions. Bourdieu (1986,46) notes that capital is *“what makes the games of society...something other than simple games of chance...”*

Symbolic capital is described as *“the power granted to those who have obtained sufficient recognition to be in a position to impose recognition”* (Bourdieu 1989,23). This is linked to

knowledge, status and authority, involving inter-relationships, interdependence and power struggles within social arenas. When two or more individuals relate to each other, flows of capital may be facilitated or prohibited by particular social relations (Purdue and Howe 2013).

Cultural capital is the valued capital of a field in terms of the cultural ways of the field and this cultural knowledge is used to underpin an individual's place in the hierarchy (Bourdieu 1984, Gauntlett 2011). Social capital is defined as *"the sum of the resources, actual or virtual, that accrue to an individual or...group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition"* (Bourdieu and Wacquant 1992,119). The way in which Bourdieu deployed this idea was to explain the *"cold realities of social inequality"* (Gauntlett 2011,2) rather than the way in which other writers use the idea as a more supportive network of social connections. Arguably, networks within physiotherapy can be viewed as supportive, having some resonance with this work regarding relationships between educators and students. Taking a more Bourdieusian view, however, social capital is deployed by groups as an exclusionary device to ensure that the 'wrong' kind of people do not enter their circles (Bourdieu 1986). While I hold to idea of the potential for social change there is a notion that the rather darker side of social capital does hold sway in some areas of education and healthcare professions. It could be argued that these phenomena provide an explanation for inequity in opportunities open to less advantaged groups such as disabled people in that only those disabled people who have the 'right' forms of capital are able to become 'one of us' (Bryne 2014).

I will now consider habitus, linking this with field and capital to briefly attend to Bourdieu's assertion that action is mediated by habitus, field and the availability of forms of capital and is not simply a mechanical response to objective structures (Bourdieu 1977). While it can have the appearance of 'rational behaviour', it can in effect be guided by a 'feel for the game' (Bourdieu 1989, Bryne 2014).

### 5.3.3 Habitus

The body and its social location are interrelated and according to Bourdieu (1977,1990a) can be understood in and through the *habitus*; management of the body being core to the acquisition of status and distinction in the field (Edwards and Imrie 2003). Habitus is a complex phenomenon but for the purposes of viewing practice educators it can be thought



of as a disposition or 'way of being' which evolves from the history of each person's individual or collective experiences: the ways people with various forms of capital 'do things' in the field. It provides a framework for members of an organisation to accomplish 'appropriate' practice, providing a sense of what actions are possible (or not) for individuals in different positions within the organisation (McDonough and Polzer 2012).

The three principles of habitus, field and capital do not exist alone but relate to each other, summarised by Bourdieu as follows:

[(habitus)(capital)]+field = practice (Bourdieu 1984)

While Bourdieu refers to the body as a bearer of value in society, in disability studies a particularly embodied approach to the concept of habitus has been deployed for example as "*habit or typical conditions or appearance, particularly of the body*" (Jenkins 1992,74) and "*ways of talking, of moving, bodily deportment and general demeanour*" (Edwards and Imrie 2003,241). Bourdieu (1989,18), however, notes "*the dispositions of agents, their habitus, that is, the mental structures through which they apprehend the social world are essentially the product of the internalization of the structures of that world*". This internalisation of these social structures and the dispositions of the agents inculcated within the habitus lead to "*a sense of one's place*" and, a "*sense of the place of others*" (Bourdieu 1989,19). So, practice revolves around the habitus; the ways in which "*the body develops habitual ways of relating to broader socio-political environments and relations*" (Edwards and Imrie 2003,242).

In addition to experiences and background such as education, class status and social position (Lee and Kramer 2013), physiotherapy habitus includes experiences of professional education and socialisation within physiotherapy programmes and the NHS; habitus is clearly identified as a product of socialisation (Adam and Wright 2014). The development of habitus is a reciprocal process in which individuals subconsciously embody and in part create the social structures of their world through everyday interaction in it (Smith 2014). As a product of social conditioning habitus is either:

*"transformed in a direction that reinforces it...or in a direction that transforms it and, for instance, raises or lowers the levels of expectations and aspirations"*  
(Bourdieu 1990b,116)

Habitus has a certain amount of inertia and tends to reproduce itself (McDonough and Polzer 2012); it is not immutable, but a fluid set of dispositions that change as individuals have new experiences and interact within new fields (Lee and Kramer 2013). These dispositions are durable and transposable; active within a variety of ‘theatres of social action’ (Bourdieu 1990, Maton 2008). Within these theatres, here we would consider institutions related to education and their integration with healthcare settings, objectives, rules and norms are established but they do not translate directly into people’s actions, they take on practical form in the habitus. The practices of the habitus are produced by, but also produce and sustain, the social field (Edwards and Imrie 2003). As Bourdieu (1990,172) suggests:

*“inscribed within...dispositions of the habitus is the whole structure of the system of conditions, as it presents itself in the experience of a life-condition occupying a particular position within that structure. The most fundamental oppositions in the structure (high/low, rich/poor etc) tend to establish themselves as the fundamental structuring principles of practice.”*

Edwards and Imrie (2003,244) note;

*“dominant classes, because of their greater access to, and possession of, cultural and social, capital have the ability, as Bourdieu (1990) argues, to define their bodies and lifestyles as superior”.*

Applying this to disability and physiotherapy, considering the ‘fundamental opposition’ of disabled/non-disabled; disabled people’s bodily status is constrained by societal views (in this case largely biomedical) which regard disabled bodies through a deficit lens, categorising them as abnormal, in need of cure or rehabilitation. The medical profession has a powerful hold over what society deems to be a ‘legitimate body’ and as Bourdieu (1990,69) notes *“symbolic power works partly through the control of other people’s bodies”*. Inequalities that result indicate disabled bodies as being of less value. This habitus may translate into the approaches of physiotherapy educators to disabled students who do not fit the expected image, disrupting accepted notions of education. Reactions to disabled people are often unconsciously learnt and so may be unthinking and spontaneous; Bourdieu (1977,79) refers to this habitus as behaviour related to the thoughtlessness of habit and habituation. If change is to be enacted this ‘thoughtlessness’ needs to be challenged; descriptions of the disabled body as broken or incompetent are not immutable but reflect context-specific interrelationships between bodily expression and social structure and agency (Bourdieu 1990).

### 5.3.4 Doxa

Bourdieu used the term *doxa*, an embedded notion unconsciously believed and practiced (Adam and Wright 2014), to distinguish it from orthodox or heterodox beliefs in which there is an *“awareness and recognition of the possibility of different or antagonistic beliefs”* (Bourdieu 1977,164). In the ‘doxic’ mode there is immediate adherence to tradition, experienced as a natural and taken for granted world, so practices come to be naturalised and relatively unquestioned.

New entrants to a field are selected and shaped *“such as to obtain from them that undisputed, pre-reflexive, naive, native compliance with the fundamental presuppositions of the field which is the very definition of doxa”*. Entry to this ‘magic circle’ can only occur by a slow process of initiation and involves *“the pre-verbal taking-for-granted of the world that flows from practical sense”* (Bourdieu 1990a,68). Bourdieu (1977) talks about incumbents of the field who have a ‘feel for the game’, who are interested in it, invested in its outcome and committed to its presuppositions or its doxa, leading to mastery and ‘sensible’ practices having the effect of *“consensual validation which is the basis of collective belief in the game”* (Bourdieu 1977,164). There is a line between ‘the field of opinion’ where practice is questioned and the ‘field of doxa’, where it is beyond question with tacit agreement by all involved being indicated by the fact that they act in accord with social convention (Bourdieu 1977).

*Doxa* is a useful lens through which to consider physiotherapists’ views of disability and how they approach disabled students’ learning experiences. Arguably physiotherapists’ doxa concerning disability involving embodied notions of client as disabled and therapist as non-disabled overrides their theoretical knowledge about equality and diversity in relation to disabled students because it is born of habit, practice, culture and history.

### 5.3.5 The field of practice education

Educators’ habitus in relation to pedagogical and physiotherapy practice forms through everyday contact with disabled clients and non-disabled students. Their choices and behaviour are likely to be linked directly to their practice; efficiency and competency in prioritisation and management of clients rather than student learning and support. These principles and practical sense enable them to get their jobs done, their sense of agency is not predicated upon notions of pedagogy or inclusive practice. This may relate to their approach to pedagogy and its priority within their other roles with links to the often

reductionist biomedical experiences of education and practice which in turn become habitus and doxa about disability and pedagogy within the clinical setting (Adam and Wright 2014).

Because students and educators are situated within biomedical learning experiences, arguably these take precedence, being more firmly inculcated than more recent notions of inclusion, widening participation and diversity, which while embedded within the NHS constitution and the policies of HEIs and the NHS, are not central to their habitus. It is challenging for disabled students (and possibly their educators) because of the field in which they are immersed, to become critically aware of their true situation and to intervene in its reality, to take charge of it. They belong to a 'culture of silence' having little capital in relation to clinical colleagues and so are relatively powerless. Arguably because students are submerged in their situation, have no voice and could be viewed as absent (Crotty 2003), the clinical educational setting may become a site of struggle. Bourdieu's ideas may help to illuminate the fundamental predispositions of physiotherapy practice and healthcare education, perhaps enabling understanding of the social dynamics involved in structuring of educators' and students' habitus.

The habitus of practice educators evolves while the contextual field in which they exist (the clinical setting) evolves, according to its own logic, (possibly involving elements of policy change, levels of available resources and technological advances) and is contributed to by the practitioners themselves (Maton 2008). Within this field, traditional relationships exist between students and educators as well as between disabled and non-disabled individuals. Deeply influential beliefs are held about disability and the 'correct' relations between disabled and non-disabled or therapist and client. There are also broader traditions and politics present in the field of the NHS and issues concerning the way in which the body has been framed historically, philosophically and socially. Intentionally constructed social structures (e.g. organisations) often have unintended effects that may not be evident to the social actors themselves (Gorski 2013). Investigating the seemingly innocuous behaviours and discourses that result can reveal something of the power dynamics within societies at both individual and societal levels. The work of Bourdieu provides a lens that helps to understand educators' practice. The concept of habitus illuminates how individual practitioners and their practices in relation to disabled students can be unconsciously influenced by their immersion in biomedical cultural practices within healthcare.

The clinical setting can be viewed as a community with its own hierarchy based on specific areas of practice knowledge. Within this community are individuals with different qualifications and competence leading to different capital and habitus (Morberg et al 2011). Mooney, Smythe and Jones (2008) explored how a Bourdieusian perspective provides insight into the spatial positioning of stakeholders and their capital within clinical education. This influences relationships, becoming a source of tension particularly for educators who are crucial for student learning and yet may be sensitive to this tension due to their positioning in relation to clients, students, managers and academic staff. They are still, however, part of the dominant culture which projects its values and beliefs about disability using social structures and drawing on capital; a practice of cultural reproduction (Adam and Wright 2014). Possession of capital grants power and privilege to the 'dominating team' giving agents (the educators) a higher status in relation to disabled students who, at least initially, have little capital. Accepted principles imposed by the clinical field are often different to those developed by students through previous experiences or backgrounds and can result in a mismatch between these sets of values (Sanders 2014).

Arguably disabled students may feel out of place in the clinical field, being expected to fulfil conditions and internalise and exhibit practices constituting the cultural capital tacitly required of its occupants. If students' own cultural capital is not valued and there are barriers to them becoming acquainted with the required capital, they may feel excluded from the field. Educators themselves, who have qualifications in health-related areas not related to an educational purpose, may struggle to prioritise students when education is not the main task of the therapy setting (Morberg et al 2011). There is an expectation that students will comply with the preconceived methods and standards required, that is as noted, the *"undisputed, pre-reflexive, naive, native compliance with the fundamental presuppositions of the field which is the very definition of doxa"* (Bourdieu 1990a,68) rather than there being a willingness to consider modification of systems and expectations as appropriate to celebrate diversity (Sanders 2014).

A range of factors are relevant here: relative levels of capital and power of educators, students and clients within the clinical field; the interactions of these social actors embedded within the largely medicalised field of healthcare; and a lack of opportunity for reflective activities related to these issues. Arguably these factors result in specific habitus

that becomes unquestioned and hence doxa within the field of practice education, leading to a continuation of embodied pedagogical and therapeutic practices with little reflection upon different ways that these could be approached.

## 5.4 Changing practice

The question here is what, above and beyond an understanding of the issues, will enable others to enter into a dialogue that is critically reflective and will influence practice?

Change is perceived as challenging and may be particularly so within the daily struggles of clinical practice, where education of students is not the main task. Habits are generated in the context of the groups in which individuals are embedded and interactions within those groups. Crossley (2013,158) asks:

*“Do the habits which cluster together and characterise particular groups manifest a consistency which, in turn, signals their attachment to a deeper orientation towards the world?”*

Arguably, as a person becomes a physiotherapist s/he is socialised into a specific way of being as a result of experiences and internalisation of the physiotherapy identity. Perhaps certain types of people, with a particular orientation to the world, are attracted into the profession. In either case influencing physiotherapists’ habitus and doxa in relation to disabled students will be a challenge.

Recently the profession has begun to take a more critical turn with the formation of an international collaborative Critical Physiotherapy Network (CPN) made up of:

*“critically-informed academics, clinicians and researchers who draw on the health sciences, social sciences and the humanities to explore, challenge and develop physiotherapy theory and practice. The Network is founded on the belief that the physical therapies can make a much more valuable and significant contribution to the lives of people today than the historically and socially self-imposed limits that the profession currently allow” (CPN 2015)*

It is hoped that working through such active, internally emerging networks, both virtually and in person, will provide opportunities to disseminate ways of thinking differently, revealing and enabling recognition of specific issues regarding disability. Having said this, I am cognisant of the fact that it is difficult to challenge these taken for granted notions. Bourdieu (1984,424) notes that agents of change are *“forced to spell out their heretical opinions in broad daylight, in defiance of the doxa, the ordinary acceptance of the usual order which goes without saying and therefore usually goes unsaid”*. This work could

therefore, in Bourdieusian terms, be viewed as 'heretical'; saying the unsaid, with the aim of defying the doxa to encourage educators and disabled students to enter into dialogue and to provide opportunities for reflection which could lead to change in practice.

## Chapter 6 - Methodology

This chapter provides a description and justification of the methodology used in this study which made use of an interpretative phenomenological approach through the medium of semi-structured interviews with eight physiotherapy practice educators. The interest was to explore their experiences of supporting disabled physiotherapy students in the clinical setting. Preliminary work was carried out via an online questionnaire to provide an overview of relevant issues and to extend an invitation to participants to take part in the interviews. Analysis of questionnaire responses informed the research questions and qualitative methods used in the substantive study. The focus in this work is the analysis of the interview transcripts – information regarding the questionnaire and its analysis is provided in Appendices 1 and 2.

Before moving on to the design and methods used in this study, the next section outlines the approach taken in relation to the main data collection and analysis.

### 6.1 Approach

#### 6.1.1 Phenomenology

Interpretative phenomenology is a version of phenomenological research methods concerned with hermeneutics and is an ideographic approach (Langdrige 2007; Willig 2008) enabling the researcher to explore participants' experiences<sup>3</sup>, gain insight into, and understanding of, the ways in which people perceive, interpret and explain their world (Stenner et al 2017). It is concerned with how people make sense of and draw meaning from those experiences. The intention is that, as far as possible, experiences are articulated in their own terms, not in relation to predefined categories. Participants are experts on their own experiences, providing researchers with understandings through their accounts of these (Smith et al 2009). As noted in Chapter 5, with the research being framed by phenomenology, interviews were used as an appropriate way to access and describe participants' 'life worlds' (Koro-Ljungberg et al 2009). Description of things "*in their appearing*" (Finlay 2009,6) was at the core of the research with a focus on the lived

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<sup>3</sup> Ideographic - focused on the particular and on detail: involving deeper analysis, aiming to enable understanding of how a particular experience is understood from the perspective of a particular person in a particular context.



experience (Gee 2011) of participants' habitus and field and their attempts to make meanings of these (Langdrige 2007; Smith, Flowers and Larkin 2009).

Hermeneutics is concerned with interpretation. In this study, there was a double hermeneutic: the researcher interpreting the participant's interpretation of their experience. This hermeneutic circle enabled exploration of the dynamic relationship between the part and the whole at a range of levels, trying to understand the phenomena that emerged along with interpretation of practice (Koro-Ljungberg et al 2009, Stenner et al 2017). This iterative approach facilitated exploration of different perspectives in relation to meanings within the data. The aim was to have an insider perspective but also to be able to look at the participant from another position (Smith et al 2009), so acknowledging the active role of the interpreter (Gardiner 1999) and that within this approach all interpretation is a 'view from somewhere' (Kinsella 2006).

### 6.1.2 Critical hermeneutics

The phenomenological approach was useful in guiding the analysis, however, due to the nature of the data emerging from the interviews, it became evident that insights offered by critical perspectives, which can be used to inform hermeneutic enquiry, would be helpful in understandings in this study. Some of the issues of interest concerned power, language and the acknowledgement of 'the fix we are in' (Kearney 2003, Kinsella 2006) in relation to the apparently unchanging state of affairs *a propos* support of disabled students. This approach allowed a more critical interrogation of the participants' accounts to gain further insight into "*its nature, meaning and origin*" (Willig 2008,63) particularly in relation to how the accounts were shaped by field, capital, habitus and doxa.

Interpretation was iterative in nature; the critical lens providing an alternative but complementary way through which to view the data. This second level of interpretation aimed to position initial description within cultural, social and sometimes theoretical contexts, asking critical questions of participants' accounts and exploring their personal 'sense-making' activities (Smith and Osborn, 2008). I acknowledge that this critical hermeneutic interpretation is more tentative and speculative than the earlier empathic and descriptive level so providing an opportunity to "*think about 'what it means' for the participants to have made these claims, and to have expressed these feelings and concerns in this particular situation*" (Larkin, Watts and Clifton 2006,104). Whilst this approach enriched the analysis and generated new insights and a deeper understanding of

participants' experience, it was crucial to be reflexive about the presentation of an alternative narrative which differed from the participant's own account of what was going on (Willig and Stainton Rogers 2008).

This level of interpretation proved to be a good 'fit' with participants' accounts of their practice in relation to their experiences and the frameworks of power in which they worked.

### 6.1.3 Thoughts from critical disability studies

As noted during reflection on the developing analysis, a critical perspective was felt to be appropriate in informing the enquiry. Critical theories:

*“produce and convey critical knowledge that enables human beings to emancipate themselves from forms of domination through self-reflection”* (Wodak and Meyer 2009,7).

Ideas from critical disability studies were useful in illuminating the relationship between the role of discourse and the (re)production of dominance (van Dijk 2009). Arguably the exercise of social power by institutions and groups (i.e. the NHS, HEIs and professionals working within these fields) may result in inequalities in relation to the position of disabled students within those fields. Possibly, the participants themselves, being part of the NHS environment, experienced inequality because of the macro-notion of institutional power (Lukes 2005).

While the participants probably would not consider themselves in need of emancipation, perhaps the often-reductive biomedical systems in which they were embedded had a dominant effect on their thinking, attitudes and behaviour. In the case of both disabled students and practice educators, the inequality experienced because of powerful institutional discourses could be viewed as being jointly produced: the dominated groups being persuaded that the dominance is natural and legitimate leading to a situation in which 'bottom up' challenge and resistance is not considered or thought to be appropriate (van Dijk 1993). The powerful effects of discourses such as the medical model cannot necessarily be *“interpreted as conscious and manipulative in intent”* (Jager and Maier 2009, 39). Arguably, they are so ingrained within society and healthcare that they become accepted unquestioningly as doxa. Exploring these issues was helpful in the analysis; the critical lens providing a more socio-political stance. It became important to analyse

participants' narratives in the light of broader social frameworks and to *"relate properties of discourse with these underlying, socially shared, representations, which group members use as a resource to talk about members of other groups"* (van Dijk 2009,78). The process was reflexive, involving much conscious thought and discussion about what participants meant and why they said what they did. I hope that the outcomes of this might contribute in some way to providing a platform to affect change in physiotherapy practice through critical understanding.

I think that it is important to acknowledge the development of my understandings as I moved through the different elements of the study, from initial conceptualisation, to fieldwork, analysis and throughout the writing up period, with a focus on the deployment of Bourdieu's social theory of practice in the consideration of my participants' accounts.

## 6.2 Methods

### 6.2.1 Literature review

Because of my previous work and experience I was aware that there was no well-defined body of literature related to the specific area of practice explored in this study. This meant that it was necessary to search widely across subjects and genres.

#### Literature search

This comprised two stages:

- i) an initial search investigating literature related to the study to ascertain whether research had been carried out in similar areas of practice.
- ii) a second search following interviews and during analysis; an iterative process involving identification of relevant search terms related to emergent themes.

Initially the following databases were accessed: Cumulative Index to Nursing and Allied Health Plus (CINAHL) and the Educational Resource Information Centre (ERIC). Key words used were 'physiotherapy', 'disabled students', 'practice education' and 'reasonable adjustments'. CINAHL Plus returned 968 articles filtered by date and English language, written between the years 2000 and 2015. Once filtered by major headings (excluding articles relating to client care and schools) this reduced to 8 relating mainly to nursing education with none pertaining to disabled physiotherapy students. ERIC returned 46 articles relating to disabled students in HE with none addressing disabled students in

healthcare education. The search was widened to the Scopus database adding the terms 'work placements', 'higher education' and 'disclosure'. This produced some results as it accessed specialist journals such as *Physiotherapy, Disability and Society* and *International Journal of Inclusive Education*.

Even with the widened remit, related literature was limited; consequently, the search became an iterative process, following the first round of analysis and continuing as the analysis unfolded, in response to the emerging themes. This was carried out by referring to a wide range of specific healthcare professional journals such as those from physiotherapy, nursing, social work, occupational therapy and radiography (from English speaking, high income countries), and those relating to education and disability. Google Scholar was used to widen the search beyond healthcare and education particularly as it was found that the disability literature tended to be scattered.

### Literature analysis

i) Initially this focussed on positioning the current study in relation to existing work. This provided background and contextual information about physiotherapy education and an overview of the limited work which, at that time, had been carried out regarding disabled healthcare students and their educators in placement settings.

ii) As data analysis continued, the literature analysis took a more critical perspective as themes emerged. The main areas of interest were disablism and ableism; power and professional identity; disability identity; and the permeating theme of 'disclosure' relating to issues concerning communication of sensitive personal information. The theoretical considerations discussed in Chapter 5 guided this analysis and theme identification using the concepts of habitus, capital, field and doxa and drew on ideas of power relationships in the practice setting. Parallels were drawn with emancipatory literature emerging from gender studies and queer theory.

## 6.2.2 Fieldwork

### Preliminary questionnaire

As noted preliminary work took place through the medium of an online questionnaire. This was largely 'academic' in Robson's (2011) terms; trying to find out something about what is going on in the world; in this case the world of practice education related to disabled physiotherapy students. Questions were governed by the purpose of the study which was

to identify the experiences of practice educators. The questionnaire, distributed electronically via SurveyMonkey, was anonymous to facilitate participants to provide frank opinions and to combat influences that the researcher's position or perceived relationship with them might have had on their responses.

There was a low (15.5% n = 113) response rate; nevertheless, the responses provided useful preliminary contextual information (see Appendix 2) and sensitisation to areas that could be explored in the interviews. The inbuilt analysis and categorisation features of SurveyMonkey were used to obtain descriptive statistics and to collate responses to the open questions. Administration of the questionnaire also provided an opportunity to invite participants for interviews.

## Qualitative study

### *Use of interviews*

Interviews are a recognised mode of enquiry in qualitative research commonly utilised when a researcher is interested in individuals' accounts, aiming to understand the meaning that people involved in situations and/or with particular social issues make of their experiences. Interviews deal with thinking and talk involving shared cultural knowledge which is subsequently transformed into text (Alsaawi 2014). The often changing historical, cultural and social contexts, in which participants find themselves, influence how they think and talk about social objects. Similarly, these contexts influence the ways in which researchers write about their findings (Alex and Hammarstrom 2007).

It is acknowledged that the narratives/discourses provided to the researcher are influenced by the interview situation and can be affected by power positions within the interview. These positions can be seen as shortcomings although both researcher and participant have some power; the former as someone with knowledge/methodological expertise and the latter as a privileged 'knower' (Alsaawi 2014). As with context, power positions can be created and may shift in the interview necessitating reflexivity on the part of the researcher to attempt to minimise the effects of this (Alex and Hammarstrom 2007).

Different perspectives may be taken in relation to the same event; the situations described and commented upon by participants depending upon the context of the interview, the listener and the intentions of those involved in the process (Alex and Hammarstrom 2007). Inevitably, therefore, responses to questions are the result of an interactional process

between researcher and participant. I acknowledge the fact that it was not possible for me, as the researcher, to be 'neutral'. Consequently, for the interview process to be ethically acceptable, I took account of the power relations and my positioning within the various discourses (Gardiner 1999, DeLuca 2000, Kinsella 2006).

An appropriate way to access the experiences of practice educators in supporting disabled students was by asking the physiotherapists themselves. Semi-structured interviews were conducted in an informal manner, permitting the conversation to develop within areas of interest (Robson 2011). It was important for me to engage with the participants and their issues, to listen attentively and to probe in order to arrive at data appropriate for analysis. Whilst I provided some focus particularly at the beginning of the conversation in the light of the questions formulated after analysis of the preliminary questionnaire; participants' concerns acted as a steer for much of the encounter. As highlighted by Smith et al (2009) these unexpected turns in the conversation were valuable as they provided information that was of significance to the participants.

#### *Interview guide development*

Following analysis of the questionnaire an interview guide was developed (Appendix 4) enabling me to think explicitly about what issues might be covered in the interview. This helped to provide a plan for any difficulties that arose such as how to phrase complex questions. It facilitated the interview process if participants were less forthcoming or preferred some structure. I identified possible prompts to encourage more extensive exploration of certain points or to move the interview on if it became difficult or 'stuck'.

#### *Interview participant selection*

Questionnaire respondents were asked to indicate whether they would be willing to take part in interviews; ten offered to participate. This was essentially convenience sampling given the time constraints of the study. The final number interviewed was eight, comprising a mixed group of experienced practice educators from a range of NHS settings in the South East of England.

#### *Data collection*

The eight participants were contacted in February 2012 to reassure them that their details had been received. As the preliminary questionnaire was being used to inform the interview schedule they were notified that they would be contacted in April 2012 to arrange an appointment. Interviews were carried out at participants' workplaces where

they were able to book quiet rooms, during July/August 2012, at mutually convenient times. Interviews were recorded using a digital voice recorder. A short introduction was followed by an opportunity for participants to talk freely about the issues they felt important about supporting disabled students. Emergent themes from the questionnaire were introduced if necessary to explore their relevance to participants.

### *Data analysis*

Audio-recordings were transcribed. It is recommended that the researcher transcribes the interviews in person to become familiar with, and immersed in, the data so providing a good basis for the subsequent analysis (Smith et al 2009). Due to time constraints and work pressures this was not possible for me and the interviews were transcribed by an external company. I acknowledge as noted by Tilley (2003) that this can influence or introduce interference into the analysis process and that I could potentially have 'missed out' on certain understandings by not carrying out transcription myself. My analysis comprised multiple readings of the transcripts, however, while undertaking concurrent review of the audio-recordings. This enabled me to become immersed in the data and extremely familiar with the text which facilitated my analysis.

I analysed the transcripts on a case by case basis in line with the idiographic approach of the interpretative phenomenological methodology, focussing first on the most detailed and engaging interview, as recommended by Smith et al (2009), I then moved on to the rest of the interview transcripts. I engaged intensively and in detail with the individual transcripts and then integrated these in the later stages of the research (Willig 2008). I listened to the recordings whilst reading the transcript to focus on the participant. As noted I read the transcripts multiple times while examining language and content and making notes of interesting points, exploratory points and comments. More interpretive noting was then developed, regarding how and why participants had certain concerns and issues and subsequently more abstract concepts were identified (Smith and Osborn 2008, Smith et al 2009). Using this approach, I was looking out for elements that would enable me to develop an understanding of participants' experiences.

I worked on description and interpretation, identifying themes whilst being mindful of the hermeneutic circle and my preliminary assumptions about what I was trying to understand (Willig 2008). In this hermeneutic process of meaning making the parts can only be understood in relation to an understanding of the whole interview and the whole can only

be understood from an understanding of the parts (Schmidt 2006). To enable understanding it was crucial to reflect the original words found in the transcripts and to relate these to the interpretations made during analysis; a circularity from presupposition to interpretation and back again, testing these presuppositions in the light of the meaning that was emerging regarding what I was trying to understand (Langdrige 2007, Willig 2008, Smith et al 2009).

After the noting mentioned above I identified conceptual themes trying to *“capture something about the essential quality of what is represented by the text”* (Willig 2008,58). At this point it was necessary to introduce structure into the analysis, thinking about the conceptual themes in relation to one another and to organise them into related clusters which then became overarching themes (Smith et al 2009). It was important to review these themes to ensure that they made sense in relation to the original data, moving back and forth between the themes I had identified and the transcripts that had generated them (Langdrige 2007, Willig 2008). This process was repeated for all interview transcripts. Once completed, overarching themes across cases were examined to identify patterns and higher order concepts which they shared as well as examples of divergence (Smith et al 2009).

In trying to understand the phenomena, and due to ideas emerging from the analysis of the interviews, the insights offered by critical perspectives, were then used to inform the hermeneutic enquiry (Kearney 2003, Kinsella 2006). I came to view the data through the lens of the Bourdieusian framework, as discussed, and it appeared that participants’ accounts were influenced by the field in which they were immersed as well as their capital and habitus within this field (Bourdieu 1977). This Bourdieusian framework was, I think, invaluable in positioning the analysis in relation to the wider socio-political landscapes of HE and the NHS.

The work of identifying themes and organising the data continued until no further new themes emerged. Themes and categories from the questionnaires and comments from different participants provided comparisons and corroboration (Smith et al 2009). This enabled the development of abstract analysis but also information which may illuminate practice and provide stimulus for debate going forward.



## 6.3 Trustworthiness of the study

Trustworthiness is an important consideration in research relating to the extent to which it is acknowledged to be sound, acceptable and convincing by people with an interest in the findings such as other researchers, policy makers, practitioners and in this case the participants.

It was important that this work was assessed against appropriate qualitative criteria and not against those routinely used to evaluate the reliability and validity of quantitative research. The use of criteria such as credibility (degree of fit between participants' accounts and researchers' interpretations), transferability (generalisability; not of the sample as in quantitative terms but of the study's findings), dependability (logical, documented, traceable procedures) and confirmability (findings being linked to the data) have been used to connote trustworthiness of qualitative research (Padgett 2017). Linked to these criteria, Yardley (2008) articulated four principles that are useful in assessing the quality of qualitative research providing a sensitive and appropriate approach. These principles can be seen in Table 1 where I also provide examples and explanation of the ways in which I engaged with these to ensure transparency and trustworthiness.

It is important that the analysis has integrity and internal coherence and does not contain major contradictions. I paid attention to deviant case analysis or disconfirming instances (Yardley 2008) to show that I was considering participants' comments and opinions that were exceptions to those more generally expressed. During the process of analysis, I constantly returned to participants' accounts to ensure that my interpretations were a good fit and linked clearly to the data; this was confirmed in my discussions with colleagues undertaking similar work and with my supervisor. The procedures undertaken during the analysis were iterative but logical and these have been documented and again overseen by my supervisor. In terms of transferability, I do not make any claims that these results can be generalised to other groups of participants and yet there are parallels that can be drawn with other qualitative research. Particularly that relating to groups from minority backgrounds and the experiences of those involved in education settings. It is acknowledged, however, that it is only when research is read that it becomes apparent whether it is contributing to insight and understanding (Willig 2008).

## **6.4 Ethical issues**

Ethical guidelines were reviewed and adhered to (University, British Educational Research Association (2011)).

### **6.4.1 Confidentiality/anonymity**

Potential participants were contacted through the database of practice educators linked to the home university and not through their NHS workplace. If they chose to respond to the questionnaire neither they nor their place of work could be identified from their submission to SurveyMonkey. All digital records and computer files were kept securely, and it was not possible to identify participants as individuals or any places of work/institutions mentioned in the questionnaire responses. Interview participants were referred to via letters/numbers to protect identities. Digital records and computer files were kept securely. Furthermore, the write up ensures confidentiality and anonymity for participants, NHS outlets in which they worked and universities to which they may have referred. No individuals or institutions are identifiable.

### **6.4.2 Informed consent and right to withdraw**

Interview participants were provided with an information sheet and asked to sign a consent form prior to taking part (see Appendix 3). They were informed that they could ask for the recorder to be turned off at any time during the interview, that they could access both transcripts and analysis of the interviews if they wished and that they could withdraw from the study at any time.

### **6.4.3 Secure storage of data**

Audio data were temporarily stored on the digital recorder and was locked away when not being used. Audio and Word Files sent to and from the transcription service were password protected. Once materials had been transcribed the audio data was deleted. All data files were stored on my computer and password protected. Once the research is complete, original data will be deleted from any computer files and paperwork will be shredded. No-one else has access to it.

### **6.4.4 Power relations**

In any research involving human participants there is the risk of harm. I was cognisant of the power relations and my positioning in relation to the participants and ensured that the study only addressed issues with which they were willing to engage. There was no coercion to discuss anything with which they felt uncomfortable.

**Table 1 Principles for evaluation of quality in qualitative research (Yardley 2008)**

<b>Principle</b>	<b>Key factors</b>
Sensitivity to context	I searched for theoretical, relevant literature, collected empirical data, focussed on the socio-cultural setting, identified participants' perspectives and was cognisant of ethical issues
Commitment and rigour	My engagement with the topic was in-depth and I ensured methodological competence/skill, thorough data collection and focussed on depth and breadth of analysis
Transparency and coherence	My description and argument are clear, methods and data presentation are transparent. I have focussed on good fit between theory and method and spent much time reflecting upon my methods and analysis to feed into coherent discussion/conclusions
Impact and importance	I believe that this work has theoretical importance (enriching understanding), socio-cultural importance (changing society) and has practical implications (for community, policy makers, practitioners)

## 6.5 Limitations

There are limitations to this study. The number of interview participants was small. Ideally, I would have liked to have sampled from a range of potential participants. This would have enabled me to select according to criteria such as geographical location, clinical area, length of experience as a practice educator, amount of experience with disabled students and universities with which they worked. In the event, ten questionnaire respondents offered to take part and eight participated. Due to these low numbers, as noted it is not possible to generalise to the whole physiotherapy practice educator population and indeed there is no intent to do this. Responses were subjective and yet similarities were identified in the accounts in relation to participants' experiences and thoughts about supporting disabled students.

The skills of the researcher in conducting interviews and the interviewer's position in relation to the participants can act as a limitation in this type of research. I have previous experience of conducting interviews and utilised the guide consistently allowing the conversation to flow as naturally as possible in order for participants to feel comfortable. I acknowledge, however, that all participants knew that I am an academic involved in the support of disabled physiotherapy students. This could have influenced the amount or nature of information they were willing to share. Three respondents were also ex-students and they may have agreed to be interviewed because of this. It is possible that this could have influenced their responses although they all qualified at least 10 years prior to the interviews taking place.

It was not an objective of the research to be generalisable to all practice educators in the UK but to explore an area which had had little attention paid to it in the literature. It was intended that the results could contribute to the body of knowledge and act as a stimulus for debate.

## Chapter 7 - Findings from Interviews

This chapter presents the findings of the study. The data is arranged thematically illustrating elements that, on detailed reading, appeared to be the most important from participants' accounts in relation to perceptions of, and thinking about, their interactions with both disabled and non-disabled students. Findings allude to participants' reports of their understandings and beliefs about disability from their personal standpoints as well as in relation to their positions and responsibilities as physiotherapists and educators. The narrative within this section includes description but also interpretation and an initial critical stance to the data that is further developed in the discussion where I return, more explicitly, to issues related to the Bourdieusian conceptual framework outlined earlier.

### 7.1 Introductory points

#### 7.1.1 Links to preliminary questionnaire

Results from preliminary questionnaire underpinned the development of the interview schedule, having provided context and some sensitisation to potentially important areas for exploration. The questions formulated for the interviews were open to encourage the participants to talk at length (Smith et al 2009), the first question being designed to encourage them to talk freely about supporting disabled students in a largely descriptive manner. Subsequent questions related directly to the issues identified as important by questionnaire responses and used as prompts to explore participants' experiences if the conversation did not lead to these naturally. In the event, participants addressed many of the issues that emerged from the questionnaire findings and the conversation was able to become more exploratory in nature.

Accounts relate to participants' supervision of students with a focus on encounters with, and thoughts about, disabled students. The narrative that emerged from the analysis was complex with both discrete and overarching themes; quotes from participants are used to illustrate these and further exploration takes place in the Discussion. Themes that emerged were organised in the following way:

Theme 1: Pressures and placements

Theme 2: Educator needs and perceived lack of support

Theme 3: Perceived student challenges

Theme 4: Disclosure - communication and honesty

Theme 5: Understandings of disability

Theme 6: Educator responsibility

The narrative appeared to flow best by ordering the themes in this way. It is important to emphasise, however, that 'disclosure' and 'understandings of disability' permeated all participants' accounts, emerging as key themes in themselves but underpinning the whole of participants' narrative. Arguably this goes some way to illustrating participants' habitus which may emerge from a taken for granted world of physiotherapy (doxa) relating to the ways that practices, in this case pertaining to disability, come to be naturalised and relatively unquestioned (Bourdieu 1977).

### **7.1.2 Participants**

Participants were experienced senior physiotherapists working in a range of NHS settings in the South East of England (Table 2). They had between eight and twenty-five years of experience supervising students and had all supported disabled students. Two participants were male, six female and one participant shared information about her own disability.

All participants other than P<sub>6</sub> were based in hospitals, four worked for some of their time in the community (this was variable, for example in clients' homes, schools or community settings such as leisure or community centres).

## **7.2 Theme 1: Pressures and placements**

This theme highlights challenges for participants in arranging student placements. Factors included increased work pressures and the, perhaps unfounded, assumption that the presence of students in clinic necessarily means a reduction in 'productivity': understood as students diverting services away from patients (Stiller et al 2004).

The perception that disabled students took more time and effort than other students was a common thread providing context for the challenges expressed by the participants. Practice educators navigate a complex path, endeavouring to maintain an effective physiotherapy service while also providing a positive and supportive learning experience for disabled students (Mooney et al 2008) within their field of operation.

**Table 2 Participant demographics**

Participant	M/F	Clinical setting	Disability?
P <sub>1</sub>	F	Acute Cardiorespiratory/ITU	N
P <sub>2</sub>	F	Mental Health Trust/Community	N
P <sub>3</sub>	F	Musculoskeletal Outpatients	N
P <sub>4</sub>	M	Musculoskeletal Outpatients	N
P <sub>5</sub>	M	Acute Cardiorespiratory and Neurology/ITU	N
P <sub>6</sub>	F	Paediatrics based in a school/Community	N
P <sub>7</sub>	F	Acute Cardiorespiratory/ITU and Pulmonary/Cardiac rehabilitation (Community based)	N
P <sub>8</sub>	F	Musculoskeletal Outpatients/Community	Y

Demands relating to reduced staffing levels in the face of a static workload were described and reported as impacting on staff, leading to extra pressure:

*“this last year we’ve lost one and a half members of our team...we’re still having to do the same case load”P<sub>1</sub>*

*“we are much shorter staffed than we used to be...time pressures are almost unacceptable...frustration levels go up...P<sub>2</sub>*

This was perceived as more challenging when supervising students:

*“The problem that I have...is that students decrease our productivity”P<sub>3</sub>*

who were expected to appreciate the educators’ conflicting priorities:

*“the pressures of the NHS have definitely increased...you can manage students but they have to understand that this is the NHS...these are our pressures”P<sub>1</sub>*

With regard to disabled students:

*“disabled students...do take...extra time out of your day”P<sub>7</sub>*

The perception that disabled students took more time and effort than other students was a common thread providing context for the challenges expressed by participants in this study. These perceived challenges were, however, occasionally balanced by observations such as:

*“There are pressures of maintaining activity levels... maintaining patient caseloads... but there...are usually ways...you can...accommodate that student”P<sub>8</sub>*

*“they [students] enrich us...they actually improve the department, they absolutely do”P<sub>3</sub>*

Arguably, if physiotherapists are under pressure in carrying out their everyday duties, they are less likely to feel able to take students. If they do, they may have less capacity to provide supportive and effective educational experiences given that education is not the main task of the therapy setting. Students took longer to assess and treat patients and disabled students reportedly slowed this down further:

*“I think having a student...ends up adding to your waiting list...if you’re increasing the support to accommodate any disability, it probably slows that down as well”P<sub>4</sub>*

These issues were perceived as more acute due to changes in the NHS. Previously pressures were not as great and there was more opportunity to devote to students:

*“when I first had students...you would...put the senior two or the senior one aside...to shadow and walk around with this student. That’s long gone...we need somebody to work as it is in real life, providing them with a degree of training alongside that”P<sub>5</sub>*

Expectations of students appear to have increased over time, increasing the pressure to perform at a higher level. Accounts noted that recent changes in the NHS could impact on whether provision of placements would be realistic in future:

*“The new structure does not...support clinical placements...if...jobs become at risk...[and] student placements decrease productivity, they will go”P<sub>3</sub>*

These overarching, mostly generic points, regarding the challenges of taking students into the clinical setting provide context for the findings regarding the relationships and sources of tension that may particularly affect these educators.

### **7.3 Theme2: Educator needs and perceived lack of support**

Overall, participants were able to identify their needs in relation to supporting disabled students but perceived that they were not always supported well to carry out this responsibility.



### 7.3.1 Training

All participants mentioned that training was important in preparing them to support students:

*"[if] we could all go on an educator's course...I think they're really important...should be a number one priority on people's PDPs [Personal Development Plans]"P<sub>7</sub>*

Specific training was wanted to develop the knowledge and skills necessary to support students with additional requirements and to address issues concerning disabled students:

*"one thing that would be really useful...a clinical educator's day on how to support disabled students...all of our staff here...need to go on a clinical educator's course. Do they go on that or do they go on a regular one, being realistic...they probably can only go on one"P<sub>8</sub>*

This need for training was emphasised by all participants, however, when relating back to the pressures they faced, they noted that in the NHS time and resources are limited. Consequently, physiotherapists must be strategic and innovative in their choices of training. A case had to be made with management to attend educator training and was not always supported:

*"my manager...she didn't want me to go on it, I don't know why"P<sub>6</sub>*

Participants' accounts indicated that they rarely met disabled students and recognised that this causes problems when trying to recall information about support strategies:

*"they [disabled students] can be so varied and they come up so infrequently, it is one of those issues that you get taught it, and then it is out of your head"P<sub>2</sub>*

If their contact with disabled students is infrequent, perhaps change in practice regarding support may be slow or may not happen at all.

### 7.3.2 Preparation

Participants thought about ways that they and the students could prepare for placements. Accounts indicated both preferred actions and occasions when experiences were less positive. A common thread was that they wanted disabled students to contact them in advance, although it was clear that only a few did this:

*"those students that do make contact...generally have better placements...I think they're engaged with the supervisor. They also know what to expect"P<sub>5</sub>*

One participant (who identified as disabled) noted she would take the initiative in contacting the student in advance to identify requirements, this reduced pressure and enhanced the placement experience:

*“I’d feel...comfortable...to ring up the student and say, “Okay, I’m...ringing to have a chat about what your needs are”...“And once that...communication had happened, it was...a much better placement...for the student and for us”P<sub>8</sub>*

Another participant, however, had not thought about asking students directly and had not been given any guidance:

*“might not be a bad thing, actually...I mean it’s a simple question isn’t it? “Is there anything we need to do before your placement...anything you’d like us to do?” ...we’ve never been advised to ask...I never have asked”P<sub>4</sub>*

A couple of educators noted they were uncertain of what to do with disabled students because of lack of knowledge and skills, for example:

*“Lack of knowledge about the actual problem itself would be the big thing”P<sub>3</sub>*

The overall impression here is one of uncertainty and a need for support. Intuitively, the university would be considered as a major source of this support, however, participants’ accounts were at odds with this expectation.

### **7.3.3 Expectations of the university**

Participants were uncertain as to what support they could expect from universities that sent students to them. While input from academic staff was welcomed, dissatisfaction with the relationships between the clinical setting, students and universities was evident and instances cited when support was not forthcoming. Preparation for disabled students was hampered by lack of communication with students and academic staff. All participants seemed unsure of their positioning within this dynamic and there was uncertainty about processes involved:

*“whether the university and the tutors would be able to disclose something...if there’s some sort of a pre-placement consent to the sharing of information...to discuss this particular student...knowing whether there is support in place already...being able to have access to support from the educator’s point of view...it would be nice to have some...contact...to discuss any issues”P<sub>4</sub>*

Although they wanted this information, participants had varying understandings of student confidentiality relating to information the university could provide and the need for student permission:

*“and the university won’t disclose it either will they, it’s up to the individual to disclose it”P<sub>1</sub>*

*“I know confidentiality-wise the university can’t advise us unless the student wants to disclose it”P<sub>7</sub>*

If students did not share information (or were unaware that they needed to) and the university did not communicate it, this was felt to present a substantial barrier to the educators’ preparation. They expected universities to be proactive, providing comprehensive support structures:

*“I would expect to have...considerable... support from the university in terms of advice...to be given sufficient notice so I could prepare myself...as much as is possible...that would be the thing that would be the most helpful”P<sub>3</sub>*

They wanted generic information that covered a range of disabilities and the strategies that might be useful:

*“maybe the colleges could make us aware of the type of disabled students...the sorts of things that have helped them...what works, what doesn’t work...information on where to find info”P<sub>2</sub>*

Lack of engagement was noted on the part of academic staff and questions raised as to whether they were positioned to support the disabled student any more effectively than the practice educator:

*“their university tutor, do they have those skills?...It’s a very...specialist area”P<sub>6</sub>*

As noted, all participants wanted notice and information about the student to enable planning, however, most noted that this was rarely provided; this was when problems occurred:

*“if that information isn’t passed on to us prior to the placement, so that we’re aware of what we’re going to have to deal with, that seems to be when the problems arise”P<sub>6</sub>*

Another participant reported:

*"[it's] unfair for the educators to go into a placement blind and not know that there is some sort of a disability" P<sub>4</sub>*

During placement participants reported difficulty contacting tutors who did not always appear to have appropriate levels of awareness of disability issues and/or individual student requirements:

*"his university tutor wasn't really aware...of how severe the problem was" P<sub>6</sub>*

*"the main issues for me have been...that the university was waiting to see...you're never quite sure if it's a problem...then you're halfway through the placement and then you're getting the university involved" P<sub>3</sub>*

### Questioning

Most participants expressed surprise when disabled students arrived without support in place. They observed that students were not performing well and suspected that this could be related to an impairment; accounts indicated disbelief that universities were not aware of these issues:

*"sometimes these students come and you think "Well, haven't the university picked up on this...why has it got to us in their second year? What's been happening before this?"" P<sub>6</sub>*

They suspected that academic staff knew about disabled students' requirements but had not considered their effect on performance on placement. Whatever the reason, the consequence was that reasonable adjustments were more difficult to organise. Feelings of disbelief and irritation were apparent when one participant found that academic staff knew that a student needed support but had taken no steps to facilitate this:

*"the student...let us know, when it became apparent...at that point we said, "...are you happy for us to discuss it with the university?" And they were, like, "Oh, yes, that's fine," and we spoke to the university. And they were, like, "Oh, yes, we knew that." And we're, like, "Well...!" P<sub>8</sub>*

This lack of communication was sometimes felt to be purposeful and unfair; academic tutors avoiding the issues and relying on the challenges of the clinical setting to act as a trigger for subsequent action rather than proactively dealing with disabled students' support needs:

*"I don't feel that's fair necessarily...I think the university has used us quite a lot here...I suppose sometimes they've wanted someone else to have that conversation with the student rather than them. That's how it feels" P<sub>5</sub>*

Staff at the university in question reportedly admitted taking this approach. There may have been many reasons for this, but it could cause extra stress for both educator and student:

*“they’ve held their hands up on a couple of occasions, where they’ve had someone difficult, and they’ve put them here...and they’ll go on that to address the issue”P<sub>5</sub>*

Although academic staff were sometimes identified as being at fault, there was reference to lack of honesty on the part of the student possibly indicating intent to deceive.

Participants did not feel that teasing this out should be their responsibility:

*“I think it’s about giving evidence to their concerns really...they perhaps aren’t quite so sure the student has...been open and honest with them...it would...be nicer...if it wasn’t always landing on our doorstep”P<sub>5</sub>*

### **Academics’ awareness**

One participant felt that academic staff had little awareness of the pressures faced by educators meaning they were unable to provide realistic advice about supporting disabled students in the clinical setting:

*“a lot of the academic staff don’t work in the NHS and that is a problem...it’s very different now and I don’t think...they understand the pressures”P<sub>1</sub>*

While academics not being immersed in the NHS environment did not necessarily mean that they were unable to understand the issues, there was, however, a reported lack of communication. It was questioned whether more collaborative work between the university, educators and students was needed to facilitate the development of equitable solutions:

*“should there be more interaction...between clinical staff and academic staff so that they know what’s real world and what we expect and what they expect?”P<sub>1</sub>*

Participants expected support from academic staff regarding disabled students throughout placements but there was uncertainty:

*“we don’t always get the answers that we want...it all comes back down to what is acceptable and what’s not and what should we be accepting them to do”P<sub>1</sub>*

*““This is what this student’s needs are,”...is there perhaps some negotiation with the university? While we can accommodate this but...that would be difficult to accommodate, and negotiating it. But, again, it’s difficult... because what is a reasonable adjustment?”P<sub>3</sub>*

Educators had clear expectations of the support they required from universities prior to and during placements to prepare and carry out their teaching effectively. While some communication was mentioned, most participants indicated that this was at best, inconsistent and at worst, absent. Any advice provided did not necessarily fulfil educators' expectations, in terms of being too late in the placement or in relation to what was 'reasonable' in the 'real world' of the NHS.

Participants' accounts indicated that in most cases, they did not feel well supported by their local university teams; this felt unfair and undermined their confidence. This illuminates tensions apparent as a result of relationships between students, staff in HEIs and practice educators themselves. While the issues noted in this section specifically concern links with HEIs, many of them also have 'a need for disclosure' as an underlying premise; explored further in section 7.5.

## 7.4 Theme 3: Perceived student challenges

Participants recognised that placements are challenging environments for students particularly in the initial stages. Nevertheless, there were still high expectations when they arrived:

*"when it's somebody brand new...you're...expected to step off the ground running. I think that's...challenging for anybody"*P<sub>6</sub>

This challenge held true even for more experienced 3<sup>rd</sup> year students:

*"It is so hard for them...they need to be at a level where they can jump from A to B ...it is...very challenging for them"*P<sub>2</sub>

As noted, research indicates that students on health-related, vocational programmes experience higher stress levels than those undertaking more conventional degrees. Participants highlighted that increased stress may also be linked with certain clinical fields which present challenges to the students, including the intensive therapy unit and outpatients:

*"ITU...is quite intimidating for anybody"*P<sub>5</sub>

*"in outpatients there's that constant, you've got 20...30 minutes...you need to see x amount of patients per week...students are under pressure in outpatients to do that as well"*P<sub>7</sub>

Participants recognised challenges for students and themselves concerning individual differences related to the specific learning needs of those students they identified as 'other':

*"[it's] not necessarily the disability that's the problem...any student will have their own...learning needs and need for support" P<sub>4</sub>*

*"it is students with different needs that come up [in training sessions] – not necessarily even disabilities but just people that don't fit the normal mould...it's making adjustments for the fact that we're all different" P<sub>3</sub>*

Issues were highlighted including high expectations of initial student performance even if they had not been in the clinical field before. Differing stresses that students experience were recognised, dependent on the clinical area and participants acknowledged that they needed to prepare for managing students with different requirements. Although they reported some appreciation of student challenges, there was a sense in which, the rules of the autonomous field of physiotherapy, the habitus of the educators and their tacit presuppositions about what constituted adherence to the specific activities of the practice placement, meant that to be accepted, students had to conform to the implicitly defined conditions of membership (Bourdieu 1977). Arguably students are expected to comply with the undisputed fundamental presuppositions of the field, that is, to a doxic state, even when they are not aware of these.

## **7.5 Theme 4: Disclosure-communication and honesty**

Participants expected students to be proactive and honest in their communication and to share information about their impairments, believing this to be crucial for them to provide support. This theme of disclosure of disability underpinned and permeated every element of their accounts with one even suggesting that it was an imperative:

*"I think it [disclosure] probably should be compulsory" P<sub>4</sub>*

All participants thought that information sharing was essential prior to the placement to enable preparation for an effective clinical experience:

*"it's so important that we know, because we can then plan...because once...you've got those patients booked in...you're...trying to accommodate a situation that needs more time, it...becomes much more challenging" P<sub>8</sub>*

Perhaps indicating an expectation that students have *a priori* understandings of their requirements, one interview participant imagined the following dialogue as to how disabled students should approach their placements:

*"Hello, I'm so and so...this is what I need on my placement, this is how I cope. Is that doable? Can I bring x, y, and z with me?"P<sub>7</sub>*

They appreciated that the situation was not necessarily easy for students, but on balance felt the information was needed:

*"I would like to think that everybody has a right to keep things private. But...it is their responsibility to be honest...if they start to struggle...it is their responsibility to go to someone and let them know why...I realise that...it isn't easy"P<sub>2</sub>*

Language used suggested that students should be strongly encouraged to share disability information; even indicating that 'arms should be twisted' although this should be done for all the 'right reasons'. These and previous comments indicate attitudes and expectations that are at odds with the legislation and guidelines. Clearly, however, these thoughts and approaches exist, perhaps illustrating a gap between educators' appreciation of the abstract notions of disability and inclusion, and their practice.

If students did not share information, negative outcomes were noted for all involved:

*"if they don't...tell you...they potentially suffer...because the educator can't support them"P<sub>5</sub>*

*"if there was no disclosure with one with a particular form of disability which required us to make...changes...I would consider that to be a real problem...I would feel resentful of the student...and I would also complain to the university"P<sub>3</sub>*

Educators clearly preferred it when students led on the communication:

*"I think it's important to get...from mouth of the student, what their coping strategies are...what they need"P<sub>7</sub>*

Some accounts, however, noted that students reported experiences of direct discrimination on previous placements which could explain their reluctance to share information:

*"I've had some students tell me...horrific stories of placements...I think people think of them as...second class citizens because they have a disability"P<sub>7</sub>*



### 7.5.1 Learning styles

Accounts indicated that one of the key ways in which participants initially engaged in communication with the students was through assessment of learning styles. This reflects the pedagogical approach taken by many academic teams when students commence their programmes:

*“one of the first things we do...trying to work out, “This is what the student’s learning style is. Is that actually their learning style?” Trying to assess that”P<sub>5</sub>*

The stated aim of this approach was to encourage students to become aware of the ways in which they learned to enable them to develop their study methods and work more effectively. All participants were introduced to the concept of learning styles at training sessions provided by academic teams, operationalised as providing a framework for the placement and exploring the students’ learning requirements. Participants indicated that engaging with the students’ preferred ways of learning at the beginning of the placement made the clinical experience positive:

*“We do it...around learning styles...”this is how we manage students here...take...the learning styles questionnaire beforehand...so I can...think a little more, with the strategies that you’ve said...how I’m going to organise your next six weeks””P<sub>5</sub>*

*“we went through the form...this is what you’ll be doing...I had a diary for them...Basically these are the days you’ll be going to the classes...”P<sub>7</sub>*

Student participation was expected, however, as indicated previously, participants tended to focus on ‘What we do’ and how students could fit into that. If, for various reasons, a student did not ‘fit in’ then issues could arise:

*“some of them are really keen...some will do the bare minimum to get by”P<sub>1</sub>*

*“it can be challenging if you don’t crack it and you’re not aware until later on...that’s where the problems come in”P<sub>5</sub>*

Mostly there were assumptions that students engaged in the learning process and were empowered to function at a high level from the start. Additionally, if disabled, they were assumed to know what their requirements were and to discuss their reasonable adjustments related to the clinical setting. As two participants noted:

*“you need to tell us if we’re not giving you what you need”P<sub>7</sub>*

*"maybe even...giving examples of strategies they used" P<sub>6</sub>*

Some participants recognised that disabled students might not be at this stage particularly in relation to reasonable adjustments:

*"when you're a student and you're on placement...you don't always know the answers...you can think, "I'm struggling with this but I'm not sure I know how to get around this.""*P<sub>8</sub>

### **7.5.2 Honesty and building relationships**

Participants noted that part of their role was to develop good working relationships with students to enhance their clinical experience. This comprised various features including: communication, 'detective work', building confidence and devising strategies. These indicated processes of learning through relationship building that permeated aspects of the placement from initial assessment to final outcome.

Styles of communication were mentioned, linked to 'honesty', 'responsibility', 'transparency' and overcoming challenge. This again often related to students communicating their sensitive personal information; expectations that students should be honest and open in their communication about disability in relation to sharing information about their impairments and reasonable adjustments:

*"I think that it's...transparency isn't it, about learning styles and openness?"*P<sub>6</sub>

One participant, working in mental health, focused on her own honesty in providing a supportive atmosphere for the student:

*"honest communication...if you talk open and honestly with somebody, you usually get good results... just caring..."*have you got a problem with this that we need to help you with?"P<sub>2</sub>

This anticipated that disabled students engaged with the idea that impairment could have an impact on their performance and were willing to share information. In most cases there was an onus on the student to take the lead on this:

*"I think it is their responsibility...they don't have to disclose everything, it's up to them what they disclose. But if it's going to impact on their placement and how they learn, I think it's extremely important"*P<sub>6</sub>

There was an appreciation, however, that students may not realise they needed to tell the educators anything:

*"If it's never something they've had to disclose, and they've managed to get to a degree level course then they may feel that they don't need to disclose it, and it's not an issue"*P<sub>4</sub>

Nevertheless, students were expected to know that they should take on this responsibility and the educators should not have to ask directly. This rather oblique way of communicating, in which educators felt that they provided opportunities for students to share information, reinforced the student's responsibility in deciding to take advantage of these opportunities, or not. One participant 'hoped' that her team encouraged this sharing, but if a student did not do this she assumed it was an active choice:

*"we give our students plenty of opportunities to disclose it, I hope...but there's some still don't choose to"*P<sub>1</sub>

When students were 'honest' and 'disclosed' their impairments, educators appeared to be more comfortable and positive; management of the situation was more straightforward:

*"because he's been upfront and honest...it's just easier to manage"*P<sub>1</sub>

If students failed to 'disclose', however, a more negative view emerged couched in terms of lack of honesty and denial. Perhaps participants believed students were purposefully hiding information and being dishonest for some reason. One participant stated:

*"I can't help you...if you're not honest with me"*P<sub>1</sub>

Others felt that students were sometimes 'in denial':

*"this person denied having any extra needs"*P<sub>3</sub>

*"I mean it's hard when they haven't come to terms with it"*P<sub>6</sub>

Participant 3 alluded to this communication as a form of 'confession', identifying that fear of stigma might be an explanation for this behaviour:

*"I think the reason she didn't 'fess up was because of the whole stigma thing"*P<sub>3</sub>

This idea of the confessional nature of disclosure permeated much of the participants' dialogue. It was taken for granted that students *should* talk about disability and the implications of their impairments for educators to provide effective learning experiences. These comments appeared to be aligned to the view that once a 'condition' is identified, 'problems' can be more easily solved and managed:

*“once we’d sat down with her and she disclosed to us that she’d had a breakdown, it was fine”P<sub>7</sub>*

*[student said] ““I suppose I should tell you it’s my dyslexia” ...I was like...right, brilliant; we can do something about that.”P<sub>3</sub>*

Mostly, however, educators seemed uncomfortable and reluctant to ask direct questions; it is possible, therefore, that students did not realise that opportunities to share information about impairments were being offered. If they provided information part-way through the placement the expectation was for a swift and informed response from university staff to enable educators to manage the situation:

*“Early response and although the students don’t necessarily disclose, the university usually would know if there’s likely to be a problem...or more challenges”P<sub>3</sub>*

When disabled students did not share information, participants indicated that they had to deduce relevant issues from observation of their behaviour. They were uncertain about whether to investigate and if they decided to, they were not sure how to go about it. They felt they needed to know about the student’s requirements to provide effective support, however, they were not confident about what to ask:

*“[it’s] really important that they...pass that knowledge on...it isn’t digging and trying to find out what’s going on”P<sub>6</sub>*

*“it’s very difficult, you can only ask certain questions, can’t you?”P<sub>1</sub>*

*“it was very difficult, because...how do you...approach...you’ve then got that thing of, “Ooh, shall I ask, shall I not?” P<sub>8</sub>*

So, students *should* share information, but educators might be embarrassed or uncertain about asking questions, perhaps indicating that this is a sensitive subject for them, not only for the students.

Interview participants noted that when students failed to share information this raised barriers to developing strategies and organising reasonable adjustments; causing stress for staff over and above that experienced when supervising non-disabled students:

*“we’re trying to unpick external things...to have to...start unpicking and unravelling things...impacting on that student’s ability to perform...which are outside of their control, is quite a lot to ask our guys”P<sub>5</sub>*

This was linked to their role in balancing student needs with those of colleagues:

*"I have to think about...my team as well because if you're supporting a student...it's putting extra pressure on the rest of the team"*P<sub>1</sub>

Some educators appeared comfortable dealing with disability issues, indicating that they could support the student effectively and were confident that they were learning and doing the 'right thing':

*"when I've been supervising students and you've come up with something that just clicks...it makes a big difference...excellent from a learning point of view for us"*P<sub>5</sub>

Other educators described noticing cues as the placement progressed. If impairments were present but possibly hidden, perhaps students were 'passing' or not realising these were affecting performance, this sometimes led to different behaviours which were noticed by educators:

*"you start to see things that don't add up...finding out week two, three, or four, makes it very difficult...to support them to develop strategies"*P<sub>5</sub>

*"It became quite apparent to us, the one with the dyslexia... "There's something not quite right here""*P<sub>8</sub>

At other times when students shared their information but then decided that they needed no support, this led to barriers and uncertainties, for example:

*"we did talk about it at the beginning...he felt he didn't need any extra help...I don't know, could it have been sorted out earlier?"*P<sub>2</sub>

All participants felt that it was essential to speak to the student directly:

*"it is...about...communication...having that conversation...because it's very different...different people have very different approaches...to how they cope with their disability"*P<sub>8</sub>

Direct communication with the students was what participants preferred, however, this process was hindered; possibly due to a number of issues. Some accounts suggested that disabled students might be fearful of stigma and stereotypical reactions from educators; worrying that they would be discriminated against because of their impairments. Additionally, educators might have been anxious about saying 'the wrong thing' or incorrectly attributing behaviour to the presence of disability.

### 7.5.3 Building confidence and developing strategies

Participants described elements that enabled students to move forward in the placement, some of these, such as building confidence, were recognised as being common to many students, however, it repeatedly became clear from participants' accounts that they saw this as fundamentally linked to the issue of disclosure. In general educators saw themselves as influential in building student confidence through their communication and provision of support. As one participant noted:

*"about 75% of the students that came on placement said... "I'm not very confident""P<sub>7</sub>*

Apparent lack of confidence was sometimes linked to the stressful nature of placements for all students:

*"[a] student...said "Oh we've not done this before," ...you know for a fact that they have...but it's that whole "I'm a bit frightened, I'm going to deny all knowledge""P<sub>3</sub>*

All participants noted that disabled students' confidence was affected by concerns about how they would be assessed. These were felt to be complex issues for students and educators relating to 'passing', stereotyping and discrimination:

*"just show...what they can do without disclosing their disability...might be a better option for them...sometimes it is, sometimes it's not...I think they feel that if they have a disability, they disclose it to some people...there's a barrier set, "Oh they can't do that" ...they're automatically going to be failed...there's going to be some discrimination between the educator and the student"P<sub>7</sub>*

*"once they'd realised...they were going to be...assessed on the merits of...how they performed as a physio student...not...anything else, it was fine"P<sub>8</sub>*

Participants identified gradual increase in the level of challenge over time as a strategy of benefit to disabled students. While recognising that this was similar for all students, accounts indicated assumptions that this process needed to be more structured and closely monitored for disabled students:

*"Do they have that building pathway...going from a less challenging...to a more challenging environment? Patients might not be less challenging...environment might be less challenging...maybe having a managed pathway for them"P<sub>5</sub>*

Participants' reported a clear willingness to support disabled students and to facilitate their educational experiences, providing examples of how they communicated this:

*“we’ll do our utmost to get you through this process”P<sub>6</sub>*

*“If we can help you in any way...If you need to ask a question...Don’t...frightened to ask...we’ll...take it day by day...if you want a debrief or you want to go over anything else...let us know”P<sub>7</sub>*

Participants wanted to provide good placement experiences, also communicating with the university and developing strategies. Links were generally instigated by the practice educator:

*“we...then linked in with the university and the student and said, “This is what we were thinking. You tell us, what do you think?””P<sub>8</sub>*

*“but it’s down to the educator to work around it and come up with strategies that will help to get the best out of the student and the best out of the placement for them”P<sub>4</sub>*

Communication was also important within their teams. Reflection on their experiences of supporting disabled students was used in staff development, supporting junior colleagues who were less familiar with educational approaches:

*“we spend a lot of time with the fives and sixes [Band 5/6 physiotherapists] in order to try and bring up the skills...it’s not specifically for the students with disabilities”P<sub>5</sub>*

Personal investment was involved and a sense of responsibility. However, one participant indicated that while she wanted to make the placement worthwhile, this had to fit around other priorities; there were no guarantees that support could be provided. This seems to relate to her ‘being honest’ with the students about the ‘real world’:

*“I always try and juggle it to...make it worthwhile...I can’t always give you that support...I’m very much one for giving real world experiences, this is it, this is the pace you have to work at”P<sub>1</sub>*

Participants described activities used to develop and support disabled students, however, the success of many of these strategies were dependent upon having access to information about students’ impairments and reasonable adjustments – returning us to the imperative of disclosure. Again, concepts of habitus of the educator and doxa of the placement and of physiotherapy provide us with a lens through which to view this situation, in that, ultimately students must comply with taken for granted practices to be admitted to the field.

## 7.6 Theme 5: Understandings of disability

The second overarching theme concerned ways that educators thought about and understood disability. As noted, the contextual biomedical NHS field in which practitioners are embedded and the presuppositions and unquestioned 'ways of being' influence their understandings and this seems to hold true for participants in this study. The language they used in describing disabled students and disabled people in general appears to be underpinned by ableist understandings.

### 7.6.1 Disabled people are clients

When talking about disability, participants' focus was on disabled clients who were often seen daily. They appeared to assume that, because they managed disabled clients, this experience would be transferrable to other relationships:

*"...supporting disability, in general...it's certainly something, as physiotherapists, you would hope that we are very good at"*P<sub>8</sub>

And yet they had little contact with disabled people outside of the therapist/client context:

*"you get lots of contact with disabled patients. But if you think of disabled people...maybe I've not thought about it"*P<sub>1</sub>

### Physicality

All participants used words regarding physicality to describe physiotherapy and disability, this was evident in much of their talk; they noted:

*"from a physiotherapy point of view, I think there's...a big perception that...it's quite a physical course...a physical profession"*P<sub>5</sub>

*"...there's the physical side first...we all walk so quickly. It's well known in physio isn't it, you scurry"*P<sub>1</sub>

*"I always think in terms of disability, you're always thinking something physical"*P<sub>4</sub>

Similar physical vocabulary described how they thought clients viewed physiotherapists as being very able:

*"Maybe...the patients' expectations of a clinician is...they have to be perfect and fit...expectations of physios are they're these superbly fit energetic people that can do everything and anything, athletic"*P<sub>7</sub>

In the light of these accounts it is perhaps not surprising that participants generally thought about disabled students with regard to their physical capabilities. Approaching the idea of



disability through a similar lens to that used with clients included the categorisation of hierarchies of difficulty in relation to type of impairment. One participant, using outdated terminology (handicaps), referred to people using their 'disability label' (dyslexic ones), othering them by describing them as 'those sorts of people':

*"I think...people with physical handicaps are easier to deal with than the dyslexic ones because it's very much black and white with those sorts of people"*P<sub>1</sub>

### **7.6.2 Assumptions about disabled people as students/colleagues**

Generally, participants assumed that unless they were alerted to a disability then students/colleagues conformed to the ableist norm. Disability in relation to students and colleagues was rarely thought or talked about, as if it were invisible or not necessary to acknowledge. If this is the case perhaps it essentially becomes a 'non-issue' and awareness remains low:

*"Sometimes if you are very accepting of disability you don't even realise it is there"*P<sub>2</sub>

*"No one really talks about it. Not no-one talks about it, but no-one thinks anything of it, more than not talks about it...It's not really something that is an issue"*P<sub>4</sub>

All participants assumed that the longer disabled students had an impairment the better they would manage in the clinical setting:

*"some that have obviously known for quite some time...and they have very good strategies in place"*P<sub>5</sub>

*"I suppose those people have had it all their lives so they know no different"*P<sub>1</sub>

This, perhaps, begs the question of how disabled students who are recently diagnosed or with a recently acquired condition could manage to effectively prepare for, and perform while on placement. Arguably it suggests a gap in relation to proactive and inclusive approaches that placement educators could take to support students at any stage. Participants often talked in dogmatic ways about disabled students needing to 'come to terms' with their disability. This was presented as a process that students should actively address pre-entry, in their preparation for placement as a precursor to 'disclosure':

*"it's really important that they...come to terms with it so that they can disclose it...as a, almost like a requirement...I mean it's hard when they haven't come to terms with it, and that's a whole other issue"*P<sub>6</sub>

While acknowledging that the situation was hard for students, the expectation was that they should work on this to prepare for placement and perform effectively once there. If they did not go through this process of acceptance, 'unresolved issues' were assumed which could cause problems:

*"significant unresolved issues...very separate to her training as a physiotherapist...a fairly quick diagnosis...a lot of adjustment...going from seeing, to not seeing"*P<sub>5</sub>

Some participants expressed particular understandings of disability based on their own experiences. These assumptions, about all disabled people who have ongoing impairments, were made based on experiences of temporary incapacity; finite situations in which participants knew they would return to pre-injury status. For example, one participant was keen to talk about her experience of 'being disabled':

*"I have to tell you this; I broke my leg two years ago...Now that was very interesting because that's my insight of being disabled...of not being able to get around and the restrictions...you're home alone all day with no one to talk to"*P<sub>1</sub>

She talked about this for a significant amount of time, focusing on the largely negative aspects of 'knowing what it's like to be disabled' and how this fed into her physiotherapy practice:

*"I hated being cooped up inside...so in a way...it does help me in my profession because I can tell patients about it"*P<sub>1</sub>

She assumed that disabled people had the same experience of impairment as she did, and that disability would be their central focus. This, she said, provided her with authority to deal with disabled clients in a different way and to understand their lived experiences of disability:

*"the other aspect that helped me was the isolation side of it and you could see how people would spiral into depression...if you had the wrong personality that could really affect people"*P<sub>1</sub>

Another area about which assumptions were made was dyslexia; this type of neurodiversity was mentioned by all participants. Anecdotally, physiotherapy is assumed to attract this group because it involves hands-on, practical skills. One participant reported in a very 'matter of fact' way:

*"[there are] loads of dyslexic physios...I think it's probably because physio is an attractive career choice for someone whose brain is wired in that way"*P<sub>3</sub>

Another noted in relation to the general population:

*“you see more and more people with it now...God when I was growing up no one was dyslexic”P<sub>1</sub>*

As the next section suggests these understandings of disability appeared to affect the ways in which participants thought about the presence of disabled students on placement.

### **7.6.3 A priori assumptions of ability/(dis)ability and students**

All participants had supported disabled students and generally reported positive experiences. Their *a priori* assumption was, however, that they would be less able than their non-disabled peers:

*“disabled students take more time. They generally have...lower patient contact”P<sub>3</sub>*

There was sympathy expressed in relation to the students’ situations but again this assumed deficit:

*“because...everything takes so much longer, how are they going to fit it all in if you’ve got a disability? And you...perhaps feel like you have to do double the amount of work, which it must often feel like. How do you do that work-life balance so you’re not totally exhausted?” P<sub>6</sub>*

It was also assumed by some participants that they needed more input and might not be able to work in all areas of practice:

*“a disabled student that needs a little bit more TLC [tender loving care]”P<sub>7</sub>*

*“it’s generally...normal and accepted now that visually impaired physios tend to end up in outpatients, because it is...quite a challenging environment, in terms of the wards and things” P<sub>8</sub>*

As noted when discussing disclosure, when students shared their information prior to placement, even though this is what all participants said they wanted, it sometimes triggered emotional responses, engendering feelings of anxiety and assumptions of difficulty and challenge:

*“Oh my God, what am I going to have to do? How bad is it going to be? How much more difficult is it going to be to accommodate it?” P<sub>4</sub>*

Arguably these assumptions of deficit, challenge and limitation could erect barriers to thinking positively about disabled students particularly in the pre-entry placement period.

#### 7.6.4 Ability/(dis)ability–experience with students

While participants showed various understandings of disabled students prior to the placement, issues arose and developed during the placement.

##### Categorisation of disabled students

Participants were polarised in their views of disabled students and their accounts suggested that they fell into two main categories; the ‘good’ disabled student and consequently the ‘bad’ disabled student. Returning to the issue of honesty, students seen as open and proactive, who had ‘come to terms’ with their disability and ‘got on with it’ were viewed positively:

*“he was incredible...he was really good and didn’t need much support...very capable, very open...got on and dealt with it himself...and didn’t really have any problems”P<sub>6</sub>*

This student was perceived as hard working, he ‘passed’ and because of this behaviour, the educator assumed that he did not have any problems. Proactive students were seen as ‘good’ because they took on responsibility; consequently, this meant that educators were less engaged with disability issues:

*“she really got on with it. Again, she’s been partially sighted all her life so it wasn’t new”P<sub>1</sub>*

Some participants had experience with ‘established’ disabled students, assuming they were able to manage on placement because they already knew how to manage well in other life settings. ‘Good’ disabled students were well prepared for placements, had no or few ‘issues’ and effective coping strategies in place. Some were admired for the way they managed; so much so that the disability almost became invisible:

*“you do see some students with fantastic coping strategies...you wouldn’t even notice that they had those problems”P<sub>5</sub>*

Others, however, found that they could not manage, and it was realised that they needed support. The ‘invisible’ disability became visible:

*“it’s only something [need for support] that comes out once they’re under an increased level of stress – like a placement”P<sub>4</sub>*

In some cases, these students were viewed as being at the other end of the spectrum; they appeared to lack insight and consequently, were seen as problematic:

*“the discrepancy between where he thought he was...and what was obvious to everyone else”P<sub>6</sub>*

*“if you end up with a student having a major meltdown on placement...a big failure like that...should have been avoided...the student didn’t want to acknowledge that she had any issues”P<sub>4</sub>*

Participants described working hard to develop strategies to help disabled students to perform in the same way as their non-disabled peers:

*“you need more time here...where can we snip...tighten up, maybe more than somebody else...in order to make your assessments still half an hour/forty-five minutes, as everybody else’s would be?”P<sub>5</sub>*

If they did not fit the mould, however, and strategies were not in place they were considered to be lacking ability and possibly failing:

*“if you don’t know...you measure them against anybody else...there is this mismatch of what they’re expecting [educator] and what they [student] can deliver”P<sub>5</sub>*

As noted, students can experience placements as particularly stressful, and yet disabled students were considered more problematic and challenging:

*“it’s the time they take to do it...it puts a lot of pressure on you as a marker to say...is this an acceptable level or not?”P<sub>1</sub>*

Most participants assumed that disabled students would take longer to undertake activities; a focus on ‘dis’ability - a deficit model. Arguably, due to lack of awareness and confidence, participants felt under pressure when assessing disabled students’ performance. Doubts about managing this situation led to feelings of isolation and a need for guidance:

*““Could they let us know what might be the challenges, and what they think we could put in place?” Because I think that is the difficulty, just not knowing...”P<sub>6</sub>*

As noted, ‘responsible’ disabled students were perceived as ‘good’. This requirement seemed to be largely unspoken, however, and students could have been unaware of what they needed to do in order to meet it. The disabled participant remembered when she was a student:

*“I’m the one that has to sit and spend longer reading an article...when I was a student at university...the extra time required as a result of my disability was my*

*time, it wasn't in terms of asking a clinical educator to give extra time. I think it's around thinking...how you do things differently" P<sub>8</sub>*

She took the responsibility to put in more effort to reach what she saw as the standard expected. Perhaps the only way for disabled students to be perceived as performing to the required level is to work harder:

*"my take is going to be influenced...by my disability...I can understand the pressures that you put on yourself, to think, "I'm in this world where I...have got this disability...I have to perform at least at the same level as everyone else, if not better"" P<sub>8</sub>*

### **Responses to disabled students' behaviour**

All participants wanted students to share their information and wondered why they did not:

*"they obviously don't feel comfortable, and I don't know why, in disclosing it to everybody" P<sub>7</sub>*

One showed an appreciation of possible student feelings and fears:

*"the fact he came and spoke to me in depth about it [mental health issue]...indicates that he wants some help with it. But he said, "I don't want to be regarded as weak." P<sub>2</sub>*

These accounts were based on narratives that they heard from disabled students. There were, however, some accounts suggesting that it might be more important for educators to be seen to be acting in a particular way than to necessarily believe certain behaviours or attitudes are wrong in themselves:

*"you've got to be very careful you're not seen as being prejudiced towards these people" P<sub>1</sub>*

Returning to sharing sensitive information, one participant reacted strongly to experiences with disabled students. She indicated that they could act in a manipulative fashion and was sceptical about how they 'used' information about disability:

*"Or they'll do it at the end ["pull the dyslexia card"] when they've not got a very good mark and say, "you weren't fair to me" P<sub>1</sub>*

This does raise questions about student motivations for, and barriers to, sharing information and whether the atmosphere provided by educators was conducive to students talking about disability issues during the placement. There is also a sense,

however, in which the educators could be viewed as being embedded within a field, not fully of their own making, in which they are disempowered and disenfranchised by the 'way things are' in relation to their dealing with disabled students and colleagues.

## 7.7 Theme 6 Educator responsibility

Participants' reported that they have varying, sometimes conflicting, roles and responsibilities in relation to disabled students completing placements. These include facilitation, standards of practice and the realities of employment. As noted, placement experiences involve professional socialisation and early development of physiotherapy identity. Students can extend and apply previously acquired theory and practice, so increasing their knowledge, skills and competence in a 'real world' setting.

### 7.7.1 Responsibilities of being an educator

Participants emphasised facilitation of good learning experiences for positive outcomes:

*"We're here to support you...not to fail you. We're here to give you an experience and for you to learn." P<sub>6</sub>*

Empathy was shown for disabled students' issues and there was awareness of feelings and fears they might experience, ultimately, however, educators expected students to manage their disability and perform to the required standards or risk failing the placement. As one explained:

*"pastoral care is part of what we do...at some point we have to judge them, we have to apply...standards and say, "Do you reach these standards because if you don't you're going to fail this placement?""P<sub>3</sub>*

Anxiety was expressed by some participants when they had to fail disabled students. They exhibited personal investment in the situation and a sense of failure in their own responsibility if they had not expended considerable efforts to enable student success. They found this challenging:

*"you know it doesn't come back to you personally but I feel I'd let myself down if I hadn't done everything I could" P<sub>1</sub>*

*"you're there to facilitate students, not to fail them...it was extremely difficult" P<sub>6</sub>*

Some students though, were said to have engaged effectively and were perceived as investing the required effort. Participants noted that it was these students who performed to expected levels, similar to their non-disabled peers:

*“the ones that can do that, and have done that by the end of the placement, feel that they are being measured equally with everyone else” P<sub>5</sub>*

It appears that in the participants’ opinions, both for themselves and the disabled students, this ‘equal measurement’ was very important.

### 7.7.2 Gatekeepers

While participants found that failing students was difficult they indicated their responsibility to maintain standards and to act as gatekeepers to the profession by ensuring student competence. This sometimes translated into questions regarding the suitability of disabled students to qualify if they fell below expectations:

*“if they can’t complete a placement how do they complete their degree?”P<sub>1</sub>*

This participant felt that she had a professional responsibility to address these issues. Some educators questioned decisions they had made in the past, wondering whether they had let emotion (empathy with, or sympathy for a student) cloud their judgement:

*“what preys on your mind is have I, out of a misplaced sense of...sympathy for this person...foisted onto the general public someone that is not capable of doing the job?”P<sub>3</sub>*

The motivation of academic teams was also questioned in relation to the powerful drivers within HE for students to successfully complete their degrees:

*“Well maybe that person isn’t cut out to do this job...sometimes I think that...universities are...more concerned about passing the student than unleashing unsafe physios on to the world”P<sub>3</sub>*

This perception of conflicting priorities resulted in an emotive response, ‘unleashing’ a damaging force into the world. Student retention, progression and decrease of attrition are major HE drivers, arguably then, practice educators may feel pressured to pass students, given that their assessments are key in providing evidence of students’ professional development.

When disabled students were successful on placement, educators were positive. However, there was little acknowledgement of student effort; student success equated with educator success; the disabled student eventually did well perhaps because of the efforts of the educator and the team rather than because of his/her own abilities:

*“No, I think we did very well with her. Well done us.”P<sub>3</sub>*



It was also seen as a learning experience:

*"in retrospect she did really well. It totally changed my...perspective...yes it was good for me...I think...I was being a little bit discriminatory...it worked really well...so that was quite positive for us"*P<sub>7</sub>

When a student was not successful, however, sometimes there was a perception that perhaps the team had failed:

*"it was very unsatisfying for us because we felt that...we like to have good placements...part of the reason we have students is because it's beneficial for all the staff"*P<sub>3</sub>

Anxiety was expressed about passing students who, in the future, might not perform effectively:

*"I'd be horrified if I passed a student who then went on to qualify...then couldn't function"*P<sub>1</sub>

Whether universities expected practice educators to enact a role in gatekeeping or not, accounts indicated that they felt that this was their role, consequently, they experienced challenges when supporting disabled students:

*"we're there to respect the wishes of that individual...yet provide a structured learning environment...keeping our team sane at the same time...is incredibly stressful"*P<sub>5</sub>

This section concerned the ways in which participants discussed their educator role in relation to outcomes. When students were successful, participants experienced this as positive, gaining a sense of satisfaction and fulfilment. When disabled students did not perform well, educators were frustrated and viewed this as less satisfying and did not necessarily feel they were supported well in these situations.

### **7.7.3 Realities of the employment context**

Some participants expressed reservations about the NHS as an employment context for disabled individuals:

*"The NHS...has no excuse not to be the golden employer for this [disabled employees]...if anyone should understand these issues it's the NHS. Having said that, that's not always the case...it's very much...looking at the turnover...if I have someone that is, for whatever reason, less productive, I can only carry that for so long...whether you acknowledge it or not, it is going to make you think twice before appointing people to certain jobs...I think that...changes in the NHS...are pushing us*

*towards less diversity because diversity can be more expensive or can be perceived to be more expensive”P<sub>3</sub>*

There were misgivings about the ability of disabled students to perform effectively, particularly in the employment setting; what is a reasonable adjustment?

*“That’s not real world [dyslexic students accessing reasonable adjustments - more time/less clients]...is it acceptable and...who’s going to take you on as a qualified member of staff?”P<sub>1</sub>*

Although there is support available for qualified disabled employees there were doubts about whether the system really works:

*“I think it’s...very difficult...there isn’t the support...almost the tolerance. Because everything is at such a pace and there’s such time constraints...people probably aren’t as tolerant as they should be...there aren’t huge resources and strategies to help these people. Nobody...most people don’t have the time to give that support and it makes it very difficult...things are tending to get dehumanised nowadays”P<sub>6</sub>*

Participants felt they knew what was required to support disabled students. These accounts illustrate, however, that there were fundamental concerns about the NHS being a suitable environment in which disabled employees can perform effectively. Arguably these concerns could influence their overall approach to disabled students from pre-entry to conclusion of the placement.

This chapter has provided an overview of the findings from the interviews. Key themes have emerged related to the field of the practice placement embedded within the larger field of NHS healthcare. The influence of participants’ habitus and doxa as well as issues concerning the relative capital of the individuals involved will be further explored in the next chapter.

## Chapter 8 - Discussion

### 8.1 Introduction

The previous chapter presented participants' accounts of working with disabled students, identifying key themes that emerged from the data analysis. This chapter briefly returns to the research questions before discussing the experiences of participants, noting what this adds to the knowledge base in my area of practice, and that of the wider profession. I highlight some dissonance between the therapeutic and educational landscapes that practice educators must navigate as part of their roles, considering implications for practice in education and in the clinical setting. I suggest how further critical examination of physiotherapists' beliefs about disability might help to disrupt habitus and doxa in relation to practice. I question the ideas of disability that are often prevalent in physiotherapy to offer insight into new ways to think about and understand clinical educational practice and disabled students.

### 8.2 Review of research questions

The questions, as noted, were linked in a temporal fashion; the first being concerned with what was already known about experiences of practice educators in supporting disabled students. It became clear from interrogation of available literature (Chapter 3) that this issue has been given little attention. While there is some focus on experiences of disabled students and their perceptions of the support they receive in HE and on placement, that of the educators themselves has had minimal consideration. Studies that focussed on educators emanated from occupational therapy and nursing. Main issues concerned lack of awareness/understanding of disability, problems with conflation of pastoral/supportive and evaluative roles, disabled students needing more support and being more challenging, the importance of the support role of the university and worries that reasonable adjustments might compromise professional standards.

The second question concerned experiences of practice educators supporting disabled physiotherapy students and was the focus of the unique element of this study. Emergent themes were: pressures and placements, educator needs and perceived lack of support, perceived student challenges, disclosure - communication and honesty, understandings of disability and educator responsibility. It is worth noting that all the issues identified in the

literature, and more, surfaced within the data analysis. There were two overarching elements evident in analysis of participants' accounts. The first involved pragmatic issues; barriers experienced, factors felt important in effectively supporting disabled students and things they perceived would make this job easier. For example, better communication with student/university, advance disclosure of students' impairments and more guidance and support from the university. The second element, that emerged on taking a more critical stance, explored the patterns of situated physiotherapy professional practices that emerged regarding disabled students; structured around an able-bodied framework, embedded within a medicalised context and a largely reductive biomedical approach to physiotherapy practice. The participants, as noted, embedded within pre-existing hierarchies and structures of health and social care, felt themselves to be the guardians of their body of knowledge and practice. Arguably, in Bourdieusian terms, viewing their interrelationships with disabled students and the 'sense of place' of disabled individuals within the field through the prism of disability constructed within this field. Participants' practices in relation to disabled students, perhaps unconsciously influenced by their immersion in the cultural practices of the field, resulting in physiotherapy habitus becoming unquestioned and hence doxa within the field of practice education: 'client as disabled' and 'therapist as non-disabled'. Disabled bodies were still viewed through a deficit lens, immediately categorising them as abnormal; in need of cure or rehabilitation. This was repeatedly illustrated in participants' accounts which indicated a solution focus: 'if we know what the 'problem' is, we can make it better'. It was challenging to identify whether participants had a critical awareness of their situation in relation to disability/disabled students that would have enabled more informed pedagogical interactions rather than apparently holding to the notion of a taken for granted cultural arbitrary (Bourdieu 1990), appearing to project their 'ways of being' in relation to disabled clients into interactions with disabled students.

The third question concerned implications of these findings for future practice. As noted in chapter 5 this work will provide opportunities to disseminate and consider different ways of thinking about disability. Taking a more critical stance to participants' stories, however, enables me to challenge the status quo, which I have characterised as the rather darker, potentially exclusionary side of social capital (Bryne 2014) that appears to hold sway in some areas of education and healthcare. This may, in some small way, enable practice to

move on by disrupting taken for granted assumptions so encouraging and invigorating debate.

### **8.3 Outcomes of the study/contribution to knowledge**

Here findings are discussed in relation to existing literature, examining what this study contributes to understandings of disability and physiotherapy identity. I acknowledge that the results cannot be generalised to all educators regarding their interrelationships with, and approaches to, disabled students. The outcomes are, to a degree at least, unique to the participants and the interpretations of their experiences. Nevertheless, an argument can perhaps be made for transferability of findings to physiotherapy education settings more generally given commonalities that exist across the NHS regarding clinical practice, professional standards and competencies.

### **8.4 A critical stance**

This study aimed to gain some insight into, and understanding of, the ways that practice educators perceive, interpret and understand their world (Stenner et al 2017); the clinical setting focussing on their experiences of supporting disabled students. The analysis takes a critical stance to everyday clinical education practice informed by insights into phenomena such as power, potential misuse of language and 'the fix we are in' (Kinsella 2006), examining reasons such practice persists and whose interests it may serve. It also explores power relations, paying attention to the notion of (re)production of these within the clinical setting and the assumptions that underpin their continued acceptance. This lens provides a way of examining common issues, questioning "*social values and norms, institutional priorities and socio-cultural power relations*" (Gibson and Teachman 2012,475) with the analysis going beyond a description of the beliefs of participants to consider the processes by which those beliefs might link to educational goals, practices and how success and failure are viewed.

Discussion draws on ideas from Bourdieu's (1977) social theory of practice whose main concepts of field, habitus, capital and doxa provide tools to examine interrelationships between individual practice and social contexts or environments as well as the (re)production of dominance and the exercise of social power by institutions and groups (van Dijk 1993). While physiotherapy practice in this study was largely located within the NHS, it inevitably intersects with a range of social processes embedded in wider socio-

political systems of relations. The use of Bourdieu and adoption of a critical stance in relation to participants' accounts enabled me to consider different and yet overlapping emphases appropriate for discussion of the emergent issues.

## 8.5 Thematic overview

While participants rarely specifically discussed the concept of disability, arguably their physiotherapy professional identity was influenced by their understandings and experiences of it. Physiotherapy habitus and doxa appeared to underpin their narrative predicated largely upon a clinical gaze. Often based upon a deficit model, their approach foregrounded repair of the body and/or provision of support to enable disabled students to change; to adapt to the dominant notion or ideology of normality. This type of discourse provides the conceptual underpinning for rehabilitation, where ideas of independence and participation are taken for granted goals (Gignac and Cott 1998) and decrease in impairment automatically equates with a proportionate increase in quality of life. These beliefs generally go unrecognised and unquestioned, operating as tacit background understandings that organise practice in the field of healthcare (Gibson and Teachman 2012). These discourses were evident in participants' accounts of disabled students, for example, noting that they take more time, have more problems in certain clinical areas or, to succeed, they must disclose disability.

Emergent themes, as noted, embedded within the clinical field, illustrate these taken for granted beliefs. Two overarching themes permeated every element of the analysis; the imperative of 'disclosure' and understandings of disability linked to pedagogy in the clinical setting.

## 8.6 A Bourdieusian approach—context for discussion

Field, capital, habitus and doxa are the concepts at the core of Bourdieu's sociology of practice, these are revisited here to provide a broader framework for discussion.

### 8.6.1 Field

In Bourdieusian terms, fields are relational spaces of their own: "*relatively autonomous social microcosms*" (Gibson and Teachman 2012,475); social and institutional arenas where individuals express and reproduce their dispositions and compete for capital. Individuals experience power differently depending upon the field and the systems of relations within it which have their own structure and forces (Bourdieu 2000, Morberg et al 2011),

indicating the importance of the influence of context on habitus (IDS 2011). Healthcare settings can be considered as fields, involving structures and sets of relationships, where groups with some autonomy have areas of practice in common. Fields have tacit rules and understandings where practices become increasingly evaluated by the domain's internal criteria, being produced by, and producing agents who have specific competence and mastery and being less affected by external influence so becoming more autonomous (Bourdieu 2000, Hilgers and Manguéz 2015). The NHS falls into the category of a relational space with networks of policies/procedures, predetermined management pathways and a largely unquestioned reductive, biomedical approach. Within this field, physiotherapists could be viewed as agents who are the "*guardians of legitimate knowledge*" (Hilgers and Manguéz 2015,7). This knowledge becomes autonomised, constituting the entry tariff for those new to the field (students), providing authority and increasing the capital of those individuals who are in a position of controlling the conditions of membership (Bourdieu 1977). This was evident in participants' accounts of the expectations they had of all students who were required to fit into the local context quickly and effectively when arriving on placement. Issues sometimes arose if they were unable to exhibit this ability due to the impact of impairment, arguably, indicating a particular interpretation of the 'sense of place' of disabled students when viewed through the prism of disability constructed within the field.

### 8.6.2 Capital

This is written about and understood in a variety of ways (Purdue and Howe 2013; Smith 2014) and, as noted symbolic, cultural and social capital resonate with this work. A person's position in a field is determined by the forms and amounts of field-specific capital they can draw upon; emerging as power or privilege used to control individuals (Bourdieu 1986). Participants were embedded within the NHS environment and their narratives indicated familiarity with being part of its culture. Within this field they could be considered as having high levels of symbolic and cultural capital (valued knowledge, status, authority in terms of the cultural ways of the field) in their social relations with students (Bourdieu 1989).

In addition to this field and the habitus it engendered, other discourses might be deemed as contributing to participants' capital in this arena. These include physiotherapy identity and pedagogical and gatekeeping roles. Indeed, this could be viewed as renegotiation and extension of their professional identity (Griffin 2008); assuming extended roles and working

across boundaries resulting in 'reprofessionalisation'. In contrast, students arriving on placement have little or no capital compared to practice educators given that they have little transferrable capital of any type due to lack of clinical experience. Arguably this results in a relatively powerless status within the field. The ways that participants described their experiences would suggest, however, that this perception of relative powerlessness varied depending upon individual students' abilities, their level within the programme of study and how they managed their impairment.

If participants view disabled students through an established lens of 'normality', perhaps considering them as 'less' or 'other', arguably the students have negative social capital if an understanding of 'normal as capital' is incorporated into the habitus of all concerned (Gibson and Teachman 2012). Contained here are deficit images that participants held of disabled people, viewed through a lens continually reproduced, for the most part, by their experiences within the healthcare field including particular communities of practice, 'ways of being' and professional identity. So as noted, although the idea of physiotherapy networks being supportive social connections (Gauntlett 2011) has resonance with this work, there were indications in participants' accounts of the darker side of social capital surfacing as a potentially exclusionary mechanism to ensure that the 'wrong' kind of people do not enter the profession (Bourdieu 1986). This could of course relate to individuals from a wide range of minority backgrounds, not just the disabled students who are the focus of this study.

### 8.6.3 Habitus

Habitus is a complex phenomenon described as a set of dispositions or 'ways of being' that evolve over time and result behaviours and attitudes within a given field. As noted, the body and its social location are interrelated and can be understood in and through the habitus, management of the body being core to acquisition of status within the field (Bourdieu 1977, 1990a, Edwards and Imrie 2003). Habitus is a social rather than individual process, although the social structures created and reproduced (unconsciously but leading to enduring patterns) are internalised by individuals leading to a "*sense of one's place*" and also a "*sense of the place of others*" (Bourdieu (1989,19). These are not immutable and may change or evolve depending on the context (Lee and Kramer 2013).

For participants in this study the field is the NHS. During education and employment, they are exposed repeatedly to specific sets of social conditions integrated into lasting



perceptions and understandings so shaping their behaviour and practice. These social structures within which participants are embedded position them in competitive hierarchies where they “*struggle for relative status*” (Gibson and Teachman 2012,475). From my review of the literature and my professional experience, physiotherapists’ identities and habitus are influenced by a wide range of factors. Similarly to nurses, physiotherapy is a largely female profession which has ‘gender issues’ regarding stereotypical links with femininity. For example, arguably there is a degree of subordination to doctors, suggesting inferiority in gender and professional status and a lack of prestige status (Turner and Whitfield 2007). Hammond (2013,128) in his work on gender with physiotherapy students, concluded that they are “*constructed in relation to the default professional position: male, heterosexual, white, middle class, and physically able*”. Perhaps the “*mental structures*” through which this social world is apprehended have been internalised by the agents in developing their habitus leading to this default position, so dovetailing with issues explored in this study.

Participants accounts alluded to the body, relating to physicality and fitness, expressing some doubts as to the possibility of disabled individuals being competent physiotherapists. This may stem from the powerful hold that the dominant medical profession has over what society deems to be a ‘legitimate body’ (Edwards and Imrie 2003) and notions of “*symbolic power [working] partly through the control of other people’s bodies*” (Bourdieu 1990,69). Arguably this view may result from participants’ concept of the ‘place’ of physiotherapists in the NHS hierarchy, concerning which attributes confer power and prestige and which are marginalised. Professional habitus will also be shaped by beliefs and understandings about disability such as disabled bodies being of less value, leading to unconsciously learnt and unthinking responses to disabled people with this behaviour being related to the thoughtlessness of habit and habituation (Bourdieu 1977).

In Bourdieusian terms, when disabled students entered and became immersed in the physiotherapy ‘field’, they engaged with the ‘habitus’ of practice educators with their relative levels of ‘capital’. Given underlying assumptions of compulsory ableness and deficit indicated by elements of the participants’ accounts, arguably any agents within this field would find it challenging to develop a critical awareness of the situation, consequently, concerns about stigma, internalised ableism and passing remain.

#### 8.6.4 Doxa

Doxa is an embedded notion unconsciously believed and practiced where there is an immediate adherence to tradition experienced as natural and taken for granted. Practices come to be naturalised and relatively unquestioned (Bourdieu 1977). This principle provides a lens through which to view participants' accounts in which there were indications of 'taken for granted' truths.

As noted, new entrants to any field are selected and shaped "*such as to obtain from them that undisputed, pre-reflexive, naive, native compliance with the fundamental presuppositions of the field which is the very definition of doxa*". Entry to this 'magic circle' can only occur by a slow process of initiation (Bourdieu 1990a,68). If we accept that incumbents of the field have a 'feel for the game' being invested in its outcomes and committed to its doxa (which leads to mastery and 'sensible practices' (Bourdieu 1977)), there will be an expectation that students will comply with the preconceived methods and standards required by the field.

Participants' accounts equated elements of physiotherapy identity with needing to be 'bright', fit, energetic people. Physiotherapy behaviour was exemplified by comments relating to physical attributes such as 'hit the ground running' and 'scurrying' around. A solution focus emerged; if a problem can be identified then it can be 'made better' or solved. Embodied notions of disability and disabled people permeated many reports of participants' experiences with disabled students; their 'non-disabled' responses embodying either over-attentiveness or invisibility (Loja et al 2012). Some indicated assumptions that supporting disabled students would be a negative experience, with lower performance levels and doubts expressed about competence and the likelihood of future employment. Overall participants' accounts indicated embedded assumptions that disabled students would fall short of required standards; for them initiation to the 'magic circle' would be even slower or sometimes impossible. Limited evidence emerged of reflection on these issues perhaps indicating the naturalised and unquestioned practices of physiotherapy doxa with disability involving embodied notions of client as disabled and therapist as non-disabled. Arguably these prevailing attitudes were more firmly embedded than recent notions of equality and diversity because of established educational, professional and environmental orthodoxies in which participants operated.

The following discussion considers elements of the habitus, capital and doxa of the field of practice education in relation to the agents within it, to illuminate and understand the findings of the study.

## 8.7 The imperative of 'disclosure'

Participants' accounts repeatedly returned to disclosure: students should 'disclose' their disability, preferably in advance of the placement. This was expressed in terms which, arguably, illustrated the doxa permeating the NHS field and the development of their physiotherapy identity whilst immersed within it. For example, the contention that students should 'come to terms' with their impairments and be responsible for disclosure which should, in any case, be required or compulsory.

As noted, unspoken assumptions exist that able-bodied identities and perspectives are preferable and should be aspired to (McRuer 2013) which poses a dilemma when considering disabled bodies and could be implicated in the maintenance and reproduction of inequality (Adams et al 2013). If we concur that the NHS is founded upon a largely bioreductive framework aligned with an ableist approach, where medical sense making is unquestioningly accepted, then perhaps it is only 'common sense' to believe that disability can and should be cured; an *"unexamined belief in the perfectibility of the living organism...and abolition of abnormalities"* (Titchkosky 2007;92). This then contributes to what might be termed 'perfectible practice'; physiotherapists view disabled clients, and indeed disabled people in general, as bodies that need fixing to bring them toward the perfectible ideal.

Similarly to my reading of the literature, most participants' accounts of disabled students are characterised by assumption of deficit, possibly as a consequence of habitual interactions with disabled clients. These therapeutic practices may be unconsciously influencing their educational practice with disabled students because of their immersion in biomedical cultural practices in healthcare. If so, this indicates unquestioned assumptions that disability can necessarily be articulated or made visible as an object on which to act.

Some participants considered concepts and approaches to disability more critically in practice, although they indicated that it was difficult for these ideas to be heard over dominant discourses existing in healthcare and socio-political arenas. They expressed

concerns that the NHS was not sensitive enough to individual requirements to be a good place in which disabled people should work.

These issues provide a context within which to examine participants' accounts of communication of sensitive information about students' impairments.

### 8.7.1 Why don't students 'disclose'?

While participants recognised that some students would not identify as disabled they were puzzled as to why they did not 'disclose'. In work with VI physiotherapists (Atkinson 2010) I highlighted factors influencing disabled people's decisions about sharing information. For example, not considering themselves to be disabled, disability identity is not perceived as a key focus, possibly explaining why all participants had experiences involving 'non-disclosure'.

Stigmatisation can be a strong influence: invisible or 'discreditable' stigmas (Goffman 1963) are difficult to manage. Some participants reported that disabled students did not 'disclose' because they perceived they would encounter stereotypical attitudes and did not want to be 'labelled' or treated differently perhaps implying a degree of internalised ableism (Campbell 2009). Bourdieu (2001,38) describes this as "*symbolic violence*" which "*triggers dispositions that the work of inculcation and embodiment had deposited in those already primed for it*" but it is also noted that this symbolic type of power cannot be experienced without the contribution of those who undergo it. Among those disabled students who may be attuned to the "*rules of the game*" (Gibson and Teachman 2012,479) disability is perhaps understood as a source of negative capital that needs to be minimised.

This being the case, it is crucial for practice educators and academic staff to be aware of these issues to support students effectively in deciding to explore and communicate the possible impact of their impairment in the clinical setting. Participants expected 'disclosure', linking this to preparation and provision of a good clinical experience, citing work pressures as reasons for 'needing to know'. However, not all participants appeared to appreciate how difficult this might be for disabled students given the power relations involved; educators being in the dominant position with greater access to, and possession of, cultural and social capital (Edwards and Imrie 2003).

Participants' narratives included experiences with students who attempted to pass whilst on placement. Some reported that disabled students recounted experiences of being

treated negatively on previous placements. Arguably, because of these issues, students may assume an identity other than their own, almost fabricating 'who they are' to conform to what they believe is expected of them in the field. This indicates a fit with Bourdieu's concept of doxa in the sense that disabled students then reinforce understandings of 'normal' as 'positive capital' and provide no counter-narrative of disability which might help to reduce reliance on an "*arbitrary construction of normal*" (Gibson and Teachman 2012,481).

### **8.7.2 Disclosure and honesty**

Participants' accounts indicated 'doxa' within which they expected students to perform. When a disabled student arrived, however, this potentially had a disruptive effect on the recognised, familiar clinical pedagogic dynamic. When considering disclosure, differences between disabled students, denoted as 'good' and 'problematic', indicated a ranking not necessarily applied to their non-disabled peers.

In the 'good' disabled student framework, disability became a non-issue because participants did not need to focus on it or provide remediation. They praised students' openness and honesty which, arguably, increased levels of positive cultural capital by apparently fitting into the field and assuming the required habitus. They took responsibility, shared information, used effective strategies and often worked extra hard to meet expectations; the 'appropriate' behaviour (Hopkins 2011; Nash 2014). All participants noted 'good' disabled students exerted extra effort to reach required standards, their assumptions and criteria of what comprised a 'good' disabled student apparently being based on the student's behaviour.

Conversely, experiences with 'problematic' disabled students appeared to disrupt the pedagogic relationship. If students did not 'disclose' and their practice failed to meet expectations, the impairment became visible and so, challenging. These disabled students were variously described as failing to assume responsibility, not being honest, failing to adjust to their situation or being in denial; mirroring accounts reported in the literature (Charmaz 1995, Nash 2014). This returns to expectations of compliance with the fundamental, taken for granted presuppositions of the field (Bourdieu 1990a). By not exhibiting the preferred behaviour of the 'good' disabled student they did not fit into the field as expected or increase their levels of capital and status.

Arguably these presuppositions may result in participants not appreciating the emotional processes involved in this situation so making disabled students appear dishonest in not 'disclosing'. The 'good' disabled student behaviour was assumed to indicate that students had 'come to terms' with their disabled identity. This might not be true, but it was unlikely that educators would discover this, because the situation provided little incentive to investigate further. In a perverse way, it might have limited the likelihood of them increasing their awareness of disability and the challenges of 'disclosure'.

### **8.7.3 Compulsory information exchange**

If a compulsory approach to information sharing were to be enacted, as suggested by some participants, it could impact on students' behaviour, subsequently affecting the ways in which educators interact with them. Hebl and Kleck (2003) describe the notion of the 'self-fulfilling prophecy' in which participants' expectations of disabled students could result in them treating those students in ways that create the anticipated behaviour. Alternatively, students who acknowledge stigmatising characteristics, can contribute to dismantling stereotypes, enabling 'the person' rather than the stigma to be seen. People who acknowledge impairment may be accorded more positive responses (Hebl and Kleck 2003), borne out by participants' accounts when disabled students 'disclosed'. In my professional experience of supporting significant numbers of disabled students, however, they frequently did not recognise or understand the impact that their impairments would have in clinical settings. This is where academic colleagues play an important role in the preparation of disabled students for their placements, however, legally, requiring a compulsory information exchange would be problematic.

Participants described expending considerable effort supporting disabled students. On further examination, these efforts often focussed on 'normalising' the situation/student to fit the habitus of the incumbents and the 'doxa' of the setting. They noted ways in which they facilitated disabled students to perform in the same way as their non-disabled peers. If educator and/or student strategies were not effective, however, this approach magnified both disabled students' struggles and the difficult balance that educators tried to maintain juggling their various roles. The competing pressures with which educators must contend have been considered, sometimes resulting in personal stress particularly when demands of their different roles came into conflict (Mooney, Smythe and Jones 2008). This may cause educators to be confused, to fail to recognise what is happening in the situation and to respond inappropriately, possibly affecting their judgement and/or assessment

decisions. Participants expressed uncertainty about levels of support they should provide and what this indicated about the competency of disabled students.

If disabled students shared information about impairment in advance, they often failed to meet educators' expectations of 'disclosure'. Anxieties arose if they did not provide enough information or merely stated that they had an impairment so disrupting expected social relations and the usual assessment processes. These processes were disrupted further if students chose to share information when they arrived, part-way through a placement, or not at all. Arguably, this compromised dialogue because of pre-existing power relations, in which students feared prejudicial or stereotypical responses that could negatively affect their experience and marks.

Participants' accounts indicated that these issues were problematic and yet they felt disempowered and unable to ascertain how best to ameliorate the situation. Without exception, however, in all phases of the placement, participants indicated that 'disclosure' was imperative and enabled them to manage the situation and support students effectively.

## **8.8 Physiotherapy: understandings of disability**

### **8.8.1 Elements of the physiotherapy approach**

Participants' accounts suggested elements recognised as comprising 'a physiotherapist' (professional knowledge, unique skills, autonomy (Robson 2006, Morris 2002)) and factors considered to denote accepted outcomes of physiotherapy practice. As these concepts evolve within the healthcare arena they can overtly shape what is taught in the pre-registration curriculum and the clinical setting. Arguably, being rooted in the largely biomedical field of the NHS, they may also have a covert influence in shaping the beliefs, values and understandings informing professional practice about disabled people, how they are viewed and 'managed'. It must be remembered that disabled students also become embedded within these networks when they undertake physiotherapy education, possibly influencing their decisions about sharing personal information when on placement.

Currently, within physiotherapy practice, there is still much emphasis on reductive biomedicine. This leaves little opportunity to focus on the complexities of social relationships although the quantitative approach to knowledge building is questioned more

regularly now with respect to AHPs (Kinchin et al 2008). Practice that incorporates the ‘art of caring’, working with clients in relation to their emotional responses to therapy has received more attention (Turner and Whitfield 2007) although more recent work in nursing has identified caring as an art at odds with the environments in which many healthcare professionals work (Goodman 2015). A major driver which mitigates against this more person-centred approach is the requirement for evidence-based practice. This has at its root a tendency towards the instrumental, quantitative methods which focus upon dysfunction and the body as a malfunctioning machine. These approaches are generally privileged and take precedence over social sciences methodologies that might provide a richer more humanistic view (Gill and Griffin 2009).

It is likely that these factors played a part in shaping the expectations of participants in relation to their work with students. When discussing the cycle of assessment and teaching there was an *a priori* expectation of students’ abilities to “*hit the ground running*” and about the resources that would be required to achieve a positive outcome. There is a dilemma here; the practice educator’s habitus in relation to the imagined ideal of supporting **any** student versus the ‘constrained’ educator within the field of the NHS; constrained by lack of resources such as support, time and money, who might be further challenged by students who fall outside of their presuppositions and require something different.

If physiotherapists were to more overtly acknowledge the position of physiotherapy and rehabilitation as “*social processes embedded within larger socio-political systems of relations*” (Gibson and Teachman 2012;474) and these discourses were more widely infused into the physiotherapy mindset, they might positively influence client care. It is to be hoped that some of the alternative approaches and paradigms discussed in chapter 2 may also inspire and support change in these areas.

### **8.8.2 Understandings of disabled students**

When discussing ‘what physiotherapists are like’ participants accounts suggested a stereotypical and relatively unquestioned physiotherapy ‘way of being’: this is what physiotherapists are like whether disabled or not. Given participants’ experiences and my reading of the available literature, it is perhaps unsurprising that few disabled students seemed comfortable in sharing information about their impairments.



Participants assumed that students should feel confident and know what they needed to perform satisfactorily on placement and what strategies they would use to manage this, expecting students to 'overcome' disability. Accounts indicated, however, that few disabled students arrived on placement suitably prepared, although their focus may have been on those who did not perform well. They sometimes appeared to be judged as failing to match up to the ideal, that is, the successful non-disabled student. Physiotherapy is strongly influenced by notions of ablebodiedness and this normative approach could have perpetuated unequal or oppressive social relations in the placement dyad. This could act as a significant barrier to inclusion in practice placements.

It is possible that educators found it difficult to break away from these ways of thinking when they encountered disabled students, if indeed they realised there was any requirement to do this. There was little evidence in their accounts that they engaged with ideas from critical disability theory that could have offered counter-narratives to these approaches. Perhaps the largely normative ethos underpinning the clinical setting acted as a barrier to participants investigating and considering more widely the lived experiences of disabled people. One aim of this work is to provide specific opportunities for discussion and to encourage a more balanced and informed approach to understanding disability differently, so attempting to combat and challenge the situations described by participants which continue to polarise their views of disabled students.

### **8.8.3 Understandings of disability**

Participants' language indicated what might be underlying attitudes towards disabled people, such as defining students by disability ("*She was a physical disability*"). This use of language is common and is described by Hebl and Kleck (2003) as a societal constraint that disabled people experience. These labels can indicate an inability to measure up to some appropriate level; being outside what is commonly termed as 'normal' and perhaps in this case "what is a 'normal' physiotherapist"? This again returns us to capital and habitus as in, only those who have the 'right' forms of capital can become 'one of us' (Bryne 2014). The physiotherapy 'way of being'; the ways that physiotherapists with various forms of capital 'do things' leading to 'appropriate practice', status and distinction in the field (Edwards and Imrie 2003, McDonough and Polzer 2012). Students are inevitably compared with the relatively unquestioned 'way of being' and stereotypical views of this were apparent in participants' talk about students in relation to 'being' physiotherapists. Perhaps the

presence of disabled students in the clinical setting challenged these views, causing dissonance because disabled people were generally clients, not colleagues.

Some use of terminology was telling; one participant referred to some disabled people as having the “*wrong personality*” and noting that almost inevitably they would become depressed. This assumption, about disabled people who have ongoing impairments, was made based on a transitory experience. Simulation is being used more regularly in physiotherapy education at both under and postgraduate levels. Pedagogically the intention of some simulation exercises is to enable participants to understand what it is like to have a condition or impairment. A criticism that is raised against this, however, is that it can lead to misconceptions about disability (Atkinson and Owen Hutchinson 2010). What is experienced is what it is like to wear a blindfold or to sit in a wheelchair. Arguably participants do not gain genuine insight into the disabling experience of having persistent impairment, experiencing none of the long term societal or personal barriers that are encountered by disabled people.

Ironically, then, what is often unintentionally by a person’s experience of temporary incapacity, is the reinforcement of the misconceptions which the exercises were designed to dismantle. This could be another factor in the development of physiotherapists’ normative professional habitus so (re)producing doxa within the clinical field. One participant’s experience of having a broken leg and the assumptions that she made about disabled people because of that were a case in point. The ‘victim’ is presumed to be either helpless or heroic. The parallel here is illustrated by participants’ apparent perceptions of disabled students as either ‘problematic’: unprepared, unable to reach recognised competency levels and needing a great deal of support, or as ‘no problem’: successful, fully assimilated with effective strategies in place and needing little, if any, support.

Sometimes students were considered through the medical lens with labelling/naming the impairment equating with easier management; the physiotherapists could somehow ‘make it better’ as they would for a client. This solution focus empowered the educators, increasing their confidence but meant that the pressure to share information could undermine the student’s position leading to a power imbalance. This was another example, in Bourdieusian terms, in which different amounts of symbolic, social and cultural capital were attributed to each of the agents in the field.

To conclude this section, it appeared that participants were often influenced by traditional views of disability which position the professional as the powerful expert and the client as dysfunctional 'other'. Widely accepted and 'evidence based' instruments (e.g. the ICF) allow the professional to step away from the client, to putatively objectify the body and to be removed from the affective domain. Disability consequently becomes more visible or 'concrete' and arguably, more manageable. As Butler (2004,21) notes:

*“the very bodies for which we struggle are not quite ever only our own...the body invariably has a public dimension; constituted as a social phenomenon in the public sphere”.*

Dominant groups (the educators) set the parameters and hold power/authority; having a greater influence in determining the structure of society (the clinical educational field). Targeted groups (disabled students) are often labelled as defective or substandard: assumed as innately incapable of performing the preferred role (Tatum 2013). Campbell (2008b) characterises this in the following way: educators act as protectors, guides, role models and intermediaries for disabled students based on the assumptions that the students are helpless, limited, dependent and only acceptable when they are unobtrusive. While this appears harsh, there was some evidence that participants viewed disabled students in this way. If this is the case, it could mean that awareness of disability issues is limited and may lead to self-perpetuating stereotypes (generally posited as pejorative (Kirk and Okazawa Rey 2013)) and can pervasively create and support prejudice (Biernat and Dovidio 2003).

## **8.9 Pedagogy in the clinical setting**

### **8.9.1 Learning styles**

Physiotherapy education seeks to focus on individual learning differences, aiming to facilitate problem solving using a critical thinking approach to encourage reflective practice and lifelong learning. These are required to meet the evolving needs of the profession and students and must be manageable for practice educators while engaging with professional values. This is a difficult balance to achieve in the healthcare field where education is not the main emphasis or purpose of clinical staff. Uncritical use of learning styles has been described as disempowering due to a dissonance between educators gaining a greater appreciation of individual differences and yet being unable to operationalise this within the constraints of the teaching environment (Kinchin et al 2008). This was evident from

participants' accounts in that they all noted learning styles and yet still often expected students to fit in with their pre-arranged timetables and teaching activities usually dictated by workplace pressures within the structured field of the clinical setting.

### 8.9.2 The role of the practice educator

Findings highlighted how participants viewed their role, indicating high levels of commitment to facilitating students' learning experiences. They did, however, describe challenges when required to assume conflicting roles. On the positive side educators wanted to provide support necessary to enable students to be successful, experiencing this as constructive, gaining a sense of satisfaction and fulfilment which could be an incentive to taking students on placement.

Participants' accounts suggested that if physiotherapists were good at 'dealing with' disabled clients then they were automatically well placed to support disabled students; the skills transferring from one group to the other. This appeared to be an empowering position for the educators. The therapeutic alliance with a client is, however, different to the relationship of an educator to a student. The traditional role of the therapist is to rehabilitate, to aid in recovery and to care for the client: the notion of normalisation and return of the client to full functioning in society (Goodley 2013). In contrast, while the role of educator in this context had enabling and facilitatory elements, participants saw themselves as having the concurrent responsibility of acting as gatekeepers to the physiotherapy profession, judging students' performance and standards of practice in relation to benchmarks set by regulatory and professional bodies. These could be considered factors in the development of educators' capital and habitus enabling positioning in relation to academic staff and disabled students within the co-mingled clinical/pedagogical field.

When students did not perform well, educators' accounts indicated frustration and dissatisfaction. Adding further layers of complexity, universities had pedagogical requirements, providing frameworks and marking criteria for placements all set within the complex and constantly changing field of the NHS. Simpson and Murr (2013,119) go so far as to characterise the passing or failing of a student as a political act which occurs because of the *"powers and privileges conferred by society on people attaining professional status"*; so, it may be the case that disabled students who failed, did so as a result of factors other than incompetent practice. While this can apply to all students, it could be argued that the

educators' understandings of disability may have been a factor affecting their approach to the assessment and evaluation of disabled students' competence.

### 8.9.3 The university

Professional experience indicates that academic teams assume that practice educators share their understanding of the ways that teaching and learning is approached and that assessment is carried out in a dialogic and agreed manner with students. This may not be the case, however, particularly if educators are constrained by the field in which they practice. Universities offer workshops for educators to provide opportunities for them to develop an understanding of teaching "*beyond basic tacit pedagogical principles*" (Kinchin et al 2008,273). Given the attention to a gatekeeping role, however, there was perhaps an inevitable focus on content and competence which may have been at odds with an appreciation of the student's learning experience. Arguably, ideas of student-centred learning might have been problematic for participants particularly if they did not see themselves primarily as educators.

While participants' accounts indicated acknowledgement of individual differences, there were many occasions when they identified a 'norm' in relation to what students should be able to do, falling outside of this led to perceptions of increased challenges. A need for resources was specifically mentioned, often relating to human cost: the effort that educators had to expend, such as more time and more supervisory input being required for a disabled student, in comparison to other students. This is a complex story which may result in both students and educators having inconsistent experiences of the clinic as an educational field.

Participants felt they did not have the expertise regarding disabled students requiring specialist equipment or more extensive reasonable adjustments, wanting advice and guidance from the academic team. This perceived lack of knowledge and skills appeared to disempower the educators; they lacked control over the situation and could not support the student which they believed had a subsequent effect on the student experience. As noted in Chapter 4 given the pressures experienced by practice educators, the provision of effective support from universities is considered to be crucial (Tee and Cowen 2012). Participants anticipated high levels of assistance from academic teams but they all described unsatisfactory experiences and issues in this regard, indicating lack of knowledge, awareness or willingness to help in cases of challenging situations with disabled students. It

appears therefore, that in this small sample the role of the university was found wanting in relation to both student and educator support. This mirrors the concerns noted by the Quality Assurance Agency (2007) regarding support sometimes being inadequate and the consensus that practice educators across a range of healthcare professions do not feel well prepared to take students (Kenyon and Peckover 2008; Walker and Grosjean 2011).

If assistance was provided by the university, this was usually a discussion between the participant and the academic team; the voices of disabled students were generally absent. Perhaps this approach disempowers the student given that both practice educator and academic have far greater levels of symbolic and cultural capital in the clinical education field. I noted one participant stating that academic staff do not know what it is like in the 'real world' perhaps indicating a difference in perceived habitus: that her cultural capital was higher than theirs in the clinical field, relating to back to 'a sense of one's place' and the 'sense of the place of others' (Bourdieu 1989). This positioning may not be helpful in building a consistent approach to supporting disabled students.

In my professional experience working with many universities in the UK, academic workshops offered to educators often allude to 'challenging' students. Issues relating to the support of disabled students are discussed under this heading, along with a range of other identified 'categories' of student. If not presented appropriately in the workshops this could accentuate or consolidate negative assumptions or expectations, with all disabled students presented as challenging. It would perhaps be more productive to think about all students arriving on placement with varying skills, knowledge and abilities which may translate into strengths or challenges. As noted by Cook et al (2012) provision of adjustments should be part of a continuum of support for all students, not as a separate entity.

## **8.10 Summary**

To conclude this section, while participants were committed to their role as educators and to supporting disabled students, there were elements of capital and habitus within the co-mingled clinical education field that generally reproduced practices, many of which were largely unquestioned (doxa), at least in a critical sense. High value was placed on their abilities to support and enable disabled students to be 'the same' and perform 'as well' as their non-disabled peers. Participants applied their tacit knowledge of the social order and did what needed to be done according to their own internalised logic about their roles as

educators and the positive outcomes of clinical education. If it was not possible to enable this 'normal' performance, issues arose about lack of support or lack of participants' own knowledge, skills and expertise. Arguably these factors went some way to (re)producing the habitus of participants and the doxa of the clinical education field and perhaps the physiotherapy profession itself in relation to disabled students and academic members of staff.

The way that disabled students were discussed and represented could be considered as worsening their social positionings and improving those of the educators. Being a 'well adjusted' disabled student with effective strategies in place could be viewed as a positive source of cultural capital by practice educators perhaps enabling these students to enhance their status in the clinical placement field. The converse would then be true for those disabled students seen as 'challenging'.

When participants had experiences where initially a disabled student did poorly but then through disclosure, support and sometimes help from the university, successfully completed the placement, negative capital was transformed into positive for the educator and to some degree, the student. It is perhaps useful to counter this to an extent by remembering that participants viewed the turnaround in students' fortunes as a result of their hard work with little attention paid to students' efforts, characterised by one participant's comment: *"Well done us!"*

Disabled students who failed retained their negative status as not having adjusted to their impairments, not putting strategies in place and however hard educators worked, even with academic support, the perception often was that they could not be successful as a direct result of their disability. This type of hierarchical valuing of individuals because of presence/absence of impairment and perceived ability to 'manage' is a concept rarely addressed by physiotherapy educators.

It is useful here to remind ourselves of the concept that habitus is a reciprocal process in which individuals subconsciously embody and in part create the social structures of their world through everyday interaction in it (Smith 2014). Bourdieu (1990b,116) talked about habitus as a result of social conditioning and that it could develop *"...in a direction that transforms it and, for instance, raises or lowers the levels of expectations and aspirations"*. I aim, through this work to offer some opportunity to 'defy the doxa', to offer the invitation

to educators and disabled students to enter into dialogue and reflective activities that might begin the process of moving the habitus in a direction that could effect some transformation; to raise expectations and aspirations through a change in thinking and practice.



## **Chapter 9 - Conclusions and Implications**

### **9.1 Introduction**

This chapter provides overall conclusions and considers implications for practice as a result of this study. It includes some analysis of the ways in which critical exploration might enable individuals to think differently about the physiotherapy profession plus some thoughts regarding possible developments in the inclusivity of the curriculum. The chapter concludes by suggesting ideas for further research and some reflections on the study.

### **9.2 Challenges of supporting disabled students**

This study highlighted that participants often regarded supporting disabled students as challenging, although this was not always identified as a direct consequence of the impact of their impairment. Arguably the values, forms of power and capital, and the resources of the clinical field that lead to particular ways of doing things which subsequently influence practice are the underlying cause of these challenges. As noted the reason for this may be that with regard to disability, these practices are largely unquestioned.

All participants' accounts indicated that barriers to effective clinical education for disabled students occurred because of workplace pressures, less than satisfactory communication and the paucity of systems in place to support both them and the disabled students in the clinical setting. These extrinsic factors over which they had little control appeared to take precedence meaning that participants did not attempt to examine or question their own established practices with any criticality.

Arguably, in pragmatic terms, many of the difficulties identified could be abrogated by establishment of processes that effectively communicate information and guidance to educators in advance of placements. Additionally, support for the students to enable them to consider ways in which their impairments might impact on clinical performance, to develop strategies and to communicate this information to their practice educators in a supported manner, could go some way to addressing these barriers. I would argue, however, that even if all the pragmatic issues could be effectively managed, the underlying issues of the field, habitus, capital and doxa of physiotherapy practice and identity, as well as the affective factors influencing disabled students' behaviour, need to be acknowledged and addressed if change is to occur.

### 9.3 Disruption of doxa?

The findings of this study have led me to think about disruption of the physiotherapy doxa. I believe that change is possible but that there are many challenges in how to approach this, in order to provide opportunities for ideas related to disability to be discussed within the profession. I acknowledge that there are limits to what I could do alone in changing the field, although I continue to work whenever possible at a national level to feed into policy developments regarding disability. Elements such as financial, workload and resourcing pressures are outside my scope of influence to change, however, it is possible to challenge awareness and understandings of (dis)ability and ableism and to enable practitioners to consider what this means for practice.

It would be logical to assume that academic staff would be well placed to co-ordinate these activities given that they are responsible for overseeing students' educational experiences. Participants indicated in their accounts, however, that overall, universities did not provide enough support in relation to helping disabled students. I would suggest, therefore, that there is work to be done with academics as well as placement educators to enable them to begin to engage with the affective domains that may influence a disabled person's behaviour or experience. The overlapping fields of HE, the NHS and disability in which the students are embedded, with the associated capital, habitus and doxa make this task more complex.

### 9.4 Practice

This study and other research indicate that there is a practice gap in relation to supporting disabled students. As far back as 2007 the Disability Rights Commission noted that poor planning, poor communication of reasonable adjustments, lack of co-operation from placement providers, lack of awareness of disability issues and relevant legislation and a reluctance to disclose on the part of students led to the potential for discriminatory behaviour to occur. More recently, Botham and Nicholson (2014) reported that in physiotherapy clinical education, a lack of insight into, and awareness of, disability issues led to a lack of confidence in both academic and practice-based staff when working with disabled students.

All participants in this study expressed a wish for more advice, but some reported that despite having access to training, the long periods between supervision of disabled

students meant that in the interim they had forgotten much of the guidance provided. Participants' accounts largely indicated a solution focussed approach, that is, if the student has 'X' impairment and we do 'Y', s/he will be able to perform at the required standard. As discussed, this could be related to the educators' doxa and habitus resulting from immersion in the well-established, largely normative biomedical field viewing both disabled clients and students/colleagues through a medical model lens. Perhaps a more productive way to address this would be to take a holistic and inclusive approach to all students, rather than viewing disabled students as a problem to be solved. If varying skills, knowledge and abilities were to be assessed on a continuum, enabling translation of these into strengths to be built upon or challenges requiring personal development, this might enable practice to move on by disrupting taken for granted assumptions, encouraging and invigorating debate, so beginning to counter the potentially exclusionary side of social capital (Bryne 2014).

## **9.5 How might change be facilitated?**

Critical physiotherapists are exploring ways in which the profession might develop by working with clients and with other professionals more effectively rather than being necessarily defined by what physiotherapists 'do'(CPN 2015). Participants' accounts foregrounded what they did, and everything that was done appeared to provide their conceptual framework for physiotherapy. Additionally, the focus within education and the curriculum is largely on content and competencies.

A reconceptualisation of physiotherapy would enable consideration and embedding of different values and principles in relation to practice. Addressing the organising principles of rehabilitation within the academic setting may be a starting point for change: a move away from reliance on biomedicine for definitions of disability and to expand the concept of movement from the purely physical to embrace sociological, emotional and political elements (Gibson 2016). This type of teaching would begin a process of problematising the concept of normalisation within rehabilitation to enable a more critical approach to be taken although it would inevitably raise dilemmas in relation to what it means to be a physiotherapist. This needs to be explored by educators, researchers and critical practitioners through further research, discussion and dissemination of ideas. The enactment of this type of 'sea change' is challenging within the education and clinical settings where decisions are constrained by a wide range of stakeholder requirements.

There is a tension between the idea of the professional working in a value free and neutral manner, in a mechanistic or instrumental way, in contrast to the more person-centred approach that celebrates difference in all its forms suggested by critical physiotherapists.

In extrapolating these ideas into the clinical education setting, support for educators would require discussion and examination of priorities to increase understandings and awareness of disability issues taking into account the pressures under which they have to work. It would be crucial for academic staff to be able to introduce these concepts without disenfranchising clinicians. It is incumbent upon physiotherapy academics and those practitioners researching and working with clients differently to lead this process but in a way that can be accepted and incorporated by the wider physiotherapy profession. In the short term, there appears to be a clear requirement for improved dialogue between academic and practice-based staff and students. Further work could be carried out to explore what might comprise this enhanced framework of communication, awareness and understanding.

In the longer term, academic staff could access the results of this study and similar research to begin to address 'the fix we are in' and to consider doing things differently. Inclusive pedagogical practice should extend beyond issues of disability. This can impact on the curriculum by providing opportunities for all staff and students to examine their understandings of difference in relation to their roles as physiotherapists: their practice and professional identity. Opportunities could also be offered to qualified physiotherapists to facilitate exploration and awareness of their own values and understandings in relation to disabled students and colleagues. This could enable examination of the differences that exist between their relationships with this group as opposed to the therapeutic alliances they forge with disabled clients.

This work has reiterated for me the importance of providing more opportunities within the curriculum, physiotherapy research and clinical network groups for exploration of professionalism and psychosocial aspects of health, through critical thinking and reflection. The new public health curriculum (Hindle 2017) and other recent developments noted in chapter 2 may facilitate this, providing opportunities for discussion and negotiation of the varying and sometimes competing discourses that exist within both physiotherapy and healthcare settings. This may initiate some challenge to the doxa and habitus of

physiotherapy and the clinical field that (re)produce inequalities, prejudice and discrimination.

There are pedagogical possibilities of assisting students to learn more effectively about difference and encouraging exploration of their social and professional identities. As noted in chapter 2 varying amounts of attention is given to these concepts in current physiotherapy curricula. Classroom discussions can encourage students to explore professional interactions with clients or colleagues, to consider how they position themselves, given their perceived identity, in relation to assumptions they might make about others or that others might make about them. This would enable them to consider how this impacts upon their practice and professional relationships in academic and clinical settings so perhaps influencing the development of their physiotherapy habitus.

## 9.6 Further research

The voices of disabled people are acknowledged to be absent in this research but need to be part of the wider dialogue. As noted, the driver for this study was an earlier piece of research involving exploration of the experiences of VI physiotherapists in their transitions from HE into the NHS. A strong theme that emerged was that of the importance of the practice educator in their student journeys. The influences described were both positive and negative but were undoubtedly formative for those disabled students. This was why I felt it important to explore the situation from the educators' perspective.

Whilst this study has provided rich and sometimes unexpected data and can be argued to have added to the overall picture of understandings of disability and the support of disabled physiotherapy students on placement, it leads to other questions that need to be addressed. I would like to return to disabled students to explore their positionings in relation to the doxa and habitus of the profession. Because of these influences students are constrained in particular ways in negotiating their physiotherapy identities given the power dynamics and regulatory frameworks existing within the structures and social relations in the field of healthcare and in the pedagogical relationships of educators with students. This affects all students, but in the light of the findings of this study, I would argue that the doxa and habitus of physiotherapy practice may be even more challenging for disabled students. The novel ways in which physiotherapy and disability have been more critically explored in this study would provide a subtly different perspective through which to examine disabled students' physiotherapy identity.

If new, more critical ways of thinking about physiotherapy identity, positioning and power were introduced into the curriculum it would be an exciting opportunity to study and gain an insight into the ways in which this might impact on students' perceptions, abilities and practice as they transition into the world of work, so influencing professional capital and habitus.

Other absent voices are those of academic staff who make up the third element in the overall picture. While still clinically aware (many being lecturer-practitioners with 'a foot in both camps'), there are other drivers with which we have to contend. While I would argue that there may be considerable overlap between some areas of our habitus, doxa and capital and that of practice educators, we are embedded within the field of education which has other emphases producing discrete requirements and workplace pressures. Enactment of the equality legislation and an emphasis on widening participation has seen higher numbers of disabled students undertaking physiotherapy education (and/or more 'disclosure'). It would be helpful to establish a fuller picture of the overall situation in physiotherapy education by engaging with this group in relation to their experiences of supporting disabled students particularly in the transition from university to clinical placement.

## **9.7 Reflective statement**

The impact of this work on me has varied. As noted in chapter 5, I have taken a proactive role in this arena for over twenty years and it has been fascinating to have the opportunity to hear participant stories and to see the situation through their eyes. However, it has also been disappointing to explore the 'the fix we are in' and to see the apparent lack of progress given the time and energy I have spent working in this field. There appears to me to be a relatively unchanging picture regarding the position of 'othered' individuals in a range of settings and more particularly the position of disabled individuals in health education. I was privileged to speak to my participants and some of their stories were quite remarkable. On the one hand I was irritated by some of the things that were said, and I felt constrained not to fully apply critical disability theory at times as it seemed too harsh a perspective to take to a profession I have been a part of for thirty-five years. On the other hand, having spent years working with disabled students and their educators, I understand the underpinning and history of the physiotherapy profession and the constraints and pressures of the world in which it operates which has defined its doxa.

I have been fortunate to work with a range of extremely generous and politicised disabled colleagues who have helped to develop my thinking in ways that are not central to the habitus of most physiotherapists.

Through presentation of this thesis and dissemination of the findings at conferences and in journal articles, by contributing to the work of our professional and regulatory bodies and continually through my everyday work, I seek to raise consciousness about these important issues. I aim to stimulate debate and to offer colleagues an invitation to enter into dialogue and to reflect to begin the process of moving habitus in a direction that could effect some transformation through changes in thinking and practice. As a result, practitioners may be encouraged to take a more critical stance in relation to established practice and 'ways of being'. As noted, through this work, I hope in some small way to set out my "*heretical opinions in broad daylight*" (Bourdieu 1984,424), to 'defy the doxa' and encourage physiotherapists (and other health professionals) to think differently and to recognise and change their habitus to the benefit of all.

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## Appendix 1 – Questionnaire

## Supporting Disabled Students on Practice Placement

### 1. Background information - you and your work

**1. Please describe your work context: e.g. hospital (ward based/OPD ), community, GP practice, school etc.**

**2. What is your clinical specialty/area?**

**3. Grade/band**

**4. Year of qualification**

**5. Please indicate your age**

- 20-29  
 30-39  
 40-49  
 50-59  
 60-65  
 Would rather not say

**6. Are you:**

- Female  
 Male  
 Would rather not say

**7. Do you consider yourself to be disabled?**

- Yes  
 No  
 Would rather not say

### 2. Supervision of students

## Supporting Disabled Students on Practice Placement

For the purposes of this questionnaire, the term 'disabled' includes the following: sensory impairments; long term health conditions with controlled, fluctuating or progressive effects (e.g. MS, RA, diabetes, chronic fatigue, epilepsy and so on); neurodiversity issues such as dyslexia, autism, dyspraxia; mental health problems; other physical impairments (e.g. amputation, arthritis)

### 8. For how long have you been supervising students?

### 9. To your knowledge have you supported disabled students on practice placement?

- Yes  
 No  
 Don't know

### 10. Do you think that it would always be important to know whether a student is disabled when coming into the clinical setting?

- Yes  
 No  
 Not sure

Please explain your response

### 11. How did you find out that the students you have supported were disabled? (Tick as many as are appropriate)

- University contacted me in advance  
 Student contacted me in advance  
 Student told me on arrival at the placement  
 Informed by a colleague  
 It became apparent through observing the student and through discussion with them during the placement  
 It was never discussed but I suspected  
 I didn't know  
 Not applicable  
 Other (please specify)

## Supporting Disabled Students on Practice Placement

**12. How would you like to be notified about disabled students who are coming to work with you e.g. discussion with student, letter from university, phone call from university staff etc?**

**13. What information do you think would be helpful?**

### 3. Training

**14. Have you attended any practice educator courses?**

- Yes  
 No

### 4.

**15. Who provided these courses? (Tick as many as are appropriate)**

- Local university  
 In house/in service training  
 Other (please specify)

**16. When was the last time you attended one of these courses?**

**17. Did the course(s) include any specific information/training on supporting disabled students?**

- Yes  
 No

If yes, please briefly indicate what was covered:

## Supporting Disabled Students on Practice Placement

**12. How would you like to be notified about disabled students who are coming to work with you e.g. discussion with student, letter from university, phone call from university staff etc?**

**13. What information do you think would be helpful?**

### 3. Training

**14. Have you attended any practice educator courses?**

- Yes  
 No

### 4.

**15. Who provided these courses? (Tick as many as are appropriate)**

- Local university  
 In house/in service training  
 Other (please specify)

**16. When was the last time you attended one of these courses?**

**17. Did the course(s) include any specific information/training on supporting disabled students?**

- Yes  
 No

If yes, please briefly indicate what was covered:



## Supporting Disabled Students on Practice Placement

### 5. Training in the work place

**18. Has your employer provided any specific training on disability?**

- Yes  
 No

### 6.

**19. If yes, did this relate to your interactions with:  
(Tick as many as are applicable)**

- The public?  
 Patients?  
 Relatives/carers?  
 Colleagues?  
 Students?  
 N/A

**20. Do you think that the training has enabled you to provide better support for disabled students in the clinical teaching environment?**

- Yes  
 No  
 N/A

Please explain your response

### 7. Working with disabled students

**21. In relation to the disability legislation, how would you rate your level of knowledge with regard to the reasonable adjustments you should make when supporting disabled students in the clinical situation?**

	Excellent	Good	Fair	Poor
Rating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**22. How well prepared do you feel to support disabled students?**

	Extremely well prepared	Very well prepared	Quite well prepared	Poorly prepared	Not at all prepared
Rating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Supporting Disabled Students on Practice Placement

**23. Please indicate your level of agreement with the following statement:**

**"My workplace supports me very well in developing my strategies for supporting disabled students"**

Strongly agree      Agree      Neutral      Disagree      Strongly disagree

Level of agreement                             

Please explain your response

**24. How many universities send students to you for practice placements?**

**25. Of these universities, how many do you feel support you well in developing your skills and strategies for supporting disabled students?**

**Please provide more information if you wish:**

**26. Where would you/do you obtain advice and guidance on supporting disabled students? (Tick all that are applicable)**

- Academic staff
- Colleagues
- The student
- Occupational Health
- Disability Service at the University
- Chartered Society of Physiotherapy
- ICSP
- External agencies/organisations e.g. British Dyslexia Association, RNIB, RNID, Mind
- Other (please specify)

## 8. Positive and negative factors

## Supporting Disabled Students on Practice Placement

**27. What factors do you feel act as barriers to you providing support for disabled students?**

**28. It is really helpful to share good practice. What has worked well for you when supporting disabled students?**

**29. What would help you to provide better support for disabled students? (e.g. information/resources, targeted training, awareness raising in the workplace, more communication with student etc):**

### 9. Other comments

**30. Please add any other comments that you feel are important**

### 10. Thank you and request for participants

## Supporting Disabled Students on Practice Placement

**31. Thank you very much for taking the time to answer this questionnaire.**

**If you would be willing to take part in an interview to explore these issues in more depth, please provide your name, a contact telephone number and email address below.**

**If you would like more information before deciding please contact Karen Atkinson on 02082234950 or email: [k.a.atkinson@uel.ac.uk](mailto:k.a.atkinson@uel.ac.uk)**

**Thank you!**

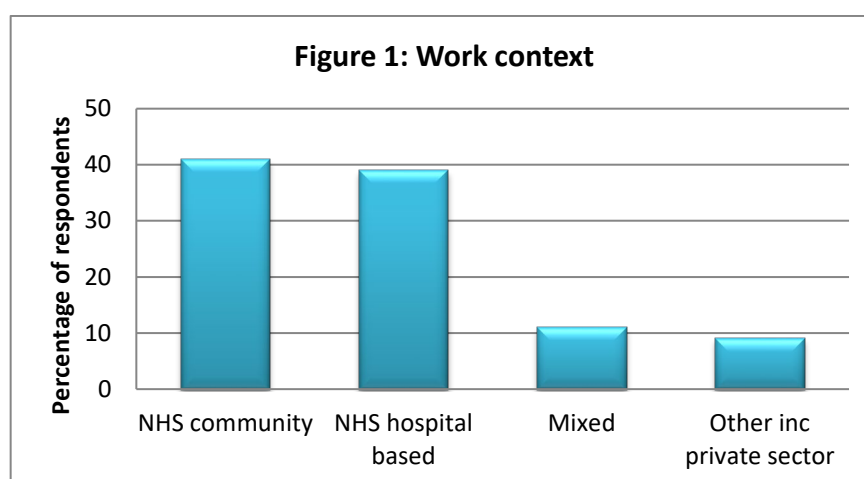
## **Appendix 2 – Analysis of Questionnaire Responses**

## Questionnaire analysis

Seven hundred and eighty three questionnaires were administered and 121 responses received (15.5% response rate). The SurveyMonkey questionnaire was closed on January 31st 2012. One hundred and twenty one respondents started the questionnaire and 113 completed it.

### Work context

Respondents worked in a wide range of contexts, mainly the NHS, but with some based in the private/independent sector. The work settings included hospitals (41%, n = 46), the community (47%, n = 53) with some working across both sectors (11%, n = 12). Those in hospitals represented both in- and outpatient settings and in the community locations include clinics, community hospitals and patients' homes. 9% (n = 7) worked in other contexts including schools, care homes, hospices and the private/independent sector (Figure 1).

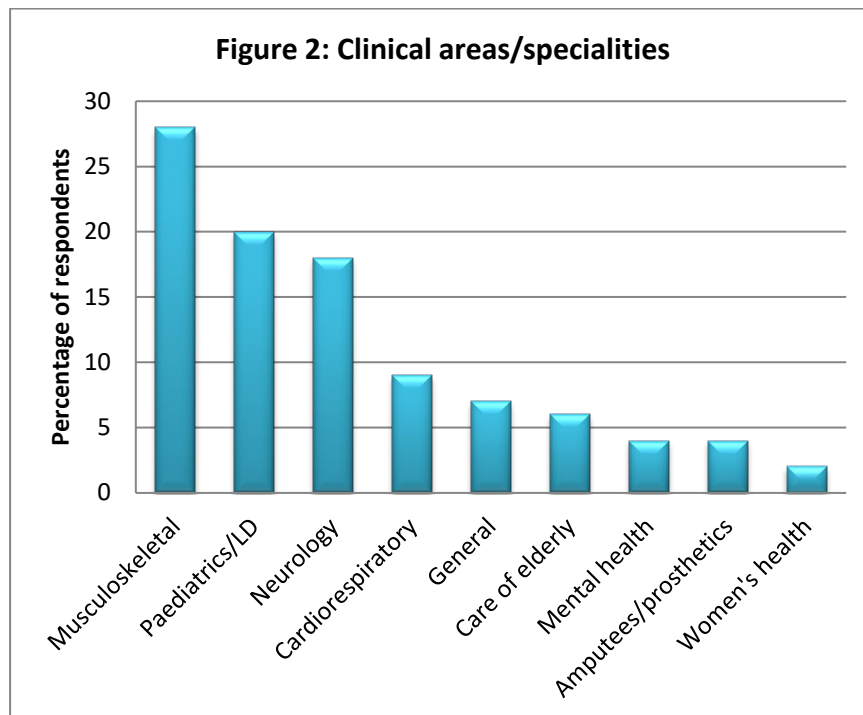


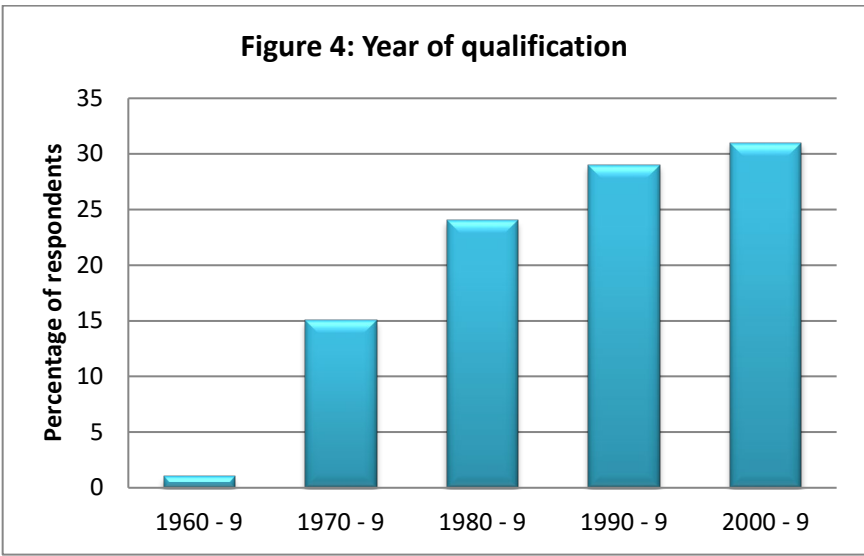
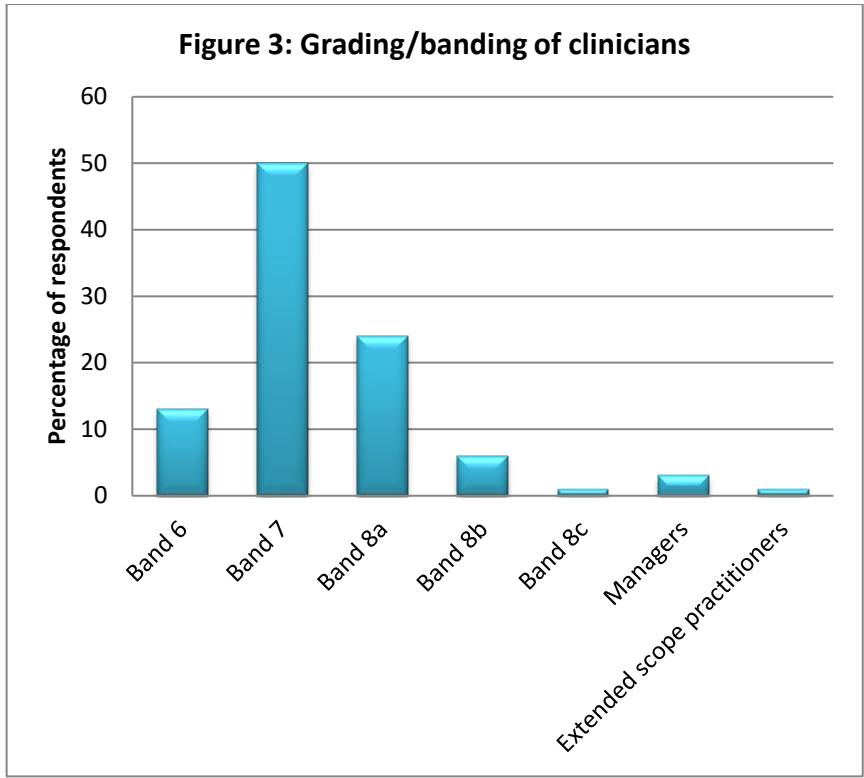
### Clinical areas/specialities

The clinical areas/specialities represented (Figure 2) reflect the range of traditional areas most students experience during their practice placements (musculoskeletal – both outpatients and orthopaedic wards, cardiovascular respiratory, neurology and care of the elderly). Students were less likely to experience in areas such as mental health, women's health, amputees and prosthetics and paediatrics although these were all represented in the sample.

### *Grading/banding of clinicians and year of qualification*

Universities generally expect practice educators to be of a senior level in order to have the experience to provide support and an effective learning environment. To be working at a Band 6 level a physiotherapist has usually worked at junior (Band 5) level for at least a year post qualification. Figures 3 and 4 show that respondents were all Band 6 and above and had been qualified for at least 3 years at the time of the survey.





No junior therapists (Band 5) responded to this questionnaire although, anecdotally, and from experience of visiting students on placement, Band 5s are sometimes delegated the responsibility of supervision.

**General demographics**

The majority of respondents (64% n = 72) were aged between 30 and 50 years and 26% (n = 29) between 50 and 59 indicating that practice educators tend to be older,



more experienced clinicians. 84% (n = 95) of respondents were female and 16% (n = 18) were male; reflecting the overall pattern within the physiotherapy profession which is predominantly female (3.75 female: 1 male (HPC 2011)). Three point five percent of respondents (n = 4) identified as disabled.

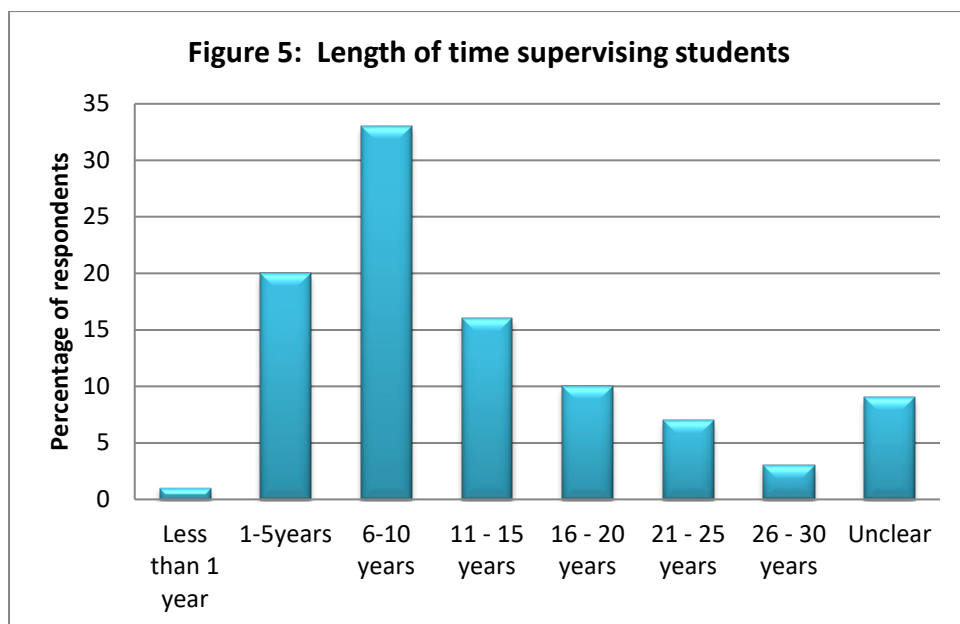
### Student supervision

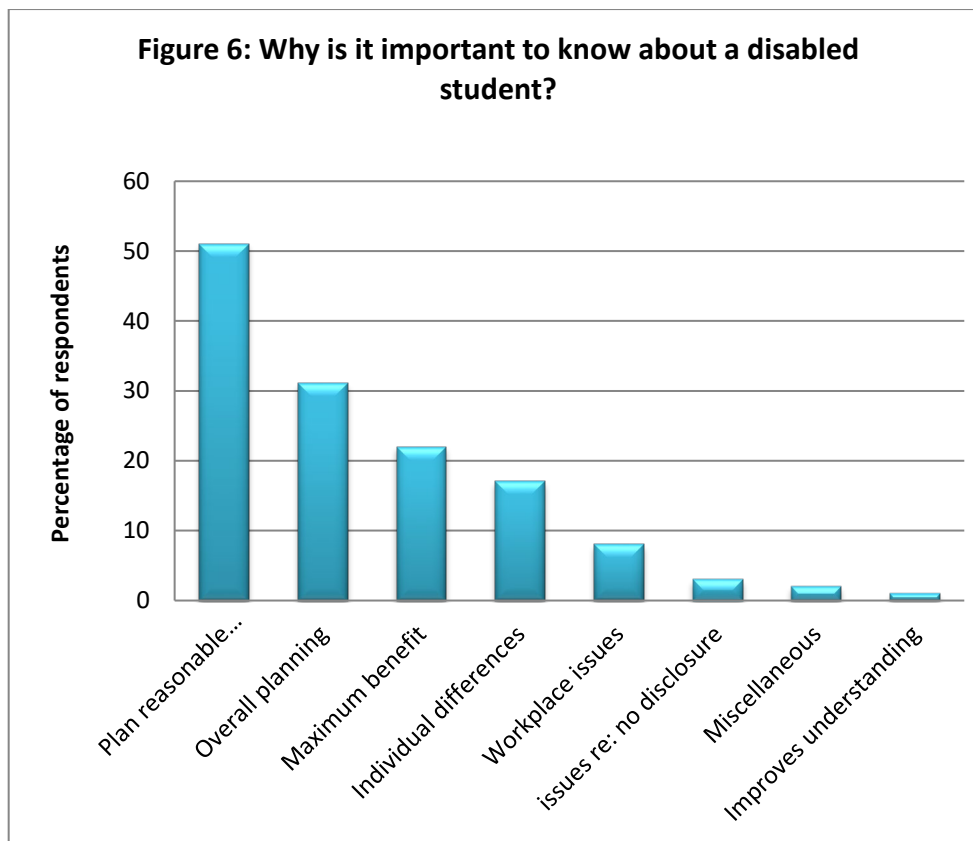
Respondents had a range of experience in relation to the length of time they had been supervising students (Figure 5). Most respondents had considerable experience of supervising students but only 62.8% (n = 71) stated that they had supervised disabled students. Thirty three point six percent (n = 38) had not been responsible for disabled students and 3.5% (n = 4) did not know.

### Disabled students

Whether they had supervised disabled students or not 91% (n = 103) of respondents felt it important to know if a disabled student was coming onto placement. The reasons for this clustered under headings relating to the need to:

- prepare and plan in advance
- put reasonable adjustments in place
- ensure that students got the most benefit from the placement (Figure 6)





Some open responses indicated that it was not always necessary to know about a student's impairment if it had no impact on performance or if the student had effective strategies in place. It was recognised that disclosure can be a difficult process as a result of issues such as prejudice and stigma. Some respondents noted that this might be too much to expect of the student in addition to the already stressful situation of being on placement. Occasional comments acknowledged that students do have a choice as to whether they should disclose to their educator or not.

Most respondents, however, felt that disclosure was essential and that non-disclosure caused unnecessary problems such as educators not being able to prepare in advance or modify workloads. If impairments were not disclosed, they thought that this could affect their assessment of the student's capabilities. They could mistake features of poor performance, such as being slow or having poor time management, as lack of competence or engagement, when these could have

been due to a student having dyslexia or dyspraxia for which effective reasonable adjustments might have been available.

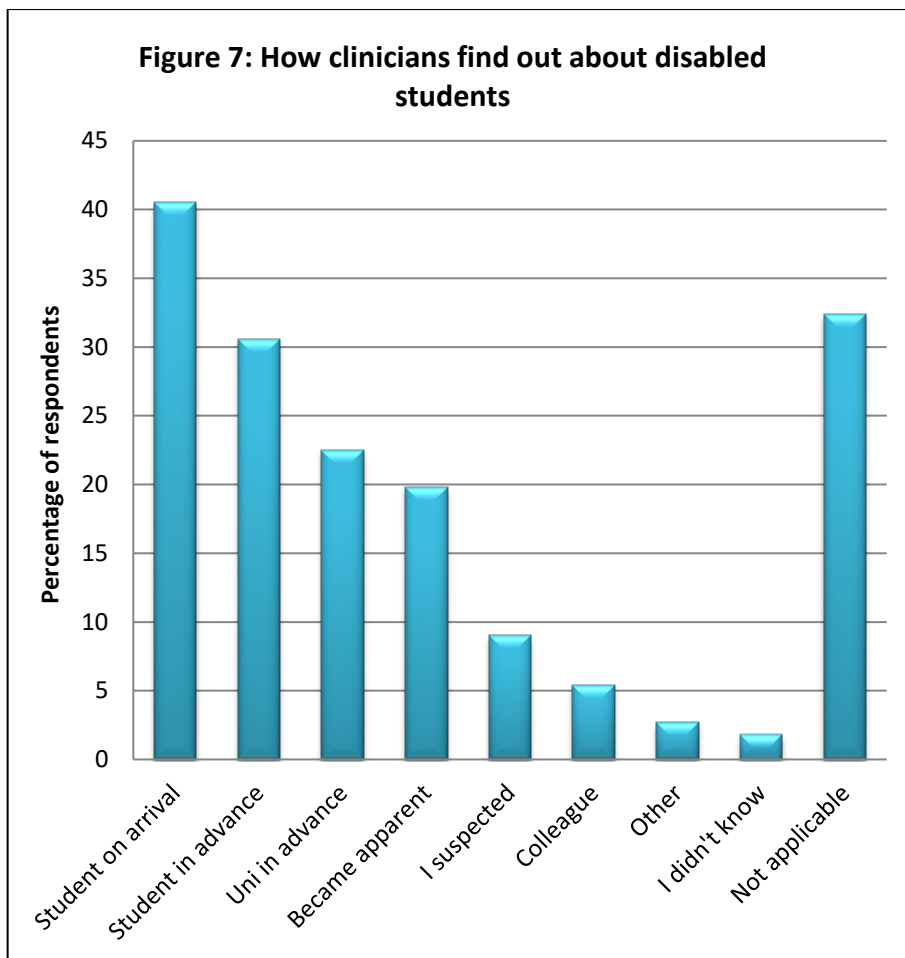
Workplace issues such as heavy workloads, staff shortages and particular types of client group or environments were identified as key reasons why respondents needed to know when a disabled student was coming to their area. One percent of respondents noted that knowing about the presence of a disabled student enabled better understanding and raised awareness of disability issues in the workplace.

Respondents reported various ways in which they found out that a disabled student was coming on placement (some indicated more than one method). The most common way they discovered this was through contact with the students themselves either in advance of, or on commencement of, the placement. In some cases the university played a part in the process (Figure 7).

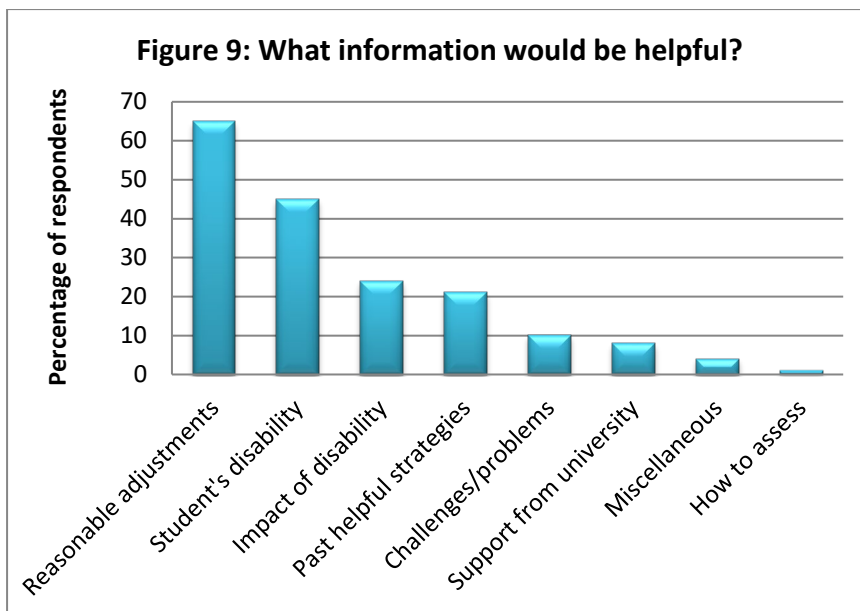
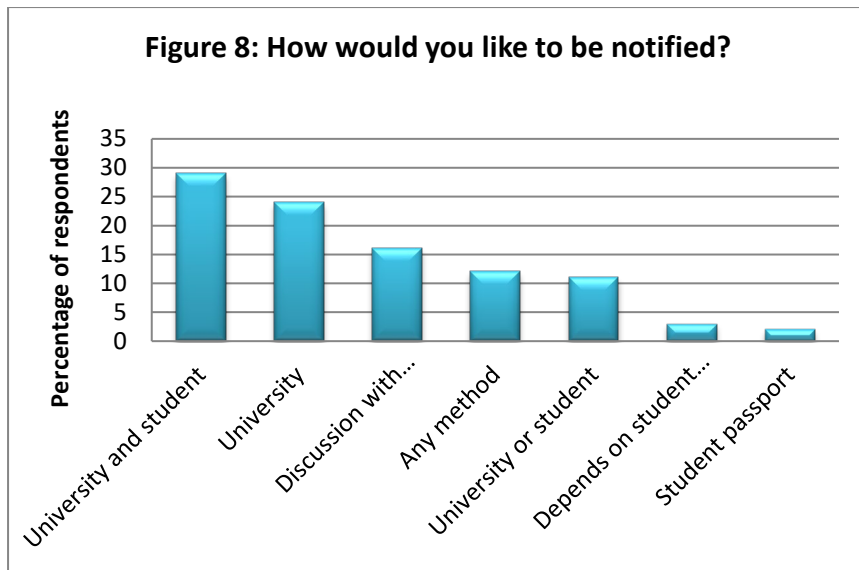
There were situations in which the student did not disclose and it became apparent to the educator during the placement that there were issues. In some cases the educator suspected there were disability issues but these were not discussed. In the latter two situations it was felt to be more difficult to support the student effectively. If the student disclosed at the beginning of the placement, preparation (for example implementation of support strategies or reasonable adjustments, modification of student workloads) was difficult due to the limited timeframe.

#### ***Notification of disability and helpful information***

Respondents were asked how they would like to be notified about a disabled student coming onto placement (Figure 8). Some were very specific whilst others were content as long as they were notified with no preference as to method. Comments indicated, however, that there was a strong desire for increased communication about these issues.



Respondents provided feedback about what information they wanted about disabled students (Figure 9). The majority (64.6% n = 73) wanted to know about reasonable adjustments; responses indicated widely differing levels of awareness of these. Some showed a good grasp of adjustments commonly implemented to support disabled students. Others clearly expressed the wish for support in this area i.e. they were aware that reasonable adjustments can be provided but were unsure about what this might entail. This was perhaps related to the requests for more communication and for more advice and guidance about disability issues.



Forty four percent (n = 50) of respondents wanted specific information about the student's disability. Many disability advisers would argue that it is not the disability (or impairment) per se which is the key issue, but the impact of that impairment in any given setting; 24% (n = 27) of respondents acknowledged this in their comments. Twenty one percent (n = 24) wanted to know what strategies the student had found helpful in the past.

Other issues concerned challenges and problems that disabled students might face whilst on placement and the need to know about support available from

universities; both that which is accessible to the student and any support that might be in place for educators.

## Training

Ninety four percent (n = 106) of respondents had attended practice educator courses. These were sessions run by a variety of providers covering a range of topics including:

- an introduction to teaching and learning theory
- familiarisation with physiotherapy programme content
- support and strategies to use in assessment of students
- how to manage challenging students
- equality and diversity issues

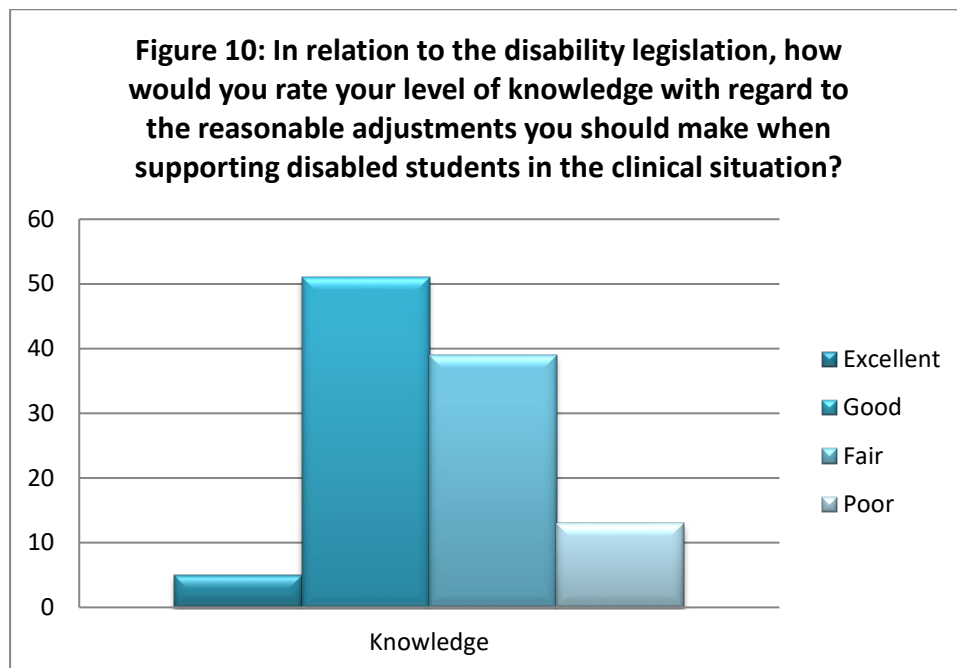
Ninety percent (n = 95) of these respondents had attended courses run by the universities that sent physiotherapy students out on placement. Twelve percent had attended in-house/in-service training provided by their employer and some had accessed training via the professional body (Chartered Society of Physiotherapy) and more informally through personal contact with academic staff. Seventy seven percent (n = 82) had accessed this training in the 3 years prior to the survey. Of the training attended, however, only one third of the courses included information on supporting disabled students; half of these focussed solely on students who had dyslexia.

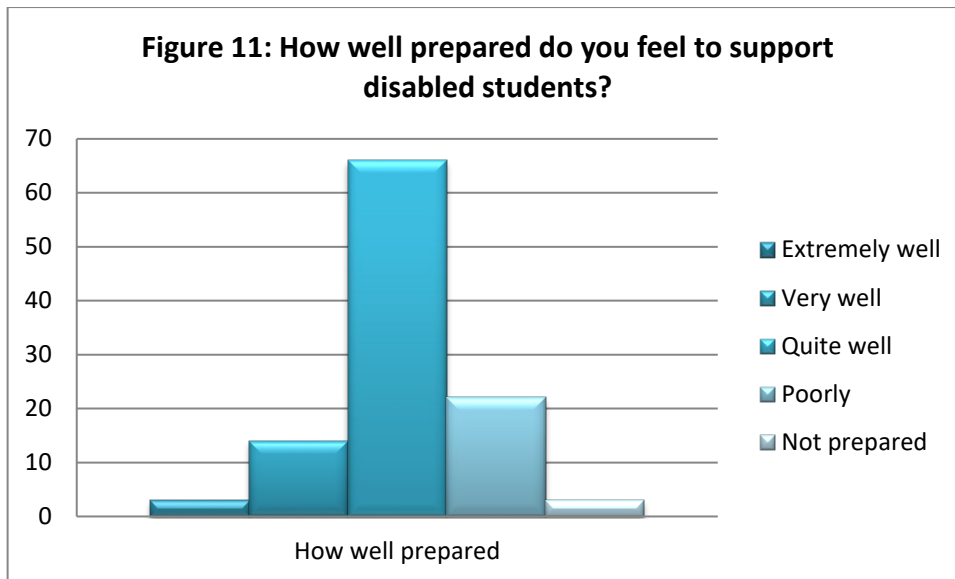
Forty two percent (n = 47) of respondents attended disability specific training provided by their employers. These focused on interactions with disabled clients, carers/relatives, members of the public and colleagues. Just over a quarter (n = 13) noted that disabled students were mentioned as part of the training session. Sixty percent (n = 28) of those who attended the disability training felt that it enabled them to provide better support for disabled students in the clinical environment. The apparent lack of attention to the requirements of disabled students in training packages may go some way, however, to explaining why many respondents felt that they needed more advice and guidance in this area.

### *Knowledge and support for working with disabled students*

Respondents were asked about their level of knowledge of reasonable adjustments in relation to the Equality legislation. The majority felt that their knowledge was good (47% n = 51) or fair (37% n = 39) (Figure 10).

Sixteen percent (n = 18) of respondents felt very or extremely well prepared to support disabled students. This was in contrast to the 58% (n = 65) who felt quite well prepared to support disabled students and 19% (n = 22) who felt poorly prepared (Figure 11). The data indicates that, within this sample, there was some lack of confidence in relation to supporting this student group. This could link to the apparent gaps in the training packages or the lack of information provided about supporting disabled students and the desire for more advice and guidance in this area.

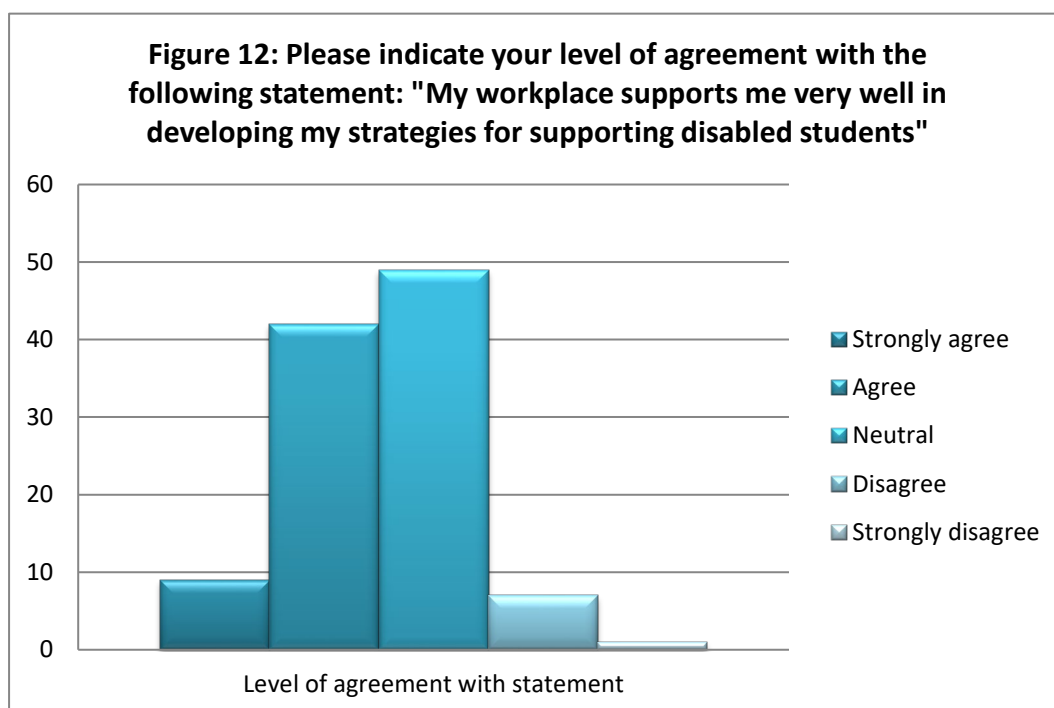




When asked about their level of agreement with the following statement: “My workplace supports me very well in developing my strategies for supporting disabled students”, 37% (n = 42) of respondents agreed and 43% (n = 49) felt neutral in this respect (Figure 12).

Ten percent (n = 11) thought that the workplace was generally flexible and supportive and 4% (n = 5) reported that they obtained informal support from colleagues. Seven percent (n = 8) noted that they thought the workplace would provide support if asked but that this had not been tested. Three percent (n = 4) commented that there was no training provided in the workplace and/or that they relied on support from the university (2%, n = 3) rather than the workplace.





## Universities

Practice educators often supervise students from different universities depending on local arrangements. In this sample the majority (60%,  $n = 68$ ) of respondents supervised students from one to three universities. Thirteen percent ( $n = 15$ ) took students from 4 universities and 18% ( $n = 20$ ) from 5 or more.

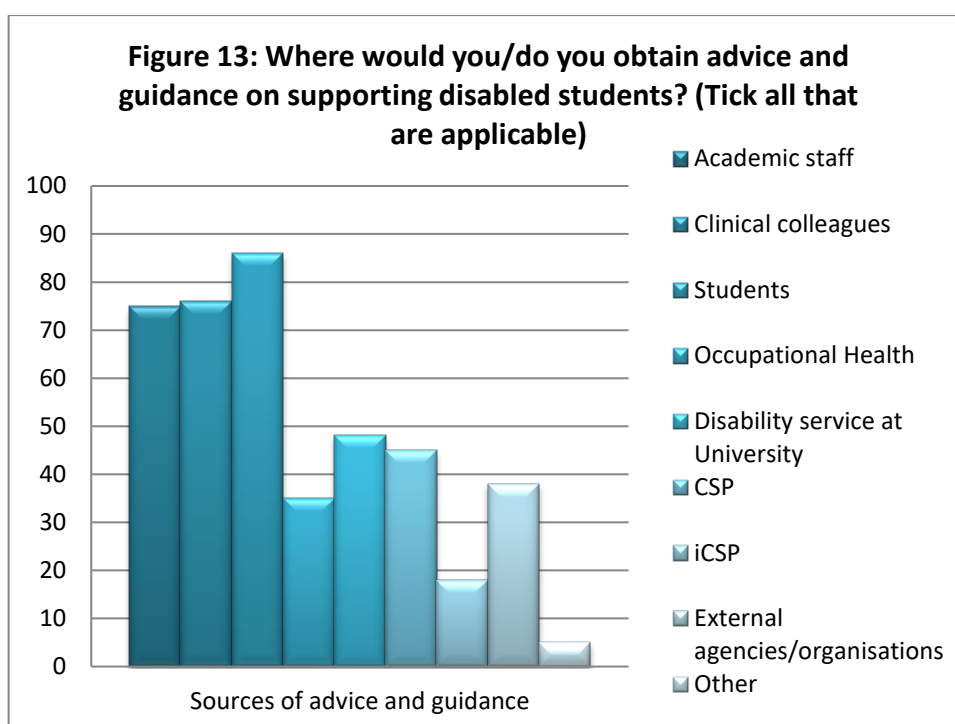
Nine percent ( $n = 10$ ) of respondents reported that they were supported by all of the universities that sent students to them whereas 17% ( $n = 19$ ) felt that they got support from some, or that the support they received was variable from time to time. Eleven percent ( $n = 12$ ) received support only on request and 14% ( $n = 16$ ) reported that they receive no support at all. Thirteen percent ( $n = 15$ ) of respondents felt well supported by their university colleagues but these only took students from one institution. Eleven percent ( $n = 12$ ) reported that they were not sure, or did not know, whether the universities that sent students to them provided any support.

## Advice and guidance, barriers, good practice and better support

The last section of the questionnaire comprised questions about where respondents obtained advice and guidance about supporting disabled students, what barriers they thought prevented them from providing this support, any good practice they had observed, experienced or instigated and lastly what they felt would help them to provide better support.

### *Where do you obtain advice and guidance?*

Respondents sought advice and guidance from a wide range of sources. Sixty six percent (n = 75) asked academic staff, a similar number went to clinical colleagues (67%, n = 76) and 76% (n = 86) talked to the students. Other sources of advice and guidance were Occupational Health, Disability Services at universities, the Chartered Society of Physiotherapy (CSP), iCSP (an electronic resource accessible through the CSP offering resources and a discussion forum) and external agencies/organisations (for example the British Dyslexia Association, Mind, Action on Hearing Loss, RNIB)(Figure 13).



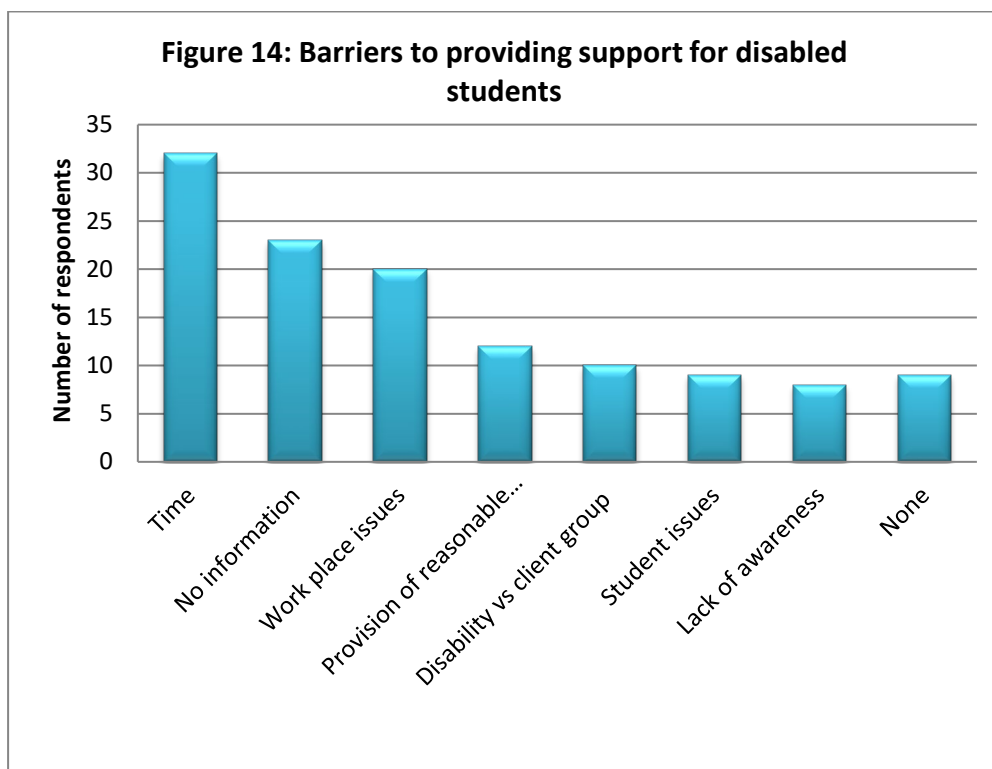
In the 'Other' category respondents noted that they would go to as many of these sources as necessary.

### Barriers

A number of barriers to provision of support were identified (Figure 14). Time was an important element for 28% (n = 31) of respondents:

- Not knowing about the student in advance gives no time for preparation
- Pace of patient turnover – disabled students may not be able to manage this
- Might not be able to commit time to supervising the student

A few responses suggested that disabled students were slower to ‘get going’ on placement and worked more slowly throughout. Some comments indicated that respondents believed that they needed to commit more time and more input to supervising and supporting disabled students in comparison to non-disabled students.



Not having information about the student was identified as a barrier by 20% (n = 23) of respondents. Some comments were supportive for example:

*“It’s different to having a patient or staff with disability. Students are there for learning and hence need to be appropriately supported. Knowing in advance what supportive strategies to follow will aid in effective delivery of support”.*

There was some focus on work planning and patient care:

*“...we plan the placement weeks in advance. If we are only informed 1 week before the placement it makes it more difficult to make adjustments without affecting patients”*

Workplace issues and poor staffing were identified as barriers to providing effective support (18%, n = 20) reflecting issues that many health care workers are facing in the current NHS climate:

*“The job can be quite pressured and it is difficult to always give the students the time they need without making them feel rushed or under pressure”*

But it was recognised that this can affect all students:

*“...poor staffing levels as it is difficult to commit the time - this would be similar for any student”*

Eleven percent of respondents (n = 12) identified provision of reasonable adjustments as a possible barrier mostly related to concerns about costs of modifications or equipment and availability of resources. Ten percent of respondents mentioned issues concerning disability and the practice of physiotherapy: either within a particular clinical area or for some respondents more widely within the profession as a whole. Some were related to the suitability of the environment:

*“Our local environment is very challenging for anyone with marked physical disability as it's a Victorian hospital with very poor disabled access”*

*“Community settings entail travel and could pose a barrier”*

Others related to particular impairments and whether this made it difficult or impossible to work in a particular area or with a specific client group:

*“Type of placement i.e. community for visually impaired for example”*

*“Clinical setting for example in paediatrics we rely on observation for a lot of our assessment and therefore a blind student would not gain the full experience if placed in this setting. Also for someone with physical disabilities may find it difficult to carry out treatments as they often rely on a certain level of physical fitness and ability to move about on the floor for play”*

Some respondents expressed more general concerns:

*“Physical disabilities - ability to practice” and “if the disability will prevent them from practicing Physiotherapy”.*

Student issues were identified as barriers by 9% of respondents mostly relating to lack of disclosure. It was recognised, however, that students may lack confidence or be fearful of the consequences of disclosing an impairment. Some comments indicated that they thought that it might affect their marks or they might experience stereotypical or discriminatory responses.

The lack of awareness of disability issues was recognised by 8% of respondents as a possible barrier but 9% said that there are no barriers to providing support for disabled students:

*“Working in setting with disabled school children we have little barriers to providing support for disabled students”*

*“None. Support is essentially pragmatic.”*

### **Examples of good practice**

The examples of good practice identified link closely to points discussed earlier (Figure 15). Thirty four percent (n = 45) of respondents reiterated how useful it was to have good communication noting that it was essential to establish a good

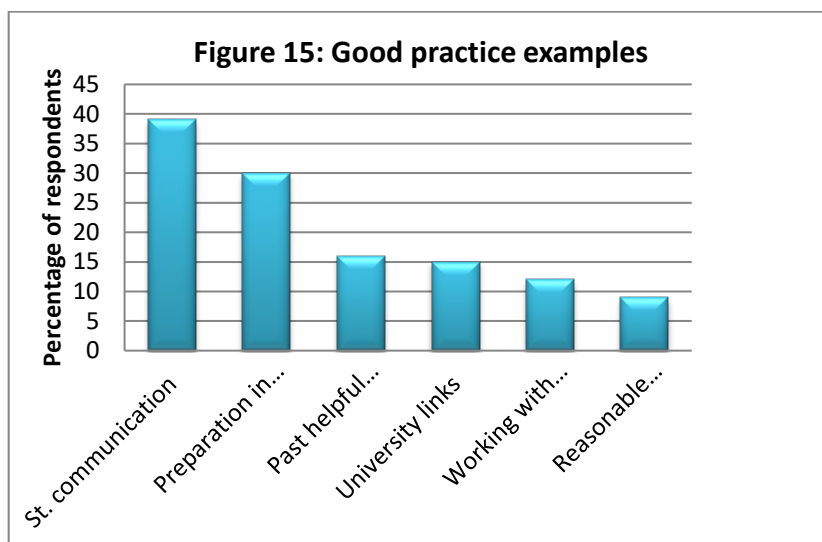
rapport with the student. The words ‘open’, ‘frank’ and ‘honest’ came up a number of times. Disclosing a disability is not a legal requirement, however educators felt that it should be encouraged so that reasonable adjustments could be made.

Good communication was linked with knowing about the student in advance of the placement to allow time for preparation (30%) and with talking to the student about useful strategies they had used (16%). Some respondents extended this idea to providing opportunities for communication to occur throughout the placement:

*“Regular review of plans to see if working effectively”*

*“Regular one to ones”*

*“to have one to one support from supervisor or peer on a regular basis”.*



Fifteen percent of respondents found that working with the university had been a helpful strategy and 12% received support from their colleagues. They noted that it was useful to have access to someone who already knew the student and/or contact with colleagues who had prior experience of supporting disabled students.

***What would help you to provide better support for disabled students?***

Fifty four percent of respondents wanted better communication with students and university staff to enable them to provide enhanced support for disabled students:

*“Definitely more communication between student, universities and educator”*

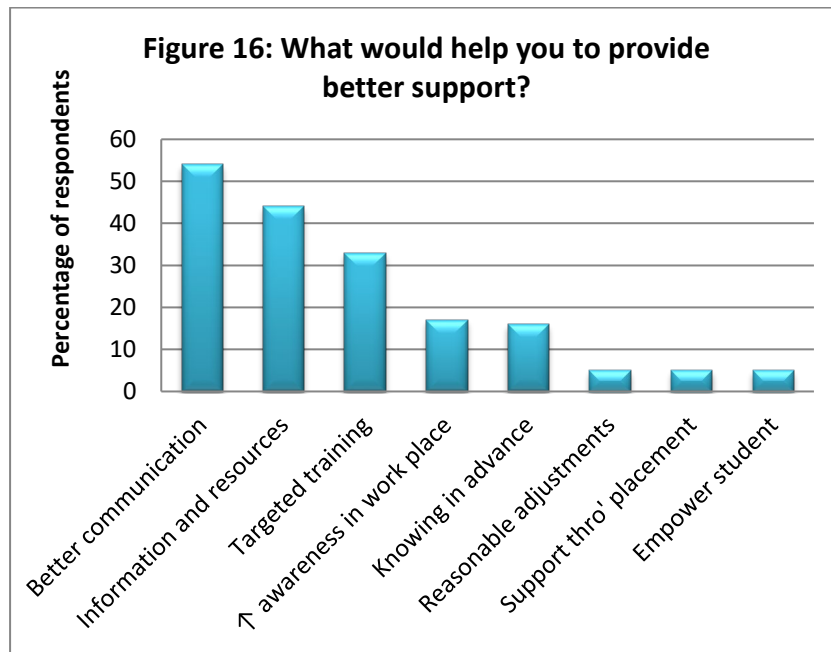
Forty four percent wanted more information and resources:

*“Information and guidance on what might be needed and examples of ways to help disabled students”*

*“Information sharing, pre made packs relevant to specific disability (i.e. how to help, what support strategies to follow etc) should be coming from Universities”*

*“Information leaflets to remind staff of contact point at universities and range of services available”*

*“more knowledge of what help we could get to support students or to make the adjustments for any disabled person”*



Thirty three percent of respondents wanted targeted training that focused on student requirements and in some cases on particular impairments:

*“Targeted training on the main types of issues that we may encounter and how best to support the student during the placement”*

*“Training - especially on learning or sensory disabilities”*

More training on disability issues would improve awareness of these in the workplace (17%), knowing about the student in advance (16%) and information about reasonable adjustments (5%) were mentioned. Five percent wanted continued support through a disabled student’s placement and another 5% felt that working with the students would be a good use of resources. The aim of this was to improve their knowledge and to empower and support them during the process of disclosure and whilst they were on placement.



## **Appendix 3 – Information Sheet and Consent Form for interview**



Leading education  
and social research  
Institute of Education  
University of London

## **Experiences of Physiotherapy Practice Educators: Supporting Disabled Students**

May 2011 – July 2012

### **Information for Practice Educators**

My name is Karen Atkinson

I am a Physiotherapy Lecturer at the University of East London and I am undertaking a Doctorate in Education at the Institute of Education (part of London University).

This leaflet tells you about my research, I hope you will find it useful. I would be pleased to answer any questions you have.

### **Why is this research being done?**

My aim in this study is to explore the experiences of physiotherapy practice educators in relation to their involvement in supporting disabled students in the clinical setting. The results will be used to develop our service in two ways: the first is to improve our advice and guidance for practice-based educators involved in the education and support of disabled students in the clinical setting; the second is, through improving our support for practice educators, to in turn improve support for disabled physiotherapy students.

### **Who will be in the project?**

One hundred practice educators will be asked to fill out an online questionnaire. A self selecting group of between 6 and 10 participants will then be interviewed about the issues in more depth

### **What will happen during the research?**

After the questionnaire data is analysed, I will use this to develop an interview schedule. I will then interview the 6 to 10 participants who have indicated an interest. The interviews will last about 1 hour and will take place at a time and in a venue convenient to the participant. The interviews will be written up and analysed to look for themes. The whole study will be written up as a thesis and then I would hope to present the results at a range of conferences and in professional journal papers. I will submit the study to the Physiotherapy Journal and hopefully present at the CSP Annual Congress.

### **What questions will be asked?**

The questionnaire aims to obtain a range of information about:

- your physiotherapy background
- experience of student supervision
- training you have undertaken in relation to supervision and equality and diversity
- your knowledge of and confidence in working with disabled students
- positive factors you have noted as well as the opportunity to tell me about examples of good practice.

If you subsequently agree to be interviewed this will provide us with the opportunity to explore the key issues that emerge from the questionnaire in more depth.

### **What will happen to you if you take part?**

If you decide to complete the questionnaire, you can very simply fill this in and submit it on line. If you agree to be interviewed I will record the session and transcribe this onto a computer later. I am not looking for right or wrong answers, only for what you really think.

### **Could there be problems for you if you take part?**

If you offer to be interviewed I hope you will enjoy talking to me. Some people may feel that some topics are difficult to discuss. If you want to stop talking, we will stop.

If you have any problems with the project, please tell me. You can contact me via phone \_\_\_\_\_ or email [k.a.atkinson@uel.ac.uk](mailto:k.a.atkinson@uel.ac.uk)

### **Will doing the research help you?**

I hope you will enjoy helping me. The research will collect ideas to help both you and your disabled students in the future and it will also help me to develop as a researcher

### **Who will know that you have been in the research?**

No-one, other than me, will be able to identify that you have been involved in the research. I will keep digital records and computer files in a safe place, and will change all the names in my reports. It will not be possible to identify places of work or institutions that are mentioned in the questionnaire responses or interviews.

### **Do you have to take part?**

You decide if you want to take part and, even if you say 'yes', you can drop out at any time or say that you don't want to answer some questions.

You show your consent to take part by filling in and submitting the questionnaire. If you then agree to be interviewed I will ask you to sign a consent form.

### **Will you know about the research results?**

If you wish I am very happy to send you a transcript of your interview and/or a short report of the results once written up.

### **Who is funding the research?**

My EdD is funded by RNIB's Allied Health Professions Support Service (AHPSS)

**Thank you for reading this leaflet.**

Karen Atkinson  
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Senior Lecturer (Physiotherapy)  
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## Consent Form

### Experiences of Physiotherapy Practice Educators: Supporting Disabled Students

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Thank you for agreeing to take part in an interview to explore your experiences of supporting disabled physiotherapy students on practice-based placements. The interview will be semi structured to provide some framework. The main aim, however, is to ensure enough flexibility to cover the issues and experiences that you feel are the most important.

The interview will take approximately 1 hour and I will use a digital device to record our session.

After I have transcribed the interview, I can send you a copy for verification if you wish. The transcripts will then be analysed to identify important patterns or themes.

I will use pseudonyms in the transcript and write up; the data obtained will be dealt with confidentially and you would not be identified in any way. Places of work and any institutions to which you refer in the interview will be anonymised and all raw data will be destroyed after completion of the study. **You have the right to withdraw from the study at any time.**

If you have any questions, please don't hesitate to contact me on 020 8223 4950, email [k.a.atkinson@uel.ac.uk](mailto:k.a.atkinson@uel.ac.uk) or mobile . Please sign below to indicate your consent to being involved in the research.

**Karen Atkinson**  
**Doctoral Student**  
**Institute of Education**

Please sign below to indicate your consent to take part in this research project:

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I wish to receive a copy of the interview transcript:

Yes  No

## Appendix 4 –Interview Guide

### **Introductory question**

Could we start by you providing some background information about yourself, work context and so on and then moving onto your experiences?

### **Possible prompts**

Where? Grading? Speciality?

Length of time supervising students?

Could we perhaps talk briefly about your thoughts on and interaction with disabled people generally?

### **Main question**

I would be really interested to hear about your experiences of interactions with disabled students and how that has been for you. What has working with them been like?

### **Possible prompts**

When you find out you have a disabled student on placement – what is that like for you?

What do you think about disabled people working in the health professions/ in the NHS?

Knowing about disabled students

How have you found out? Is this acceptable? What could be better?

Why important?

What do you want to know?

**Training** - Can you tell me about how prepared you feel for taking disabled students?

**Universities** - What is your experience of university input in this process?

**The student** - I wonder what part you feel the student plays in the whole process?

**The work context/NHS?** - In your opinion does this have any impact?

**Good practice** - What has worked well for you?

**Barriers** - What have you experienced that gets in the way of providing support for disabled students?

**What do you want?**

**What could be improved?**

**What could help you provide better support?**

**Any other points that you think are important about these issues?**