# Newly Qualified Physiotherapists' Expectations and Experiences of their First Posts – A Qualitative Study.

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## ABSTRACT

This research was based on the premise that an exploration of the experiences of newly qualified physiotherapists could lead to a better preparation for the rapidly changing workplace by identifying the tensions and dilemmas newly qualified practitioners face.

The initial review of the literature revealed limited research in physiotherapy relevant to an understanding of experiences of newly qualified physiotherapists. In consequence the literature relevant to professional socialisation, identity formation, and professionalism was also reviewed. The physiotherapy profession's reliance on the biomedical model of healthcare and positivistic research approaches was reviewed in order to highlight the lack of qualitative physiotherapy research.

The research in this study is essentially illuminative and has adopted an inductive, phenomenological approach. Semi-structured interviews and reflective field notes were utilised to collect the data. Ten newly qualified physiotherapists were interviewed three times. All data collected was analysed using an inductive and interpretive approach. Three main themes were identified – doing the job; becoming a professional; and the future. The evidence suggested that they 'learnt the ropes' of the dominant culture and conformed in order to be seen to be doing a good job and thereby socialised into the professional. There was little time for CPD activities or any involvement in research. In this way the culture within physiotherapy departments was maintained.

It is concluded that if physiotherapy is to adapt to the many changes in the NHS, then it must foster a working environment where newly qualified physiotherapists are encouraged to develop further their graduate skills and implement relevant research findings into their practice to provide patient care.

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# GLOSSARY

| | |
|---|---|
| **ACE** | Accreditation of Clinical Educators |
| **AHP** | Allied Health Professional |
| **CAQDAS** | Computer Assisted Qualitative Data Analysis Software |
| **CEDP** | Career Entry and Development Profile |
| **CPD** | Continuing Professional Development |
| **COT** | College of Occupational Therapy |
| **CSP** | Chartered Society of Physiotherapy |
| **DOH** | Department of Health |
| **EPB** | Evidence-based practice |
| **HPC** | Health Professions Council |
| **IFS** | Institution Focused Study |
| **ISI** | Institute for Scientific Information |
| **LAMP** | Leadership, administration, management and professional skills |
| **NHS** | National Health Service |
| **QAA** | Quality Assurance Agency |
| **RCT** | Randomised Control Trial |
| **SPSS** | Statistical Package for Social Sciences |
| **TDA** | Training Development Agency for Schools |

# CHAPTER ONE

# INTRODUCTION

The research aims to explore the expectations and experiences of newly qualified physiotherapists during their first year of work, to give them a 'voice' as they progressed from student through to employed physiotherapist and understand their lived experiences. These experiences of newly qualified physiotherapists may lead to a better preparation for the rapidly changing workplace.

The National Health Service (NHS) is acknowledged by many authors as a rapidly changing work environment (Potts, 1996, Adamson et al, 1998, Hunt et al, 1998b, DOH, 2000). Since the publication of the White Paper *The New NHS Modern, Dependable* (DOH, 1997) and the subsequent *NHS Plan* (DOH, 2000) there has been significant continuing change in the delivery of healthcare in the UK (Bithell, 2005). There has been a move away from the biomedical model of healthcare, with its 'top-down' approach, to a more holistic model with the aim of involving the patient in their treatment and empowering them to make informed decisions about their care. There is no longer the emphasis on cure but also care and the improvement of life for long-term illnesses and health promotion and education (Richardson, 1999b, Higgs & Jones, 2000). The provision of healthcare is being shifted away from acute hospitals to community-based services (Adamson et al., 1998, Masters, 2004). In order to monitor and improve the quality of healthcare, Clinical Governance (DOH, 1999) has been developed and there is now an emphasis on Evidence Based Practice (EBP). Healthcare professionals now have

to demonstrate their continued 'fitness' to practise through Continuing Professional Development (CPD) activities, which will be monitored by the Health Professions Council (HPC) (O'Sullivan, 2004, HPC, 2006).

Changes within the NHS affect, and will continue to affect, Physiotherapy for many years (Potts, 1996, Adamson et al., 1998, Hunt et al., 1998b). In 2001 the government announced that by 2009 there would be an increase of 59% in the numbers of physiotherapists employed by the NHS (NAO, 2001). This represented an increase of 9,200 physiotherapists working in the NHS (NAO, 2001). This was aimed partially to alleviate the national vacancy rate of 7.8% for qualified physiotherapists (CSP, 2000) with the main increase to come from an increase in numbers of students in Higher Education. The government also proposed that some of the increased number would come from 'returners' to work, overseas physiotherapists and better retention within the NHS. A significant number of physiotherapists leave the NHS after their first post, with some remaining physiotherapists working outside the NHS, and others leaving the profession completely. Since 1992 Physiotherapy has been an all graduate entry profession (Sparkes, 2002a) and the cost per year to the NHS of training a physiotherapist is on average £5,570 (NAO, 2001). Physiotherapy programmes in England and Wales are approved and lead to membership of the Chartered Society of Physiotherapy (CSP) and registration with the HPC.

This research was undertaken in response to the need to understand the experiences of new graduates at career entry. The development of newly qualified health professions in

their first year of work has been acknowledged as important (DOH, 2007, Morely, 2006). There is an expectation that such an understanding may lead to better preparation for the rapidly changing workplace. The research sought a response, through the voices of newly qualified physiotherapists, to the research question

"What are newly qualified physiotherapists' expectations and experiences of their first post?"

The research was intended to help understanding of the experience, highlight good practice, and thereby enhance the experience for others.

As the expectations and experiences of newly qualified physiotherapists are poorly represented in the literature, the research concentrated on their perspective. If the profession is going to evolve in the current climate of change within the NHS then newly qualified physiotherapists need to work in an environment which will foster critical reflection of their practice and value the implementation of change based on valid research findings. If newly qualified physiotherapists find themselves in a working environment where the emphasis is on learning unquestioned, current practice and maintaining current approaches to patient management then the profession will be unable to meet the challenges of the new NHS. Newly qualified physiotherapists who are encouraged to work autonomously including self reflection, EBP and CPD, will be able to initiate, to adapt to, change and deliver a better service to patients. Therefore the purpose of this research is to offer critical insights into newly qualified physiotherapists'

experiences and their continued development of skills that will enable them to continue to develop as a practitioner and meet the changes in the future.

An inductive, qualitative approach to the research question was adopted. Phenomenology allowed the exploration newly qualified physiotherapists' expectations and experiences of their first posts. Ten newly qualified physiotherapists (graduated July 2002) participated in the research. They were interviewed three times, once before they started their first post, then not less than four months after commencing their first post and the third not less than eight months into that post. Reflective field-notes were also kept. All data was analysed using a thematic approach and three themes were developed. The implications of the findings of the research are discussed in the final chapter along with suggestions for further research. As this was a qualitative study with a small sample size, there would be no attempt to generalise the results beyond this group of physiotherapists and no claims made that the research was representative of the whole population. However, it may be possible to transfer some of the findings and implications to other physiotherapists in similar situations and have relevance for educationalists and managers involved with newly qualified physiotherapists.

This research is one of a small number of qualitative studies in physiotherapy, which is dominated by quantitative research and the 'gold standard' Randomised Control Trial (RCT). Physiotherapists need carefully to consider the value of interpretive qualitative research and not to dismiss it. The main reason for dismissing such approaches may be based on attempts to judge qualitative research using the same criteria applied to

quantitative research. If physiotherapists do not value qualitative approaches in research then they will not be able to research some areas of their practice and will ignore the voice of the individual, whether it be the patient or in this research the voice of the newly qualified physiotherapist.

Chapter two reviews the literature relevant to newly qualified physiotherapists. The literature relevant to professional socialisation, identity formation, and professionalism was reviewed. Also studies specifically investigating physiotherapists' expectations and experiences were reviewed. The literature in this area was found to be very limited, therefore the search was extended to occupational therapy where more literature was found. The physiotherapy approach to research is examined in detail to gain an understanding of why the literature relevant to newly qualified physiotherapists was so limited particularly when compared to occupational therapy. This chapter contextualises the research in this thesis and demonstrates a greater understanding of the issues relevant to newly qualified health professionals. Therefore chapter two fulfils the requirements of the Institution-focused study (IFS).

Chapter three describes the choices made when deciding on the framework adopted to investigate the research question. The process of data collection and analysis is described.

Chapter four presents the results and analysis including verbatim extracts from the data. Three main themes are identified.

Chapter five discusses the analysis in relation to the literature relevant to the experience of newly qualified physiotherapists' first year of work. The chapter aims to develop a theoretical framework of the experience of being a newly qualified physiotherapist which illuminates the experience and therefore informs both the undergraduate and work environment through the implications drawn from this research.

Chapter six concludes with the four main findings and reflects on their implications. The limitations of the research are discussed and suggestions are made for areas of further study. The significance of the research and its relevance to research in physiotherapy is considered.

# CHAPTER TWO

# THE LITERATURE REVIEW

# (THE INSTITUTION FOCUSED STUDY)

## 2.1 Introduction

This chapter contextualises the research in this thesis and demonstrates a greater understanding of the issues relevant to newly qualified health professionals. Therefore chapter two fulfils the requirements of the Institution-focused study (IFS).

The Instructional Focused Study (IFS) starts with a literature review of professional identity formation, professionalism, nature of experience, and transition from novice to expert practitioner. All these issues were all perceived to be potentially relevant to the newly qualified physiotherapist. The IFS then presents a review of research relevant to newly qualified physiotherapists. Available research relevant to the IFS is discussed from two perspectives: research that investigates newly qualified therapists' perceptions and research that investigates other experienced therapists' perceptions of newly qualified therapists including research which involves both newly qualified and more experienced therapists. Given the limited literature in the field of physiotherapy, the review was widened to include Occupational Therapy because the education and working environments of both professions are similar. As the literature in this area was found to be sparse physiotherapy research in general is discussed in an attempt to explain why research relevant to newly qualified physiotherapists is so limited. The study concludes with a summary of the IFS.

## 2.2 Literature Review Research Questions.

Professional identity formation, professionalism, nature of experience, transition from novice to expert practitioner were all issues that were identified as being relevant to newly qualified professionals working in healthcare and therefore were critically reviewed in the first part of the IFS.

The second part of the IFS sought critically to review the literature specifically relevant to newly qualified physiotherapists with the following questions in mind:

- What literature is available that is relevant to newly qualified physiotherapists' experiences of their first posts?
- What does this literature report about these experiences?
- What is the nature and quality of the research?

As the physiotherapy literature was found to be very limited the same questions were used to explore literature in occupational therapy (Appendix I). The details of the literature search methods are given in Appendix II.

## 2.3 The Terminology

The terminology used in the reviewed research varies from graduate to newly qualified therapists to beginning practitioners to newly qualified practitioners. Therefore for

consistency the term 'newly qualified' is used to refer to graduates from healthcare professions in their first year post qualification.

## 2.4 Overview of the Literature Relevant to Newly Qualified Professionals

When newly qualified professionals enter the workplace they become a member of a profession and they experience a process of professional socialisation. Although much of the literature explores this experience from the moment the undergraduate begins their studies there are some studies relevant to postgraduate experience. Some of these studies may be of direct relevance to newly qualified physiotherapists. Before discussing physiotherapy's 'unambiguous professional profile' (Richardson, 1999a, p.461), the literature relevant to professions and professionalism will be discussed. Having discussed the claims to professional status, the professional socialisation of new members of a professional group will be explored with particular reference to physiotherapy.

### *2.4.1 Professions and professionalisation.*

Defining 'a profession' has been attempted by many. Some argued that there still isn't a definition for professions (Porter, 1992, Hoyle & John, 1995) and others argued the definition will continue to evolve (Downie, 1990). Indeed Hoyle & John (1995) argued that 'a profession' is a term which defies definition but it is a widely used concept in everyday life and the media. The criteria for professional status which emerged from the literature can be summarised in the following way and are detailed in Appendix III:

- performs a unique and essential social service;
- founded on intellectual techniques;
- long periods of specialist training/education;
- formal educational requirements;
- responsible for judgements made and acts performed within the scope of practice;
- both individual and group autonomy;
- commitment to expand and develop expertise;
- emphasis on the service performed rather than financial rewards;
- self-governing independent organisation of practitioners;
- knowledge base/professional culture;
- operates a code of ethics;
- able to speak publicly on broad issues relevant to the body of knowledge;
- period of professional socialisation;
- high social standing and earning.

The criteria above are claimed by various authors from many areas but the authors from physiotherapy concentrate on the unique role and knowledge base, university education, autonomy and self-regulation. Many occupations, such as accountancy, social work and physiotherapy may have now been accepted by many as professions. Although there are desirable aspirational aspects of professional status, there are criticisms and public dissatisfaction with professions. This dissatisfaction is based in the belief that rather than focussing solely on the needs of the patient/client the professions have been less altruistic and have put their responsibilities to their members first. Lack of public accountability

has led to external monitoring of the professions and more public involvement in decision making processes (Morris, 2002). It has been argued that the increased accountability through external monitoring has led to erosion of the claims of some groups to be a profession (Furlong, 1992).

For Cant & Higgs (1999) and Hoyle & John (1995) professionalisation is the transformation of occupations into professions. Whereas Sparkes (2002a) states that professionalisation takes place on three levels. Firstly, on a national level where there is a shift in society both economically and socially. Secondly, the process of moving from an occupation to a profession, and finally the process by which an individual becomes a professional. It is this final level that this part of the literature review will concentrate on. However, the claims that physiotherapy is profession or not, will be discussed.

The CSP stated that

> Physiotherapy is a health care profession concerned with human function and movement and maximising potential. Physiotherapists are autonomous professions (CSP, 2002, p.19).

In the late 1980's and early 1990's Dyer (1982), Palastanga (1990), Sim (1985) and Samuels (1987) all wrote about the development of physiotherapy as a profession. In 1987 Samuels stated that

> Physiotherapy is a relatively young profession and it has had to fight hard to achieve its independence from the medical profession (p.584).

There was a lull in the debate about the professional status of physiotherapy until Richardson (1999a) claimed physiotherapy was a profession as there had been a gradual acceptance of a structured body of knowledge and expertise, there was a regulatory body, a code of practice and physiotherapists practise autonomously. Richardson (1999a) argued that if students are educated about professionalism then they will continue to develop professionally as qualified practitioners and thus will "ensure the sustained development of the profession" (p.461).

However, Richardson (1999a) wrote that

> physiotherapists need a clear view if the purpose and intent of their profession and a conscious awareness of a professional identity which encompasses purposeful actions to pursue professional goals in changing practice contexts throughout the span of their careers. (p.462).

Hunt et al. (1998a) claimed there is an overlap between the generic skills of a graduate and physiotherapy professional requirements such as self directed lifelong learning, contribution to the knowledge base etc. Wiles & Barnard (2001) stated that physiotherapy was a profession under going change. Therefore these authors seem to be suggesting that

there was an acceptance that physiotherapy was a profession by the beginning of the 21st century.

Others argued that physiotherapy has not yet achieved professional status and should be considered a 'paraprofession' (Helders et al., 1999, Sparkes, 2002a). Sparkes (2000a) claimed that if physiotherapy is to become a profession then it is the educators in universities are central to this process. Educators must concentrate on education processes that are effective and proven (through primary research) and unique to physiotherapy.

Helders et al. (1999) also argued that physiotherapy has not yet established its identity and that physiotherapy was not a profession because it still did not have a substantial knowledge base. It may be that until recently physiotherapists have been happy to rely on 'expert' opinion rather than research (Morris, 2002). This view that physiotherapy has not obtained professional status or an identity may be because these authors are expecting there to be a fixed identity rather than accepting that identity and a profession may continue to develop and that a goal of a fixed identity may not only be unattainable but also undesirable. For a profession to develop it must evolve and change with the times. If this evolutionary model of professional development is accepted then the professionals belonging to the group will have the ability to influence the development of the profession. Saks (1999) argued that professional identity changes over time and that the subgroups of a profession are the main bases for professional identity. Therefore charging university lecturers (a sub group) with the sole responsibility for the development of the profession is simplistic, particularly as physiotherapy lecturer may have yet to recognise

their identity (Sparkes, 2002a). Although professional socialisation does begin, and therefore academics need to be fully aware of their powerful influence, within the undergraduate programme it continues into newly qualified physiotherapists' first posts and their future career.

Another issue to consider when deciding if physiotherapy is a profession is its knowledge base. As already stated healthcare systems today are very different from two decades ago. The widening context of practice means that physiotherapists are no longer solvers of patient problems. Physiotherapists find themselves in an environment where they have to define their scope of practice, no longer work primarily in the single NHS but in a more competitive market of GP practices, acute Trusts, Primary Care Trusts, private hospitals etc (Richardson, 1992, Higgs & Hunt, 1999, Helders et al., 1999, Lindquist, 2006). All this is within a framework of quality assurance, public accountability and multidisciplinary practice. The evidence-based knowledge base for physiotherapy has been questioned by many in the past (see section 2.8). Richardson (1999b) recognised that the changing healthcare environment has meant that

> the evidence base and theory of physiotherapy needs to be made explicit so we are clearly able to define the uniqueness of our practice and our professional purpose amongst others in the healthcare team (Richardson, 1999b, p.13).

Although this is a noble aspiration this may be something that also constantly evolves and therefore there is no fixed definition, and a belief that professions are able to define themselves is naïve and unachievable. Parker et al. (2006) found it was easier to find agreement regarding what was not a part of professionalism rather than what constituted professionalism, the same may apply for the concept of a profession.

Therefore for many authors the process of professionalisation is one of an occupation becoming a profession. The criteria for an occupational group to be able to claim professional status are given in Appendix III. Authors in physiotherapy have concentrated on the unique role, the knowledge base, university education, autonomy and self-regulation. Public accountability has led to external monitoring of practice of many professions including physiotherapy. The Chartered Society of Physiotherapy is the professional body and physiotherapists are expected to demonstrate professionalism. Therefore professionalism will be reviewed in the next section.

*2.4.2 Professionalism*

Consensus in defining professionalism is difficult to find (Parker et al., 2006). In the health arena most definitions of professionalism include respect for the patient, altruism, integrity and advocacy (DuToit, 1995, Parker et al., 2006). Others state that

> professionalism can be regarded as professional behaviour which will maintain the status of the profession in a static practice environment, whereas professionalisation is related to professional action which shows

> the character and spirit of a profession to work dynamically towards achieving goals of professionalism, in response to competition or change (Richardson, 1999b, p.464).

Walker & Drury (1995, cited in Sparkes, 2002a) developed this into the concept of an expert professional who has professional boundaries that are 'semi-permeable' and allow new skills through but does not allow existing skills out. Although this analogy is useful it must be treated with care. New skills should be evaluated before included in new practice and the development of a professional is not just the adding on of new skills (Shepard & Jensen, 1990). Hunt et al. (1998b) stated that the process of clinical reasoning allows physiotherapists to manage the large amounts of complex information they are presented with and cope with change.

For Hunt et al. (1998b) professionalism is

> the application of a set of principles, attitudes and behaviour standards and patterns to the practice of the discipline of physiotherapy (p.266).

As already mentioned the healthcare service is changing and graduates will need to be able to adapt to these changes (Higgs & Edwards, 1999). Graduates now have to cope with the explosion in knowledge which can be incorporated into practice by clinical reasoning (Higgs & Jones, 2000) and by being 'reflective practitioners' (Schon, 1987). Southon & Braithwaite (1998) argued that healthcare reform threatens professionalism.

Government policy has led to the development of patient-centered care and the empowerment of the patient to make informed choices. Interdisciplinary teamwork is perceived as being at the centre of these developments but as this team working process develops then professional autonomy decreases and professional boundaries become blurred (Richardson, 1999a, Adams et al., 2006). Although physiotherapists may claim they offer a quality service, the attractions of cheaper services offer by 'generic' therapists may seem very attractive the purchases of services (Jones, 2006). However, with the emphasis now on rehabilitation in the community based around GP practices there may be many opportunities for Allied Health Professionals (AHP's) to develop their role and offer services to patients in their community. Therefore newly qualified practitioners may find themselves in a working environment where their professional identity is challenged, which may lead to uncertainty and stress. Richardson (1999a) claimed that students from two physiotherapy programmes were unable to identify the unique role of physiotherapy in healthcare, but she does not discuss if newly qualified or more expert practitioners would be better able to define the role. Undergraduate education may strongly influence the professional development of a physiotherapist but what happens post qualification?

Many authors discuss the role of the professional in the development of the profession (Helders et al., 1999, Higgs & Hunt, 1999, Richardson, 1999). If part of being a professional is being a change agent then the profession will evolve and develop. Higgs & Hunt (1999) present the model of an 'interactional professional'. The 'interactional professional' is one who can interact with a system which is not only complex but

uncertain. These professionals are not only able to demonstrate competence and reflective practice, they are also able to assume social responsibility and demonstrate interaction and leadership. They are proactive and responsive. Although Higgs & Hunt (1999) present this model of the beginning practitioner at the very beginning of their career there seems to be the tacit assumption that if universities can produce 'interactional professionals' then the profession will change.

What does not seem to be considered by these authors and others is the power of the work environment in which these new graduates will find themselves in. What also needs to be considered is the experience of newly qualified physiotherapists in their first posts post to explore the process of professional socialisation and how the work environment influences their development.

*2.4.3 Professional socialisation and identity formation*

Socialisation is frequently presented as two processes, primary socialisation, experienced during childhood and secondary socialisation when a person becomes part of wider society (Howkins & Ewens, 1999, Clouder, 2003). Becoming a professional is part of secondary socialisation, in fact Howkins & Ewens (1999) argued that professional socialisation is so important that is should be considered separately as tertiary socialisation. Professional socialisation is the process of induction into the culture of a profession. It is a social learning process where the person acquires the skills and knowledge of a profession and part of this process is the development of a new self-

identity, values and attitude (Hall, 1987, Joseph, 1994, Howkins & Ewans, 1999, Richardson, 1999a, White & Ewan, 2002). Most of the literature refers to students, ie before graduation (Melia, 1987, Walker & Naylor, 1991, Hunt et al., 1998a, Howkins & Ewens, 1999, Clouder, 2003, Lindquist et al., 2006) – as pointed out by Bond & Bond (1994). Hall (1987) claims that much of the research on careers focuses on the early career experiences but he does not define what is an early career experience, is it at entry to the career in an undergraduate programme or when the graduate first joins the paid workforce? It is the process by which an individual learns about the values and beliefs of a profession and thereby becomes committed to that profession (Richardson, 1999a, Sparkes, 2002a) and could be seen as a process of social control (Cahill, 1996). This process is critical in the identification of a professional role and the development of professional skills (Lindquist et al., 2006).

> The transformation of a novice to a professional is seen essentially an acculturation process (du Toit, 1995) and the process of professional socialisation to occur throughout life (Clarke, 1997 cited in Lindquist et al., 2006, p.130).

Lindquist et al. (2006) identified other professions, such as nursing and occupational therapy, have investigated students' experiences of professional socialisation, whereas physiotherapy had far fewer studies. Most of the studies concentrated on the undergraduate (Cross, 1997, Richardson, 1999a). Richardson (1999a) found that the participants could not identify the unique role of the physiotherapist in the

multidisciplinary team. White & Ewan (2002) perceive socialisation of nurses as learning about the culture of nursing and as culture is hidden and implicit it is difficult to define. Because the inference of what it means to be a professional nurse is based on unconscious assumption of nurses and that the culture is ever evolving in a changing healthcare system, it is hardly surprising that 'fixed' definitions are elusive. There should be encouragement of change amongst the group members, rather than maintaining the status quo.

> The ideal outcome ...is a self-image which permits feelings of personal adequacy, satisfaction and autonomy in the interpretation and performance of the expected role (White & Ewan, 2002 p.190).

Cant & Higgs (1999) describe three stages of professional socialisation. Firstly anticipatory socialisation which takes place before the students start the programme, then professional socialisation as an undergraduate and finally socialisation into the workplace. Shuval (1980, cited in DuToit, 1995) describes three phases of professional socialisation (pre-socialisation, formal socialisation and post-socialisation) which are similar to Cant & Higgs expect for Shuval's definition of the post-socialisation phase which extends until retirement, during which time the outcomes of the formal socialisation phase are considered. It is the socialisation into the workplace which this literature review concentrates on. For most newly qualified health practitioners the workplace has traditionally been acute hospitals (Kelly, 1996, Cant & Higgs, 1999, Heslop et al., 2001).

For Richardson (1999a) the process of socialisation is one where "students imperceptibility assimilate a web of taken-for-granted values based on a social consensus of professional behaviour" (p.463). This presents a passive model of socialisation, where the individual is moulded into the role and is frequently presented in the literature and could be perceived as a barrier to the development of a professional and a profession, often labelled a 'functionalist' approach (Bond & Bond, 1994). This model at worst could be described as indoctrination, where there is little room for change and therefore the status quo is maintained (Sparkes, 2002). More recently Clouder (2003) has drawn on the work of social constructionists and presented an interactive model of professional socialisation or 'interactionist' approach (Bond & Bond, 1994). This approach allows for a new members of a group (profession) to construct their identity as a group member by through interaction with the older members of the group by sharing group understanding of what is required to be a member of the group. The structure of the profession is determined by the shared meaning of its members but this structure can also be modified by its members by debate and change practice. Therefore tensions can be perceived between the professional structure and the perceptions and experiences of the individual, particularly as a newcomer to the profession (Clouder, 2003) or possibly each time a newly qualified physiotherapist experiences an identity crisis, for example, when they change rotation (Stronach et al., 2002). Cant & Higgs (1999) add a third approach - a conflict critical approach where professional practices are determined elsewhere in society. They argued that newly qualified healthcare professionals frequently find themselves in a hospital environment where the culture of the hospital is a powerful influence on their professional development and that many graduates are ill-prepared for

hospital politicking and coping with change (Heslop et al., 2001). Watson (1992) argued that the undergraduate education programme develops the individual so they can qualify as a professional, but it is their postgraduate experience which determines if the individual remains a professional.

Hall (1987) presented a model of a person's career as a 'bundle' of socialisation experiences a person moves through during their working lives. Therefore implying that professional socialisation does not stop at entry to the profession but continues as the graduate develops but this is an area which has been poorly researched. In Hall's model there are three levels: individual processes, person-environmental processes and institutional processes. Although this model is directed at managers the model does present a more longitudinal view of professional socialisation and

> in studying socialisation, we are concerned with the way the person learns as he or she makes the transition from the old role to a full integration in the new role (p.302).

Hall (1987) discussed the importance of role transition when a person enters an organisation or profession and the processes that occur at this point in a person's development. This transition is characterised by a separation phase from the old role, to an initiation phase and finally incorporation phase when the new status as incorporated into the person's identity (Van Gennep, 1960). Louis (1980, cited in Hall, 1987) claimed that transition is achieved through a process of 'sense-making', where a person initially is

exploring the new identity, which may lead to surprise and discomfort, but by continuing to explore the individual discovers their identity within the group and therefore settles in. Therefore when starting a new job there are four stages: preparation, encounter, adjustment and stabilisation (Nicolson, cited in Hall, 1987). Therefore identity acquisition is not just an undergraduate pursuit but part of lifelong learning (White & Ewan, 2002). Physiotherapy students need to be encouraged, during undergraduate education, to be commitment to lifelong learning and ongoing professional development throughout their career (Richardson, 1999a).

Kim (2005) and Jenkins (2004) suggested that collective identities, such as physiotherapy, have boundaries which define inclusion and exclusion. Identity is defined by these boundaries. Identity is constructed by official/institutional policies (positioned/nominal/collective) and by the experience of the individual (positional/virtual/individual). Positioned or nominal or collective identity is the socially constructed identity of what it means to others to be a physiotherapist, for example. Whereas positioned or virtual or individual identity is how the individual physiotherapist perceives their own identity, based on their experience of being a physiotherapist. Therefore it is possible for somebody to be called a physiotherapist but the actual meaning of what it is to be a physiotherapist may be very different for that individual.

Jenkins (2004) presented a view of the world from an individual's position in a pragmatic interpretive framework which helps explain how identity develops. He suggested that the world is constructed by humans by three distinct orders:

- individual order;
- interactional order;
- institutional order.

The last two orders linking with other authors' views of professional identity formation (Kim, 2005, Hall, 1987, McGowen & Hart, 1990). A professional's behaviour is determined by how the individual views the world (Richardson, 1999a).

Professional craft knowledge is the intuitive ways of knowing how to do something which is related to how an individual experiences the working environment (Titchen & Higgs, 2000). As individuals construct their identity and knowledge from experience it is important for them to have opportunities to critically reflect on their experience of practice. Richardson (1999b) suggested that professional knowledge is constructed by an integration of propositional and procedural knowledge with personal experience (experiential knowledge) in practice, which is underpinned by reflection. Korthagen & Kessels (1999, cited in Spouse, 2001) categorises professional activities into 'epistemic'- formal and generalised knowledge and 'phronesis'- craft knowledge.

> Professional development is dependent upon their ability to be situationally responsive and continually to review and evaluate their work through critical thinking, clinical reasoning and the process of reflection (p.467).

If learning and development is to be facilitated practitioners need to be encouraged to understand their experiences and link these experiences to the knowledge base. This will

lead to the development of their clinical reasoning skills (Titchen & Higgs, 2000). In order for an individual to learn from an experience then, for example, they need to reflect on an event which may demand alternative solution which when applied and is perceived as beneficial, then new knowledge is generated, as described by Schön (1983).

The work culture in which newly qualified physiotherapists find themselves may conspire against their professional development, both the development of their knowledge and identity. In the literature much is made of the Continuing Professional Development (CPD) and the Health Professions Council (HPC) will audit physiotherapists' CPD in 2010. Authors such as Richardson (1999b) and Spouse (2001) argued that there are well established learning theories that support the teaching of propositional knowledge but there are few that consider the development of professional knowledge which is largely based on experiential knowledge.

Richardson (1999a) claims that it is important for physiotherapists to have a 'consciousness awareness' of their professional identity but she does not explain how this identity is formed or defined. This links to Hall's (1987) view of socialisation into a career where he described the role as being the 'external or objective status' and the 'subidentity' as being how that person views themselves in relation to the role and is therefore an 'internal or subjective self-conception' (p.302). McGowan and Hart (1990) claimed that the person experiences change at two levels, firstly externally meaning the requirements of the role and secondly internally as their own 'self-conceptualisation associated' with the new role. This process is not a passive one but there is an interaction

(Jenkins, 2004, White & Ewan, 2002). The novice professional does not just absorb their new role by watching role models but they interact with others bring their own personalities, learning and agendas into the process (Fitzpatrick et al., 1996, Richardson, 1999b, Day et al., 2005). In nursing Du Toit (1995) identified changes in values, behaviour and the individual's concept of 'self' during the socialisation process which led to the development of their nursing identity.

The experience of being a physiotherapist will be developed through socialisation into the profession. Within this process there is an interaction between what it means to be a physiotherapist as constructed by society and what it means to the individual. Identity formation is an ongoing feature of human life, it is not static, and may change as an individual progresses through their career (Day et al., 2005). For example when a student joins a physiotherapy programme they may have mainly a perception of what it means to be physiotherapist based on media perceptions of physiotherapists on sports fields. As their experience of physiotherapy develops as they progress through their career then their perceptions will change. Richardson (1999a) found that finalist students were unable to describe what it meant to belong to the physiotherapy profession, this may be due to the constant evolution of a physiotherapy in the very changing healthcare scenario or, as suggested by Richardson (1999a) that little was done in the curriculum to develop professional identity. Stronach et al., (2002) suggest that a person might experience an identity crisis each time they move through a period of change, for example when promoted. Also the process may not be a progressive linear process but one which stops and starts (Howkins & Ewens, 1999).

Jenkins (2004) claims the process of identity formation is ongoing and can never have an ending. However, White & Ewan (2002) state that

> The ideal outcome of such a socialization process is a self-image which permits feelings of personal adequacy, satisfaction and autonomy in the interpretation and performance of the expected role (p.190).

This suggests that these authors perceive an endpoint to the process, although this may be many years into a nurse's career. Perhaps it is more appropriate to consider a nursing or physiotherapy career in 'bundles' as described above by Hall (1987) and therefore professional socialisation and identity formation is an ongoing process (Lindquist et al., 2006).

Robinson & McMillan (2006) claim that in education it is how teacher educators' construct their identity that "is central to effecting innovation within a change policy environment" (p.328). There is some evidence that academics concentrate on the discipline specific skills rather than generic skills, such as communication (Hunt et al. 1998b).

*2.4.4 Examples of professional socialisation*

In 1992 Richardson stated that the growth and development of the physiotherapy in a changing world was in part reliant on the presentation an 'unambiguous professional

profile'. How this professional profile is developed in the student (as most of the literature refers to the undergraduate experience) and post-graduate (one study) will now be examined although it is recognised that there is little research in healthcare about professional socialisation (Clouder, 2003).

Richardson (1996, cited in Richardson, 1999a) described a work culture based on number of patients treated equalled competence. Number of hours completed in clinical practice was important rather than individual care and the demands of the changing health service. The newly qualified physiotherapists in this study seemed to be embarking on an apprenticeship rather than autonomous practice. They 'added' on skills rather than integrated them. The emphasis is on cure (the medical model).

Richardson (1996, cited in Richardson, 1999a) suggests that although universities may be preparing graduates for a changing workplace the culture of the workplace may hinder professional development. She suggested the student/graduate can challenge rather than accept the prevailing culture and expectations of their supervisors if they have a strong professional identity. Therefore the emphasis is placed the educationalists to educate the undergraduates so they have a strong professional identity. She does not consider the clinical educators and supervisors who are role models for the newly qualified physiotherapists (Cant & Higgs, 1999). Richardson (1993) clearly links education in universities with that in practice placements when considering the development of the professional. However, she does perceive a culture gap where knowledge learned in the

classroom has to be unlearned and re-learned in the clinical environment, depending on the setting.

Richardson (1999b) clearly perceives that if the graduates have clear professional identity then this will lead to

> a physiotherapy culture in the workplace which will foster professional autonomy and professional development in individuals and in dong so will ensure the survival of physiotherapy in health care for the future (p.473).

Her participants seem to be experiencing a passive form of socialisation, a functionalist perspective. Whereas she seems to be advocating a more active role and an 'interactionalist' approach.

In comparison Hunt et al. (1998b) take the view that graduates have discipline specific skills and are technically competent. They also possess graduate generic skills (communication, thinking, learning techniques and problem solving skills) but because of the changing healthcare system these skills may not mean competence in the workplace. Graduates need also to make a contribution to professional development. This

> can be achieved through the graduates' own adaptation to changes and professional development, and through their research and scholarly input to the profession's knowledge base (p.264).

They argued that professional socialisation at the beginning of a programme often concentrated on the differences between healthcare professions and therefore the students tend to focus on the unique skills of the profession. However, other programmes, such as the one referred to in this thesis, have long emphasised the importance of working together in team and identifying areas of similarity between healthcare professions. Over 15 years ago the shared learning modules change the emphasis away from professional differences to an emphasis on learning together about issues that were pertinent to healthcare professionals (Dept of Health Studies, 1999). This approach to curricula design is supported by Morris (2002).

Lindquist et al. (2006) reported on a study of student physiotherapists' experiences of professional socialisation. They identified four pathways of learning development and professional growth. These pathways are identified in the undergraduates but there is no discussion of the application of these pathways to post graduate work experiences. Lindquist et al. (2006) concluded that their study showed that professional socialisation could 'be seen as a random process that occurs through osmosis' (p.137) rather than the more active social interaction as described by other authors (Howkins & Ewens, 1999).

Adams et al. (2006) investigated first year health and social care students' professional identities from 10 professions including nursing, occupational therapy and physiotherapy. They reported that these students already had strong professional identities, with the strongest professional identity being found in physiotherapy students. Also students with the greatest cognitive flexibility (greater ability to structure knowledge in response to

different and changing situations), previous working experience in their professional area and great professional knowledge had the highest professional identity. One of the possible reasons for this could be the competition for selection on university programmes, particularly physiotherapy, and admissions tutors will select students based on their ability to demonstrate an understanding of the role of the physiotherapist. Adams et al. (2006) reported on first year students and as yet any changes in professional identity as the student move through their programmes and into the 'messy' world of professional practice have yet to be explored.

Authors of the previously cited research seem to assume that if undergraduates can be given a strong professional identity then they will feel comfortable in expressing their professional views and therefore able to change practice. When Physiotherapy moved to an all graduate entry level profession there was a tacit assumption that newly qualified physiotherapist would emerge from universities with generic skills, such as research, which would enable the development of the profession. However, there has been little research exploring the first post experiences for the newly qualified physiotherapist (see section 2.5) and therefore it could be claimed that the culture in physiotherapy departments also needs to change. The assumption that there is bottom-up process to changing a culture where the new practitioners are the change agents may be flawed. Although revolution does come from the ranks, it might be more appropriate, in the changing context of healthcare, that developing the profession is part of every physiotherapists role. When a department is committed to change then its new recruits should feel comfortable in developing themselves as a professional as well as having a

voice in the development of the profession. White & Ewan (2002) suggest one way discrepancies in practice could be reviewed would be to encourage novices to identify where are conflicts between theory and practice and then this be developed into a critical and reflective learning opportunity for all parties.

When reviewing the earlier nursing studies it must be remembered that most student nurses in earlier studies were part of the workforce, rather than supernumerary as in medicine, physiotherapy etc. However, some of the studies had comparable findings. Olsen & Whittaker (1968) found that their student nurses identified strategies to survive their programmes of study. As with Becker's (1961) medical students, the student nurses developed tactics to help them discover what ward staff expected of them which enabled them to modify their behaviour and act as required. The students developed techniques, such as 'fronting' and psyching out' to ensure that they were seen at their best by ward staff.

Melia (1984) in her seminal study described how student nurses learnt two versions of nursing depending on the situation. One version was presented by the school, the 'ideal, professional' version, and the other version as presented by ward staff the 'realistic, workload' approach which involved " a much more pragmatic approach to patient care than the 'professional' version offers" (p.138). Although these nurses moved round different wards and specialities, this was not an apprenticeship scheme, as the student nurses did not work with skilled experts, they worked with auxiliaries. Melia (1984, 1987) also identified the 'unwritten rules' of nursing and how the students developed

strategies which enabled them to pull their weight, look busy (not chatting to patients), and to learn the ropes. "The students seemed to be describing a code or set of rules which, if followed, would allow them to present the kind of behaviour that trained staff found acceptable" (Melia, 1987, p.18). Once accepted the students were happy because they felt part of a team.

Mackay (1989) also reported two versions of nursing the 'proper' and the 'realistic' way. She suggested that part of the problem lay in the way student nurses "are isolated and abandoned to 'the system' when they step on to the ward" (p.16). She also identified that the students participated in a system similar to the apprenticeship system which involved some 'sitting nest to Nellie' which helped to develop the 'realistic' version of nursing. These students were also reported as being concerned with the psychological and emotional, as well as the physical care of the patient, however, the students soon discovered that any other care other than physical care was not seen as working by the ward staff. Mackay stated that "this socialisation ensures the continuation of nursing and its ideologies without challenge" (p.133). In another study of student nurses' clinical experiences (Windsor, 1987) it was found that student nurses' learning could be divided into three categories – nursing skills, time management and professional socialisation.
Holland (1993) investigated nurses' ritualistic behaviour on a ward. Although rituals were identified there was no indication that these rituals were harmful to the patient. It was recognised that there was the potential for these rituals to be based on outdated practice and unsupported by the literature. Kelly (1996) supported Holland's (1993) findings and graduate nurses were strongly influence by the rituals of accepted practice

and the first year post graduation was seen as an 'obstacle course'. The participants stayed so they 'prove to themselves that they can do it (p.1068).

Much has changed in nurse education. Project 2000 moved nursing programmes to universities and students on these programmes became supernumerary to the needs of the ward. Gray & Smith (1999) investigated the professional socialisation of a group of Project 2000 nurses. They found that for these students the mentor and the learning environment were the two key factors in facilitation of professional socialisation, rather than the supernumerary status of the student. Melia (1987), Windsor (1987), Fitzpatrick et al. (1996) and Spouse (2001) also found that mentors were important in the socialisation of nurses. Other studies have identified not only the importance of the clinical environment in the socialisation of nurses but the also the academic environment (Wilson & Startup, 1991, Fitzpatrick et al., 1996).

Burkitt et al. 2001 described 'the processes of nurse socialisation that create a strong identity of the 'good nurse'. The authors identify two distinct 'communities of practice' – the academic and clinical environment in which the nurse's identity is constructed. Some of the problems of developing an identity were linked to relationship between the two communities of practice and to the lack of definition of what is actually involved in nursing practice. Nursing has a strong shared identity, where the nurse is committed to caring for the patient with compassion and empathy, this also involves some personal involvement with the patient. Stress occurs when the nurse is unable to deliver such care,

when this image of a 'good nurse' cannot be delivered because of the context care and its limitations (Burkitt et al., 2001).

Clouder (2003) investigated the experiences and perceptions of undergraduate occupational therapists over the whole programme of study. She found evidence that these undergraduates were active participants in the socialisation process, which she described as 'individual agency'. The examples of 'agency' were given as 'learning to play the game' and 'presentation of self'. For example, written and unwritten rules were identified by the participants and then strategies adopted so the game could be played. Although 'playing' the game could be seen as passive acceptance of the rules of the profession, these participants also developed strategies that meant they could be seen as challenging the rules. Clouder concluded with the view that although the profession is a powerful influence on the development of professional identity there is also an active role of the individual that should be considered.

Davys et al. (2006) stated that personal presentation is part of identity expression and therefore how an occupational therapist appears in the workplace is part of their professional identity. They argued that any kinds of judgements about a professional's appearance should be based on the code of ethics and professional conduct and not on personal views. What is important is that the professional realises the implications and consequences of their personal presentation. If the way the professional dresses is viewed negatively by the client then the therapist could be viewed as lacking in professionalism.

However, the context of the service provision may need to be taken into consideration, as appearance in one setting may be inappropriate in another.

The experiences of student teachers were also considered as part of this review because they have a period in the 'real' world of schools during their teacher training programmes. In his study, Tickle (cited in Holly & McLoughlin, 1989) found that although student teachers were initially concerned with learning 'the secrets of the trade', achieved by observing teachers, the students "also showed how they were capable of elucidating, examining, explaining and extending their practical knowledge through reflection on their ... teaching" (p.98). Therefore this was an active process and the student teachers recognised a professional code.

In common with many other professions teaching is facing the challenge of a rapidly changing more complex working environment where

> the world of teaching is demanding that teachers are able to act as professionals, interpreting and analysing educational events, acting in a variety of situations, reflecting on their own performance, and acting collaboratively with others (Robinson & McMillan, 2006, p.328).

Day et al. (2005) concluded that imposed change and reform by government without acknowledging the core identities of teachers threatens the commitment of teachers to their profession and the delivery of high quality education.

What can be seen from the literature reviewed that there has been a move away from the view that professional socialisation is a reactive process to one where the individual is proactive participant (Clouder, 2003, Howkins & Ewens, 1999). Generally much of the literature seems to suggest the process of professional socialisation is linear and progressive, however, more recently there are suggestions that professional socialisation may be a process that 'stops and starts' or at least slows down and the speeds up when the individual experiences change (Howkins & Ewens, 1999). Authors such as Adams et al. (2006), Heslop et al. (2001) and Holland (1999) all highlight the importance of role models in the process of professional socialisation and the transition from novice to expert practitioner.

*2.4.5 Transition from novice to expert practitioner*

The transition from novice to expert practitioner may take many years and is not the focus of this literature review, which only covers the period up to one year post qualification. However, it is acknowledged there is a transition between student (novice) and qualified practitioner (with more expertise). In nursing Heslop et al. (2001) identify this transition phase as being an 'obstacle course' where the new nurse has to prove they can cope with the bureaucracy of the hospital environment and therefore take a functionalist view of socialisation as the nurse conforms to rules of the workplace. Similarly Holland (1999) investigated student transition to the qualified nurse and found the process to be ill-defined but often ritualistic. The ritualistic transition phase reinforces the existence of the 'ideal' nurse as helping and caring for sick people. Much of this work was based on Van Gennep (1960) who perceived transition as being a rite of passage, which he subdivided

into 'rites of separation, transition and incorporation. This can mean that novices are not automatically accepted into a community of practice and can be marginalised (Cope et al., 2000).

Benner (1984) described five levels of competency – novice, advanced beginner, competent, proficient and expert – based on the 'Dreyfus model (1981). She claimed that competence was only achieved after two to three years work in a similar situation. Her criticism of nursing research into practice was that it concentrated on socialisation processes and not on how knowledge is embedded into practice. From the literature reviewed in this chapter physiotherapy researchers have concentrated on knowledge development and its value in a changing healthcare environment and not on the professional socialisation of its graduates.

Many authors from different disciplines highlight the importance of role models through this transition phase and the relevance of the 'theory-practice gap' (Holland, 1999, Heslop et al., 2001, Adams et al., 2006). The 'theory-practice gap' is discussed in section 2.5.2. Traditionally the apprenticeship model of education has emphasised the learning of skills from an expert. This expert has achieved this status in a relatively stable system and change is not so rapid (Higgs & Titchen, 2001). Today newly qualified practitioners face a rapidly changing knowledge base, making it impossible to just add skills learnt from an expert. Therefore the development of the 'interactional practitioner' is suggested by Higgs & Hunt (1999) (see page 16).

Newly qualified practitioners will face many barriers to their transition from novice to expert such as; the environment in which they find themselves working, the value placed on different types of knowledge and how knowledge is used in practice (Higgs & Titchen, 2001). Higgs & Titchen (2001) explored the concept of 'professional artistry' (Schön, 1987).

> Professional artistry enables the practitioner to use professional judgement to apply a blend of propositional, professional craft and personal knowledge and techniques to address practical problems in the messy world of practice (p.528).

The clinical reasoning skills of novice practitioners are often limited when compared to experienced practitioners. This leads to reasoning errors when making clinical decisions and therefore the education of novice practitioners, whether that be students or newly qualified practitioners, needs to develop clinical reasoning skills. This can be facilitated by peer learning and actively engaging the novice in their own learning (Ladyshewsky et al., 2000). Again the research is concentrates on undergraduates.

Many professions advocate reflective practice and clinical reasoning (Clarke, 1995, Clouder, 2000). Theories of clinical reasoning and reflective practice can be and are integrated into today's curricula, either partially or fully. If theories of clinical reasoning and reflective practice are part of the undergraduate education of physiotherapists, what

happens to foster these skills when the newly qualified physiotherapist enters the workplace?

*2.4.7 Summary of the literature relevant to newly qualified professionals*

This section of the IFS has reviewed professional identity formation, professionalism, nature of experience, and transition from novice to expert practitioner relevant to newly qualified professionals. Much of the literature is relevant to the newly qualified physiotherapist. Most of the research concentrates on students and there is little referring to post graduate experiences although there is an acknowledgement that professional socialisation and the development of a professional identity is an ongoing process that might span a person's whole career (Day et al., 2005).

Authors have found the concepts of a profession, professionalism and professional socialisation difficult to define as they may be concepts that continually evolve (Downie, 1990, Porter, 1992, Hoyle & John, 1995). The physiotherapy literature is divided on the status of physiotherapy as a profession (Samuels, 1987, Palastanga, 1990, Helders et al., 1999, Sparkes, 2002a).

The process of professional socialisation is the process of induction into the culture of a profession and could be perceived as a process of social control or indoctrination, if the emphasis of the process is on the maintenance of the status quo (White & Ewan, 2002). The transition from student to newly qualified professional can be ritualistic and conforming (Holland, 1999, Heslop et al., 2001). A constructionalist view of professional

socialisation is a process where shared meanings are negotiated by members of the group and continue to be re-defined or changed by the members and therefore the profession can evolve (Bond & Bond, 1994). The process of professional identity formation is influenced by official/institutional polices and by the experience of the individual (Kim, 2005, Jenkins, 2004). Individuals construct their identity and knowledge from experience and this is facilitated by clinical reasoning (Titchen & Higgs, 2000).

This section also identified that there were few studies which had investigated the professional socialisation of newly qualified physiotherapists. Therefore the next section of the IFS considers the limited research that is published about newly qualified physiotherapists' expectations and experiences of their first post which is not directly linked to the socialisation process.

### 2.5 Overview of the Literature Relevant to Newly Qualified Physiotherapists

The literature relevant to newly qualified physiotherapists is reviewed in two sections. Firstly from the point of view of just newly qualified physiotherapists and secondly from the point of view of more experienced physiotherapists including papers which involve both experienced and newly qualified physiotherapists. This section of the IFS will show that studies of newly qualified physiotherapists' perceptions of their first posts are few in number and limited in their relevance, as will be summarised in section 2.5.3.

### *2.5.1 Newly qualified physiotherapists' perceptions of their first posts*

The literature relating to new graduates' expectations and experiences of their first post is sparse. Only one published article from the UK was found. When the scope of the search was widened to include other countries four more articles were found and also an article from 1987 was included. A summary of the literature is given in Table 2.1. The previous section in this review has identified why the literature exploring newly qualified physiotherapists' perceptions is limited.

Table 2.1 demonstrates the lack of research relevant to newly qualified physiotherapists' perceptions of their first posts. Only one piece of research was conducted in the United Kingdom (Warrinder & Walker, 1996). Research reported from other countries must be viewed with care, as there may be differences in the provision of healthcare and the expectations of newly qualified physiotherapists. The area of research was very different in each study therefore making outcomes difficult to compare. Although four of the studies used a questionnaire as their method, there was a very varied response rate and the style of questions again makes comparisons difficult.

Each study is reviewed and its relevance to the three questions in section 2.2 is discussed. Any similarities and differences between the studies are also discussed.

**Table 2.1 A summary of physiotherapy literature relevant to newly qualified physiotherapists' perceptions of their first posts**

| Author(s) | Date | Country | Area of Research | Participants | Method | Pilot | Response rate |
|---|---|---|---|---|---|---|---|
| Schwertner | 1987 | USA | Perceptions of professional role | 15 | Questionnaire | No | 93% |
| Scutter & Goold | 1995 | Australia | Burnout | 66 | Questionnaire | No | 60% |
| Warrinder & Walker | 1996 | UK | Choice of first post | 108 | Questionnaire | Yes | 72.5% |
| Hunt et al. | 1998a | Australia | Gap between academic & 1st post environment | 239 | Questionnaire | No | 31% |
| Ohman & Hagg | 1998 | Sweden | Gender issues in perceptions of professional role | 8 | In-dept interviews | No | N/A |
| Connelly et al. | 2001 | USA | Changes in attitudes & perceptions about research | 115 | Questionnaire | Yes | 31% |

Schwentner et al. (1987), in the USA, investigated the changes in perceptions of physical therapy graduates of their professional role. The research was based on a model of professional socialisation that has been called into question in recent years (Clouder, 2003, see section 2.5.3). Fifteen newly qualified physiotherapists from one cohort were sent questionnaires at the beginning of their undergraduate course, just before graduation and 12 to 18 months into their first posts. The authors claimed the demographic data of the sample was similar to the overall profile of physical therapists for the whole country. The findings supported the literature, which suggests that professional socialisation does not stop as soon as the person qualifies (Richardson, 1999a). Part of the process of professional socialisation is CPD. Newly qualified physiotherapists in this country are required to complete a professional portfolio demonstrating their continuing professional development. In 2010 physiotherapists will be audited by the HPC and evidence of CPD will form part of the requirements for renewal of registration with the HPC and all practising physiotherapists in this country must register the HPC. From July 2006 all health professionals must keep a record of their CPD activities (HPC 2006). Schwerter et al. (1987) found that these participants' perceptions of their roles had changed in the first 12 to 18 months post graduation. The main changes in perception related to the participants' perceptions of their professional role. The authors suggested that some of these changes may be due to courses promoting "professional goals and ideals that are inconsistent with those encountered in the work environment" (p.699). This 'theory-practice gap' is discussed later in this review (see section 2.5.2). In the early years post graduation newly qualified physiotherapists may be more focussed on the job than on the bigger picture of the profession. Schwertner et al. (1987) found that the participants had

little time for teaching from seniors, no time for research and few were members of a professional organisation. In this country successful completion of a pre-registration approved course in physiotherapy enables the graduate to become a member of the Chartered Society of Physiotherapy (once fees have been paid) and most graduates become members. However, as the HPC evolves and the cost of registration increases new graduates may question the value of belonging to the professional body. The study also demonstrated that this group of graduates was satisfied with their jobs. This study was conducted in America and over 14 years ago and in consequence the reported views of the participants may not be applicable to the UK. However, the study does attempt to investigate changes in individual perceptions over time.

Schwertner et al. (1987) make four recommendations for further research, and one is directly relevant to the research approach adopted in this thesis. The authors recommended that interviewing the participants would benefit any future research as "insight into individual feelings and perceptions may be gained" (p.700).

An Australian study (Scutter & Goold, 1995) investigated 'burnout' in newly qualified physiotherapists. An attempt to contact all physiotherapists who had graduated in the five years prior to the study was made. The 122 contactable graduates, with less than five years work experience, were sent a questionnaire. The questionnaire included the Maslach Burnout Inventory. Seventy-two graduates returned the questionnaire, but 12 had to be excluded as they had worked for "less than 75% of the time since graduation" (p.116). The authors made no attempt to compare the demographic data to the whole

group and therefore assess the representativeness of the sample. The authors stated, "burnout develops when an individual is exposed to chronic stressors and frustrations which exceed their tolerance and mechanisms for coping" (p.115). Sixty percent of respondents recorded moderate to high levels of emotional exhaustion, one of the characteristics of burnout described by Maslach & Jackson (1981, cited in Scutter & Goold 1995). There was an overall perception that physiotherapy was a moderate to very stressful profession.

Some Scutter & Goold (1995) of findings may be relevant to a UK setting. In the study physiotherapists working in public sector hospitals reported higher levels of burnout. Factors cited which increased stress were dealing with unrealistic expectations, making decisions on their own, too much work, responsibility and poor feedback. All of these could be relevant to newly qualified British physiotherapists. The authors claimed that when the results were compared to physiotherapists who had been working for more than five years the more recently qualified physiotherapists showed higher levels of burnout. Therefore, as newly qualified physiotherapists were at greatest risk of developing burnout, and strategies needed to be developed to combat this risk. Scutter & Goold (1995) perceived the first step in this process as creating an awareness of the problems faced by newly qualified physiotherapists, research that has as yet not been conducted in this country. However, one of the limitations of this piece of work is that the researchers were unable to contact physiotherapists that had already left the profession, possibly due to 'burnout', as the authors claim, but there could have been other reasons.

Warrinder & Walker (1996) surveyed by questionnaire all final year physiotherapy students from five programmes just before graduation about their choice of first posts. The study is now a little dated, as currently there is a shortage of junior posts with some newly qualified physiotherapists unable to find work (Wilde, 2006). A pilot study had been performed on a sample of students from the previous cohort. There was a good response rate to the main study but variations between programmes were not discussed. The three most important factors influencing choice of first post were 'attitudes of potential supervisors', 'in-service training', and 'attitudes of potential colleagues'. The findings also indicated that the inclusion of paediatrics, neurology and out-patient rotations were important in deciding on first posts. The authors also felt that these newly qualified physiotherapists were focussed on short-term career development rather than long-term issues, such as promotion. Although the authors mentioned in their conclusion the importance of potential employers providing realistic information about posts to aid retention, they do not consider further research aimed at investigating newly qualified physiotherapists' experience of their first posts. As mentioned above the issue for newly qualified physiotherapists today may be one of finding a post to apply for, but once they are in post it will be important to ascertain the reasons for staying in the NHS.

In an Australian study, Hunt et al. (1998a) surveyed, by questionnaire, all newly qualified physiotherapists (n=239) from one university in order to investigate the gap between the academic and first post environments. The research revealed that newly qualified physiotherapists perceived that there was a gap between their undergraduate studies and the reality of the workplace. The questions used in the questionnaire were derived from

informed comments of 67 experienced practitioners in the field. The format of the questions enabled the data to be analysed using the Statistical Package for the Social Sciences (SPSS). Some demographic characteristics of the sample are presented but without the same data from the whole cohort it is impossible to draw any conclusions as to the representativeness of the sample.

Although this research is essentially an evaluation of the course, some of the factors identified, as being important in their first posts may be relevant to British physiotherapists. For example, communication skills and coping in the workplace. However, some care must be taken when considering these results in a British context, as there are differences in the curriculum and delivery of the courses. For example, the authors acknowledge that the curriculum studied by these graduates assumed that students would learn communication skills as they progressed through the course. For the participants in the study reported in this thesis communication skills are taught in a specific interprofessional module (Dept of Health Studies, 1999). The research identified particular areas where the newly qualified physiotherapists perceived differences between "knowledge and skills gained as a result of their university education and those required in the workplace" (p.125).

Although Hunt et al. (1998a) conducted their study in Australia, the authors described changes in the workplace that could be compared to the NHS. Both countries are witnessing changes in the delivery of care from centralised hospitals to an emphasis on care in the community. Such changes require more co-ordination between teams of

healthcare workers. This has stimulated debates about the blurring of professional boundaries and the possibility of a generic practitioner capable of delivering the whole service in the patient's home. Both countries are also witnessing more resources being devoted to health promotion and prevention of illness. The authors claimed that their findings are of international importance as they inform the debate on 'fitness for purpose'. However, they did not acknowledge the limitations of the sample, as this was a single cohort study. The authors did acknowledge that some of the non-respondents may have already left the profession due to 'burnout'. They also proposed that burnout may be linked with lack of preparation in the academic environment for first posts.

Ohman & Hagg (1998) investigated, in Sweden, the attitudes of newly qualified physiotherapists to their professional role with particular emphasis on the responses made by different genders. As with research by Schwerter et al. (1987) the Swedish study was based on a model of professional socialisation that has been called into question in recent years by Clouder (2003)(see section 2.5.3). The design utilised in-depth interviews and a list of the themes covered in the interviews was given. The authors used 'member-checking' to triangulate the data. The authors make no attempt to generalise the findings of this small study to the whole population of physiotherapists, but they do relate the sample to a theoretical framework developed to address professional socialisation within physiotherapy. Although the study was conducted in Sweden there are similarities to the British system. For example, in both countries a new qualified physiotherapist is expected to work independently and, develop their CPD portfolio; and in both countries there is no formal mentorship system and the education of physiotherapists has moved from diploma

to degree level. The study identified four 'ideal' types of professional. These were 'coach', 'entrepreneur', 'supervisor' and 'treater', and these reflected the attitudes of the participants to their professional role. These 'ideal' types were then related to gender. Whilst the research reported in this thesis is not particularly related to gender some of the characteristics described by the participants in the Swedish study may also be reported by British newly qualified physiotherapists. For example, Swedish female participants described themselves as supporting patients and providing help, whilst male participants perceived themselves as training patients, investing their time in and working as part of a team. Female participants were also more satisfied with their work than male participants.

Connolly et al. (2001) investigated student and newly qualified physiotherapists' changes in perceptions and attitudes towards research. Wiles et al. (1999 cited in Barnitt & Salmond, 2000) had suggested that graduates from health care programmes had little time for reflective practice and their skills in evaluating and implementing research into current practice were, in some places, seen as challenging accepted practice. Connolly et al. (2001) surveyed both students and graduates and although they found that students attitudes towards research improved, the newly qualified physiotherapists found evidence based practice was not applicable in their first posts and they were not supported when they tried to implement research and therefore they conformed and followed established procedure. Connolly et al. (2001) concluded that these newly qualified physiotherapists did not perceive research as being important to clinical practice.

### *2.5.2 Experienced physiotherapists' perceptions of newly qualified therapists including research which involves both newly qualified physiotherapists and more experienced physiotherapists*

A module developed to address perceived weak management skills, such as those identified by Kenyon & Ilott (1997) (see Appendix I) was evaluated by Clouder & Dalley (2002). The module was designed to bridge the gap between clinical education and the realities of clinical practice. The module was developed by involving 200 clinical educators and was delivered during the four final weeks of the clinical education programme. The module was then evaluated, immediately after completion, by the students, clinical educators and clinical visitors (university staff). Six months later the newly qualified physiotherapists were sent questionnaires. The feedback from the initial evaluation was positive with the students feeling they were able to take on more responsibility, able to 'get on' with the job and 'they felt more like a professional'. The responses at six months post-qualification indicated that although the graduates had perceived a gap between academic life and working life they felt that the module had given them the capacity to cope with the transition. Newly qualified physiotherapists perceived that their self-management skills and their acceptance into the team had been enhanced by the module. Support was perceived as being there when required - usually when dealing with more complex cases. However, the research did highlight the lack of information given by the employer about newly qualified physiotherapists' first post, as many did not know which speciality they would be working in when they started their job. The authors felt that the employers had an important role in the facilitation of the

transition from student to employee. The authors acknowledged the limitation of the research in relation to evidence that some professionals tend to view their courses favourably (Wiles et al., 1999 cited Clouder & Dalley, 2002). However, it should also be noted that the newly qualified occupational therapists did not have any experience of not having studied such a module and there was no six-month questionnaire to their managers or clinical educators. Many of the educational opportunities mentioned in the description of the module are common opportunities available in final clinical modules, although they might be part of the 'hidden curriculum' rather than explicit in the learning outcomes. For example, in final placements it is common for students to be given more responsibility for their own time management. Indeed in the programme from which the newly qualified physiotherapists in the research for this thesis graduated, the final two placements are six weeks long (instead of four weeks) so that the students have more time to develop their role and become part of a team (Dept of Health Studies, 1999).

A more recent study (Lopopolo et al., 2004) utilised a Dephi technique[1] to investigate Leadership, Administration, Management and Professional (LAMP) skills needed by a newly qualified physiotherapist working in America. As this is an American study, and the focus of the research is based on "the need to develop a better understanding of the business-related skills that physical therapists use" (p.139) great care must be taken if generalising any of these findings to the UK, as most physiotherapists in this country do not enter the private sector until later in their career. Thirty-four physiotherapy mangers participated in the study. The first two rounds of the research concentrated on defining the list of LAMP skills and then rating these skills in relation to clinical management. It

was only the final round that concentrated on the perceived LAMP skills required by newly qualified physiotherapists. The study found that all the defined LAMP skills were important in the management of clinical practice, but that the managers perceived that newly qualified physiotherapists only needed moderate to extensive knowledge in 44% of these skills. The top rated skills were 'communication, professional involvement and ethical practice, delegation and supervision, stress management, reimbursement sources, time management and health industry scanning'. The authors acknowledged that the first two skills were relevant to all areas of clinical practice but the others were more relevant to the management and administration of clinical practice. Both the CSP's *Curriculum Framework* (2002) for entry into the profession and the HPC's *Standards of Practice* (2003) require management and administration to be included in pre-registration programmes if they are to gain approval. However, no research was found as to the importance of these factors in the newly qualified physiotherapist in this country. Also Lopopolo (2004) did not evaluate if these skills were evident in newly qualified therapists and if these therapists were 'fit for purpose'.

The 'fitness for purpose' debate has been an issue for the profession for many years. Physiotherapy in Britain has been a graduate profession for 15 years. Initially there were concerns about the move from hospital-based to university-based programmes of physiotherapy (Roskell et al., 1998). However, a newly qualified graduate physiotherapist is now accepted into the workplace, and although their profession specific skills have been questioned by clinicians (Roskell et al., 1998) it is unclear what opportunities are available to practise their graduate skills.

There is little in the literature about what 'fitness for purpose' actually means, or of manager expectations of a newly qualified therapist that demands a degree level qualification. American research (Huebler, 1994) asked health service managers and administrators about newly qualified practitioners. The respondents identified weaknesses such as clinical skills and lack of understanding of the environment in which they worked. Masters (2004) published a report which aimed to establish ways of increasing the number of junior posts available in London and to develop areas of good practice in supporting newly qualified physiotherapists so they would be retained in post and progress to senior posts in the NHS, where there is a national shortage of physiotherapists. The report was based on a questionnaire sent to London physiotherapy managers. The recommendations were similar to those contained within guidance from the CSP (2003). For example, managers should provide agreed levels of supervision. The recommendations mainly addressed the development of new posts through the use of more community or 'non-traditional' rotations. However, as also suggested by Hunt et al (1998b), the managers did express some concerns about the skill level of the newly qualified physiotherapists. It should also be noted that despite the warnings in the report about potential job shortages in 2005, little was done and many 2005 graduates remain unemployed (Wilde, 2006). Masters (2004) stated that "Higher Education Institutions should inform undergraduates that they will never be out of work if they remain flexible" (p.17), advice that has turned out to be very poor indeed.

Much of the debate about 'fitness for purpose' revolves around the 'theory-practice gap'. The physiotherapy literature acknowledges, to a limited extent, the divide between the

education of students and the reality of professional practice in the workplace (Richardson, 1992) and possible developments in education to meet the challenges of the changes in professional practice (Hunt et al., 1998b, Potts, 1996).

Roskell et al., (1998) acknowledged the paucity of research or discussion on a 'theory-practice gap' in physiotherapy and therefore examined physiotherapy from the experience of nursing authors in this area. The authors claimed that the physiotherapy profession was in conflict and that the conflict had been emphasised by the changes within the NHS. Central to this conflict was the 'theory practice gap', a gap identified as being due to

> the divergence of holistic and biomechanical approaches to therapy, perceived inconsistencies between professional education and clinical practice, and the gap between research evidence and the reality of practice in the clinical setting (p.223).

Roskell et al. (1998) made a comparison between the nursing and physiotherapy professions and links made with educational theory and the development of professional courses within the university environment. She felt it was necessary to examine the nursing literature as the 'theory-practice gap' had received little attention in the physiotherapy literature. Having made the comparison she came to the conclusion that physiotherapists need to fully consider the 'theory–practice gap' and use the nursing experience to inform any conclusions.

Two papers have been published which discuss the issues of professional socialisation of physiotherapists (Hunt et al., 1998b, Richardson, 1999a). These papers are reviews of the literature and both place the blame for the 'theory-practice gap' firmly with the universities. Hunt et al. (1998b) challenged educational establishments and the profession to make sure their programmes meet the needs of the community. Hunt et al. (1998b) acknowledged that the transferable and professional specific skills gained by all graduates at university should equip the new graduate with the skills to cope in an ever changing workplace. However, they felt the challenge was to maintain a balance between the profession specific skills and the broader skills, which would enable a graduate to contribute to the development of the profession in a changing NHS. The paper was based, in part, on some old references to out dated practice. For example, it claimed that physiotherapy education concentrates on the acquisition of profession / vocational specific skills, when many physiotherapy programmes had moved on to educating students about transferable skills, team working and communication. This is the case of the newly qualified physiotherapists participating in the research reported here who graduated from a programme with a long history of inter-professional education (Dept of Health Studies, 1999).

The development of interprofessional learning within undergraduate programmes was supported by Wheeler et al., (2000). They investigated the practical skills and preparation for practice of 67 newly qualified occupational therapists and physiotherapists. Also included in the study were the perceptions of clinical supervisors and managers, who were questioned about 'interpersonal, clinical and management, and interdisciplinary

working' of newly qualified therapists. Although the aim of the research was to compare two different styles of physiotherapy education, it did show that all respondents viewed newly qualified therapists positively and there was little difference between graduates from different styles of physiotherapy education. The 'theory-practice gap' was not perceived as an issue for these newly qualified therapists. Hunt et al. (1998b) suggested collaborative working between academics and clinicians to foster integrated programmes and working. The authors did acknowledge that when new graduates enter the workplace, collaborative skills may be difficult to foster because newly qualified physiotherapists become focussed mainly on improving and gaining competence in their clinical skills. The authors criticised programmes for concentrating "on the acquisition of technical skill *versus* understanding and analysis" (p.268). They proposed a list of strategies for programmes of physiotherapy to adopt to facilitate the transferable generic skills, many of which are now part of undergraduate programmes. However, they did not address the issue of the challenge to the profession to deal with the reality of the workplace in which the new graduates find themselves, where they will be encouraged to concentrate on profession specific skills. Even if their university education has equipped them to deal with a changing workplace, they may find themselves in an environment where their role models encourage the status quo, and even if they feel they would like to change things, it may be perceived as more professional to maintain the status quo (Wiles et al., 1999 cited in Barnitt & Salmond, 2000).

Richardson (1999a) described professional socialisation in the physiotherapy profession. She argued that it is important for the student physiotherapist to have a good

understanding of the profession and their professional role. This understanding needs to continue to develop in first posts and beyond if the individual and the profession are to continue to develop. Richardson (1996b), in an unpublished piece of work, investigated newly qualified physiotherapists' experiences of the "work culture" (p.469). Like Wiles et al. (1999, cited in Barnitt & Salmond, 2000) she suggested that the work environment that was described by the graduates might hinder professional development.

The 'theory-practice gap', if it exists, may be more relevant to the realities of practice, where newly qualified physiotherapists are expected to work in traditional core rotations offered by the Trusts and the role models will be the clinicians who work in these rotations who may provide a profession specific model of socialisation rather than the inter-professional role the degree programme has prepared them for. The NHS is undergoing massive changes and there are attempts to remove the professional boundaries, but without the support of the professionals 'doing' the job, the role model for these graduates will continue to be profession specific. Barnittt & Salmond (2000) supported this view as her research found newly qualified therapists had little time to use their 'reflective practice' skills during the first six months of work as they were concentrating on 'fitting in' to the new environment and departmental ways of working. McCluskey (2004) also supported the view that graduate skills were being under-valued in the working environment.

*2.5.3 Summary of physiotherapy literature relevant to newly qualified physiotherapists*

Studies of newly qualified physiotherapists' perceptions of their first posts do not figure prominently in the physiotherapy literature. The literature reviewed in the previous section demonstrates a small number of non-UK studies, and although some have relevance to this country, care must be taken when generalising from these small scale studies. Generally there is little information on how the studies were conducted. The findings from these studies do indicate that newly qualified physiotherapist tend to focus on short term career issues (Warrinder & Walker, 1996) and that there might be a perceived 'theory-practice gap' (Schwertner et al., 1989, Hunt et al., 1998a). The literature also suggests that newly qualified physiotherapists are likely to find themselves in a working environment where the status quo is encouraged and their graduate skills are under-valued (Schwerter et al., 1989, Hunt et al., 1998b, Richardson, 1999, Barnit & Salmond, 2000, Connolly et al., 2001, McCuskey, 2004). Both Warrider & Walker (1996) and Clouder & Dalley (2002) noted that employers often supplied little information regarding newly qualified physiotherapists' first posts, which may hinder the transition from student to newly qualified physiotherapist working in the NHS. However, most of the physiotherapy literature reviewed is of limited relevance as the focus of the studies are only indirectly related to the aims of the study reported here.

Other authors have focussed on issues relating to 'fitness for purpose' of the newly qualified physiotherapist and the 'theory-practice' gap (Richardson, 1992, Potts, 1996, Hunt et al. 1998b, Roskell et al., 1998). They discussed the 'theory-practice gap' and the

division between transferable generic skills taught in Universities, and often expected by managers, versus the expectations of clinicians of practical profession specific skills. This division led to conflict in the clinical environment (Wiles et al., cited in Barnitt & Salmond 2000, McCluskey, 2004).

This paucity of literature in physiotherapy led to the examination of another profession's research in the same area. Literature relevant to the experiences of newly qualified occupational therapists was reviewed in order to find some concepts or models, which might help to reveal newly qualified therapists' experiences of their first posts.

## 2.6 Overview of the Occupational Therapy Literature Relevant to Newly Qualified Occupational Therapists

As the previous sections had identified that there were few studies which had investigated newly qualified physiotherapists' expectations and experiences of their first post which were not directly linked to the socialisation process, the relevant literature in occupational therapy was also reviewed.

As in section 2.5 the literature relevant to newly qualified occupational was reviewed in two sections, the details of the review can be found in Appendix I. The following summarises the relevant literature in occupational therapy.

### *2.6.1 Summary of occupational therapy literature relevant to newly qualified occupational therapists*

It is difficult to make comparisons because the research focuses on different areas. Some authors focused on the initial transition between student and newly qualified occupational therapist (Leonard & Corr, 1998, Rugg, 1996, COT, 1995, Hummell & Koelmeyer, 1999, Lee & MacKenzie, 2003) whilst others focussed on other periods of time (Bailey, 1990, Tryssenaar & Perkin, 2001). Others focussed on factors influencing choice of first posts (Bailey, 1990, COT, 1995, Atkinson & Steward, 1997), attrition (Bailey, 1990, Rugg, 1996), differences between expectations and actual work, the 'theory-practice gap' (Rugg, 1996, Atkinson & Steward, 1997, Sutton & Griffin, 2004) and preparation for actual work (Atkinson & Steward, 1997, Adamson et al., 1998).

The literature is now summarised in two parts – findings and recommendations.

2.6.1.1 Findings

The findings reflect a negative view of first posts, a view that could be due to the focus of the researchers. Rather than focusing on the whole experience, authors have focussed on aspects such as attrition (Bailey, 1990, Rugg, 1996a), choice of first posts (COT, 1995, Atkinson & Steward, 1997), the differences between expectations and actual work (Atkinson & Steward, 1997, Rugg, 1999b, Atkinson & Steward, 1997, Sutton & Griffin, 2004), and stress (Leonard & Corr, 1998, Rugg, 2002, Rugg, 2003).The literature reported that newly qualified occupational therapists found the support and supervision offered as crucial towards their success in their first posts (Parker, 1991, Leonard & Corr, 1998, Hummell & Kolmeyer, 1999, Rugg, 1999(b) 2003, Tryssenaar & Perkins, 2001, Lee & Mackenzie, 2003, Sutton & Griffin, 2004). Many newly qualified occupational therapists had concerns over their professional role (Bailey, 1990, Parker, 1991, Rugg, 1999b, Lee & MacKenzie, 2002, Steenbergen & MacKenzie, 2004). Linked closely to concerns about professional role were doubts about their professional skills (Atkinson & Steward, 1997, Spalding, 2003, Tryssenaar & Perkins, 2001, Lee & Mackenzie, 2003). However two studies, (Adamson et al., 1998, Atkinson & Steward, 1997), found that their newly qualified occupational therapists felt they were well prepared for aspects of their clinical role, including essential tasks, communication with patients and their current professional development, but poorly prepared for communication with other professionals, workplace management and their knowledge of the health industry. Other

studies noted complaints about the excessive amount of paperwork involved in clinical practice (Bailey, 1990, Leonard & Corr, 1998).

2.6.1.2. Recommendations

The literature reviewed in this section makes various recommendations to address some of the findings. To address the 'theory-practice gap', it was recommended that the amount of supervision given to students on clinical placements be reduced to reflect the realities of practice (Rugg, 1999b & 2003, Sutton & Griffin, 2004). However, it might have been more appropriate to suggest more assessment of individual needs for support both pre and post qualification so that supervision could be allocated effectively. In areas where poor support was identified then it was recommended that newly qualified occupational therapists should be encouraged to demand more help and more support should be made available (Parker, 1991). However, Leonard & Corr (1998) reported that newly qualified occupational therapists were receiving sufficient support and Tryssenaar & Perkins (2001) found that by six months their newly qualified occupational therapists were seeking out support when required. Other recommendations were in-depth induction programmes (Parker, 1991, Hummell & Kolmeyer, 1999), training for staff involved in the supervision of newly qualified occupational therapists (Parker, 1991) and stress management courses for newly qualified occupational therapists (Hummell & Kolmeyer, 1999).

### 2.7 Summary of the Literature on the Newly Qualified

A review of the literature revealed little about the newly qualified physiotherapist. The research found in both professions was often dated and did not reflect the many more recent changes in education and employment for occupational therapists and physiotherapists. For example, many of the early studies focussed on newly qualified therapists who had qualified with a diploma and not a degree as the final award. Moreover, whilst The Chartered Society of Physiotherapy publishes quantitative data on numbers entering the profession as well as information on those leaving (CSP, 2000), there is little research into the experiences of a newly qualified physiotherapist.

The search of the occupational therapy literature revealed more studies. The findings and recommendations of these studies are summarised in section 2.6.1. Some authors (Spalding, 2000, Tryssenaar & Perkins, 2001, Lee & Mackenzie, 2003, and Steenbergen & Mackenzie, 2004) adopted a qualitative approach to explore the experiences of newly qualified occupational therapists.

As the literature review of newly qualified physiotherapists' experiences of their first posts was found to be so sparse in comparison to occupational therapy it was decided to review, in the next section, physiotherapy literature in general to investigate physiotherapists' approaches to research and if this could explain the paucity of research in this area.

## 2.8 Physiotherapy Literature

The literature search revealed little literature relevant to newly qualified physiotherapists it was decided to review in this section physiotherapy research in general in order to explore any reasons that might explain the paucity of the research.

Authors acknowledge that physiotherapy research development, when compared to the past, has been considerable recently and that potential is good (Potts, 1996, Sherrington et al., 2001, Bithell, 2005). However, many physiotherapists over the years have called, and continue to call, for an increase in physiotherapy research (Bury, 1996, Higgs & Titchen, 1998, Brauer, 2003, Helders, 2004). Indeed Clemence (1998) explained that research relevant to evidence-based healthcare was limited in physiotherapy and therefore had relied heavily on evidence from nursing and medicine when he considered the potential for physiotherapy's evidence-base.

There are nearly 32,000 practising Chartered Physiotherapists in the UK and 177 physiotherapists are registered with the CSP as having higher degrees (DPhil, PhD), although some of these members are not still practising (Attew, 2005). In 1996 there were more than 40 physiotherapists with DPhil awards and five professors (Potts, 1996). In 1994, Parry estimated that only a maximum of 1% of physiotherapists were conducting and publishing research. Moore (1997) and Baxter (2002) identified that physiotherapists are often classified as clinicians or researchers, and although there are more clinicians now who would also classify themselves as researchers the divide still exists.

In 2000 Bithell wrote, in her role as Scientific and Clinical Editor of *Physiotherapy* (the journal of the CSP), "we (physiotherapists) are uncomfortably aware that we have far too little 'hard evidence' at present" (p.58) and she felt there was a need for a cultural change which would lead to "a more research-based profession" (p.58). Physiotherapy has strong historical links to medicine and therefore research has tended to focus on quantitative techniques linked with the predominant 'medical' model of practice and the Randomised Control Trial (RCT) as the 'gold standard' for research (Shepard et al., 1993, Carpenter, 1997, Clemence, 1998, Ritchie, 2001, Grimmer et al, 2004, Johnson & Waterfield, 2004). Bithell argued, as have other authors such as Parry (1997) and Ritchie (2001), that RCT's may not be either realistic or desirable in physiotherapy. There are many other approaches to research that may be more favourable to physiotherapy practice but whilst the 'medical' model of research dominates (Parry, 1991, Norenen & Wikstrom-Grotell, 1999, Morris, 2002, Gibson & Martin, 2003) many researchers may be put off, feeling their work will not be valued or even publishable. Indeed the current climate within the NHS could be perceived as being in conflict when considering the research agenda. On the one hand there is the drive to empower the patient, to understand treatment from the patient's point of view, and on the other hand is government policy of developing quantitative outcome measures for the NHS which will satisfy purchasers of the service (Parry, 1997, Clemence, 1998, Richardson, 1999b). This has led NHS professionals, including physiotherapists, to embrace 'evidence-based' practice (Bithell, 2000). As 'evidence-based' practice is based on the medical model of 'evidence-based' medicine it is hardly surprising that quantitative research predominates (Wakefield, 2000). Parry (1997) stated that

> evidence-based physiotherapy is a battle of agenda: the response of a specific treatment protocol versus the response of the person to individually designed physiotherapy (p.423).

By accepting in the past the medical model, many areas of physiotherapy practice have been deemed 'un-researchable' thereby leading to a lack of research and an over reliance on quantitative methods (Johnson & Waterfield, 2004). Policy within the NHS has also led to research being funded that investigates 'treatments' so that resources can be spent more effectively (Bithell, 2005). For many this means the evidence comes from RCT's, systematic reviews, meta-analysis (Nieuwboer, 2004), expert guidelines (Ritchie, 2001) and quantitative methods (Parry 1991). However, "particularly in the field of physiotherapy, RCT's are not always feasible, practical and appropriate" (Nieuwboer, 2004, p.iii). Indeed some authors acknowledge that qualitative research has an important part to play in the development of the profession's knowledge base (Bithell, 2000, Parry, 1997, Clemence, 1998, Ritchie, 2001).

Often qualitative research within health is perceived as being the fore-runner to qualitative research, helping to clarify the research question and the generation of the hypothesis. It is recommended that qualitative methodologies used in healthcare settings are used to support the findings of quantitative research (Murphy et al., 1998).

Occupational Therapy has faced similar dilemmas when developing its evidence base. Hammell (2002) described how occupational therapists have tried to adopt evidence-

based practice. This has meant the use of 'therapist-centered' research in order to demonstrate effectiveness due to dominance of the medical model in healthcare research. However, this compromises 'client-centered' practice used by occupational therapists. Therefore Hammell (2001) advocated 'client-centered' research that would give the patient a voice. Physiotherapists have long claimed an holistic approach to patient care, and this needs to be extended to research if physiotherapy is going to continue to develop its research base. There also needs to be an acknowledgement that individuals can bring their own unique perspective to the research process, rather predominately concentrating on quantifiable outcomes of research.

Researchers who conduct studies using quantitative methods recognise that RCT's need supplementing with other forms of data in order to add to an approach that concentrates solely on the patient's pathology and intervention (Lettinga et al, 1997, Bithell, 2000). Popay & Williams (1998, cited in Ritchie, 2001) used an 'Enhancement Model' to describe this dual approach, and used a 'Difference Model' to describe an approach that just used qualitative methods. However, so long as Physiotherapy is judged by the hierarchy of the 'medical' model, where RCT's are considered the 'gold standard', then the evidence will remain scarce (Bithell, 2000, Krefting, 1991). Bithell (2000) recognised that findings from qualitative research cannot be generalised to the whole population, but she asserted that qualitative studies can "contribute an additional dimension which should lead to an informed judgement" (p.59). Both Bithell (2000) and Barnitt (2004) perceived the lack of information about patients excluded from the sample in RCT's as a flaw in the reporting of such research. Gibson & Martin (2003) called for research into clinical

practice that takes into account the patient's perspective. However, as yet physiotherapy has very few studies in this area and even fewer that consider the student or newly qualified physiotherapists' perspective. Due to the wide range of variables that affect the patient/physiotherapist interaction the process of quantitative research where, for example, only standard/average patients are included in the data can mean that the outcome of the research is not relevant to clinicians trying to treat a patient who is not average (Bithell, 2000, Nieuwboer, 2004).

Gibson & Martin (2003) therefore argued that physiotherapy research should also focus on the 'lived experience' of the patient. Physiotherapists may be beginning to recognise that physiological (and therefore measurable) processes are not the only factors that influence the outcome of treatment (Bithell, 2000).

Writers have recognised that there are difficulties in assessing the volume, let alone the quality, of physiotherapy clinical research (Herbert et al., 2001, Moseley et al., 2002). Attempts to assess volume have been based on counting RCT's and systematic reviews, relevant to physiotherapy, recorded on databases, or by counting qualitative and quantitative articles within journals. Based on such attempts to assess volume Herbert et al., (2001) took the view that there

> is enough (research) to tackle many fundamental clinical questions, though there are not yet enough trials in most areas of physiotherapy

> to provide convincing replication on every permutation of therapy in every setting for every patient group (p.204).

Moseley et al. (2002) investigated the number of clinical trials indexed on the Physiotherapy Evidence Database (PEDro). It is claimed by PEDro that most English language RCT's and systematic reviews relevant to physiotherapy are included in the database (Walker-Dilks, 2001). Moseley et al. (2002) found that since 1955, when the first physiotherapy trial was published, the number of RCT's had increased. In the years between 1995 and 1999 an average of 155 trials were published. The first systematic review was not published until 1982 but in 1999 fifty-nine were published.

Moseley et al. (2002) also suggested that in order for physiotherapists to keep up to date with the physiotherapy literature they would have to read about 155 trials and 59 reviews a year. However, they made the assumption that only RCT's and reviews are acceptable in the evidence base for physiotherapy and that physiotherapists would not be selective and would read all the research rather than just the research relevant to their speciality. Also their assumption that physiotherapists would read the available literature is challenged by Metcalfe et al. (2001) who found that 39% of their sample of therapists did not perceive reading research articles as a high priority and Turner (2001) who found that many physiotherapists were not aware of the published literature. Bithell (2000) also expressed her concern that statistical tests were not fully understood by physiotherapists in clinical practice. This view was supported by Metcalfe et al. (2001), who found that 80% of their respondents admitted they were unable to understand the statistical analysis

of data presented in research articles. Authors also acknowledge (Clemence, 1998, Herbert et al., 2001, Metcalfe et al., 2001) that many clinicians do not have the time to review articles and even if they did they may not have the skills to effectively appraise the literature. McCluskey & Lovanni (2006) asserted that this not only a problem for physiotherapists but for all health professionals. Many clinicians may not have received an education which included research methods, as physiotherapy only became a graduate only entry profession in 1992 (Sparkes, 2002a), and even if they did learn these skills in an undergraduate programme, such skills need updating regularly (Brauer, 2003, Nieuwboer, 2004). Even for those who have had some training in research methods, the medical model has dominated and so according to Ritchie (1999)

> health professionals trained in the so-called scientific method of research and knowledge production have found it hard to come to terms with the idea that there might be another way of knowing that could result in sound, credible research findings (p.253).

According to Higgs & Titchen (2001) the reliance on the dominant medical model has led to an over valuing of propositional knowledge by professions particularly physiotherapy coupled with a lack of understanding of 'professional craft knowledge' and how this interacts with other forms of knowledge.

Counting the number of RCT's and reviews does not assess the quality of the research. Therefore Moseley et al. (2002) went on to find that only 52% of the trials had a

moderate to high quality rating as determined by the PEDro scale. Although Bithell (2000) acknowledged that databases such as PEDro have helped physiotherapists realise that there are more RCT's in physiotherapy than was thought, she felt there were still too few large scale trials. Other authors are also concerned with the quality of the trials and reviews (Herbert et al., 2001, Hopwood & White, 2001, Turner, 2001, Grimmer et al., 2004). For example, RCT's were biased because of the methods of randomisation adopted, 'unblinded' participants (Herbert et al., 2001) and poor methodological quality (Turner, 2001). Systematic reviews were of poor quality because details of search criteria were not given and only limited ranges of papers were included (Hopwood & White, 2001). This is not only a problem confined to physiotherapy. For example, a study by Haynes (1991, cited in Bithell, 2000) found that of 6,000 articles relevant to internal medicine only 300 were worthy of inclusion in the evidence-base, as the others were flawed or invalid.

Many authors (Gibson & Martin, 2003, Bithell, 2000) have called for qualitative research to be considered as a valuable source of evidence for physiotherapy practice. However, there is concern about how qualitative research is judged (Parry, 1991, Ritchie, 2001, Johnson & Waterfield, 2004). Gibson & Martin (2003) argued that

> qualitative research has been misunderstood in physiotherapy partly because of mistaken attempts to evaluate qualitative studies according to the evidence-based practice hierarchy where the status of qualitative research is not acknowledged (p.353).

Gibson & Martin (2003) found 584 research articles published in four physiotherapy specific journals between January 1996 and April 2001 and of these only 25 (4.3%) were qualitative in character. Carpenter (1997) reported that the majority of the studies published in *Physiotherapy Canada, Physiotherapy* and *Physical Therapy* used quantitative designs. In an attempt to improve the quality of research published in *Physiotherapy* it was re-launched in March 2004 with an external publishing partner, and the number of issues was cut to four (from 12). In 2004 the four issues published contained 29 research articles of which 20 were quantitative pieces of research, two were literature reviews, three case reports, one audit tool report and three were qualitative in design. Only one was linked to education, a survey of Lecturer/Practitioners (Stevenson et al., 2004). Although there may be many reasons why qualitative research may be underrepresented in the literature (Gibson & Martin, 2003) one reason may be due to the reluctance of editors to publish such work because their readers may have difficulties in understanding the approach. For example, the editorial comment on an article by Lettinga et al., in 1997, offered a justification as to why such a piece of work had been published as there was concern that many of the readers would have difficulty understanding the methodology section in particular. Given this lack of understanding amongst clinicians about the value of qualitative research, few studies are undertaken and few are published (Gibson & Martin, 2003).

Gibson & Martin (2003) also found that when the above process of counting articles was applied to Occupational Therapy journals then 29.7% of published articles would be classified as qualitative studies. Hammell (2002) acknowledged that OT's were

increasingly using qualitative methods in their research. Similar differences in published qualitative research between occupational therapists and physiotherapists, were noted by Barnitt (2004). She felt that the differences reflected differences in philosophy between the two professions.

To a certain extent quantitative approaches to research are perpetuated within universities, as the majority of physiotherapy lecturers will have worked in the clinical field for many years before entering academia and their emphasis in consequence may still lie with clinical quantitative research. The drive for clinicians to seek employment in a university setting is often to give them the opportunity to conduct clinical research relevant to their area of practice. However, in the USA the drive to conduct research has led to post graduate students and academics conducting more and more research on 'normals'/students, rather than patients, due to the pressure to publish and the length of time to recruit patients rather than students (Hasson, 2000). Signs of this trend may also be seen in universities in this country. Also the emphasis on the value of quantitative research by some academics and clinicians has led to areas such as educational research being largely neglected by the profession.

Gibson & Martin (2003) asserted that more physiotherapists should become involved in qualitative research and follow other professions, such as occupational therapy and nursing, who have already embraced qualitative research. For example, Richardson (1992) suggested that

> findings from qualitative research...will help educators to gain a clearer idea of the realistic needs of the novice practitioner and should inform the educational process so that a continuum of education will develop which can genuinely facilitate professional growth (p.25).

She argued that Physiotherapy research was, and still is, based on the medical model and until physiotherapy develops its own paradigm it will not develop a strong evidence base. She stated that physiotherapy constantly strives to utilise hard science when many questions about physiotherapy cannot be answered by such an approach. Perhaps the debate about which methods are best would be better understood if the profession ceased to focus on the quantitative versus qualitative debate, accepted that both approaches have value and focused instead on the research question when deciding which approach to adopt and when evaluating research (Newham, 1997). There is also a danger that without a theoretical knowledge base and a conceptual move of healthcare away from the medical model that physiotherapy research will become detached from the realities of practice (Parry, 1991, Richardson, 1992, Higgs & Titchen, 1995, Bithell, 2005).

Although many academics and academic institutions use Institute for Scientific Information (ISI) impact factors as a measure of quality, applying such a standard to physiotherapy is problematic, as most of the physiotherapy journals do not attract an impact factor (Maher et al., 2001). The UK *Physiotherapy* journal does not attract a ranking in ISI lists, although it is recognised by many physiotherapists as a valuable source of evidence. Indeed for many practising physiotherapists in the NHS it is the

journal that arrives by post every three months and keeps them appraised of recent research. Turner & Whitfield (1996, cited in Turner, 2001) found that 29% of physiotherapists only read *Physiotherapy* and did not read any other journals that were relevant to physiotherapists. A study by Maher et al., 2001, aimed to identify the core journals of physiotherapy based practice. *Physiotherapy* was ranked fourth when only exclusively physiotherapy journals were considered. Others have tried various methods to rank physiotherapy journals (Bohannon, 1999, Wakiji, 1997 cited in Maher et al., 2001). Bohannon (1999) ranked *Physiotherapy* as second.

Therefore although *Physiotherapy* does not attract an impact factor it is read by practising physiotherapists and is highly ranked amongst physiotherapy journals. This creates a dilemma for physiotherapy educationalist who will want their research to be read by as many physiotherapists as possible and thereby be part of the evidence base whilst also wishing their work to be published in high impact journals to improve their research profile in the wider academic community.

Sparkes (2002b) acknowledged that physiotherapy research is still in its infancy and that

> little effort in Higher Education is spent on developing an ethos of educational research within physiotherapy, and instead clinical research tends to dominate the practice of higher education academics (p.487).

Whilst clinical physiotherapists are encouraged to embrace evidence-based practice, physiotherapists in universities strive to provide this clinical evidence. However, physiotherapists in education have been slow to develop their own evidence base (Morris, 2002, Sparkes, 2002b). Sparkes (2002b) suggested that this may be because physiotherapists working in the academic setting may perceive themselves as physiotherapists first and educationists second. Physiotherapy lecturers are not generic physiotherapists but usually specialists in their particular field of physiotherapy, for example musculoskeletal physiotherapy with its strong link to the biomedical model (Grant, 2005). Indeed Moseley et al., (2002) found in their search of PEDro that most of the RCT's listed were in the musculoskeletal field. Richardson (1992) urged physiotherapy educationalists to research professional practice, to inform educational programmes. DeSouza (2003) acknowledged that educational issues are a rich source of data, for example, when considering multidisciplinary working. However, the drive within universities for research and the way funding is allocated will mean that physiotherapy educationalists will be pushed more towards clinically based research with a consequent negative effect on research into educating students (Bury, 1997, Sparkes 2002b).

This section of the IFS has considered physiotherapy research in general. The literature shows that Physiotherapy research is dominated by a medical model of research and by quantitative methodologies. The research is also dominated by clinical research, which adopts a 'therapist-centered' approach, one in which the patient's voice is lost, as are many of the variables that affect the outcome of the therapist/patient interaction. There is

also very little research into the education of physiotherapists at undergraduate or postgraduate level.

## 2.9 Conclusion

"Few professionals talk as much about being professionals as those whose professional stature is in doubt" (Etzoioni cited in Stronach et al., 2002, p.109). This could be said to be true of physiotherapists today as they face an uncertain future in the ever rapidly changing healthcare environment. Rather than worrying about their claims to be a profession or not it might be more beneficial to consider how its newly qualified practitioners are socialised into the working environment, as any skills developed in their undergraduate programmes to deal with the changing nature of the profession may be stifled and therefore endanger the development of the practitioner but the profession as well.

Jarvis (1983) stated "that during the process of professional education a concurrent learning process is occurring – that of socialisation" (p.88). Where socialisation is the dominant learning process then the prevailing culture is maintained unquestioned. If the emphasis is on education then the students are encouraged to critically reflect on their practice. In order for a profession to develop, the education of its students must encourage autonomy by the development of independent study and thereby allowing and encouraging the students to critically evaluate their proactive. Autonomous students may then become practitioners who, once qualified, will be in the position to initiate change from within the profession. As White & Ewan (2002) stated that the process of

professional socialisation is not one of indoctrination with the aim of producing stereotypes, but one which will allow the individual to bring their own traits and experiences to the process and allow them to develop as a professional and thereby develop the profession.

Much of the research reviewed, particularly in physiotherapy (Hunt et al., 1998, Richardson, 1999a&b, Clouder, 2000) concentrates on the undergraduate. The transfer of physiotherapy programmes from hospitals to universities signalled the move from a concentration on vocational/discipline specific skills to the generic skills of a graduate (Hunt et al. 1998). Hunt el at (1998) recommend nine curriculum strategies which will help develop generic skills. She argued that if students are active participants in their learning they will develop life long learning skills which will enable them to take new directions in the future and have a role in the development of the profession. However, she does not consider what happens if the undergraduate acquires these skills but then finds themselves in a working environment that where professional specific skills are highly valued and more generic graduate skills nor encouraged. Although the argument is that new graduates should be capable of initiating change, this may be more difficult when the graduate is faced with the dilemmas of the workplace and accepted practice. Richardson (1996, cited in Richardson, 1999b) found that the workplace stifled the skills of newly qualified physiotherapists which would allow then to develop as professionals and thereby develop the profession. She acknowledged that there are powerful factors in the workplace that tend to maintain the status quo through a model of apprenticeship rather than a model which would foster their professional development.

What is evident from the literature is the paucity of research once the student has graduated. Bond & Bond (1994) describe this post qualification period as secondary socialisation. An honours degree programme should encourage students to be life long learners and presumably continue to develop as a professional. It is acknowledged that initial professional socialisation will occur during the undergraduate programme by interaction with educators, both in the academic and clinical environment, other physiotherapists and fellow students (Richardson, 1999a) but it is unclear from the literature how newly qualified physiotherapists continue to develop as a professional.

Although the core responsibility for initial professionalisation of a novice practitioner may lie with educators on the undergraduate programme (Sparkes, 2002a), what happens after graduation has been poorly explored in physiotherapy.

Research exploring newly qualified physiotherapists' experiences of their first posts is sparse and few consider the process of professional socialisation in their first posts. Richardson (1992) called for qualitative research into the needs of newly qualified physiotherapists so the profession and educationists could be informed and professional growth facilitated. The literature review presented here shows that this challenge has so far not been accepted. This may be due to a reluctance to acknowledge the value of the individual's voice, whether that be the patient or student or newly qualified physiotherapist, in the research process. Each individual brings their own experience and interpretation to the research process which allows the phenomena under investigation to be explored.

This IFS has reviewed the available literature on newly qualified therapists and other related professions. It has demonstrated a paucity of literature, particularly in physiotherapy. The literature is especially lacking in physiotherapy in the area of newly qualified physiotherapists' expectations and experiences of their first posts. Newly qualified physiotherapists are in an excellent position to reflect on their experiences and therefore provide valuable data that might inform practice for future therapists.

What is evident from the literature is that the majority of the research relevant to professional development concentrates on the undergraduate experience. Richardson (1999a) claimed that undergraduates need to be equipped with a clear vision of professional identity. A graduate with a clear vision of professional identity will be able to influence the continued development of the profession. Research has found that professional identity and role confusion is a problem for newly qualified occupational therapists (Rugg, 1996, Lee & Mackenzie, 2002). For the reasons identified in this chapter little research has been done involving newly qualified physiotherapists in their first posts and in the light of these findings this research aimed to explore newly qualified physiotherapists' expectations and experiences of their first posts. Therefore the research question was developed:

"What are newly qualified physiotherapists' expectations and experiences of their first posts?"

The next chapter details the methodology and methods adopted to explore the research question.

Endnote:

1. Dephi technique is a research method which seeks to find consensus of opinion from a group of experts in the field being researched by the use of survey techniques, usually a questionnaire (Lopopolo et al., 2004)

## CHAPTER THREE

## METHODOLOGY

### 3.1 Introduction

This chapter evaluates the methodology and method chosen to investigate the research question.

'What are the newly qualified physiotherapists' expectations and experiences of their first posts?'

The chapter describes the research process.

### 3.2 The Research Framework

As the research question set out to explore expectations and experiences an inductive approach was adopted and located with the qualitative research paradigm. Denzin & Lincoln (1994) described qualitative researchers as people who

> study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them (p.2).

The framework for this research was constructionism, interpretivism, phenomenology and interviews (Crotty, 1998). Within this framework an analytical approach to the data analysis was based on thematic induction. (Strauss & Corbin, 1998, Kvale, 1996).

> Constructivism assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and the viewed, and aims towards interpretative understanding of subjects' meanings (Charmaz, 2000, p. 510).

Therefore a constructivism approach acknowledges the co-construction of knowledge that takes place in the interview situation through the conversation between the two participants. Reality is what a person perceives it to be (Kvale, 1996). The aim was to allow the participants to tell their stories of their first posts (Clouder, 2003) and allow the illumination of the experience of their first posts. Interpretivism and phenomenology allows the stories told by the participants to be interpreted to illuminate their world (Moustakas, 1994) so the researcher would come to understand their experience and the key elements of the experience. By allowing the participants to talk about their experiences rich data would be elicited from the perspective of the newly qualified physiotherapists and the analysis of the data would 'create a collective description of their collective experience' (May, 2002 p. 129).Within the processes of data collection and analysis the co-construction of knowledge by all the participants, including the researcher, is acknowledged. The researcher's own experiences and cognitive framework will influence these processes.

The method chosen for data collection was interviews as

> if you want to know how people understand their world and their life, then why not talk to them (Kvale, 1996, p.1).

Interviews were used to explore the experiences of the newly qualified physiotherapist in their first post as according to Kvale (1996) the research interview can be

> treated as a specific professional form of conversational technique in which knowledge is constructed through the interaction of the interviewer and interviewee (p.36).

Mason (2002) suggests that the interview interaction between the participants will generate data relevant to the area of research. Interviews will be used in preference to questionnaires as they allow the generation of rich, insightful data potentially reflecting the experience of the interviewees (Mason, 2002, May, 2001, Murphy et al., 1998). Fontana & Frey (2000) state that

> interviewing is one of the most common and most powerful ways we use to understand our fellow human beings (p.361).

Qualitative interviews aim to construct meaning (Kvale, 1996, Resnik Mellion & Moran Tovin, 2002) which are different from other forms of interviews where the aim is to gather facts, ie: media/celebrity interviews (Cisneros-Puebla et al., 2004). The researcher's experience of interviews is predominantly either therapeutic, used to elicit information about patients, or when interviewing candidates for posts. Both these types of interview could not be described as a 'research interview' (Kvale, 1996). Therefore pilot

interviews were organised to facilitate the researcher's skill when interviewing for research purposes.

The research literature refers to various forms of interview: the structured interview; the semi-structured and the unstructured interview (Cohen et al., 2000, Fontana & Frey, 2000). By adopting a semi-structure interviewing method then the research question could be explored. The details of the interviews are given in section 3.5. The aim of the interviewer was to attempt to be guided by the participant as they described their experiences and to check with the participant that the interviewer's understanding of the experience was accurate (Kvale 1996, Cisneros-Puebla et al., 2004).

## 3.3 The Study

### *3.3.1 Introduction*

Chapter two considered the context of the research. It described the environment in which the newly qualified physiotherapists would work and evaluated research relevant to these graduates. The new graduates would find themselves in a constantly changing NHS, with many new policies, developments in patient care, and changes in attitudes towards the profession. The research would potentially focus on some of these issues at a local level. Morse (1994) suggests that at least six participants and between 30 and 50 interviews are appropriate for studies which aim to explore the experiences of participants. Ten newly qualified physiotherapists during their first year working in the NHS participated in this research. They were interviewed at three different times during this first year, a total of

30 interviews. Their expectations and experiences were explored using semi-structured interviews.

*3.3.2 The participants*

The number of participants was small in comparison to quantitative studies. However, the qualitative data gathered was intended to "provide rich insights in order to understand" (Bowling, 2002, p.338) the experience of the newly qualified physiotherapist. Given that this was a qualitative study with a small sample size, there would be no attempt to generalise the results beyond this group of physiotherapists and no claims made that the research was representative of the whole population. However, it may be possible to transfer some of the findings and implications to other physiotherapists in similar situations and have relevance for educationalists and managers involved with newly qualified physiotherapists. The study was limited to physiotherapists working in the London Region as this region has the highest vacancy rate for physiotherapists in England working in the NHS (CSP, 2000) and was the most convenient for the researcher who lived in London. The researcher was the BSc (Hons) Physiotherapy programme leader for these participants, which also facilitated access. All graduates from the 1999 - 2002 cohort were written to asking them to participate in the study, if they met the inclusion criteria. The inclusion criteria were that the participants:

- graduated in July 2002 from the BSc (Hons) Physiotherapy programme at Brunel University;
- held a first post in the NHS in the London area (inside M25);

- were working in a rotational post. (A rotational post was defined as a contract which involved the newly qualified physiotherapist working in different physiotherapy areas for a period of time, usually four months.)

Therefore this was a convenience sample (Bowling, 2002).

Initially, 11 newly qualified physiotherapists replied to the invitation to participate in the research. However, one graduate withdrew from the study after the first interview and therefore is not included in the research.

### 3.4 Method of Data Collection

Semi-structured interviews were used to collect the data. A semi-structured approach allowed the researcher and participant to explore issues, without being confined by a pre-designed list of questions.

### 3.5 The Semi Structured Interviews

The newly qualified graduates were interviewed at three different times:

- first interview was after the results and final degree classification but before starting their first post;
- second interview not less than four months into their first post;
- third interview not less than eight months into their first post.

This timescale was chosen so all the graduates had experienced at least one rotation at the time of the second interview and at least two rotations by the third interview. This

included physiotherapists working at different hospitals but within the same Trust. However, before these graduates could be interviewed, pilot interviews were undertaken.

*3.5.1 The pilot interviews*

Four graduates, from the previous cohort to the participants of the main study, were interviewed. These four graduates were all based at the same hospital and were all at least four months into their first posts. The aims of the pilot interviews were to:

- explore the field;
- develop the interviewer's interviewing technique;
- identify any problems with the proposed data collection and analysis method.

> "The very openness and flexibility of the interview, with its many on-the-spot decisions ...put strong demands on advanced preparation and interviewer competence" (Kvale, 1996, p.84).

Therefore careful consideration was given to the issues of questions to be asked, the briefing of the interviewees, the context of the research, and access to the field and participants. The questions developed are listed in Figure 3.1. This list was not rigidly adhered to, as described below.

**Figure 3.1: Questions developed for the pilot interviews**

- How long have you been at ........?
- How long on this rotation and which rotations have you done?
- Which rotations did you like best/worst and why?
- Best/worst experience and why?
- Think back to when you came into Physiotherapy, why did you choose PT? Does it match to your experiences now?
- What did you expect when you started your first post?
- How does it compare to clinical placements? Differences theory and practice?
- What would improve your job?
- What would you advise anybody who was thinking about becoming a PT?
- What do you see yourself doing after you finish your rotations?

In order to access the field, 'the gate-keepers', the physiotherapy managers were contacted (Fontana & Frey, 2000). The interviews were conducted during working hours, and therefore required the consent of the managers for the interviewees to take time away from patients. The manager approached was very helpful, but contacting them was very time consuming. Once the manager had been contacted the interviewees were approached. Again this was a lengthy process involving leaving messages and waiting for telephone calls and arranging times and venues. This experience led to a Participant Case Profile being developed for the main study (Figure 3.2).

The interview venue was difficult to organise. After the first interview emphasis was placed on a quiet room. After the second interview it was also realised that a plug point

needed to be available. The interviewee had arranged to do the interview in a room which had once been a cupboard and therefore did not have a plug point. This interview eventually took place in a very hot 'splint' room. The final interview emphasised the point of the interviewee being encouraged to book a quiet room. On this occasion the interviewee had assumed that the staff room would not be used between breaks. This was not the case, and the interview had to be halted whilst a more appropriate room was found. Even when seemingly a perfect room had been booked for an hour, the interview was interrupted because the taps needed checking by an engineer and this could not be done later. Other important contact issues were the location of the nearest car park, and making sure both the interviewer and interviewee had contact numbers. All these points were added to the Participant Case Profile (Figure 3.2). A completed Participant Case Profile can be found in Appendix IV.

**Figure 3.2: Participant's Case Profile**

Name:
Contact number:
First post:
Start date:
Profile of participant: Age, Gender, Admission profile, Exit profile.

**First interview date and time:**
Consent form completed:
Comments:

**Second interview date and time:**
Arrangements: Directions, car park and cost, quiet room with socket, Manager's permission, contact numbers.
Comments:

**Third interview date and time:**
Arrangements: Directions, car park and cost, quiet room with socket, Manager's permission.
Comments:

Kvale (1996) states that "a good interview question should contribute thematically to knowledge production and dynamically to promoting a good interview interaction" (p.129). It seemed that the good interview questions arose from the more spontaneous questions. The original questions devised were good for starting a dialogue, but as the interviews progressed it became obvious that referring to a piece of paper for the next question sometimes interrupted the flow of the interview. Therefore an interview 'issues list' was developed (see section 3.5.2).

Another important part of the process was active listening (Mason, 2002). This was very important as it provided feedback to the interviewee that the interviewer was interested in the subject of the interview. Listening actively also meant that points could be clarified and depth sought where appropriate, thereby checking the researchers understanding of what was being described by the participant. It also meant that questions were not asked twice by rigidly following the prescribed list of interview questions. At the same time as listening actively, the interviewer was reflecting on the content of the interview and relating it to the research question and developing more questions to explore issues in more depth. The interview was a challenging situation for the interviewer but over the four interviews the skill of active listening and handling a social interaction was developed (Mason, 2002).

The interviews lasted about an hour, but transcribing the tapes took many hours (Bowling, 2002) and produced many pages of single spaced typing. It was not always possible to hear exactly what was said. It was difficult to decide whether to transcribe all

the 'extras' i.e. laughter, pauses, O.K.'s etc. Also it was noticed that all the non-verbal communication was lost, which could affect the richness of the data. Videotaping the interviews was considered for future interviews. However, the expense and the setting up of the equipment would be prohibitive. Also interviewees might feel less inclined to participate, or answer questions if they were being videotaped. The tape recorder tended to become less intrusive (Bowling, 2002) as the interview progressed and all the interviewees reported they had felt relaxed and able to talk and answer the questions during the interview. It was important to create a relaxed supportive atmosphere so the participant could express their thoughts. This kind of atmosphere was apparent when the interview became more like a conversation (Fontana and Frey, 2000). The interviews developed more into conversations when fewer pre-determined questions were used and therefore a checklist of issues was referred to for guidance (see section 3.5.2).

The pilot interviewees provided the researcher with valuable feedback, which enabled a smoother, more organised, and more reflective data collection process in the main study, as detailed in sections 3.5.2 and 3.5.3.

*3.5.2 The first interview*

All the newly qualified physiotherapists who responded to the letter and met the inclusion criteria were interviewed between July and October 2002. The participants were sent a letter prior to the interview date, covering the aims of the study and the informed consent form. At the beginning of the interview the informed consent form and Participant's Case

Profile were completed. The Participant's Case Profile was developed from the pilot interviews and the issues covered during the first interview are listed in Figure 3.3.

At this stage an Interview Record Sheet was developed (see Appendix V). This was used to track the participants through the study and remind the researcher when to make contact to arrange the next interview. This was kept in the researcher's diary for easy reference.

A tape recorder, external microphone (with spare battery) and 90 minute tape were taken to each interview. Each tape was given a code for the interview, participant's initials and date of interview i.e. 4/DW 7/02. Before each interview both the interviewer and interviewee spoke for a few moments, whilst being recorded, to ensure the tape recording would be audible. Each interview started with a similar format, congratulating the participant on their degree, a brief explanation of the research and completion of the Participant's Case Profile. This relaxed approach covering easily available, non-confrontational information was deliberate to facilitate a more conversational style of interview (Kvale, 1996). The interview then proceeded to cover the list of issues that had been developed from the research question and the pilot interviews, (see Figure 3.3). It was decided that rather than have a list of questions, as used in the pilot, a list of issues was developed, to hopefully enable the interviews to flow more like a conversation (Kvale, 1996). There was no particular order to the list to allow the interviews to flow in any direction and thereby aid understanding of newly qualified physiotherapists'

expectations of their first posts. The development of an issues list allowed the questions to be

> flexible, open-ended and broad enough to enable a thorough investigation to be carried out on facets of the phenomena, while providing adequate focus for the researcher (Resnik Mellion & Moran Tovin, 2002, p.111).

**Figure 3.3: Issues covered during the first interviews**

- Choice of first post
- Interview
- Expectations of first day, information received about Dept, rotation etc.
- Rotations
- Expectations of participants
- Expectations of other staff
- Support
- Research
- Least looking forward to
- Most looking forward to

*Issues added as interviews progressed*

- Expectation when first applied to Physiotherapy programmes
- Expectations for the future – short and long-term

After each interview, reflective comments were made on the Participant's Case Profile, then later on, the tape was listened to and reflective notes made, these two activities formed the researcher's reflective diary and were the starting point of the analysis (Stake, 1995, Resnik Mellion & Moran Tovin, 2002).

### *3.5.3 The second and third interviews*

The second interviews took place not less than four months after commencing their first post and the third interviews not less than eight months into that post. Each newly

qualified physiotherapist was contacted and the date and time of the meeting arranged, and the logistical arrangements were covered, as on the Participant Case Profile (Figure 3.2). Permission was sought from each participant's manager. Before the interview each participant's previous interview tape(s) was re-listened to, and any additional points noted. Again each interview started with a similar format, a brief reminder of the research and a question about how long they had been in their first post. The interview then proceeded to cover the list of issues that had been developed from the research question, the pilot interview and previous interview(s), as detailed in Figure 3.4. Brief notes were made after each interview, and later the tapes were listened to and notes made, thereby continuing the initial stages of analysis (Resnik Mellion & Moran Tovin, 2002).

Issues for the first interviews focused on the participants' expectations and the later interviews on their actual experiences.

Once all the interviews were complete, the tapes were transcribed by a professional transcriber. The transcribed interviews were then checked against the audiotapes to ensure accuracy.

**Figure 3.4: Issues covered during the second & third interviews**

**Second Interview:**

- First day of new post
- Induction
- Rotations
- Expectations of participants
- Expectations of other staff
- On-calls
- Support
- Research
- CPD / Courses
- Best experience
- Worst experience
- Expectations after completing rotations

*Issues added as interviews progressed*

- Comparisons with student experiences
- Job improvement
- Best thing about being qualified
- Worst thing about being qualified
- ***Third Interview:***
- Rotations
- Senior posts
- Support
- Research
- CPD / Courses
- Best experience
- Worst experience
- Expectations after completing rotations
- Expectations met

*Issues added as interviews progressed*

- Most important thing learnt since qualification
- Theory – practice gap
- Good / bad physiotherapists
- Stress
- Staff expectations of newly qualified physiotherapist

## 3.6 Data Analysis

### *3.6.1 Procedures and approaches*

The analytical process did need to be exploratory, inductive and systematic to meet with the requirements of the research design. By adopting an inductive and interpretative approach to data analysis it was hoped themes would emerge from the data analysis (Murphy et al., 1998). Different analytical approaches to were considered (Miles & Huberman, 1994, Denzin & Lincoln, 2000, Robson, 2002, Flick, 2002). A modified 'grounded-theory approach', as described by Flick (2002) & Ryan & Bernard (1994), was chosen to analyse the data. This approach to data analysis is based on work by Strauss (1987) and Strauss & Corbin (1998) and would allow the researcher to tease out the concepts the participants related to the phenomenon under investigation – that of being a newly qualified physiotherapist (Kvale, 1996). The researcher

> co-creates with the subjects the meanings he or she reports, and through interpretation constructs elaborate stories (Kvale, 1996 p.207).

The analysis used the following procedure:

- a case profile for each participant was completed. This included descriptions of the participant ie age, gender etc and brief descriptions of the relevant issues mentioned during the interviews (Appendix IV);
- each set of interviews was then coded and sub-categories, categories and themes developed;

- these sub-categories, categories and themes were then cross checked with the original transcribed interview;
- the categories and themes were used to analyse each participant's set of interviews. At this stage, further codes, sub-categories, categories, themes were developed, or modified;
- the reflective fieldnotes and diary were also reviewed.

As suggested by many authors (Denzin & Lincoln, 2000, Stake, 1995, Strauss, 1987, Strauss & Corbin 1990) the analysis of the data began early, after the first interview (Kvale, 1996). The transcripts were read several times by the researcher to get some sense of the experience. The researcher recognised that this process was constrained by her own life experiences and own professional cognitive structures and therefore it is acknowledged that the researcher acts as a filter in the process of data analysis. As the analysis proceeded reflective comments of the researcher were recorded, and as codes, sub-categories, categories and themes emerged from the data, the issues covered during subsequent interviews were added. As 30 interviews had been conducted the process of data analysis was daunting, worrying, frustrating and at times boring but it was also exciting, illuminating, reflective, challenging and rewarding. One of the crucial points of the data analysis was the realisation that at points the researcher was totally submerged by the data but at others distant. This need to step away from the data analysis is acknowledged by Dickie (2003) as important, as it allows time of reflection and but also, the ability to return to the data with 'fresh eyes'. Whilst immersed in the data the researcher was aware that she needed to be looking for new phenomena by being

sensitive to inconsistencies and different views of the participants but also being aware that

> sometimes the researcher will end up generating new concepts, but on other occasions will be relating ... her observations to pre-exiting notions (Bryman & Burgess, 1994, p.6).

These pre-existing notions are based on the researcher's own experiences which are influenced by emotions and the researcher's own cognitive framework. Therefore the researcher will make decisions about issues to be pursued and select areas to be explored in more depth.

The initial coding of the transcripts took many, many hours. The analytic tool described in section 2.7.2 had a memo function which allowed each code to be described. This helped as it allowed quick identification of similar codes that could be merged and also a quick source of clarification when returning to the data after periods away from the analysis. The memo function also facilitated the merging of codes into sub-categories and then categories and eventually the themes. Also during the data collection and analysis stages, little 'rituals' (Dickie, 2003) and rewards began to develop which facilitated the process. For example, a cup of coffee and biscuit (preferably chocolate) was required before sitting in the car in the car park, or on the tube, and writing reflective field-notes; a walk on a sunny day if a set amount of coding had been completed; and decisions about the relevance of coloured paper, font and highlighting colours. At others time it was important to find another person to talk to about dilemmas and problems. The use of a computer programme eased the process as it not only helped organise the data but it also

help the access to the data as it did not matter where the researcher was working the data was easily and quickly retrievable. Section 3.7.2 discusses the use of a computer programme for the analysis of qualitative data.

The process of checking for new codes and comparing them to identify similarities and differences continued and codes merged to form the sub-categories and categories. The categories depicted

> the problems, issues, concerns, and matters that are important to those being studied (Resnik Mellion & Moran Tovin, 2002, p.114).

*3.6.2 Analytic tools*

The use of a computer programme was considered as part of the analytical process. The four pilot interviews had produced vast amounts of data. The literature relevant to the use of computer programmes in the analysis of qualitative data was reviewed and the issues relevant to this research are now presented.

Information Technology tools are used by many researchers from different paradigms for transcribing, analysing data and writing up research papers (Miles & Huberman, 1994). For example, a computer programme (*Refworks*) has been utilised to produce the references for this thesis. There are many different software packages for analysing qualitative data. All these packages are grouped under the acronym CAQDAS (Computer Assisted Qualitative Data Analysis Software). As CAQDAS is an umbrella term for

many different computer packages, and most of the literature does not consider individual packages but reviews all computer programmes of this type together, making comparisons is difficult (Barry, 1998). It is important to remember that qualitative programmes will not analyse the data, but they will help with organising and reflecting on the often vast amounts of data and therefore support the research process (Flick, 2002, Weitzman, 2000).

Many people, including researchers, are reluctant to use computers. For example, Barry (1998) states that she speaks "as an ex-technophobe who has come to appreciate how technology can help me do my job better, faster and more creatively" (p.2). According to Tesch (1990) there are many myths about the use of computers and many qualitative researchers believe these myths. Silverman (2000) argues that this view of computers may have its roots in the qualitative approach that has "rejected the technological appearance of statistical work, which smacked of dehumanisation, over-control, obsession with technical puzzles" (p.155).

Some qualitative researchers may perceive the computer as a tool for analysing hard quantitative data and any attempt to subject qualitative data to such a technological tool for analysis would undermine the ontological and epistemological position of the researcher. One project designed to introduce qualitative researchers to CADQAS, claimed that negative perceptions of technology are "usually replaced by positive ones and enthusiasm for positive ways in which the technology could help them once they started to use such programmes" (Barry, 1998, p.2).

However, before deciding on the actual programme to be used in the analysis of the research, the advantages and disadvantages of such an approach to data analysis were considered (Flick, 2002).

3.6.2.1 Advantages of CAQDAS

The advantages of CAQDAS relevant to this research are speed, rigour and representation of the data. These advantages and their relevance to this research are discussed below.

Speed

CAQDAS packages claim to "help automate and thus speed up and liven up the coding process" (Barry, 1998, p.2). The interviews from this research produced large volumes of data and using a CAQDAS package facilitated the process.

If time can be saved, by using CAQDAS, then the researcher is given

> more time to think about the meaning of data, enabling rapid feedback on results of particular analytic ideas so that new ones can be formulated (Silverman, 2000, p.156).

Qualitative researchers who have become familiar with using CAQDAS claim there is more time for analysis (Barry, 1998) and this analysis "becomes more devoted to creative and intellectual tasks, less immersed in routine" (Silverman, 2000, p.156). Identifying patterns by looking for particular words can be very quick and may reveal things

overlooked by more 'traditional' methods. Some researchers claim that CAQDAS enables the researcher to have an aerial view of the research and therefore see things that cannot be seen from the ground, i.e. when using non CAQDAS methods (Silverman, 2000). However, some authors claim that CAQDAS users must be careful not to lose the richness of the data in the search for patterns or words (Bowling, 2002).

Rigour

The use of CAQDAS is claimed by some to facilitate rigour and consistency in qualitative data analysis (Silverman, 2000, Flick, 2002, Weitzman, 2000). For example, it would have been easy to count how many times a phrase relating to (for example) 'lack of confidence' occurred in the data. However, this approach to data analysis could be perceived as an attempt to analyse qualitative data from a quantitative perspective and therefore lead to conflicts in the underlying philosophical assumptions. Silverman (2000) argues that many social researchers do not see this conflict as being a problem.

Representation of the data

Some programmes will facilitate the display of the data in the final report (Flick, 2002) and the researcher's thought processes when analysing the data Weitzman (2000 cited in Denzin & Lincoln, 2000). For this research the themes, categories, sub-categories and codes were displayed as networks (Figures 4.1, 4.2 and 4.3). Also the use of memos facilitates the coding process.

#### 3.6.2.2 Limitations and disadvantages of CAQDAS

Four limitations and disadvantages of CAQDAS relevant to this research were identified.

Using word processors CAQDAS

Some authors argue that researchers only need a word processor to do all the things CAQDAS can do (Coffey et al., 1996), as the process of transcribing can allow the researcher to analysis the data. Indeed the data set for this research has to be typed into a word processing package before it can be imported into *Atlas-ti.* However, due to the length of the interviews, a professional transcriber was employed to transcribe the tapes and therefore the researcher would not initially be so familiar with the data, and then packages such as *Atlas-ti* would facilitate the process of analysis.

A narrow approach to analysis

Some authors claim that CAQDAS can support code and retrieval of grounded theory but is less able to cope with narrative analysis. For example Coffey et al., (1996) state that CAQDAS

> generally is more valuable for the organisation and retrieval of content than the discovery of form or structure (p.176).

Although many packages are developed for use of specific theories, so long as the researchers are aware of the limitations and philosophical positions of the analysis, then the programme can be very useful. The data was analysed using *Atlas-ti*, a CAQDAS

package. Conceptual diagrams can be built to show emerging ideas. However, *Atlas-ti* can be used to just code and retrieve data like other programmes but it has the potential to do more sophisticated things (Fielding 1994, Coffey et al., 1996).

Although CAQDAS has been linked to 'grounded theory' in many cases, it has also been used to apply "methods of discourse analysis rooted in phenomenological and ethnographical approaches" (Kelle et al., 1995, p.6). This leads to another fear in the literature that CAQDAS will be considered as the only, or more acceptable, approach to data analysis in certain areas (Coffey et al 1996). Again some researchers may take this point of view, but most will use CAQDAS appropriately. Lee & Fielding (1996)

> show that users tend to cease the use of a specific software rather than adopt their own analysis strategy to that specific software. There seems to be good reasons to assume that researchers are primarily guided by their research objectives and analysis strategies, and not by the software they use (p.6).

Indeed, Coffey et al., (1996) states that before utilising computer packages the method of analysing the data should have been decided and therefore computer packages support the analysis. As discussed the approach to data analysis was chosen before deciding on the computer programme (see page 98).

Distance from the data

Researchers may become distant from their data when using CAQDAS packages (Barry, 1998, Kelle et al., 1995). As the data is entered it becomes decontextualised, and, it is claimed, that the researchers may never go back to the original transcripts. In the literature there are examples of very complicated analysis and coding when the researcher has lost sight of the original data (Barry, 1998). Barry (1998) claims that CAQDAS is only a tool for data analysis and therefore it depends how it is used to determine the depth and quality of the data. It is also possible for a researcher using other methods of analysing qualitative data to perform only a superficial analysis and thereby produce research that is "lacking in rigour and depth" (Barry, 1998, p.2). Care was taken in this research to refer back to the original texts at frequent intervals. Other methods of data collection (reflective diary, fieldnotes and member checking) were also used to triangulate the data.

Quantification

As the text can be coded and counted there may be a temptation to analyse data statistically. Authors claim that researchers using CAQDAS programmes

> can be seduced by the capabilities of software into treating categorically index slices of data as more concrete variables, and conducting quantitative variable analysis (Barry, 1998, p.3).

This could lead to testing of hypotheses and analysing only significant numbers and re-occurrences. Some qualitative researchers do count and treat their data to statistical analysis perhaps to make their research more acceptable in the dominant paradigm of positivism. To do this involves ignoring the epistemological position of qualitative research (Barry, 1998). However, it is not only researchers who use CAQDAS programmes to analyse their data who may be tempted to use more positivist methods of analysis on quantitative data. Within research in healthcare settings qualitative research can be perceived as preceding quantitative research and quantitative research as being the only valid form of research. Indeed although there is acknowledgement by the dominant medical model that qualitative research may have some value, some researchers are tempted to develop checklists to ensure rigour in qualitative research, thereby reinforcing the dominant paradigm (Barbour, 2001). It is therefore vitally important that researchers realise the epistemological position before starting a piece of research and certainly before any data analysis commences.

Having considered the above advantages and disadvantages it was decided to use a computer software package to analyse the data, as such a package would offer a quicker and rigorous way of analysing data. It would facilitate a better overview of the coding of 30 interviews and allow the easy merging of codes to form sub-categories. The memo function would also allow for easier resumption of coding when a break was taken and the use of networks would make it easier to display the final themes.

3.6.2.3. The choice of computer programme

Fielding (1994) describes three types of software packages; text retriever, code and retrieve and theory building packages. Weitzman (2000) adds text based managers, and conceptual network builders to the list. For this research a computer package called *Atlas-ti* was utilised. Both Weitzman (2000) and Fielding (1994) categorise *Atlas-ti* as a theory building software package. However, Weitzman (2000) does point out that *Atlas-ti* has a graphical network builder connected to it. A theory building package will allow the researcher to use the codes to be related to a category or categories and develop relationships between codes and categories without losing contact with the original text (Flick, 2002). *Atlas-ti* is based on theoretical coding (Flick, 2002) which was the chosen approach to analysis for this research. *Atlas-ti* was also available on the University network and therefore it was not necessary to buy the software.

3.6.2.4 The experience of the computer programme

Learning to use the programme

Whilst *Atlas-ti* is acknowledged as a 'user-friendly" programme (Barry, 1998), the researcher attended a university run tutorial on the programme. It was very useful to have a group tutorial to introduce the package from someone who was using the programme as part of their research. The group tutorial was followed up with an individual tutorial once the data set was available. Miles & Huberman (1994) acknowledged that

> although tutorials supplied with programmes can help, the best way to learn a new programme is to use it on real tasks, with support from your friends (p.44).

For example, the data was transcribed using a word processing package (Miles & Huberman, 1994) and in order to import a 'Word' document into *Atlas-ti*, the word file had to be saved as a text file and with a two inch margin to give enough space for coding. This kind of advice is usually only provided by experienced users. Also *Atlas-ti* is located on 'the network' and without help locating the package, following the path to it may have been difficult. Once the programme was open then it was straightforward and easy to learn. Although it was still extremely helpful to have a more experienced person, who knew how to use the programme, available (Miles & Huberman, 1994). There was also a CAQDAS support group and web page support based at the University of Surrey (www.soc.surrey.ac.uk/caqdas). Having found this resource, two more courses were attended, at Surrey University, at the data analysis stage of the research.

The *Atlas-ti* screen was easy to negotiate and the coding could be done on screen. The ability to attach memos to reflect on the data as the analysis developed was also extremely useful (Coffey et al., 1996). The programme offered a comprehensive tool to organise the data. The ability to organise data and other aspects of the research process (i.e. reference lists) enabled the researcher to spend more time analysing and reflecting on the data.

However, as with most computer packages there was a constant process of updating and therefore packages are very quickly out of date (Barry, 1998, Silverman, 2000). Indeed whilst working on the analysis 'flyers' were received announcing another update. This point also applies to any books written on computer analysis as Tesch (1990) acknowledges in her conclusion to her book.

> The programmes described here are only a beginning. They will undoubtedly change and improve and new ones will appear (p.299).

Strategy for analysing the data using Atlas-ti

Flick (2002) recommended the development of a strategy for analysing data using computer programmes. The following strategy was utilised based on Flick's 2002 recommendations:

- import the transcribed data in the correct format;
- code the data (open codes);
- write memos;
- take each code and compare the texts related to each code;
- integrate relevant codes;
- develop categories.

However, as the researcher used the software package for this research, the researcher became familiar with the process of analysis. The data remained clear and rich, and the researcher remained in charge of the process.

Although the researcher found there was an initial learning curve with the new programme, this was quickly off set by the speed of the computer programme in supporting the analysis of the data Weitzman (2000).

By using the University's Virtual Private Network, it was possible to view and analyse the data at home or in the University, therefore negating the need to carry around huge boxes of data or disks. The ability to type on to a computer screen and then process the data without the need for reams of paper or photocopies was perceived as a huge advantage as the researcher became more comfortable with working with virtual texts.

In this research the ability to review the data quickly facilitated the development of categories and themes. For this research it was possible to easily review all the codes in a category or theme to check interpretations and reorganisation of material became an easier task.

### 3.7 Ethical Principles

Ethical approval for the research was sought from the Education Department of Brunel University and this was granted.

For this research the following ethical issues were identified:

- access to the participants;
- power relationships;
- informed consent;

- disclosure;
- anonymity and confidentiality (Hammell, 2000).

*3.7.1 Access to participants*

Initially all the participants were contacted by letter, asking them to participate in the research. For the first interview the newly qualified physiotherapists were not employed and therefore only their permission was required. For the second and third interviews the graduates were employed and therefore their managers (gatekeeper) were contacted. This raised the issue of anonymity. The managers were told that a junior physiotherapist was taking part in research that had been approved by the Department of Education Ethics Committee at Brunel University. An outline of the research project was also provided. None of the managers approached raised any issues or asked the identity of the physiotherapists, thereby maintaining anonymity.

*3.7.2 Power relationships*

As the ex-course leader for these physiotherapists it was important to time the interviews after the participants had received their results and satisfactorily completed the course. None of the participants was contacted until after the publication of their final year results.

*3.7.3 Disclosure*

Careful consideration was given to potential disclosure by a participant of an issue and/or an event that had affected them emotionally (Smith, 1996). As a lecturer in

physiotherapy, with many years experience of visiting students on placements and dealing with such issues, the researcher felt able to deal with such a situation should it arise, but no disclosure issues arose.

*3.7.4 Informed Consent*

Each participant needed to be fully informed of the planned research and any risks or benefits, so they could make an informed decision about participating in the study. Once the newly qualified physiotherapist had expressed an interest in participating in the study, they were sent an informed consent form (Appendix VII). The form explained the research, and the research process. The participants were assured they could withdraw from the study at anytime without giving any reason. Also, the participants were informed the interviews were to be taped. A few days later the participants were contacted and the date arranged for interview. At the beginning of the interview, any questions about the research were discussed and the informed consent form signed and witnessed by another lecturer.

*3.7.5 Anonymity and Confidentiality*

It was important to maintain anonymity and confidentiality for these participants and their workplaces. Therefore all the participants were only known as codes on any documentation, the code only been known to the researcher. In writing up of the analysis, any other relevant parts of the thesis, any publications and presentations the participants were given pseudonyms. Any reference to Trusts or Hospitals was similarly coded or removed from any documents. The researcher had to be careful when discussing the

findings with others not to be drawn into answering a question that would breach confidentiality and anonymity eg: "was my Trust involved in the research?" The issue of confidentiality was also important as there were potential issues of disclosure of difficult situations and their emotional impact on the participants (Walker et al., 2005). The researcher had many years experience of visiting students on clinical placement and dealing with such situations.

### 3.8 Positioning and Reflexivity

As already discussed in section 3.2 the framework for this research was constructionism, interpretivism, phenomenology and interviews (Crotty, 1998). A choice of such a framework by the researcher reflects the researcher's beliefs regarding how knowledge is constructed and how their presence within the research process has an influence on the outcome. The interactions (interviews) between the researcher and interviewee are part of the research process. Also the researcher's interaction with the data during the analysis is part of the research process. Therefore in this study the researcher is part of the process and interacted with the interviewees to understand the experience from the interviewees' perspective. The researcher was not a neutral by-stander and it is important in qualitative research to acknowledge the position of the researcher (Murphy et 1998, Hammell & Carpenter, 2000). The constructivism approach adopted for this research acknowledges that the researcher also creates the data and has an influence on the data analysis through their interaction with the participants. Therefore the data does not

> provide a window on reality. Rather, the 'discovered' reality arises from the interactive process and its temporal, cultural, and structural contexts. Researcher and subjects frame that interaction and confer meaning upon it (Charmaz, 2000, p.524).

As the researcher is part of the interaction it is important to acknowledge that the researcher's background, experiences and interests would have an influence on the process (Hammell & Carpenter, 2000).

It was recognised that the researcher's:

- age;
- gender; and
- status;

would have an effect on the whole research process and these issues are considered below.

*3.8.1 Age*

The researcher was older than the participants, had been qualified as a Chartered Physiotherapist for nearly 20 years, and had not worked in the clinical environment for a number of years. These issues could affect the researcher's perceptions of the research. However, by acknowledging these issues the researcher was alert to any differences in her experience from those of the participants.

*3.8.2 Gender*

The researcher was the same gender as six of the participants, and therefore could influence the data collection stage of the research. Female or male participants may decide differently, if it was appropriate, or inappropriate, to discuss certain issues with the researcher. Also gender may affect the whole research process, and it is important that the researcher acknowledged that gender does make a difference as to how people experience a situation (Dyck, 2000).

*3.8.3 Status*

The researcher was formerly these newly qualified physiotherapists' programme leader and therefore had been in a position of authority in relation to the participants. Although the research was deliberately conducted after these newly qualified physiotherapists had successfully completed the course, there was still an element of programme leader / student power relationship, especially at the beginning of the first interview. Therefore two more factual and more relaxing issues were explored at the beginning of the first interview. As the interview progressed the relaxed nature of the conversation seemed to facilitate open responses from these newly qualified physiotherapists. During the second and third interviews the status issue seemed less important as the newly qualified physiotherapists were interviewed in their workplace and therefore the interviewer was an invited guest and not in the role of programme leader. Also being a physiotherapist and therefore part of the group being researched may have helped to develop trust and rapport (Smith, 1996).

The researcher was aware that although the above issues were carefully considered, a 'neutral' position could never be achieved or even desired. But by being aware of these issues, a good rapport developed and the interviewee and researcher relaxed which enable both participants to talk freely about the experience. The researcher was aware that their life experiences and professional cognitive structures would act as a filter and for example areas of particular interest would be pursued and explored. However, by acknowledging the researcher's influence on the process research process broadly consistent themes would be identified which would help explore the experience of the first year of work for these newly qualified physiotherapists thereby contributing a rich holistic account created from multiple perspectives and extend the limited body of knowledge in this area.

### 3.9 Summary

This chapter has covered the choices made when deciding on the methodology and method to be adopted to address the research question of this research. The chapter has described the research process and covered the detail of the organisation of the research. The analysis of the data is presented in the next chapter.

# CHAPTER FOUR

# RESULTS AND ANALYSIS

## 4.1 Introduction

This chapter presents the results and the analysis of the data generated by the research process, as described in the previous chapter. The analysis begins with a profile of the 2002 cohort of newly qualified physiotherapists and compares this to the profile of the participants. The process of the data analysis is described. The details of each of the themes, which arose from the analysis, are given and each theme is summarised.

Eleven participants agreed to take part in the study and were interviewed. However, one participant withdrew from the study after the first interview without providing a reason. Therefore only the data from the ten participants, who had been interviewed three times, were included in the study.

## 4.2 Profile of the 2002 Cohort of Newly Qualified Physiotherapists and the Participants.

The profile of the 2002 cohort of newly qualified physiotherapists was compared to the profile of newly qualified physiotherapists from the 2002 cohort working in the London area and the profile of the participants and is summarised in Table 4.1. At the time of collecting the first destination data for the cohort, five newly qualified physiotherapists

were travelling and/or not applying for jobs. One newly qualified physiotherapist did not respond to the survey. Therefore of the 58 newly qualified physiotherapists in employment, 22 (38%) were working in the London region, including the 10 (17%) participants in the study. The study group represented 46% of the 2002 cohort who worked in the London region for their first post.

Sixty-four newly qualified physiotherapists graduated in 2002 with an age range of 21 to 38 years.

On admission to the course 44 (69%) were standard entry and 20 (31%) were mature students. The standard entry students all had three A Levels or equivalent qualifications. Of the 20 mature students 11(55%) had degrees, seven (35%) had one A Level and two (10%) students had an access qualification.

Ten newly qualified physiotherapists participated in the study, and their ages ranged from 21 to 38 years. On admission to the course six were standard entry and four were mature students. The standard entry students all had three A Levels. Of the four mature students one (25%) had a degree, two (50%) had one A Level, and one (25%) student had an access qualification. Table 4.1 displays other data relevant to the cohort, graduates working in London and the participants.

**Table 4.1 The cohort profile in relation to the profile of newly qualified physiotherapists working in the London area and the participants' profile.**

| | **Cohort** | **Graduates working in London** | **Participants** |
|---|---|---|---|
| **Number** | 64 | 22 | 10 |
| **Age Range** | 21 to 38 yrs | 21 to 38 yrs | 21 to 38 yrs |
| **Gender - Female** | 73% | 55% | 60% |
| **Gender – Male** | 27% | 45% | 40% |
| **Degree 1st** | 9% | 14% | 20% |
| **Degree 2.1** | 45% | 41% | 50% |
| **Degree 2.2** | 44% | 45% | 30% |
| **Degree 3rd** | 2% | 0% | 0% |

Table 4.1 shows the age range of all groups to be the same. Although there are some percentage differences between the gender and degree profiles the numbers are small. This was a self-selected sample and the limitations of such an approach are discussed in section 6.2 (see page 228).

Eight of the participants had been on an undergraduate clinical placement at the Trust where they found their first post.

Table 4.2 shows that all of the participants except Jake experienced 'traditional / core' rotations. (All names have been changed to maintain anonymity.) Jake's Pain Management rotation had included treating out-patients, in the out-patients department. Part of Brian's Neurology rotation included some community work.

**Table 4.2. The rotations completed by each participant during the research**

| Participant | 1st Rotation | 2nd Rotation | 3rd Rotation |
|---|---|---|---|
| **Jake** | Pain Management & Rehabilitation Out/In Patients | Paediatrics | Amputees & Intensive Care Unit |
| **Philip** | Medical | Out Patients | Orthopaedics |
| **Linda** | Neurology and Medical | Out Patients | Orthopaedics |
| **Georgina** | Care of the Elderly | Out Patients | Intensive Care & surgery |
| **Lisa** | Neurology | Respiratory (Surgery) | Out Patients |
| **Nathan** | Out Patients | Out Patients | Respiratory |
| **May** | Neurology | Out Patients | Orthopaedics |
| **Brian** | Out Patients | Neurology (some Community) | Care of the Elderly |
| **Lauren** | Out Patients | Care of the Elderly | Neurology |
| **Kath** | Out Patients | Respiratory (Surgery) | Care of the Elderly |

## 4.3 Length of the Research Process

The participants were interviewed between July 2002 and September 2003. All were interviewed within the timescales set out in Chapter three. One participant had a long period of sick leave during the research and therefore only working months were counted when calculating when to interview the participant.

The 30 interviews of 40 to 60 minutes were conducted. The tapes of the interviews were transcribed professionally. The transcripts were then checked for accuracy by the researcher. (See Chapter three for the details of this process).

## 4.4 The Data

The interviews and fieldnotes produced large amounts of data, which were analysed as previously described in Chapter three, section 3.7. The researcher had to develop skills for dealing with text in electronic format, which was read directly from the computer screen, as the documents were not initially printed. For example, a work plan was developed which enabled the researcher to spend parts of the day working on electronic texts and the rest working on other aspects of the thesis or other activities. The maximum amount of useful time that could be spent on coding or reading the primary electronic documents was two hours, at which point it became difficult to concentrate on the task and therefore there was potential to make mistakes when coding. It became apparent that

attempts at coding for longer periods would affect the trustworthiness of any findings (Krefting, 1991, Walker et al., 2005).

### 4.5 Analysis

The analysis and reflection began as soon as the interviewing process started (Stake, 1995). Whilst the interviews were tape-recorded, and therefore detailed note taking during the interviews was not required, brief notes were made. These notes were often single words, to remind the interviewer to pursue issues raised later on in the interview so the thought process of the interviewee was not interrupted. This proved to be a useful technique, as issues were not forgotten. This process had been developed during the pilot interviews. After the interview, initial thoughts were noted down and any interruptions recorded. This process was also developed during the pilot stage. Later each tape was listened to and detailed fieldnotes made. Before the second and third interview, preceding tapes for the participant were again reviewed, so issues from the previous tapes could be revisited if needed. Again, this process was useful as the participants seemed to appreciate the fact that their previous comments were being referred to and possibly valued.

All tapes were transcribed by a professional transcriber. To maintain anonymity and confidentiality the names of participants were changed and all references to any Trusts or colleagues by name were removed from the data.

Once the tapes had been transcribed, they were re-listened to and read, along with the fieldnotes and reflective comments. *Atlas-ti* was then utilised to code all the transcribed data. Throughout this process a reflective diary was kept, either using the memo function available in *Atlas-ti,* or a notebook, when the researcher was unable to access the computer.

The tapes were analysed for coding purposes in two different ways - in date order and by participants (see page 98). This provided a method of checking the rigour of the coding process. The data was then reviewed holistically and as the analysis progressed categories and themes began to emerge. Codes were combined when necessary and then 'networks' were developed to display the information. Codes were clarified, by using memos. For example, did the code 'expectations of senior staff' refer to the expectations of the staff of the graduate or participants' expectations of the staff? Also codes were clarified as they were set up by using memos, for example, the 'future short-term' was taken to mean whilst the participant worked as a junior in their first post and the 'future long-term' was defined as working, or otherwise, after their first post.

At the beginning of the analysis many codes were identified but as the process continued few additional codes were identified. A 'saturation' situation was reached (Stake 1995). Some new codes also emerged at the beginning of the tapes from the second and third interviews.

The initial coding process produced 142 codes. To examine these codes, a list of the codes was printed out and cut up. This helped both to merge codes and to discover the initial structure of the networks and the themes. This could have been done using the software but at this stage it seemed easier to have a floor covered with paper, so the big picture could be easily seen. It also helped in the identification of redundant codes, for example, 'contact with other students'. These codes formed the basic structure for the sub-categories, categories and ultimately the themes. The three themes that emerged were:

- 'Doing the job';
- 'Becoming a professional';
- 'The future'.

The only data to be analysed separately were the questions relating to their choice of first post and the induction process. These questions were used in the first and second interview to relax the participants and to allow them time to become used to the tape recorder and the situation.

*4.5.1 Summary of data analysis*

The data analysis progressed as planned (see page 98). The data appeared to be rich and insightful (Walker et al., 2005). There were times when the researcher felt submerged in the data and at times distracted by an interesting issue that was not directly relevant to the

research question. However, by focussing on the task and the research question, the feeling of being submerged in the data became less of a problem. Three themes were identified and are presented in the next sections along with the analysis of the first two questions.

### 4.6 Analysis of the Initial Two Issues

In order to relax the participants the interviewer asked questions about their choice of first post and their experience of their job interviews. The questions around these two issues were designed to be easy to answer and non-confrontational as recommended by (Kvale, 1996).

The analysis is presented with the names of each of the participants according to interviews 01, 02, 03 and with extracts from the data to illustrate the themes.

#### *4.6.1 Choice of first post*

All of the female and one male (Brian) participant cited location as being the most important factor when deciding where to apply for posts, whilst the other male participants rated their positive experiences on placement as being the crucial factor. The location factor related to the time and expense of travelling to and from work. They all chose to remain in London because they felt settled in the area.

*I decided I'd actually rather be close to home and I'd get more out of not being tired...even though it's a small hospital.* (May 01)

Both May and Lauren had considered more 'prestigious' hospitals, but in Lauren's case she had turned down a job offer in a more 'prestigious' hospital preferring a post nearer home. Brian had the choice of two posts at hospitals he rated as 'equally good' and then proximity to home had been the deciding factor, although both had initially been selected for an application as they were in a similar area and therefore both were close to home.

Only Nathan felt that the reputation of a hospital had influenced his choice but he had also a positive placement experience there. Jake, Nathan and Philip rated their student clinical experience as being highly influential in their choice as they felt placement experience offered them the chance to 'know them really well' (Nathan 01). Eight participants had been on a clinical placement where they now had their first post. These participants reported a placement at the hospital had some influence on their choice. These placements had been a good experience and they had felt they were part of a team and worked well with others.

*The reasons being, I was at a placement and I really enjoyed it and I got on really well with all the people (and) I just really enjoyed it there, that's important if you go into somewhere to work, you want to get on with the people that you're working with.* (Jake 01)

Georgina felt she had achieved her objectives in choosing her first post as it was close to home and 'my placement (there) was by far the best'. (Georgina 01)

The other factor considered by May, when deciding on their first post, was staffing levels.

> *There was one place I went and talked to people and they were talking about being very short staffed and therefore the juniors were running the ward completely sort of single-handed.* (May 01)

The only other negative factor that had influenced choice was reported by Georgina. She had been to an open day where a junior was actively discouraging students from applying for posts as there was little support available for juniors.

*4.6.2 The job interview*

All the participants had been interviewed for their first post. Nathan was the only participant who had applied to only one hospital, the others having applied to either two or three, except for Kath who had applied to six. May, Georgina, Jake, Nathan, and Kath had one interview, the others either two or three interviews. All had been offered a job following their interview. Linda, Brian and Lauren had more than one job offer and they decided which to accept based primarily on location.

The interviews varied from 30 minutes to three hours. Six of the participants had been interviewed by two or three panellists, who were either friendly and trying to relax the candidate (May, Philip, Linda, Brian) or 'very stern' (Lauren 01) and for one participant the interview 'was like an oral exam, it was really tough' (Kath 01). The data revealed a variety of questions ranging from patient orientated (Lauren, Philip, Brian, Jake, Nathan), to current issues in the NHS (Lauren, Jake), to placement experiences (May, Linda), to university experiences (Nathan), to management problems (Lauren). One participant experienced a different selection process. Georgina was put into a group with two other candidates. She was then expected to prepare a problem list, goals and plan a treatment for a patient, which she then had to present back to the whole group. She then had a short written examination, followed by a 30-minute interview. Lauren was also expected to prepare a management plan for a patient with Multiple Sclerosis.

When the rest of the data were analysed three themes were developed:

- 'Doing the job';
- 'Becoming a professional'; and
- 'The future'.

## 4.7 Theme 1: 'Doing the Job'

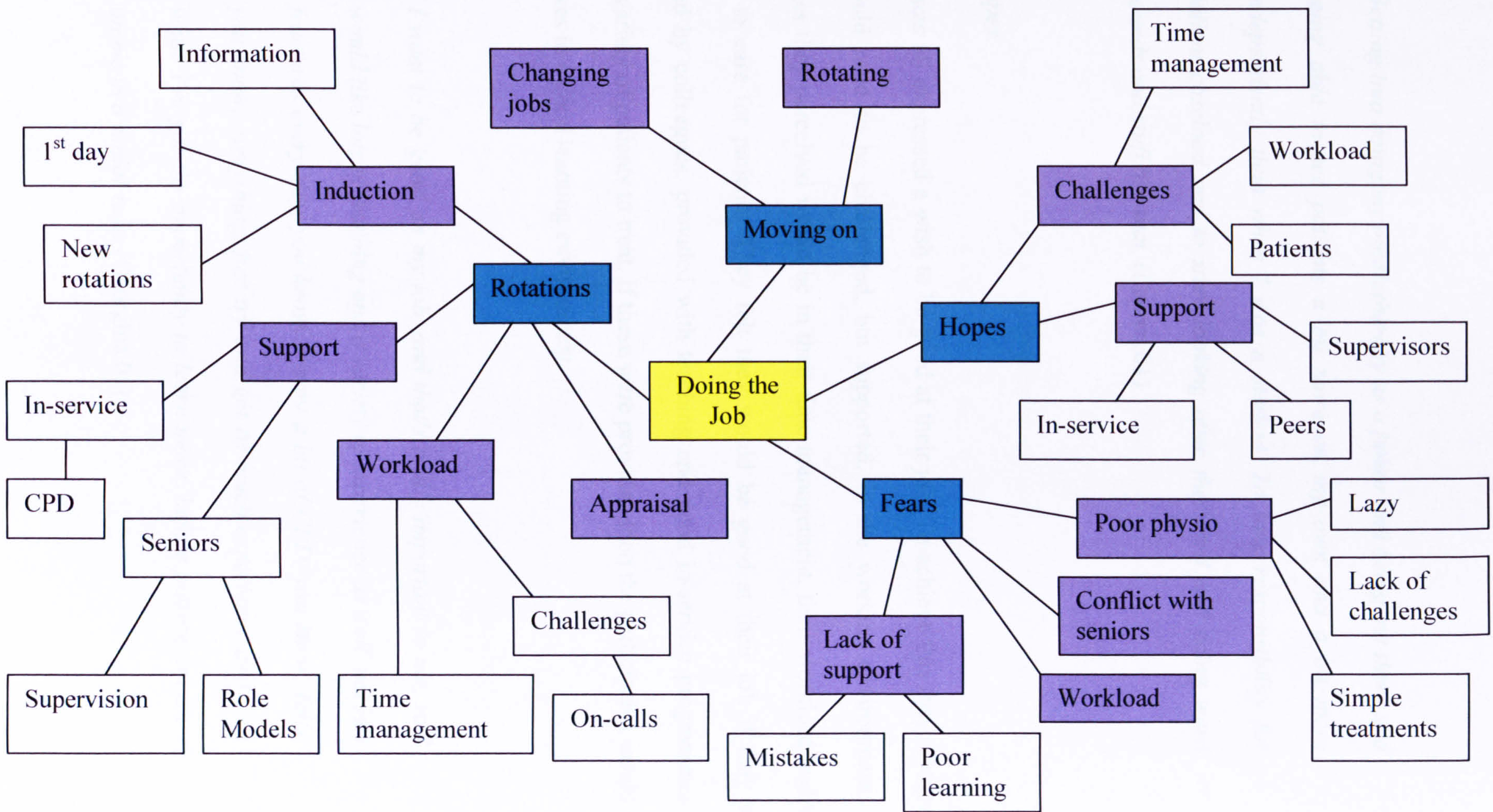
Figure 4.1 shows this theme, together with the relevant categories, super-codes and examples of codes. Yellow denotes the theme, blue the categories and mauve the sub-categories and white the codes.

'Doing the job' (Philip 03) was perceived as the transition from being a student to being a practitioner. The participants were all in rotational posts and therefore at the beginning of each rotation there was a period of transition, although these were shorter with each rotation (Lisa 02, Philip 03) and as Lisa stated

> *There's no point in me getting funny about it, because it's part of what I do as a junior, this is what I have to do, so I just have to settle in and get my head down and get to grips with it.* (Lisa 02)

The defining structure of 'doing the job' was the rotation participants were allocated to. Nine participants knew which rotation they would be working on before they started their job. The participants expected the rotations to be different from their student experience of rotations. They expected more responsibility, more independence, a supportive atmosphere, and exposure to patients and work they had not been expected to cover as a student (Jake 01, Linda 01, Lauren 01, Brian 01, Kath 01, May 01, Philip 03).

Figure 4.1. The relationship between the ‘Doing the Job’ theme, the categories, the sub-categories and examples of codes



*Getting into doing my physiotherapy as a junior and being out there and being able to see patients a bit more on my own and a bit more independently than when I was a student. To take responsibility for patient caseload and to start looking after the ward and doing ward rounds and stuff like that.* (Lauren 01)

*4.7.1 Hopes*

Participants all expressed a wish to be good at their job. To achieve this they recognised they would need to be challenged, but supported, in the working environment. The challenges they perceived would be in their time management, their workload and their abilities to care for patients. They felt they would be good at their job if they were supported by colleagues, provided with teaching and good in-service programmes and given a variety of patients to treat. If these were provided then the participants would find themselves in a good learning environment.

*I want to be good on my job, and that's really important to me, so I would like lots of teaching and a variety of experience as well, not just fractures every day, you know, I want a bit of CPD, you know, falls, you know, everything, just try and get as much experience as I can, while I've got the opportunity to learn more, before putting pressure on me in a senior role.* (Georgina 01)

They were looking forward to being part of a team, not an outsider (Philip 01), building on previous knowledge (Jake 01, Nathan 01), feeling settled (Georgina 01, Nathan 01, May 01), structure in their life (May 01), job satisfaction (Philip 01), being an adult (Brian 02), fun (Lauren 01), money (Lauren 01, Nathan 01, Linda 01) autonomy (Jake 01, Kath 01, Linda 01), and making a difference (Georgina 01, Kath 01).

> *I expect it to be enjoyable, to be honest with you, I mean physios as a whole, physios are fun people and the work, well, the work is hard work, you know, but it's also, I think any job, you shouldn't do it unless you enjoy it. At the end of the day, you're there to help someone else. So I think for me it's really important that I do make a difference, even little things.* (Georgina 01)

*4.7.2 Fears*

Six participants mentioned the dangers of becoming a poor physiotherapist (Georgina 03, Jake 03, Linda 02, Kath 03, May 03, Philip 01). A lazy physiotherapist was one who did not do their CPD, someone who came to work just to do the hours and then went home. Some perceived this as a physiotherapist who did not care about their patients or profession. Such physiotherapists were few and far between, but all participants, who talked about this issue, had witnessed such approaches and were concerned about themselves slipping down this path through boredom if they were not challenged. In later interviews the importance of being challenged was mentioned many times. If left with

little support they felt they would stick to simple treatments which may be safe but would not necessarily benefit the patients or extend their own skills.

> *You just become kind of comfortable in doing that, the day to day stuff, the simple stuff.* (Philip 01)

Although they expected to work hard and carry much heavier caseloads, some worried that if the load was too heavy and 'convey belt-like' (Kath 01) they would have little time for reflection and therefore their learning would be limited.

They were least looking forward to any conflict with seniors (May 01, Philip 01), being thrown in the deep end (Brian 01, Lauren 01), on-calls (Georgina 01, Jake 01, Linda 01), being useless or incompetent (Lauren 01), getting up every morning and not having long holidays (Brian 01, Nathan 01).

> *That maybe I just won't be good enough to improve on what I already know, that maybe I won't remember everything, maybe I'll make mistakes and maybe I'll hurt somebody.* (Linda 01)

> *I think its, got the potential to be a stressful job, if you allow it to be, but I feel if you're organised, I think that is the biggest part of it.* (Nathan 03)

They were expecting support from seniors but they also acknowledged that more would be expected of them. They perceived the first few months as 'finding their feet' (Lauren 01) and 'learning the ropes' (Jake 01). They were expecting to build their confidence and knowledge base (Linda 01). They expected to be challenged, one participant expressed this as a need to 'be pushed' (Nathan 01) to perform well. They knew they would have a high workload and they would be challenged to keep on top of this load. However, they were keen to learn and the participants rated highly the importance of experience as the way they would learn.

*4.7.3 Rotations*

Participants mostly took part in 'core' rotation (Masters, 2004) and as shown in Table 4.2. Only Jake had a non 'core' placement, although, this was still within an acute setting. Most managers believe that the 'core' rotations were musculoskeletal, neurology and respiratory (Masters, 2004).

Once the participants had completed their first rotation they came to perceive a rotation as being a continuation of their student clinical placements. They recognised the obvious differences (eg length of rotation) but that this gave them more time for learning more skills. They felt that in many ways there was less pressure than when a student as they 'were not out' to impress their seniors, as they were not marked at the end of the rotation (Jake 03, Linda 02, Nathan 02, Philip 02). Nathan (02) also felt it was possible to 'blague' his way through a placement whereas rotations were too long to be able to adopt such a strategy. Another participant summarised:

> *When you're on placements you can sometimes feel that you can blague your way through seeing patients and treat them this way and treat them that way, because you know that if they don't get better, they'll be taken over by someone else. Now, you think, when a patient comes in, there is no scope for passing them onto someone else. You can get help with it, obviously if you don't understand anything or whatever. But at the end of the day you're a lot more responsible for them, so therefore if your assessment is not thorough, it's only going to cause you problems later down the line. It's a lot more kind of like do the job right the first time.* (Philip 02)

Although physiotherapeutic specific skills were highly rated, Lauren (02) and Georgina (03) realised that communication and time management skills were the skills that were developed the most during their first year. Most struggled initially with their time management skills, often finding it hard to manage a caseload without help. This help was usually available but not always (Kath 02). Linked closely to time management were their organisational skills. However, this led some participants to recognise that not all patients referred for physiotherapy would get better (Philip 03, Georgina 02). This was a very important lesson for these participants, as they developed more realistic expectations. For Kath (02), Lisa (03), Nathan (02), Brian (02), Lauren (02) Out-Patients presented a major time management challenge. All except Linda (02, 03) found themselves in a very busy, structured working environment.

*It was really busy, really rushed, you know. I found it really hard to start with, just the difference, you know, coming from the wards, where it's just a little bit more relaxed and you're not set such a tight time schedule.* (Lisa 03)

However, the pressures did not put them off working in out-patients. They felt that the experience had been very demanding but they had learnt 'loads' from supportive seniors. Linda was the only one who had been 'put-off' out-patients. She found herself in an out-patients department away from the main site and she had found herself isolated, not part of the team and with time on her hands.

Some participants had poor experiences, mainly related to a rotation. A striking feature was the variation in experience of rotations, even within one Trust. Some rotations were perceived as being extremely tough (Philip 03) and others 'a cruise' (Jake 02). On less demanding placements some participants were able to go onto 'autopilot' (Philip 03), but then they felt they needed challenges to keep them interested and in one case this had led to some research (Philip 03). In one Trust a participant had such a poor experience that it was decided not to put any more new physiotherapists on that rotation, until they had experienced a few other rotations and 'found their feet' (Philip 02). The basic structure of a rotation was described by the participants as an induction, senior support, workload, appraisal, in-service, appraisal and moving on. The quality of the provision of this structure varied from rotation to rotation, as is described and discussed below.

#### 4.7.3.1 Induction

Only Linda (01) and Kath (01) had received information, beyond contracts, about their first day or induction. They had been told when and where to turn up but none had received a formal induction programme, although nine knew which rotation they would be on. May (01) expected the induction period to be short as the hospital was short staffed. However, most expected to spend time during induction completing administrative tasks and visiting various parts of the hospital.

> *I think for the first few months, it will be really finding my bearings and finding out the way that everything works and everything, you know, the politics and everything together and then once I find my feet, hopefully, I really will be able to develop as a, you know, as a practitioner and really build on my skills and become a lot more competent. I mean hopefully I am competent, but in myself, I feel that I have a limited knowledge that I would like to definitely start to build upon within a couple of months. Even with the six week placements, you feel as if you're really starting to learn things by the end of the six weeks. So, hopefully within twelve weeks, you're really starting to pick up more and more.* (Jake 01)

All the participants were expecting some induction to their new posts but only Kath had received any details as to what would happen when she arrived on the first morning. There were mixed feelings about their first day. Linda (01) hoped it would be 'hopefully

nice, hopefully relaxing…as long as they don't throw me in at the deep end'. They were all expecting to fill in forms and complete administrative tasks. Georgina (01) and Kath (01) expected to treat one or two patients on their first day. However, the reality for Linda (02), Kath (02), Lisa (02) and Brian (02) was very different as summarised by Brian 02.

> *I thought the 1st day, it would be quite easy, the 1st week, I thought would be quite easy, it would be a bit of a coast and you'd spend different times in different departments and it would be sort of quite leisurely. In fact, I was sort of given an hour introduction and then a full patient load, which as sort of, my heart was in my mouth a little, to say the least!...it was the most hectic day I've ever experienced in my life...it was OK, there you go, sink or swim.*

Lauren (02) had another experience as she stated her induction 'fantastic, I didn't see a single patient'. However, if the induction was too slow and cautious it was perceived as boring (Jake 02). Both Philip (02) and Lauren (02) felt they had been well supported through the induction process. However, when Linda (02) rotated into another hospital within the same Trust she found the slow start boring

> *They didn't overload me with patients, which was nice, but I had a lot of free time on my hands and it did get a bit boring, but then that's probably*

*because if you're sitting round being bored and you've got no-one to talk to, its even worse.* Linda (02)

The participants (Lisa 02, Linda 02) recognised that at the beginning of each rotation there was a period of adjustment, and they were resigned to this change.

> *I think it's kind of because you know that you have to change, so you just accept it and whether you like it not, its not really, you just have to get on with it, don't you, because, you know, a couple of months I'm going to face another completely different change and there's no point in me getting funny about it, because its part of what I do as a junior, this is what I do, so I just have to settle in and get my head down and get to grips with it.* (Lisa 02)

#### 4.7.3.2 Workload

Workload was considered as being the number of patients treated in a day. Some participants were allocated some administration duties (Nathan 02, Kath 02, Lauren 02) but these were done in their lunch breaks.

All had completed an out-patient rotation by the end of the first year and although most enjoyed their out-patient rotations, they often felt the work load was very high in comparison to other rotations and there was no time for other jobs or CPD (Kath 02, Lauren 02, Brian 02, Nathan 03). Although they had expected this high workload, as they had experienced it as students (Kath 01, Lauren 01), they were still not prepared for the

number of patients they were expected to treat per day. They relied on patients not turning up to get their notes up to date and get their extra duties completed (Kath 02, Nathan 02, Philip 02). They also sat at their desks during the lunchtime, eating and writing up notes and they completed their paperwork after work (Kath 02, Lauren 02, Brian 02). They felt they were on a 'conveyor belt' (Brian 02, Kath 02), and when support was lacking this turned to disillusionment with the job, because it seemed that the number of patients treated was more important than the quality of service (Philip 03).

> *Well, it was 8.30 and it was sort of patients every half an hour, sort of until, it was like a conveyor belt, you had patients sort of half an hour, unless it was a new patient and then you had sort of forty five minutes until 4.30 at the end of the day. With obviously a gap in the middle for a lunch break, so forty-five minutes. But basically, the lunch break was always a lot shorter than that, because if your morning had run a bit later, because patients turned up a bit later, it kind of ate into your lunch break, so you'd finish a bit later and then there was always admin to do and the only time I got to do that was lunch time, so I used to quite often just sit at my desk, eat my sandwich and do it then.* (Kath 02)

When they moved from out-patients onto other rotations, they often felt they had more time to deal with the 'whole' patient and their problems, and these rotations felt less 'regimented' (Kath 02) and they were more able to manage their time (Nathan 03). Some felt 'swamped' (Kath 02, Philip 03) along with other juniors, but when they asked for

help they were told to muddle along and this was the 'real' world and they had to learn to cope. So they learnt 'to play the game' (Kath 02), in order to survive, as described below and 'not let it get to me' (Linda 02)

> *I mean obviously every department runs differently and different seniors like things done different ways. It's similar to being a student in that way, you know, you have to adapt to the way that they like things done.* (Philip 02)

However, Kath (03) perceived a change in herself as she moved through the rotations, she began to feel

> *different about things...I just felt more confident in decisions that you made and generally your time management improves, so that helps you as well because when you first start, time management is hard and that adds to your stress in a way, because you've got to do your workload, but you've got to fit everything in.* (Kath 03)

Brian (03) and Philip (03) also felt by his third rotation that he was better able to keep up to date with his paperwork and manage the workload. Georgina (03) felt she could cope with heavy workloads if she had good senior support.

Not all the workload problems were limited to out-patients. Where the participants experienced staffing shortages there were problems in managing caseloads. There were

times when not all the patients were seen and this led to frustration especially when patients who were suitable for rehabilitation were fitted in, if there was time and sometimes not seen at all (Kath 02, May 02, Philip 02). However, because patients could be 'left' it meant the workload was more manageable in comparison to out-patients where patients turned up regularly for appointments (Kath 03). For Brian (03) the experience of a four month rotation on outpatients led him to 'never want to go back to outpatients again and I just find it very intimidating'.

The participants learnt to prioritise and

> *justify not treating someone and that's a massive thing, because I think when you first qualify, you feel that you need to treat everybody and you can actually reason now for why there's no point, you know, there's no benefit, I think that's a massive thing and that comes with experience and confidence.* (Philip 03)

These problems were made worse when rotations were isolated from the rest of the Trust, either being at a small local hospital or sometimes just too far away from the main department, or sometimes that lunchtimes were at different times. Therefore at times juniors could feel isolated (May 02, Jake 03, Philip 03, Georgina 03, Lisa 03, Lauren 02).

However heavy the workload on a rotation it was important that the participants were challenged.

*It would be very easy to come in, I think, do your job and go again and I think I would go mad. I need something more slightly to challenge me. You know, on (my first rotation) we had lots of that, but (on this rotation), it would be very easy to come in, do what you have to do and go again. I couldn't, I don't think I could cope with that, because I need, I need that challenge.* (Jake 02)

Challenges were perceived to be variety in their caseload, acquiring new skills / knowledge and developing their time management skills (Brian 02, Jake 02, Philip 02). If challenged they were prepared 'to go the extra mile' and stay late, or do more courses (Georgina 02, Nathan 02, May 03). If they were not pushed they became less motivated and kept their heads down until the rotation was completed (Philip 02).

*I think if it's too simple...if it's not challenged me, if I'm just going through each day and doing the same thing and knowing what I'm doing and nothing new, then I think I will get bored with it.* (Linda 01)

Nathan (02) also recognised that lack of challenges led to complacency and being less conscientious. Good supervisors were able to provide challenges with support which led to high performance; whereas a poor supervisor offered high challenge and low support which led to stress and burnout or low challenge and low support which led to apathy (Hunter & Blair, 1999).

When rotations were poor the participants felt like 'workhorses' (Philip 02). The workload was not evenly distributed, and they felt stressed and taken advantage of. Many strived for perfection early in the first year, but they had to learn strategies to 'cut corners' (Kath 02) and they also learnt to expect that they may not be able to treat all the patients that needed treating, and therefore to prioritise patients (Philip 03). This led to frustration as, in many cases, patients who would have benefited from rehabilitation had to be left untreated if there were too many acute patients in need of physiotherapy (Kath 03).

The part of the workload these participants had not experienced as students was the on-call system, where they would be expected to carry the 'on-call' bleep overnight and potentially be 'called-in' for any patient that might require emergency physiotherapy. All the participants were worried about this aspect of the job and Linda (01) predicted she would be 'scared, I'll sit at home and tremble'. In the event, when they started their first posts they found a lot of support available for them in relation to on-call, as summarised in Table 4.3.

By the second interview only Kath had not done an 'on-call'. The majority had been given a telephone number of a senior to ring if they ran into problems whilst 'on-call' and were unsure what to do. All felt well prepared and supported for their first on-call and all of those who had been called in had a good experience except Georgina, who had 'a nightmare' (02) but had reflected on the experience the next morning with her supervisor and, although her confidence had been knocked, she had done the right things. By the 3rd

**Table 4.3 The support available for on-calls and experience of on-calls**

| Participant | Tel No | In-service | External Course | 2nd Interview 'called-in' | 3rd Interview 'called-in' |
|---|---|---|---|---|---|
| Jake | | Yes | | No | Yes |
| Philip | Yes | Yes | | No | No |
| Linda | | Yes | Yes | No | No |
| Georgina | | | | Yes | Yes |
| Lisa | Yes | Yes | Yes | No | |
| Nathan | Yes | Yes | | No | Yes |
| May | | Yes | | No | Yes |
| Brian | Yes | Yes | | No | Yes |
| Lauren | Yes | Yes | | Yes | Yes |
| Kath | Yes | Yes | | No | No |

interview those who had not been called-in were beginning to become frustrated, as they wished to 'get it over and done with' (Kath 03) and Linda was actually doing more than her allocation in order to get called (Linda 03).

4.7.3.3 Support

The term 'support' was identified 228 times in the coding process, the next most frequently used code was musculoskeletal – 156 uses. All participants were expecting to be supported by their supervisors but they recognised this may be different from their experience whilst a student. 'I'm worried about relying on them too much and expecting

their support too much' (Lauren 01). Brian (01) hoped his supervisor would be 'like a counsellor'.

Georgina (03) experienced good support from her peer and senior II's but the communication between levels of management above Senior II level was so poor that the

> *senior IIs and juniors, they're just literally sticking together and they literally just help each other out.... You don't tend to go to management, because you don't think it's going to be solved.* (Georgina 02)

When support was lacking the physiotherapists found they were unable to complete their work to a satisfactory standard. They asked for help but in some cases they were just told to get on with things (Kath 02, Philip 02) and in one case this led to a participant threatening to resign (May 02). Although the issue was partially resolved, problems still remained. Therefore they felt frustrated, particularly if the continuity of patient care was compromised (Kath 03, May 02). The amount of support per week was not crucial, but the support had to be organised to be of value (Linda 03).

> *She was really nice, really friendly, but she wasn't that organised, wasn't that structured, so we didn't really get that much chance to do proper in service training.* (Lisa 02)

The support from seniors was closely linked to the amount of supervision they received. The amount of support they received was determined by the quality of the senior responsible for them. A good senior providing support was also perceived as being a professional and a role model for the junior physiotherapists (Georgina 02). Kath (03) had experienced poor support and then good support on the same rotation.

> *The last month that I was there, somebody came back who'd been away doing an MSc, so they'd been on sort of study leave and she was the clinical specialist for respiratory and she was brilliant and she spent a lot of time with the juniors, so it kind of completely changed when she came back and I think if she'd have been there all along, it would have been fantastic, it would have been an awesome respiratory placement, because even in the couple of weeks that I saw her, I learnt so much.* (Kath 03)

From the participants' descriptions their support came from their supervisors, who were perceived as experts (Lauren 02, Brian 02). The supervisors were there to advise them about patient management and act as role models (Nathan 02).

> *Someone that's approachable and open and answers your questions, but also encourages you to look up things and learn things for yourself, oust someone, yeah, I think approachable is the most important thing.* (Linda 03)

Approachability and encouragement were also important for Lisa (03) and Lauren (02). When good supervision was available from their seniors the participants felt supported (Lisa 02). When there were problems with their supervisors the participants learnt to play a game so they were perceived in a favourable light. 'It's taken me a while to figure out how to be around her' (Linda 03). May (02) adopted a strategy of 'not letting it show', when things were getting on top of her. Philip (02) adopted a similar strategy. Others were initially prepared to vocalise their concerns but learnt from experience and found themselves keeping their

> *mouth shut…because I think I just don't want to rock the boat and I want everything to go well and to get a lot out of it and to keep people on your side, because you want them to help you when you need it. You don't want to put people's backs up.* (Kath 02)

She also felt that

> *they don't encourage you to have a voice and to voice your opinion. I mean I don't mean being bolshy, but actually say what you think and contribute to discussions, really, it's kind of like, well, you're a junior, you don't contribute to this discussion.* (Kath 02)

For Brian (03) this had resulted in him and another feeling intimidated, but they kept their heads down and waited for the rotation to end.

What is apparent from this research is the variability of support available on rotations. All had experienced rotations with some excellent support and all except Jake had experienced poor levels of support from their supervisors. All the participants were supervised by physiotherapists. Uniprofessional support might lead to a very narrow view of their working environment and although it will mean profession specific skills are developed, generic professional skills may be neglected. Although support is important for newly qualified physiotherapists (Wilde, 2005), it may be more appropriate to provide a non-physiotherapy source of support.

All participants, except Brian, attended junior meetings, which form a peer support group. However, one department had dispensed with the meetings as they felt they were just an opportunity to moan (Lisa 03). These meetings usually took place every two months and for all it was the opportunity to discuss problems with rotations and on-call/weekend issues. Georgina found that these meetings were used for a journal club as well as the issues above. However, the journal club part of the meeting had been terminated by the 3rd interview as there was little interest or active participation by the juniors. Both Parker (1991) and Cusick et al., (2004) recommended newly qualified peer support groups.

In-service programmes provided for the participants gave support and also formed part of their CPD. None of the participants expected to be allowed to attend externally run courses during their first year, but expected the seniors to provide in-service teaching relevant to them. They also expected to participate in more general departmentally

organised in-service and hospital run courses. Only Linda and Lisa went on externally run courses and these were provided to support them on the on-call rota. The in-service programme mainly concentrated on developing their profession and speciality specific skills particular to the rotation. The standard and regularity of the in-service programme varied from rotation to rotation. For example, Linda (03) experienced one rotation where 'it was a bit hit or miss' and another where she had been sent a list of topics prior to the rotation starting, to choose the topics she would like included in the in-service programme. Both Lisa and Georgina found programmes that were tailored to their specific needs. All reported differences in time allocation for in-service between rotations, for example Jake (03) reported two of the rotations had one hour per week whilst another had allowed three hours per week. Nathan had experienced on one rotation one morning per month being set a side for in-service where a set syllabus was followed. All agreed there were differences and Brian (03) stated 'it depends on the department, it was excellent in out-patients, not so good in neuro'.

In addition there were departmental in-service meetings, which brought together all the physiotherapy staff, across the hospital. Whilst more general issues were discussed it was still profession specific (Lisa 02, Georgina 02).

4.7.3.4 Appraisal

All participants were appraised during each rotation. They set objectives at the beginning of their rotation with their supervisor. Nathan (03), Brian (02) and Kath (03) reported that these objectives were competency based and generally speciality based. So participants

were encouraged to concentrate on developing their physiotherapy practical skills. Brian (03), Lauren (02), Nathan (02) and Kath (03) all recognised similarities between appraisal and their student assessment forms. Nathan reported

> *It felt a bit weird the first time I had my appraisal, I was expecting them to say what grade I'd got and how well I'd got on.* (02)

He also had the same experience at his second appraisal. Others felt 'you're sort of in this situation when you are still being assessed in a way' (Kath 03).

### *4.7.4 Moving on*

Moving on was perceived in two different ways by the participants. For most it meant moving on to a new rotation (rotating) but for Kath (03) and May (03) it also meant moving jobs.

#### 4.7.4.1 Rotating

Towards the end of rotations a decision was made as to which rotation the participant would move to next. Again a variation in process was demonstrated not only between Trusts but also differences within Trusts. All the participants, except Nathan, Lisa and Jake, were asked for a short list, usually three, of preferred rotations. For Lauren (03) and May (03) their choices were influenced by staffing levels on potential rotations.

*I thought about doing respiratory, but we've just lost our superintendent and our senior I, so we've got a lot of locums in, so I want to wait until the department's a little more stable, before I do it. I mean, yeah, it has to be done, because it would give me so much more confidence.* (Lauren 02)

Others (Philip 02 and Georgina 02) quickly learnt to be strategic in their choices, by choosing unpopular rotations in the hope that next time the person in charge of the allocation would give them a popular rotation as they had been helpful in their initial requests. Philip also stated that he

*went for orthopaedics, because you hear things through the grapevine that orthopaedics is a little and bit more relaxed than other rotations and I'd done medical, which I thought was very stressful...I thought I'd just go onto some, go onto autopilot for a while.* (03)

Lauren (02) also recognised as she was 'the baby' (newest to the Trust) she was unlikely to get a popular choice of rotation. The person deciding on the allocation varied, sometimes it was an experienced junior (Kath 02), others the juniors decided at a meeting (Philip 02 and May 02) and for the rest the manager decided. In Lauren's (03) situation the second rotation had been decided by the manager but she became fed up with the complaints and had told the juniors to organise it amongst themselves. All of these approaches have one thing in common, the short term nature of a potential development

plan for a junior therapist as well as implications for their CPD. Only Nathan (02) and Lisa (02) had a clear idea of their progression through the rotations. The value of the current rotation system has been brought into focus by the crisis in junior posts (Limb 2006) and many are beginning to question firstly the value of rotations for all newly qualified physiotherapists and also the reliance on the 'core rotations'.

4.7.4.2 Changing jobs

Both Kath and May were in the process of changing jobs by the 3rd interview. Kath was having to re-locate because her partner's job had moved. She was upset about not being able to complete her rotations as she felt, although they had been demanding, she had good support and an excellent experience. The choice of her next hospital would be based on the rotations offered. May (03), however, was moving because she was dissatisfied with the rotations the Trust offered and the level of support due to poor staffing levels, with many part time senior staff and locums. She also felt she had been misled when she applied for the post

> *The junior had left because it was so awful. But I didn't know that when I was accepting the post.* (May 03)

Georgina experienced a rotation with poor supervision but was not tempted to move to another post

*because it's convenient, I won't lie to you, you know I can bike to work in five minutes, it's easy on call and I love the people, the people I work with are fantastic.* (03)

Georgina also felt that if she needed to move on she would look for a place which offered 'good team support' (03).

All the participants were still working as physiotherapists at the end of their first year. Rugg (1999b) reported an attrition rate of 7% for the newly qualified occupational therapists in her study. However, another 24% of her participants reported they were likely to leave the profession permanently in the next year. She also reported that factors the influenced retention of staff were CPD opportunities, the quality of interpersonal support and perceptions of autonomy. Discrepancies between expectations and the realities of practice were linked to attrition (Rugg 199b). May had expected good support (01) and she experienced poor supervision and this was the main factor in her decision to move jobs (03).

*4.7.5 Summary*

Most participants were quietly confident about and looking forward to their first posts. All were anxious but excited, as they did not know exactly what to expect. They expressed fear and a lack of confidence in their own abilities, and were particularly concerned they would harm the patient through lack of knowledge. They were expecting

lots of support and lots of support from their seniors. The participants were aware of the challenges of managing their own time and caseload.

When the participants experienced poorly organised busy rotations with little support they struggled, which led to stress and illness (Philip 03, Kath 02). Philip (03) stated that the juniors, when they arrived at work in the morning, 'took a deep breath' and held it all day and would 'only let their breath out on getting out the door at 4.30'. May (02), Kath (02) and Linda (02) all experienced being left on their own to cope, either due to poor staffing levels or annual leave, which increased stress levels and frustrations as they felt they did not have enough time to treat all the patients and often patients with rehabilitation potential were left untreated.

However, they did learn to cope with the stress and once they 'got to know the routine, I knew where to cut corners, (Philip 02). Other coping strategies mentioned were, 'switching off' and not taking work home with them (Jake 03, Nathan 03) and going to the gym straight after work (Philip 02, Nathan 03, Linda 03). Both May (03), Linda (02) and Kath (03) relied on support at home to help them and May (03) learnt to not get 'too upset about things' and Philip (02), after a particularly difficult rotation stated

> *I think I just got to the stage when I was quite stressed and I thought, damn it, I'm just going to do what I can, not get stressed.* (02)

The participants mentioned frequently in the interviews emotions often linked to their lack of confidence. They were nervous, anxious, fearful, frustrated, and found things daunting, particularly at the beginning of each new rotation. They also recognised these feelings as being similar to undergraduate placements. They felt there was an element of luck in their job and they often mentioned that sometimes they felt they were unlucky.

Emotions about first weekends and on-calls were related to not knowing what to expect. Different Trusts had different approaches to preparing their newly qualified for their first weekend and on calls. These ranged from attendance at external courses to internally run courses, to having had to be on a respiratory rotation, to spending afternoons with seniors on ITU. Some newly qualified physiotherapists volunteered to do an early weekend 'to get it out of the way' (Jake 02).

Pay was mentioned frequently as being the worst part of the job (Linda 01,02,03, Kath 01, May 01, Georgina 01, 02 Brian 02, 03, Lauren 02, 03, Jake 01, 02, Nathan 01, 02, Philip 02). They felt poorly rewarded for their work. The situation was made worse as they could no longer have the extra jobs they had as students and therefore had no supplementary income. But they did have more freedom in the evenings and at weekends, and they did not feel under pressure to study. The issue of poor pay was highlighted by one participant, when asked about the attractions of locum work.

> *Better pay, much, much better pay, really, I mean our locums, we've had a few that have become permanent staff and she cried when she saw her*

*bank balance, how much money she was going to lose through becoming permanent.* (Lauren 03)

Good rotations were perceived as where the participant learnt a lot, specifically their physiotherapy specific skills and increased their knowledge base which led to increased confidence and increased responsibility. The most rewarding part of being qualified revolved around patient contact (Kath 02, Jake 02, Philip 02, Lauren 03). 'I just feel such a sense of achievement and so pleased for the patient' when treatments had been successful (Kath 03). The participants also enjoyed making their own decisions and taking responsibility (May 02, Philip 03, Georgina 02), being part of a team (Philip 01, Linda 03, Georgina 02) and being settled in one place and not moving on every four weeks (Lauren 02, Georgina 02). Conversely for May (02) and Philip (03) they also felt that responsibility was very daunting and the most worrying part of their job.

The participants recognised that they need to be flexible to get the best from a rotation as stated by Lisa

*I mean obviously every department runs differently and different seniors like things done different ways, you know, you have to adopt to the way they like things done.* (02)

Overall the participants were happy, they expressed feelings of job satisfaction. They had experienced at least three rotations and they all noted big differences in the structure of

rotations, even within the same hospital. Support was the most important issue for these physiotherapists. If they felt supported they developed as a practitioner. However, without support they were stressed and felt they were just 'workhorses' (Philip 02). They developed methods of dealing with high workloads and lack of support, but this often led to frustration as it compromised patient care. These participants learnt to fit in and meet the expectations of their seniors. The beginning of rotations was often stressful as they learnt the rules of a new rotation, this was linked to their experiences when starting new placements as students. They developed strategies for dealing with conflict and some developed a thick skin to ensure they did not become involved with issues not related to patient care.

By the end of the year the participants felt settled and valued the job security and in particular the people they worked with. They had learnt that they sometimes could not solve every patient problem and learning to say 'no', when appropriate, was an enlightening experience. They learnt how to manage their own time and how to prioritise their workload.

The most important thing learnt for some participants was reflective practice as it 'makes me feel like a better clinician' (Jake 03). Reflective practice was important and had been developed over the year; however, this did not extend to completion of their CPD portfolio. It seems that although reflective practice was rated highly, the completion of portfolios was seen as a chore and many took on a mechanistic approach and just filed

courses and incidents without actually writing reflective accounts (see page 204 for further discussion).

The important things these participants said they had learnt by the end of the first year to enable them to do the job were:

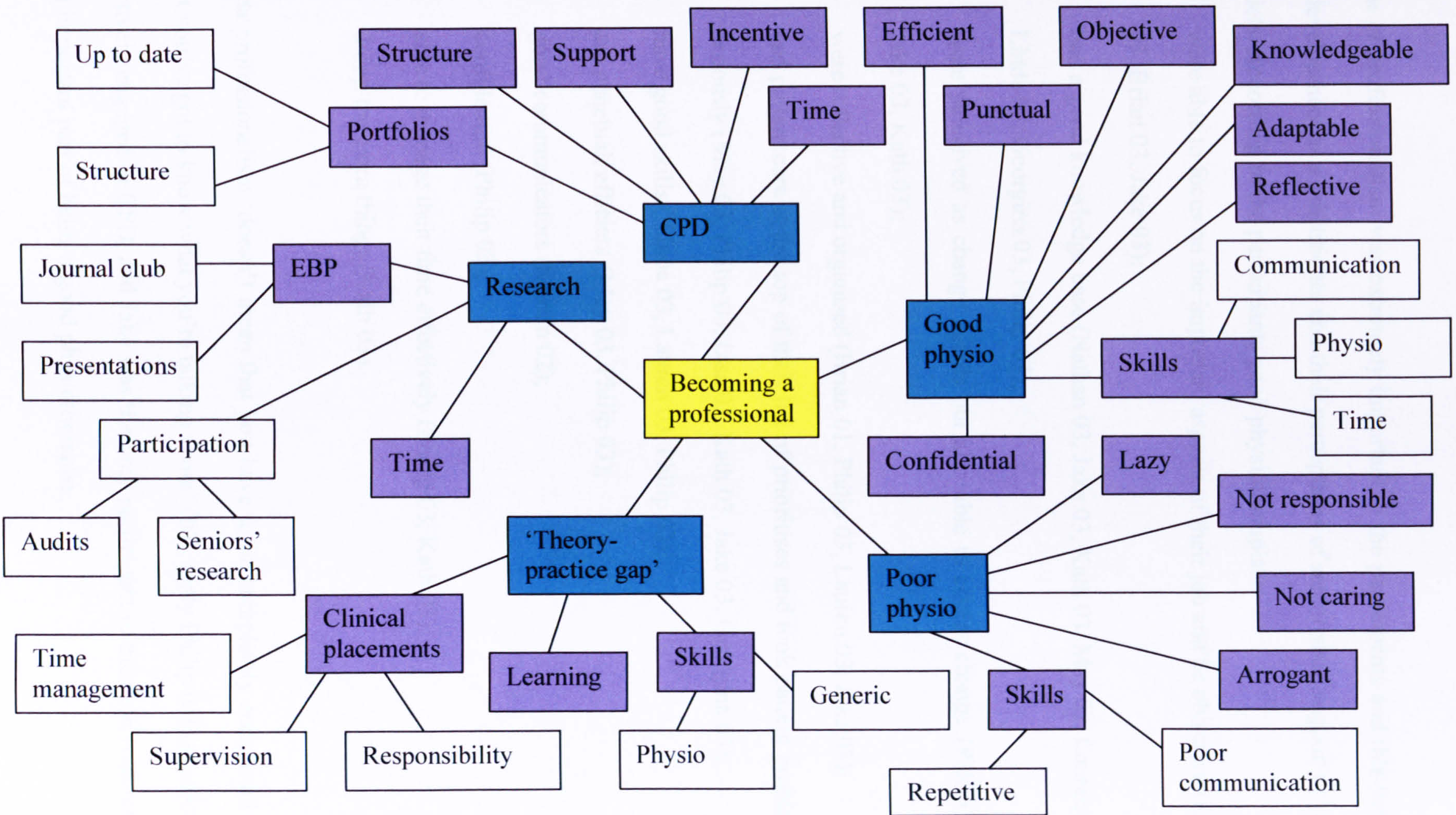
- 'physiotherapy can't solve everything' and being realistic and learning to say 'no' and be able to justify this decision (Linda, Georgina, May, Philip);
- Prioritisation and time management (May, Kath, Georgina);
- Learning (mainly by experience) (Kath, Brian, Georgina, Lisa, May);
- Reflective practice (Jake).

Therefore they learnt to do the job.

**4.8 Theme 2: Becoming a Professional**

Figure 4.2 shows this theme, together with the associated categories, sub-categories and codes. CPD and research dominated this theme. Yellow denotes the theme, blue the categories and mauve the sub-categories and white the codes.

Figure 4.2. The relationship between the 'Becoming a Professional' theme, the categories, the sub-categories and examples of codes



The issue of professionalism was extremely important to the participants and this linked to their development as a practitioner and their perceptions of senior staff as good or poor role models. According to the participants good physiotherapists:

- were able to focus on the important aspects of their job and be objective (Kath 03, Brian 03, Jake 03);
- had a good knowledge base (Nathan 03, Jake 03, Kath 03, May 02, Lauren 03, Linda 03, Georgina 03, Philip 03);
- were perceived as change agents but also able to accept change (Philip 03, Jake 03, Kath 03);
- were reflective and organised (Brian 01, Philip 03, Lauren 03, Jake 03);
- had patient care at the top of their list of prioritises and took patient problems seriously (May 03, Philip 03, Lisa 03, Kath 03, Jake 03, Georgina 03);
- have good skills ( Linda 03, Lauren 03, Philip 03);
- are punctual, efficient (May 03, Philip 03);
- good communicators (Lauren 02);
- confidential (Philip 03);
- able to manage their time effectively (Philip 03, Kath 03);
- doing the extra things (Kath 03).

For Linda professionalism 'doesn't mean that you have to be completely serious all the time, but you've got to know what you're talking about' (03). Only Philip (03) mentioned being actively engaged in CPD, and Jake was the only participant to mention research as being an important part of being a good physiotherapist.

These participants aspired to being good physiotherapists and recognised that some of the early steps in this process were, taking responsibility for their actions (Brian 03), which included not relying on the same close supervision of student education and realising that often there was nobody watching them closely and therefore they needed to be able to recognise their own mistakes (Philip 03).

Poor physiotherapists were seen by the participants as:

- continued doing the same thing, came to work just to do the job and relied on recipe treatments (Philip 02, Linda 03, Kath 03, May 03, Georgina 03);

you get others who come in, do their job and go home...they do what they have to do and they don't take any more on board. (Jake 03)

- were lazy and did not take responsibility (Jake 02, Philip 03);
- were not caring, did not listen to patient, not perceptive, not picking up on patient needs; (Linda 03, Kath 03, May 03, Georgina 03);
- were arrogant (Philip 02), 'thinks they know everything' (May 03).

In order for them to be a professional physiotherapist, they needed support. However, Jake was aware that

*It's very easy to switch off and be quite robotic about the whole thing.* (02)

None of these participants mentioned any concerns about their professional identity or role. They were aware of the transition from student to qualified practitioner but the most important aspects of this transition related to the support they received from seniors. Although the transition took place over time the initial shock of being 'a physio' was mentioned by May

> *It was quite daunting, really. Just walking up onto the wards and just being addressed as 'physio'. I was thinking hang on a minute, I'm a student. Oh no I'm not!* (02)

Towards the end of the first year the participants were confident in their skills and admitted that learning when physiotherapy was inappropriate for a patient was an important factor in their professional development (Kath 03, Philip 02).
They clearly felt that their role as a physiotherapist was well respected in the team and therefore felt part of the team (Philip 03, Linda 03, Lauren 03).

> *You just have a niche and it's nice having a niche and fitting in.* (Lauren 03)

They felt they could clearly identify and aspire to good professional behaviour. However, they did recognise times when they could have done more for the patient but budget and

time restrictions meant that, for example, rehabilitation patients were not treated (May 02, Kath 03).

The participants at times described an environment where the maintenance of the status quo was encouraged (Lauren 02, Kath 03).

> *So I'm just kind of keeping my mouth shut and keeping a low profile and getting on with my job.* (Kath 02)

By keeping their 'heads down', and being in a familiar physiotherapy-centred environment might be a reason why they felt safe in their professional role and perceived professionalism as 'knowing the job' (Linda 03) and they understood their role.

*4.8.1 CPD*

Table 4.4 indicates the use of CPD portfolios before the participants started work and then again after four and eight months. All the participants, except Lisa and Lauren, had an up to date portfolio before starting their first posts. Both May (01) and Linda (01) reported that their portfolios were a mechanism for filing their clinical assessment forms, in-service training notes and their research project. Only Georgina (01) had used her portfolio to reflect on experiences.

> *every placement I did positive experience and negative experience and I've reflected back on it and it's like, oh, how would I handle that*

*differently, I'd do this now. It's nice to look back on, because you think, how could I change that.* (Georgina 01)

All those who had completed their portfolios felt the incentive had been their job interviews (Nathan 01, Kath 01), and had been disappointed if their portfolio was not looked at during the interview (Nathan 01, Kath 01). They also expected to have time allocated to their seniors for discussing patients and any problems, to do some presentations themselves. They all recognised the need for CPD and most had their portfolio up to date. However, they were unsure if they would be encouraged to maintain a reflective practice portfolio once they entered the 'real' world.

They all expected to be given time to complete their portfolios, but after four months only three participants were given protected time and by eight months five participants were allocated protected time during the rotation. Only Linda (03) and Lisa (03) were consistently given protected time over their first year in employment. Table 4.5 shows there was an inconsistency even within Trusts about the allocation of CPD time. For example, on one rotation the participants found themselves with allocated CPD time and seniors checking the portfolio was completed, whereas on other rotations within the same hospital there was no time allocated for CPD and the participants were expected to fill in the portfolio when they had time or when they were at home (Kath 03, Lauren 03, Nathan 03, Philip 03, Lisa 03). However, for rotations where CPD was closely monitored (Lauren 03, Philip 02) the participants felt that if they did not keep their folders up to date 'that I'd be in some way chastised for that, maybe, because they were very hot, hot'

**Table 4.4 Participants' CPD Activity (blank indicates no response)**

| | CPD up to date before starting work | CPD up to date after 4 months | Given protected time for CPD | CPD up to date after 8 months | Given protected time for CPD |
|---|---|---|---|---|---|
| **Jake** | √ | | | | √ |
| **Philip** | √ | √ | √ | √ | |
| **Linda** | √ | √ | √ | √ | √ |
| **Georgina** | √ | | | √ | |
| **Lisa** | | √ | √ | √ | √ |
| **Nathan** | √ | | | √ | |
| **May** | √ | | | √ | √ |
| **Brian** | √ | | | √ | |
| **Lauren** | | | | √ | √ |
| **Kath** | √ | √ | | √ | |

(Philip 02). On other rotations the incentive to complete their portfolios was because they knew they would be expected to produce a completed portfolio at the end of the rotation (Nathan 03, Philip 02).

It is hardly surprisingly that there was also variation in the use of portfolios. Again some were using the portfolio as a filing system (Lauren 03, Linda 02, Kath 03) and others were completing reflective practice forms (Georgina 03, Lisa 03). Jake (03) admitted that he had been given a CPD folder when he started work, which was where 'all the information is bunged in there and it's not in any order and I haven't actually taken time to write it out' and therefore he felt he could not claim to be keeping his portfolio up to date. Both Jake (03) and Brian (03) perceived little value in the process as 'we're just doing it to prove that we actually are doing it' (Jake 03). The biggest barrier to completing their CPD portfolios was time (Nathan 02, Kath 02, May 02, Philip 03) although Lauren (03) felt she had received little guidance as to what to include in the portfolios, and reflective practice was the most difficult part to document (May 03). Whereas Lisa (02) was given time when 'we all sat down and did CPD things and one of the Senior IIs sort of was helping us'. Philip was given protected time on one rotation where 'at the end of in-service, there was meant to be a five minute protected time,but it was so hectic, that you'd feel guilty sitting there and doing it' (02).

*4.8.2 Research*

The influence of research in their first posts was perceived differently by the participants. All except Georgina, Lisa, Nathan and Brian expected to be involved in audits. Jake (01), May (01) and Georgina (01) expected to read articles which would inform their practice but not as much as when they were students. They also expected seniors to provide information about current research and all except Lisa, Nathan and Lauren were keen to help in supervisor's research projects if the opportunity arose. By the time they had

finished their first three rotations they were all reading journal articles. Predominantly these participants read *Physiotherapy* and only read other journals if their senior photocopied an article for them (Nathan 03). The main driver to read articles was for 'journal clubs' and presentations the participants were expected to prepare. Along with in-service training, this limited reading was their main source of evidence-based practice. None of the participants had found time to visit the hospital library. Only Georgina (02) had performed an on-line search from home when she had a patient with an unusual condition. Table 4.5 summarises participants' expectations and experiences of research in their first posts.

Jake found himself involved in some of the seniors' research projects. He had actively involved himself – he 'just roped himself in' (02). Jake was the only participant by the end of the first year who had not completed his CPD portfolio but he was the only participant who was actively involved in research beyond completing audits which focussed on service delivery. The other participants either felt they did not want to be involved in research, as expressed by Nathan

> *I just feel at the moment that I've got enough to do, just staying on top of what I've got to do and then trying to learn as much as I can without taking on extra work.* (03)

or that they needed more guidance before they could do any research (Philip 03).

**Table 4.5 Participants' expectations and experiences of research in their first posts**

| | Expectation of Research | Keen to help | Journal Club | Presentations | Involvement in research |
|---|---|---|---|---|---|
| **Jake** | Audit | √ | √ | | Senior research projects |
| **Philip** | Audit | √ | | √ | Audits |
| **Linda** | Audit | √ | √ | √ | Audits |
| **Georgina** | | √ | √ | √ | Audits |
| **Lisa** | | | √ | | Audits |
| **Nathan** | | | | √ | |
| **May** | Audit | √ | | | |
| **Brian** | | √ | | √ | |
| **Lauren** | Audit | | √ | | |
| **Kath** | Audit | √ | | √ | Audits |

In some Trusts there were some well known researchers in physiotherapy but the participants did not perceive themselves as 'worthy' enough (Lauren 03) to approach them or encouraged to find out more about their research (Philip 03, Linda 02). In one Trust physiotherapists with reputations for either national or international research or

even attendance at conferences led to a research focus within the physiotherapy department and the participant being involved in research (Jake 03).

Lauren and Philip had devised their own audit for a presentation they were required to do at the end of a rotation. For Lauren (02) it had been a frightening experience and she had been severely criticised by the senior in charge as the audit had exposed an area of poor practice. Philip (03) had yet to present his audit and he was struggling with the analysis and he felt he needed more support to complete the task.

As with CPD, time was mentioned as a barrier to research but there was also a perception that research was not the highest priority of the learning goals for the first year when compared with hands on physiotherapy skills as well as learning from experience (Brian 03, Kath 03, Nathan 03).

*4.8.3. Theory-Practice Gap*

Although none felt there was a huge difference between being a student and working in their first posts from a knowledge point of view, they all felt there had been a 'massive learning curve' (Philip 03) over the first year. As the year progressed the participants gained in confidence as their skills improved. They recognised how much they had learnt during their first year but they also felt they had been initially well prepared for their first posts and most perceived little or no gap between their knowledge at the end of their degree and what was expected of them at the beginning of their first posts.

The differences between being a student on clinical placements and being newly qualified for these participants were the increased levels of responsibility, staying longer in one speciality, and not being watched. The participants had different views about how much they were being expected to 'perform' for their supervisors when compared to being on clinical placements as students. Lisa (03) and Kath (03) both felt they had worked hard as students and therefore rotations 'were just an extension of that (placements)' Kath (03). Others (Nathan 03, Philip 02, Lauren 02, Jake 01, Brian 01) all felt that not being watched and assessed all the time was an important difference but they recognised that they did need to know when to ask for help. Both Lauren (02) and Brian (01) described this as having more freedom.

> *It's different, you know, its very different. Like I say, you're not out to impress anyone, you can do as little or as much as you want to do, whereas before in clinical placement, you kind of had to impress... Its just different, its funny, you feel much more independent, its not like there's always someone looking over your shoulder, so I prefer it.* (Jake 02)

However, even when the participants felt they were not being judged they did recognise there were times when they needed to 'play a game' (Philip 02) and 'play ball'. Some reported actively changing themselves to please their supervisors. This reflected tactics they had already developed whilst students (Georgina 02, Lisa 02.)

*You spend the whole time just trying to create what this physio, who was your supervisor, wanted you to be...You're programmed into a way of thinking by that physio and you have to literally backtrack yourself and go back.* (Georgina 02)

Two areas where the participants did find themselves consistently challenged and where there were differences from their student placements were their time management skills and levels of supervision. They noted differences in these between their placements and rotations. As previously discussed in section 4.7.3 this may be due to very tightly structured placements provided for students and therefore they are given little opportunity to manage their own time and begin to expect high levels of supervision. Sutton & Griffin (2004) reported that inflated expectations of first posts meant that expectations were often not met in the workplace. The implication, as identified by Clouder & Dally (2002), is that time management skills should also be included in academic modules towards the end of physiotherapy programmes.

*4.8.4 Summary*

Their development as a professional in their eyes relied heavily on their 'role' models. Based on their experience of their role models, they perceive their CPD as being a short-term means of recording achievement and research as being relevant only to their current professional practice.

The participants used different analogies to compare student life to working life. One compared it to 'riding a bike with and without stabilisers' (Brian 03), and another to 'swimming with and without arm bands' (Philip 03). These comparisons with learning in childhood and adolescence support the view of the participants who commented on how they had grown up or become an adult during their first year as a qualified physiotherapist. As Lauren and Lisa say

> *we're not babies any more.* (03)

**4.9 Theme 3: The Future**

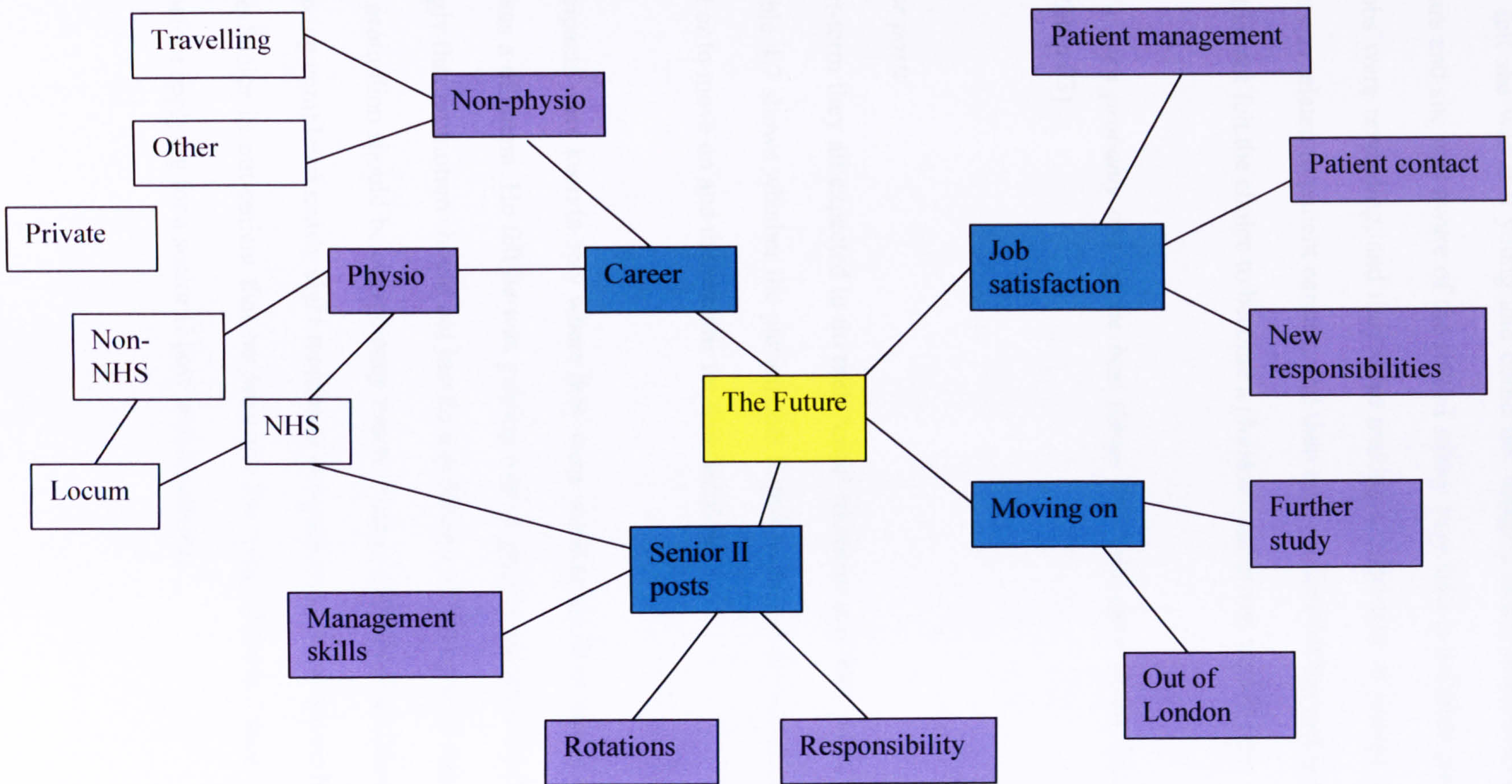
Figure 4.3 shows this theme, together with the associated categories, sub-categories and codes. Yellow denotes the theme, blue the categories and mauve the sub-categories and white the codes.

*4.9.1 Job satisfaction*

These newly qualified physiotherapists reported feeling satisfied with their jobs. All but one participant (Linda 03) felt they would continue to be a physiotherapist in the future.

> *what keeps me, I think it's the fact that it is so different and every case is something new.* (Jake 03)

Figure 4.3. The relationship between the 'Future' theme, the categories, the sub-categories and examples of codes



Linda (03) felt she was still young and could not imagine doing physiotherapy for the next 40 years and she was aware of the risk of injury may lead to a career change. They felt their jobs were rewarding, and they were making a difference to patient care. Their satisfaction was related to patient contact, and their new responsibilities and autonomy. A mature participant felt the choice to become a physiotherapist was a good one.

> *It's been probably one of the best things I've ever done in my life.*
> (Philip 03)

*4.9.2 Senior posts*

In the short-term they all expected to do their 'core' rotations and then move to a Senior II post. Table 4.7 shows whether the participants hoped to stay at the same Trust to do a senior post or to move on and the reasons for this decision.

Four participants were keen to stay where they were working for their senior post but for Jake this was a dilemma. He felt he was gaining lots of good experience but he also felt very strongly that promotion should not just be a reflection of 'doing your time' (02) as a junior but promotion should be competency based. Nathan (03) also had this experience. Despite having completed nearly eight months in out-patients (two rotations) he had been told by the Senior in out-patient that he must get his 'clinical hours' done in the core rotations before applying for a senior II post in out-patients.

Six participants perceived staying in their first posts to do all the available rotations, even if this took three years as in one case (Lauren 02). Some felt they should stay in the same Trust to do their senior II rotations, and others felt it was important to change Trusts when they moved into senior II posts to gain different experiences (see Table 4.7). Even at the end of this first year, some felt the pressure to move into senior posts, especially where there were long term vacancies at senior II level (Linda 03, Philip 03). Many perceived that there was a big gap between Senior II and the next levels of management (Georgina 02, Jake 03, Philip 03). In many cases the juniors felt close to their senior II

**Table 4.6 Participants' views on senior II posts**

| | **Stay in current Trust** | **Reasons for choice** |
|---|---|---|
| **Jake** | Yes | Good senior rotation, but would have to do 2 years as junior first. |
| **Philip** | Don't know | Not sure what he wanted to do. |
| **Linda** | Yes | Good atmosphere, 'my kind of people' (03) |
| **Georgina** | No | Wanted a different experience. |
| **Lisa** | Yes | If Out-patient/Orthopaedic rotation offered |
| **Nathan** | Yes | Static Senior II post in out-patients |
| **May** | No | Moving to new junior post, where hopefully she would do her senior posts |
| **Brian** | No | Wanted 'change of faces and environment' (03) |
| **Lauren** | Yes | Very friendly staff |
| **Kath** | Don't know | Wished to remain open minded |

and that there was a good working relationship, although they realised that the more senior a person became the more the need to develop management skills and accept responsibility. Due to lack of support for senior staff the participants saw senior posts as being very stressful.

> *I was managed by a Senior II, who was stressed out to the max, really, but she was a lovely person, a really, really, nice person.* (Philip 02)

The participants saw senior posts as taking on more responsibility, having more administration duties and being responsible for taking students and supporting juniors. Some (Georgina 03, Linda 03, Jake 03 and Philip 03) felt reluctant to take on these roles because it would mean less clinical contact time, and treating patients was frequently mentioned as the best part of the job.

*4.9.3 Non NHS work*

Right from the first interviews the majority of the participants did not expect to stay in the NHS and some spoke about private practice (Linda 01, 02, Brian 03, Philip 02, 03, Nathan 02), and others about travelling (Lauren 01, 03, Nathan 03, Brian 03, Lisa 02). Although they recognised the advantages of NHS work from a job security point of view (Philip 03, Georgina 02) , paid holidays (Lisa 02), maternity leave/flexible working (Lisa 02, Georgina 02), team work (Philip 02) and support (Philip 02), the attractions of private (better paid work) were still perceived as the way forward (Brian 03, Philip 03). One participant, however, admitted that 'deep down they would like to stay in the NHS'

(Philip 03) as it provided job security, structured training, and team work, but realistically the need to buy a property and the poor pay in the NHS would make private work inevitable.

> *I don't know, it's just pressures of finances, being totally honest, it's just I'm trying to buy somewhere at the moment and it's just, on what we earn, it's absolutely ludicrous.* (Philip 03)

One participant felt private work offered far more options than NHS work, however, he was particularly interested in one particular area of sport.

> *In the private setting, they've got everything to hand so much more easily. Because they're paying, they go straight to x-ray, MRI and the podiatrist is next door.* (Nathan 02)

There were differences in how the participants perceived locum work. This depended on how locums were treated by the department and Trust. Some locums became involved in the supervision of juniors, whilst others came to work to treat their patients and did not become involved in any 'extras'. All participants, except May 03 and Kath 03, considered locum work as an option for the future, especially in Trusts where the locums were treated as a full member of staff and in one place a locum had been in post for over two years.

*Locums here have been here for two years...I think they're particularly lucky here, because the locums here get treated so well. I'd feel sometimes as a student that the locums were there as a slave and they were there to wheel out patient after patient after patient. Here they get training, in service, you know, they get tea breaks, coffee breaks and they have very flexible hours. Literally the hours are worked for the train times, which is very good. Most places say, get up at 6.30 in the morning. Here it's like start when your train comes in, but I think they're particularly lucky here, they are very friendly.* (Georgina 02)

When the locums were approachable then the juniors felt they could ask for help. When help was on offer from locums the quality of the support was generally excellent, although the juniors remained wary of asking because 'some locums get a bit funny about that' (Georgina 02). Other participants had other experiences of locums and felt they were 'worse than useless' (Lisa 02), and in one case (May 02) relied on the physiotherapy assistant to run the ward rather than the locum.

Therefore most of the participants perceived a locum post as a way of making more money but only to be considered once they felt confident of their abilities and therefore able to work with little support.

There was a sense of hope that *Agenda for Change* (DOH, 2003) would alter the situation and they would be rewarded for hard work and not just the hours worked (Jake 02). If this

happened they felt there would be more of an incentive to stay in the NHS. One participant spoke with bitterness about how it was expected that they would have to complete a certain amount of time as a junior before they could apply for Senior posts. He felt this was unfair as their development as a professional was not taken into account and some may have the skill for a senior post before others (Jake 02).

There was a perception that moving out of London was the only way to afford housing and a different life style. Many recognised the benefits of living in London, whilst younger, but some reflected that as they took on senior posts and settled down they would need to move further out, or become a locum to make more money (Philip 03, Linda 03). However, for Lauren she was

> *enjoying it, I'm 21 and I don't need to worry about money, I've got enough to have fun.* (02)

Three participants (Philip 02, Nathan 03, Lauren 01) spoke about the possibilities of undertaking a Masters course or PhD in the future, but two of them (Nathan 03 & Lauren 01) wished to combine this with travel and therefore study, for example, in Australia.

*4.9.4 Summary of the Future Theme*

Like in Schwerter et al. (1987) overall the participants were happy although to remain happy they recognised that they needed to continue to be challenged and inspired by

patients and colleagues. With one exception, all could see themselves remaining physiotherapists, but not necessarily in London or within the NHS, or even in this country.

Before they started work the participants were very open minded about the future, there were no definite plans, and even at the end of this research they still were open minded. They recognised their need to complete the 'core' rotations before they applied for senior posts. They realised there were many options available to them in the future and as yet they had generally not made any choices.

### 4.10 Summary of the Expectations and Experiences of These Newly Qualified Physiotherapists

All the participants felt their expectations of their first posts had been either fully or partially met. For Lisa (03) her first post had exceeded expectations and she found herself in a job where she enjoyed working, found it rewarding and stretched her both mentally and physically. Lisa (03), Georgina (03) and Lauren (03) all recognised that there were 'up and downs' to the job, and that sometimes all their expectations were not met, but they were all very happy in their first posts. Both Nathan (02) and Jake (03) admitted they had had doubts about their future as physiotherapists whilst they were students but now they were settled in their jobs and 'I can't imagine myself doing anything else' (Jake 03). The expectations that had not been met were those relating to support (May 03, Philip 02). When support was lacking it had led to considerable stress and worry.

Overall these participants were happy with their first posts. However, their experience was very profession specific and with changes in the NHS some of the areas identified by the participants as being weak need to be addressed if future newly qualified physiotherapists are going to cope in a working environment with less support from seniors and in posts which may not rotate or even be within the confines of an acute Trust.

> *I just didn't realise the amount of job satisfaction you would get out of it, when I first signed up to do physio...I never realised the difference you make to people's lives.* Philip 03

These participants felt they had 'grown up' over their first year as a qualified physiotherapists. They were 'transformed' from student to physiotherapists, this process was linked to changes a person goes through when moving from child to adulthood. This socialisation process will be discussed in the next chapter. This chapter has detailed the analysis of the data and the development of the themes. Each theme has been described and summarised. The next chapter discusses the analysis in relation to the literature.

# CHAPTER FIVE

# THE DISCUSSION

## 5.1 Introduction

The previous chapter presented the results and analysis. In this chapter the analysis is discussed in relation to the literature relevant to the experience of newly qualified physiotherapists first year of work. This chapter not only draws upon peer-reviewed papers but also literature published by the CSP, as such information provides a resource for those working both in the clinical and academic environment.

The analysis had aimed to code the data from the concepts within the transcripts to account for what each participant had said about a concept. From the codes the data, subcategories and categories emerged, which eventually formed the themes. Within any theme there is a range of experience which is typified by verbatim quotes presented in chapter four.

This chapter aims to develop a theoretical framework of the experience of the first year post qualification for these participants and discuss this in relation to the literature reviewed in chapter two and other literature reviewed once the themes emerged. The data collection and subsequent analysis was co-constructed by all participants, including the researcher, and the themes help to make sense of the first year qualification. The participants told their stories. The emergent theoretical framework will extend and

contribute to the limited research in this area. The framework will not only illuminate inadequacies in the undergraduate programme and the working environment but will also highlight good practice. From this key implications will be drawn which will inform practice.

The three main themes were:

'Doing the job'

'Becoming a professional'

'The future'.

The experience of these newly qualified physiotherapists during their first year of employment will now be discussed. This section concludes with a discussion about how these participants constructed their professional identity which is based on the emergent themes and what this meant to these participants to be a professional physiotherapist. From the discussion it will be seen that these newly qualified physiotherapists predominantly experienced an apprenticeship model of socialisation to the workplace. Although these graduates were equipped with professional skills to challenge, for example, the current practice of prevailing culture was strong and these graduates learnt to conform to the demands made by their supervisors, peers and the predominately dominant physiotherapy culture in which they worked.

## 5.2 The Experience

The story for these participants begins with their expectations of their first post. These expectations were based on their reasons for applying for the post and their experiences of the interview (see section 4.6.1 and 4.6.2). These findings are different from the work of Warrinder & Walker (1996). These participants reported location as being the most important factor in choice of their first post, whereas Warrinder & Walker (1996) reported attitudes of potential supervisors as being the most important factor with location only rated sixth as a factor. Clinical experience as a student was not given as a factor influencing choice and reputation of the hospital was rated last of the factors presented by Warrinder & Walker (1996). In occupational therapy researchers such as COT (1995), Atkinson & Steward (1999), Lee & Mackenzie (2003) all reported location as being an important factor in choice of first posts. Previous clinical experience was also reported as an influence by Atkinson & Steward (1999) and Lee & Mackenzie (2003). However, with the recent changes (Hunt, 2004) in the job market for newly qualified physiotherapists, and probably occupational therapists, all these reported influences may have changed and the most important influence on choice of first post may now be availability of work. The NHS pay the training fees for the majority of students in the UK. The students therefore had an expectation that they would find work in the NHS. This expectation was not met in 2005 and Thornton & Beeton (2006) argued that the 'psychological' contact between the student and the NHS had been broken. There now need to be strategies for the NHS and universities to support these newly qualified unemployed physiotherapists so that they will be able to enter the workforce when and if jobs become available.

The variation in the process of interviews for newly qualified physiotherapists is becoming an issue for the profession. At meetings within the London region with managers and HEI's the issue of competency of newly qualified physiotherapists was raised (Masters, 2004). Although the graduate physiotherapist is now accepted in the workplace their profession specific skills have been questioned (Roskell et al., 1997, Hunt et al., 1998b). Employers of newly qualified physiotherapists question the level of clinical/profession specific skills. Therefore at interview it is deemed necessary to ask questions which 'check' these skills. These concerns could be due to a 'theory-practice gap', as discussed in Chapter two (section 2.5.2). Work by Thornton (2006) aimed at exploring the selection and interview process with clinical managers has highlighted the issue of differences in styles and processes of recruiting new juniors.

If questions are being used at interview to assess competency, rather than to assess which interviewee is the best candidate, then there are issues that need to be addressed by universities, professional and statutory bodies. All physiotherapy programmes in this country at this time were approved by a university, the CSP and HPC. *The Curriculum Framework for Qualifying Programmes in Physiotherapy* (CSP, 2002), the *Standards of Proficiency* and the *Standards of Education and Training* (HPC, 2003) all expect the newly qualified physiotherapist to be a competent practitioner on completion of the programme. Although there will be differences in graduates from different programmes, a competency level must be achieved. Managers were involved in the development of both frameworks, but if they are now questioning the competence of newly qualified practitioners in relation to this framework then the frameworks either need reviewing or

the methods used to assess approval of programmes need to be re-assessed. If there is mismatch then this might be due to a 'theory-practice gap' based on the generic skills as emphasised in the academic modules in the university-based part of programmes and the more profession specific skills expected in clinical practice (section 4.8.3).This questioning of physiotherapy specific skills may also reflect the dominant physiotherapy culture in the workplace, where rather than being encouraged to be an 'interactional' physiotherapist (Higgs & Hunt, 1999) or even a 'reflective practitioner' (Schön, 1987) these newly qualified physiotherapists were seen as apprentices.

The participants all had hopes and fears for their first posts. The fear of making mistakes has previously been identified by Harris & Naylor (1992), Walker & Naylor (1991), Leonard & Corr (1998) and Lee & MacKenzie (2003). Lee & Mackenzie (2003) identified that this fear arose from low self-esteem in their clinical skills and an awareness in a gap in their clinical knowledge. Although participants realised they had a lot to learn they valued the skills they had acquired as students. These newly qualified physiotherapists seemed to be expecting skills to be either added to their repertoire or refined to achieve competency.

Tryssenaar & Perkin (2001) also identified this element of self-doubt early in the first year of practice. In their research as the year progressed they demonstrated less self pre-occupation and a shift to more concern about the patients' welfare. Although periods of self-doubt were evident within this study, the shift to patient-centred concerns cannot be

identified. Throughout all the interviews the participants were concerned with patient care and successes led to job satisfaction. For example,

> *I like meeting the patients and getting involved in their care and helping them to achieve what they want to achieve. I like helping them to be able to get home, especially elderly patients. It's such an achievement when you get an elderly patient back home, I love that.* (Linda 01)

> *Rehab patients up in ITU, I would say were some of my best experiences, getting people out of bed and sort of doing more active rehab, when you're getting to that stage and the patients are so pleased with their progress.* (Kath 02)

These findings from this study are similar to research by Tryssenaar & Perkins (2001). They reported a stage of 'great expectations' which occurred towards the end of the last placement and the beginning of the first post.

The rotational structure experienced by these newly qualified physiotherapists was an important influence on their first year of work (section 4.5.3). This was the main influence on 'doing the job' and it placed these newly qualified physiotherapists firmly in a environment which valued profession specific skills. Both Atkinson & Steward (1997)

and Masters (2004) stated that there is a belief within occupational therapy and physiotherapy that newly qualified physiotherapists need experience in 'core' acute hospital settings before they work in the community. However, with the current crisis in junior posts and the vacancies in community posts, the profession is having to address the issue of rotational posts and work in the community (Masters, 2004, Limb, 2006, Hobden, 2006). The development of non-rotational posts, which will allow 'fast-tracking of juniors into senior posts, may be a solution (Masters, 2004, Limb, 2006). However, if non rotational posts are only developed in the 'core' rotations, they may be perceived as rotations where newly qualified physiotherapists who already know where they want to specialise (Limb, 2006), and then community rotations may still have recruitment problems, as many students will not have had an experience of a community rotation.

When these participants first joined the workplace few experienced an induction process and some experienced a modified induction process when they changed rotations (section 4.7.3.1). This may be due to the fact that the graduates will have all completed at least 1,000 hours in the workplace during their clinical education modules as undergraduates and that rotations are perceived as a continuation of undergraduate practice. As previously reviewed in Chapter two numerous authors have recommended that realistic information should be provided by employers for newly qualified staff before they start their job (Warrinder & Walker, 1996) and that induction programmes should be provided for newly qualified therapists (Parker, 1991, Hummell & Kolmeyer, 1999). The CSP (2003) recommended

> an induction programme to include access to departmental polices, visits to rotation areas as appropriate, introductions to key members of staff of own and other professions, individual objective settings, access to CSP and local standards. (p.5)

However, the evidence from the participants in this study suggests that the induction process varies considerably from Trust to Trust, and in some places may have been rather neglected as was also found by Flemming & Tullis (1996). The COT (1991, cited in Flemming & Tullis, 1996) extended the concept of induction as not just being for newly qualified staff but for all levels of occupational therapists. Parker (1991) recommended that induction programmes should be perceived as development programmes which may extend over many months, rather than one or two days at the beginning of a therapist's career. This approach could be linked with the CSP required for objective setting and the requirements of appraisal.

Only two participants had received any information, beyond contracts, before they started. Lack of information before starting work was also reported by Clouder & Dalley (2000). This may have led to some of the fears experienced by the participants. This is in contrast to their experiences of student placements where detailed information is provided prior to their start date (Fleming & Tullis, 1996). As students, these participants were used to negotiating their own learning contracts, and vocalising their expectations. This process should be continued into their first posts and beyond to encourage reflective

practice and potentially give the newly qualified therapist a voice within the organisation in which they work.

Gibbs (2002) argued that when money is spent on a new piece of equipment then money is also spent on maintenance and training for the staff using it. Conversely when money is spent on recruiting new staff very little is spent on supporting and maintaining (retaining) new staff within the hospital during their early employment which may lead to additional stress for the new employee. Gibbs (2002) therefore recommended that not only should the new employee have an induction programme which includes a general introduction to the hospital (generally organised by Human Resources) but also a more specific programme, which requires input from managers of departments to create an induction programme tailored to the needs of the individual. Flemming & Tullis (1996) suggested that induction in occupational therapy was neglected and it was seen as a job for Human Resources. Also the rapidly changing workplace of the NHS there needs to be induction into the whole NHS. Combining wider issues with the specific needs of the individual, the rotation and the physiotherapy department may help newly qualified physiotherapists develop as 'interactional' practitioners (Higgs & Hunt, 1999).

Flemming & Tullis (1996) also argued that induction should not only be for new staff, but be also available for any member of staff going through a transition period, for example when rotating through specialities or promotion and therefore should be part of CPD. This long-term view of induction reflects the view of Parker (1991) and if such a process was tailored to the needs of the individual there might be less disillusionment with the

profession and the attrition rate would fall (Bailey, 1990). An 'unseen' effect of early career attrition from the profession will be the lack of juniors moving into senior posts and fewer senior staff able to support newly qualified therapists, thereby perpetuating the cycle and leading to more disillusioned staff.

For newly qualified teachers there are Career entry and development profiles (CEDP).The profile supports statutory induction arrangements.

> The CEDP helps your initial teacher training (ITT) provider prepare you for an active role in your induction period. It will help your school to understand your strengths and experiences by the end of ITT, and support dialogue between Newly Qualified Teachers and induction tutors (TDA, 2007).

The profile supports the newly qualified teacher through their first year of teaching. The emphasis is on professional development. Initially a tutor from the ITT provider facilitates the students to, for example, identify their strengths and weaknesses. The newly qualified teacher takes their CEDP to their first job and shares it with their induction tutor. An induction plan and objectives are then developed and regularly reviewed during the first year of work (TDA, 2007). Although there are similarities to appraisal and CPD portfolios there is an importance difference in that the specific needs

of a newly qualified professional are identified and supported in the workplace. The newly qualified teacher is expected to take an active role in the process.

Part of the experience of learning 'to do the job' was the management of their workload and the development of their time management skills. Covic et al. (2003) identified poor time management skills as being an issue for graduates from a Health Science Faculty in Australia. They argued that due to the increased workload, decreased funding, increased knowledge base and accountability a health professional needed "to acquire excellent time-management skills to perform their duties efficiently" (p.47). Adamson et al., (1996) identified good time management skills as being very important for newly qualified occupational therapists. From the participants' first interviews time management skills were not identified by them as a particular issue. This may be because students are very closely supervised when on placement and particularly on out-patients placements their workload is planned by their clinical educator. As recommended by Rugg (1999b & 2003) there is clearly a need for physiotherapy educators and supervisors to review the amount of close supervision given to students, especially in year three placements, to more accurately reflect the level of supervision in their first posts.

Kenyon & Illott, (1997), Clouder & Dalley, (2003) and Lopopolo et al. (2004) identified good stress and time management skills as being important for newly qualified therapists. Adamson et al. (2001) argued that newly qualified therapists did not need courses to facilitate these skills but more guidance from their supervisors to help develop such skills. Leonard & Corr (1998) identified three main stressors (professional,

organisational and patient contact). The participants in this study identified similar stressors, for example a patient contact stressor was the fear of making mistakes which was also identified by Parker (1991), Harris & Naylor (1992) and Walker & Naylor (1991). What was crucial was that when expectations were not met stress was increased (Scutter & Gould, 1995). What emerges from this is the importance of student clinical placements providing a realistic working environment rather than an overprotected, over supervised placement. Although students will need more support it must be made clear that this level of support will not continue once qualified and in final clinical placements the students should be given more responsibility and less support.

In order to develop their physiotherapy skills they relied on support from their seniors and fellow juniors. At times this was a rewarding process but at others it was perceived as constraining and the participants felt they had to conform to the prevailing expectations of the seniors and other staff. Sweeney et al. (2001a) suggested

> that supervisors can collude with the supervisee at some unspoken level to engage in behaviours that minimise the anxiety for either or both parties (p.338).

Various authors have highlighted the lack of research on clinical supervision (Hunter & Blair, 1999, Mason, 1998, Sweeney et al., 2001a). The CSP stated

> While physiotherapists are undoubtedly using what equates to clinical supervision on an informal basis, research shows that the majority of physiotherapists are unaware of what formal clinical supervision is and how it can support them in practice (CSP, 2005c, p.3).

It may be that the supervision of students model is so firmly embedded in physiotherapy practice, as suggested by Sweeney et al. (2001c) for occupational therapy, that this model has been applied to post-graduate rotations without considering the different needs of graduates. Sweeney et al. (2001c) stated that

> there is some evidence that occupational therapy may have adopted supervision without adequate attention to the costs involved in the process, in terms of training, time, commitment and emotional consequences...many occupational therapists have adopted a 'formalised' front-line management approach to supervision, without adequate attention to the theoretical background and training implications inherent in the successful operation of the process (p.427).

The same could be said of physiotherapy. A search of the literature revealed only articles related to student supervision, for example Baldrey-Currens & Bithell (2000), and only one information paper on mentoring, which was specifically related to CPD (CSP 2005d). It is important that physiotherapists consider the implications of supervision because as

Sweeney at al. (2001c) suggested, "supervision, as it is currently practised in occupational therapy, can be damaging in terms of the individual's morale and can weaken the relationship between both parties" (p.427).

Within the literature, and probably within the profession, there is some confusion over exactly what supervision is. Mason (1998) suggested that in occupational therapy supervision is often misunderstood. However, she also suggested that mentoring is part of supervision, which the CSP (2005c) clearly states is not the case. Hunter & Blair (1999) described the essential components in supervision as being support and challenge, a supervision contract (written and reviewed regularly), training in supervision (for both parties) and review and feedback (the responsibility of both parties). The process of supervision is collaborative (CSP 2005c). Good supervision can lead to:

- Job satisfaction (COT 1995);
- Provision of a higher quality service (Leonard & Corr, 1998, Hummell & Koelmeyer, 1999, Hunter & Blair, 1999);
- Development of professional identity (Bailey, 1990, Lee & MacKenzie, 2003, Steenbergen & MacKenzie, 2004);
- Improved retention of staff (Rugg, 1999b);
- Development of professional skills (CSP, 2005c).

Sweeney et al. (2001b) found that supervisees' expectations were often not met in practice. Participants in this study also had similar experiences (Kath 01, 02, 03, Linda

01, 03, May 01, 02, Philip 01, 02). This may be due to their supervisors being also their line managers and perhaps the participants' expectations of having a mentor rather than a supervisor. In Sweeney et al.'s (2001b) study the mismatch in expectations meant that the newly qualified occupational therapists adopted strategies to present a professional face to the supervisor and limit any disclosure of weaknesses. The participants in this study also adopted such strategies. Hunter & Blair (1999) reported on the supervision of occupational therapists and identified issues relating to the aims and process of supervision. They perceived supervision as hierarchical, including establishing lines of accountability, and developing competence. Similarly Sweeney et al. (2001a) described supervision as directly linked to the professional expertise of the supervisor.

Sweeney et al. (2001a) supported the view, which might also be found in physiotherapy, that an expert clinician means they are also an expert supervisor. Much the same as an expert researcher meant an expert lecturer, a view which prevailed in universities until Dearing (1997). Since then universities have introduced training in education for new lecturers. The CSP have only a non compulsory accreditation scheme for clinical education (CSP, 2004b) so nothing exists for supervisors of juniors, who will also supervise students. Therefore the model for supervision of students may be applied without fully considering the issues, as discussed above (page 196). Parker (1991) supported the view that supervisors of newly qualified staff need specific training and support.

Cusick et al. (2004) conducted action research within an occupational therapy department in Australia. This led to the development of more streamlined arrangements for supervision alongside a new protocol for supervision of newly qualified staff. Such an approach could be developed in this country to emphasise the role and process of supervision.

In their study Sweeney et al. (2001b) found that the supervisee wanted 'a positive and directive supervisor' (p.382), who would clearly facilitate their professional development and monitor their progress. This formal, very structured teacher-led approach was highly valued by the supervisees, but was one not provided very often by the supervisors. The supervisors preferred to adopt an egalitarian approach to supervision, where the supervisee was expected to lead the process, to request help when required (Sweeney et al., 2001a). This mismatch between supervisor and supervisee expectations led to the development of coping strategies by both parties particularly if the supervisor was a line manager and responsible for appraisal and writing references for the supervisee.

Both May (03) and Philip (02) perceived that some of the seniors were experiencing high levels of stress and in May's case she avoided confrontation even when she was having problems because she did not want to add to the stress levels of her supervisors.

Other health professions have adopted a mentoring process for newly qualified staff (Wilding & Marais-Strydom, 2002), whereas physiotherapy has adopted a supervisory approach. Dancer (2003) described a mentor as a 'coach, facilitator, sounding board,

critical friend, net-worker and connector and role model" (p.22). The participants in this study found the level of support varied each time they changed rotation or when somebody returned or left the rotation. In order to facilitate the transition into the workplace, for these participants, it may have been more appropriate to not only identify a supervisor who would provide expert supervision on the rotation but also identify a mentor, for at least the first year, who would remain constant even though the rotations would change. A mentor is not line manager or supervisor and not necessarily from the same profession but somebody who has more expertise and experience (CSP, 2005d, Cole, 2003).

Although there are many potential problems with such a system, there would be advantages. If an interprofessional mentor scheme was developed then newly qualified staff may not be mentored by somebody from their own profession. This would have the advantage of widening the socialisation process for the newly qualified physiotherapist and the possibility of understanding broader issues with the organisation. Such a mentoring scheme would need to be clearly defined, as there is much confusion over the role of the mentor and mentee, and the aims of such a scheme (Dancer, 2003). For example, "it is the mentee and not the mentor who makes decisions, and that the practice is non-judgemental and completely open, based on mutual respect and confidentiality" (Dancer, 2003, p.22). Other authors (Wilding and Marais-Strydom, 2002) support the view that mentoring should be non-judgemental and that mentoring is a two-way process (CSP, 2005d, Cole, 2003).

To implement a mentoring scheme time and money would be required. Such a scheme would need to be evaluated in order to assess its benefits to the NHS. A scheme may be more than just within one hospital, it could be Trust-wide or even between different Trusts. In Australia a mentoring scheme for occupational therapists has been successfully developed and evaluated (Wilding & Marais-Strydom, 2002). This scheme was "to support, empower and provide CPD" (p.224) for both the mentor and mentee. The programme was web-based with the occupational therapists accessing it from their computers at work or at home. Good support can be provided by telephone or email as described by Lee & MacKenzie (2003).

The CSP recommend mentoring in relation to CPD (CSP, 2005d). They state that a mentor should not have a judgemental role and "ideally, the mentor is not a formal supervisor or line manager in the workplace" (p.3). Participants in this study reported support coming from their supervisor, colleagues and peers but there is no mention of a specific mentor to help them develop their CPD or consider issues beyond the rotation. The CSP (2005d) does recognise that some Trusts run mentoring schemes but this was not the experience for these participants.

It may also be appropriate to consider a mentoring system for undergraduates, where, for example, third year students would mentor second year students. A development of such a system would be for a newly qualified physiotherapist to mentor a third year student.

What is apparent from this research is the variability of support available on rotations. All had experienced rotations with some excellent support and all except Jake had experienced poor levels of support from their supervisors. All the participants were supervised by physiotherapists. Uniprofessional support might lead to a very narrow view of their working environment and although it will mean profession specific skills are developed, generic professional skills may be neglected. Although support is important for newly qualified physiotherapists (Wilde, 2005), it may be more appropriate to provide a non-physiotherapy source of support. If newly qualified physiotherapists only receive uniprofessional support the apprenticeship model of socialisation will continue to be reinforced.

Along side the theme of 'doing the job', coping with working in a environment heavily influenced by physiotherapy techniques and culture, was the 'becoming a professional' theme (section 4.8). Their role models in this process were senior physiotherapy staff. However, unlike studies reported in the occupational therapy literature (Bailey, 1990, Parker, 1991, Rugg, 1999b, Lee & MacKenzie, 2003, Steenbergen & MacKenzie, 2003) these newly qualified physiotherapists seemed to have few concerns about their professional identity. They recognised that part of their professional development included reflective practice but the development of their CPD portfolios was a reflective of the working environment and reactive to situations rather than proactive in the planning of their future learning and professional development.

The Health Act (1999) required all Health Care Professionals to document CPD so that they could demonstrate up to date competent practice (DOH, 1999, Alsop, 2002, Warne, 2002, O'Sullivan, 2004). The HPC was made responsible for monitoring CPD. However, the details of how this will be monitored have only recently become clear and from summer 2008 health professionals will have to provide evidence of CPD relating to their previous two years of practice, although physiotherapists will not be audited until 2010 (HPC, 2006). The evidence for physiotherapists will be in the form of the CSP portfolio (CSP, 2005a). The potential for monitoring by the HPC has driven therapists to complete their portfolio but Warne (2002) suggested that physiotherapists also need to rely on "their sense of pride, professional identity and overall well being" to provide their "intrinsic reward" (p.223) to motivate them to complete their portfolio.

The participants in this study perceive their portfolio as a means of documenting what they have done, rather than planning for the future, as suggested by Alsop (2002). This may be because the participants perceive CPD as being about competency. The CSP have adopted an outcomes based model with the evidence of CPD presented in a portfolio (CSP, 2005a). Although this evidence is required for the HPC, there seems to be little evidence from the participants that they are planning and documenting their future learning. Rather they perceived a beautiful, well organised portfolio reflecting what they had done, as the most important outcome of their portfolio. The content was either about their reflective practice sheets or attendance at courses. Eraut (1994) stated that competence was only one part of a professional's role. Atkinson & Steward (1997)

suggested that CPD should not just be led by immediate needs but be part of a long-term development plan. A mentor can facilitate this process (Harrison & Hong, 2004).

In Australia CPD has been linked to mentoring programmes (Wilding & Marais-Strydom, 2002). Wilding & Marais-Strydom (2002) suggested that mentoring was not only a valuable CPD activity for the mentee but also the mentor as both participants "grow through sharing in the mentoring process" (p.225). The importance of mentoring is also reinforced by occupational therapists involved in mentoring being able to claim CDP points which count in the national accreditation programme. CPD was seen as an individual activity most of the time by these participants, which led to isolation and feeling unsupported but a mentoring scheme could enhance the experience for both mentee and mentor (Cole, 2003). The CSP perceive CPD as being an integral part of practice, as does occupational therapists (Harrison & Hong 2004), and the CSP recommend, a half day per month protected time (CSP, 2005e). Table 4.5 demonstrates that this is not always achieved in practice and varies between rotations, as only three participants (Philip, Linda and Lisa) had protected CPD time at the time of the second interview. This had risen to five (Jake, Linda, Lisa, May and Lauren) by the third interview

As already identified (see page 198) there is some confusion over the roles of supervisor and mentor. Harrison & Hong (2004) called for a clear definition of the roles of manager, supervisor and mentor. Newly qualified staff may have to deal with people in all three of these roles which can be confusing.

The CSP does provide information for newly qualified physiotherapists about CPD (CSP, 2005a, 2005b). The CPD portfolio is issued to all undergraduate physiotherapists in the first year of their course. The CSP requires

> CSP members in all practice settings must maintain a portfolio of learning activities as evidence of their CPD which demonstrates what activities have been undertaken, evaluates what has been learned from them and reviews how learning has impacted on practice (2005b, p.3).

Although CPD is relatively new term (O'Sullivan, 2004) in practice physiotherapists have been doing it for many years, it is the process of documenting the evidence which has been slowly accepted as part of professional practice (Warne, 2002). This may be due to lack of time (Metcalfe et al., 2001) or reluctance by physiotherapists to have their practice scrutinised (Warne, 2002). For these participants lack of protected time limited their ability to complete their portfolios.

In occupational therapy some of the literature claims that recruitment and retention are positively influenced by CPD opportunities (Rugg, 1999b, Alsop, 2002, Hunter & Nicol, 2002). However, a systematic review of the relevant literature of the influence of CPD on recruitment and retention found little evidence of any influence. The limited evidence that was reviewed found that personal and professional issues had a bigger influence on recruitment and retention (Hunter & Nicol, 2002).

Although these participants recognised a 'good knowledge base' as being part of being a professional, the development of their own knowledge base was generally limited to professional craft and personal knowledge, rather than propositional, scientific and theoretical knowledge (Higgs & Titchen, 2001). The CSP *Curriculum Framework for Qualifying Programmes in Physiotherapy* (2002) lists research skills as being part of the outcome measures for newly qualified physiotherapists. These participants were taught research skills as part of their undergraduate programme and all had successfully submitted a 10,000 word dissertation. Despite this these participants were not encouraged to develop their research skills in their first year of work. The focus for skills development was their profession specific skills rather than their research skills. When Lauren (02) presented the findings of an audit that exposed an area of poor practice she was severely criticised. Schwerter et al. (1987), Connolly et al. (2001) and Wiles et al. (1999 cited in Barnitt & Salmond 2000). McCluskey (2004) reported graduates as having no time for implementing research into practice. Most of the participants attended journal clubs but there is no evidence that any of them implemented any of the research reviewed into their practice. Newly qualified staff had little time for reflective practice and their skills in evaluating and implementing new practice were seen as a threat to current practice. In such cases newly qualified staff conformed and reverted to established procedure. Barnitt (2000) and McCluskey (2004) concluded that graduate skills were very difficult to use in the busy clinical environment.

Although it is recognised that newly qualified physiotherapists will not have the skills to lead research projects (CSP, 2004a), it is vital that newly qualified physiotherapists base their practice on appropriate evidence as the CSP claimed

> Physiotherapy is a profession with a strong scientific basis, which is committed to excellence in patient care through utilising the best available evidence in its practice. (2004a, p.3).

For this to happen newly qualified physiotherapists need to be encouraged to use their research skills in the clinical environment, not just be rewarded for following established practice and not 'rocking the boat'. They need to read more widely than *Physiotherapy* and be actively encouraged by more established members of staff to become involved in research. Active researchers within departments need to support and develop the research skills of the newly qualified so they feel competent to change practice (Clemence, 1998). Such an approach would lead to a positive attitude towards research within departments (Morris, 2003). Clemence (1998) states there is "a recognised cultural divide between researchers, clinicians, and managers" (p.258) which has led to a 'research-practice gap'. If universities were more actively involved in supporting their newly qualified physiotherapists in their first posts and offered support for development of research skills in the clinical environment then stronger links could be developed between all relevant groups, thereby changing the view that there are two distinct career pathways for physiotherapists – research or clinician (Baxter, 2002, Moore, 1997). Grimmer et al.

(2004) support much closer collaboration between clinicians and researchers to produce more relevant research.

These participants did not perceive a large gap between theory and practice as their rotations in many aspects closely reflected their student placements (Wheeler et al, 2002). On both they were encouraged to concentrate on profession specific skills. This could be seen as a way of maintaining the 'status quo' within the profession, for example, for many years there has been an all graduate entry to the profession, and yet these participants were not expecting or expected by others to use their research skills. These expectations are fostered from their first visit to clinical placements as students. Although the universities are charged with providing the NHS with graduates who can 'engage in research' (CSP, 2002, p.24), these values seem not to be valued in the clinical environment where the emphasis lies on treating as many patients as possible within the limited resources. This could be identified as a 'theory-practice gap' but because research skills are not valued highly on clinical placements then the gap becomes hidden to the student and the newly qualified physiotherapist.

Some authors have reported a 'theory-practice gap' (Richardson, 1999, Rugg, 1994, 1999b, 2002, Tryssenaar & Perkins, 2001). Potter (2001) claims this gap is due to unrealistic expectations of newly qualified physiotherapist, which are based on their experiences of undergraduate clinical education. Others (Hunt et al., 1998b, Potts 1996) write about the changing workplace physiotherapy graduates find, and will continue to find, themselves in and most charge the universities with providing programmes of study

which will give the graduates the generic skills for developing as practitioners within this ever changing system. These generic skills have a close relationship with the QAA outcomes for any undergraduate programme (QAA, 2001a). There is though a conflict/tension between generic needs and profession specific needs as experienced by the newly qualified physiotherapists in their first post. The challenge now is to find strong role models in clinical practice, who conduct and value research in their day to day management of patients. These role models need not only to help in the supervision of students and newly qualified staff but also to provide mentorship to encourage the development of research skills. Role models need to encourage autonomous practice and create a culture where newly qualified physiotherapists are encouraged to challenge practice and integrate skills within their own professional practice.

Inevitably towards the end of a rotation and towards the end of the first year, in the final part of this story the participants considered their future and reflected on their experience of their first physiotherapy post. These newly qualified physiotherapists were happy in their first posts. They all enjoyed coming to work and they reported that they were satisfied with their jobs. However, as also reported by Warrinder & Walker (1996) they were focused on their short-term career development rather than long-terms issues, such as promotion.

There was a perception that senior posts were stressful because of the lack of support available when promoting staff. Fleming & Tullis (1996) suggested that staff undergoing promotion have induction needs, and these needs are frequently not considered when staff

are promoted into more senior posts. Mentoring for newly qualified staff has already been discussed (see page 193). If newly qualified physiotherapists feel there is more support for seniors then they might be encouraged to participate in 'fast-tracking' schemes, as suggested by Masters (2004), and not complete all their rotations. These participants also felt that if they were to move on into more senior posts they would need support and training in non-physiotherapeutic skills areas.

These newly qualified physiotherapists clearly understood their role and enjoyed this role

> You feel you are central, key. You aren't the most important person on the team, but you're part of the team pulling together, you know, so it's quite nice because you're valued in what you (Jake 03).

This perceived understanding of their job and their value within the team is different from the experiences of newly qualified occupational therapists (Bailey, 1990, Parker, 1991, Rugg, 1999b, Lee & MacKenzie, 2002, Steenbergen & MacKenzie, 2003). These newly qualified physiotherapists did not question their professional identity. They constructed their identity from their role models, senior physiotherapists and the dominant culture they found themselves in. The issue for these newly qualified physiotherapists was one of their developing the confidence and their knowledge of when physiotherapy was not appropriate and that they could not cure everything were important aspects of their first year in employment. However, there was often a

frustration when patients who they knew could benefit from physiotherapy had to be left untreated in preference for acutely ill patients.

Alsop (2002) claimed that a competent professional not only

> required practical knowledge (but) a critical approach to practice, a flexible mind able to adapt to change and the capacity to generate new professional knowledge (p.202).

As reported by Hummell & Koelmeyer (1999) these participants were satisfied overall with their first posts, unlike Parker (1999) who reported that after six months of work newly qualified occupational therapists were "disillusioned and unhappy" (p164). The participants were proud of their work and wanted to provide the best possible service within the limited resources. Similar findings have been reported in occupational therapy (Alsop, 2002).

These newly qualified physiotherapists found themselves in an environment that closely resembled their experience of undergraduate clinical placements. This environment continued the professional socialisation process that had started as a student and therefore they felt safe and confident in their developing professional identity. These newly qualified physiotherapists describe events where they were encouraged to not rock the boat and conform to current practice (section 4.7.3.3). Therefore they could be perceived as describing a process of professional socialisation that encourage the status quo

(Sparkes, 2002) and Cahill (1996) describes this as a process of social control. There is little evidence of 'interactionist' model of professional socialisation, as described by Clouder (2003) and Bond & Bond (1994). In the current changing healthcare environment newly qualified physiotherapists may find themselves faced with an environment which will encourage them to voice their opinions and value new skills and evidence. Therefore they will interact with their environment, be an active participant in the process and thereby play an active part in the development of the profession (Higgs & Hunt, 1999).

Examples of this passive form of professional socialisation can be seen in their attitudes towards CPD and research. They expected to be 'given' time to complete their CPD. CPD was a process to record incidents or courses but not to plan for th future. Only one participant had 'roped themselves' into any research and taken a proactive role, then rest were happy to leave research to others and only read articles (not in *Physiotherapy)* when directed to by their senior. Even Appraisal was seen more as an assessment which concentrated on the development of their profession specific skills rather than widening their experience.

Therefore these newly qualified physiotherapists felt comfortable with their practice. Initial concerns which did challenge them were linked to their time and caseload management skills. They learnt the ropes and learnt to fit in to the physiotherapy environment in which they found themselves working.

### 5.3 The Summary

From the experiences of these newly qualified physiotherapists the first year of work can be illuminated. Their stories tell about their job satisfaction and hopes, but also their fears. Particularly important issues are; the structure of their rotations, the support they receive (including induction and supervision), the management of their workloads, their CPD and the development of their knowledge of profession specific skills. By the end of the first year they perceived themselves as professional physiotherapists. They found themselves in a working environment which socialised them to physiotherapy practices that encouraged the status quo rather than an environment of professional development which challenges accepted practice and encourages its new recruits to embrace change which would encourage the development of the profession. This working environment was familiar to them as it closely resembled their undergraduate working environment. The emphasis was on their 'apprenticeship' and gaining experience based on the number of hours completed and by gaining knowledge from experts.

From the analysis of the data and the discussion of the analysis in relation to the literature the four main findings of the study are presented as follows:

1. There was little induction into their first posts for most of these newly qualified physiotherapists (section 4.7.3.1);
2. The main difficulties for these participants revolved around caseload management and time management skills (sections 4.7.3, 4.7.3.2, 4.7.3.3);

3. There was considerably variability between rotations particularly relating to supervision and CPD activities (sections 4.7.3, 4.7.4.1, 4.8.1);
4. These newly qualified physiotherapists found themselves in a working environment which valued profession specific skills and other skills, such as research skills were undervalued and they had little or no time to develop these skills or to consider their role in the workplace beyond the physiotherapy department (sections 4.7.3, 4.8.2, 4.8.3).

These all contributed to an environment where socialisation concentrated on developing profession specific skills, with little reference to the evidence, and the maintenance of the current situation, rather than fostering a process of professional development which would facilitate the development of the 'interactional professional' who would be capable of adapting in the continual changing healthcare arena (Higgs & Hunt, 1999). Such a professional would also be able to initiate change and evaluate the consequences of any changes.

The concluding chapter reflects on the findings and their implications. The limitations of the research are also discussed. Finally the research and its relevance to research in physiotherapy general is considered.

# CHAPTER SIX

# CONCLUSION

This research aimed to explore newly qualified physiotherapists' expectations and experiences of their first posts. The literature relevant to newly qualified physiotherapists was reviewed and found to be limited. Therefore physiotherapy literature in general was evaluated and the review expanded to include relevant research from another similar profession, occupational therapy, but with a different approach to research in general. The literature revealed a paucity of research into newly qualified physiotherapists' experiences and a research question was developed to explore these experiences. Ten newly qualified physiotherapists participated in the study. All were interviewed three times with the aim to learn directly from them about their expectations and experiences (Krefting, 1991). The interview transcripts of the interviews along with reflective diaries produced data provided accounts of their lived experiences and how they learnt the job and developed their professional identities. They struggled at times but they 'learnt the ropes' and reported high levels of job satisfaction at the end of their first year of practice. These newly qualified physiotherapists did not report being unsure of their professional role, which is in contrast to newly qualified occupational therapists (Bailey, 1990, Parker, 1991, Rugg, 1999b, Lee & MacKenzie, 2002, Steenbergen & MacKenzie, 2004).

The four main findings of the study were:

1. There was little induction into their first posts for most of these newly qualified physiotherapists (section 4.7.3.1);

2. The main difficulties for these participants revolved around caseload management and time management skills (sections 4.7.3, 4.7.3.2, 4.7.3.3);
3. There was considerable variability between rotations particularly relating to supervision and CPD activities (sections 4.7.3, 4.7.4.1, 4.8.1);
4. These newly qualified physiotherapists found themselves in a working environment which valued profession-specific skills whereas other skills, such as research skills were undervalued and they had little or no time to develop these skills or to consider their role in the workplace beyond the physiotherapy department. Therefore current practice was left unchanged and the status quo maintained (sections 4.7.3, 4.8.2, 4.8.3).

The first year of work for newly qualified health professionals has been recognised as a important part of their careers, and labelled as 'preceptorship' by the Department of Health (DOH, 2007). This research has illuminated this important stage in the career of newly qualified physiotherapists and the findings are important as implications can drawn from them for consideration by the qualifying programme, supervisors, managers, and the professional and statutory bodies. These are discussed below.

### 6.1 Implications

The findings from this research suggest some implications for consideration by the programme from which these participants graduated but where appropriate for other qualifying programmes, supervisors and managers, and professional and statutory bodies.

### *6.1.1 Implications for the qualifying programme*

All these newly qualified physiotherapists graduated from one BSc (Hons) Physiotherapy programme and therefore the implications need to be carefully considered by the programme team.

#### 6.1.1.1 Easing induction into the workplace

As identified earlier (see page 192) as undergraduates these participants were used to being provided with information before clinical education placements as part of the induction process when they arrived on placement. As this is an example of good practice that can be provided for students on the university programme, it may be of value if a similar process was encouraged by the programme for newly qualified physiotherapists when they start their first rotation in Trusts that provide placements for this programme. Alongside this it might be appropriate to encourage newly qualified physiotherapists from this programme to vocalise their expectations when they start work, so 'psychological contracts' are not broken (Suttton & Grifffin, 2004). In this way if their expectations are unrealistic then they can be reviewed and realistic expectations developed.

In order to ease newly qualified physiotherapists into the workplace the programme team should consider developing career entry and development profiles. These are used in other professions such as teaching and could clearly link to CPD, appraisal and mentoring. CEDP's would be written jointly by the students and lecturers at the end of

the programme. The student would be facilitated to identify their needs when they entered the workplace and provide information for their manager and supervisor. Therefore newly qualified physiotherapists would enter the workplace with a clear view of their professional needs.

#### 6.1.1.2 Developing caseload and time management skills

The participants in this study reported problems in dealing with their work load and managing their time (sections 4.7.3, 4.7.3.2, 4.7.3.3). Adamson et al. (2001) identified that good time management skills are important for newly qualified physiotherapists. Covic et al. (2003) recommended that undergraduates are targeted early in their course and those with weak time management skills identified. These participants graduated from one physiotherapy programme and these findings imply that the programme team should review the teaching of time management skills across the whole programme. The university currently offers a programme of support for student learning, including time management skills but it may be appropriate to identify students with weak skills in this area and encourage them to seek help. It might also be advantageous to review the time management skills as taught for the academic modules and apply them, where appropriate, to clinical modules.

#### 6.1.1.3 Preparing students for variations in supervision in the workplace

*The Curriculum Framework for Qualifying Programmes in Physiotherapy* (CSP, 2002) requires newly qualified physiotherapists to be able to manage their time effectively. Therefore as recommended by Rugg (1999b, 2003) physiotherapy educators and

supervisors could consider reviewing the amount of close supervision given to students, especially in year three placements, to more accurately reflect the level of supervision in their first posts. In this way student physiotherapists may gain more experience of managing their own time. By both reviewing time management skills early in the programme and by assessing the levels of supervision required in clinical education then both the academic and clinical time management skills of graduates may improve.

As suggested in Chapter five (see page 197) the student supervision model may be so firmly embedded in physiotherapy practice that this model may also be being applied to post graduate supervision without considering the different needs of graduates (Sweeney et al., 2001c). Confusion in the literature as to exactly what supervision is and uncertainty over mentoring was also identified (see page 198). It is clearly important to address this implication since the nature of supervision if it is to be fit for purpose has to be responsive to the needs of the supervisee and that will change as a therapist's career develops. One approach to this that could be offered through the qualifying programme is the development of a Masters module in clinical supervision cover for both supervision at undergraduate and postgraduate levels. Not only could this form part of clinicians' CPD but the module could also be accredited by the CSP as part of their Accreditation of Clinical Educators scheme.

#### 6.1.1.4 Consolidating and valuing research skills

The fact that research skills and CPD were seen as subordinate to professional specific skills poses a question to a qualifying programme as to how best to consolidate these more firmly in new graduates.

The programme team could, for example consider how CPD and research activities are promoted across the modules. All students are given a lecture before starting clinical modules covering CPD and the completion of portfolios. As the HPC will audit CPD in 2010 (HPC, 2006) it might be relevant for the programme team to consider ways of reviewing portfolios within the academic modules or as part of the personal tutoring system. Likewise the use of research skills in first posts needs to be reviewed and the students need to be encouraged to be involved in journal clubs and any research activities that may available.

Although it is perhaps understandable why these newly qualified physiotherapists valued so highly their profession specific skills, it is important the programme continues to emphasise the value of more generic skills. In the current climate of job shortages for newly qualified physiotherapists, their generic skills may enable them to apply for posts which may not advertise specifically for a physiotherapist, but a physiotherapist may have the appropriate skills for the post. The programme needs to consider working more closely with the university's careers service, to give advice on how to present curriculum vitaes and interview skills.

Although the findings of this research cannot be generalised to other physiotherapy programmes, some of the findings may be relevant to other newly qualified physiotherapists in similar situations. For example, if other programmes, as Covic et al. (2003) also reported, perceive graduates to have poor time management skills then thy may want to consider methods of identifying students with weak time management skills early in the programme and then offer them extra help to develop strategies to manage their time more effectively.

*6.1.2 Implications for supervisors and managers*

For most of these participants there was little or no induction into their first posts or each time they changed rotations. These participants were working in 10 different Trusts and this lack of adequate induction needs to be acknowledged as an important finding. The participants reported variable amounts of information provided before they started their first post and the induction process varied from Trust to Trust (section 4.7.3.1). Managers and supervisors could consider developing a clearly structured induction process, linked to appraisal and including an evaluation of the induction process (Fleming & Tullis, 1996, Parker 1991).

Relevant information could be provided before the newly qualified physiotherapist starts work similar to the information provided to students before commencing a placement. An induction checklist could be developed based on CSP (2003) guidelines (Fleming & Tullis, 1996). The checklist could include both general induction to the Trust and specific

induction to the department (Gibbs, 2002). This would ensure newly qualified physiotherapists covered all the areas suggested by the CSP guidelines and any local requirements within the Trust.

Mentoring programmes linked to induction could be considered not only to support newly qualified physiotherapists but also more senior staff as they are promoted (see page 193). Consideration could also be given to appointing mentors who are not physiotherapists (see page 201) so newly qualified physiotherapists would get a wider view of their working environment. The current crisis in graduate employment may mean that in the future there will be fewer senior physiotherapists to supervise newly qualified staff (Grant, 1995). Supervision by other health professions may become common practice, as predicted by Richardson (1993). Mentoring of more senior staff by non-physiotherapy staff my also help developed knowledge about issues beyond the physiotherapy department.

Induction needs of junior staff when moving into more senior posts could be reviewed and appropriate support provided. This research suggests that there may be little support for juniors as they move into senior posts (see 181) and that this may be one factor in leading them to consider non-NHS posts.

These participants found problems with case load management and time management skills. Although it is probably inappropriate for newly qualified physiotherapists to participate in time management courses (Adamson et al. (2001), supervisors and

managers might consider how they can foster the time management skills of newly qualified physiotherapists in the busy working environment. For example, rather than throwing a newly qualified physiotherapists in at the deep end with a full case load on day one (see page 140), a more phased approach may be more supportive and allow the further development of time management skills. If the newly qualified physiotherapist discussed their strengthens and weaknesses with their supervisor at the beginning of a rotation then an appropriate caseload could be agreed, with set targets for being able to cope with a full caseload.

As already discussed (see page 204) physiotherapists' CPD activity will be audited by the HPC in 2010. Managers and supervisors need to consider the provision of CPD activities for staff. These participants reported considerable variation between rotations in the provision and support of their CPD. In the current NHS environment of funding cuts, both managers and supervisors could consider a more consistent system of providing CPD opportunities for staff, as co-ordinated activities across rotations may lead to savings in time and staff effort, due to duplication, and better use of individual staff skills. Closely linked to CPD, was participants' experience of research and the role of research in practice. As previously discussed (see page 210) researchers within physiotherapy departments could consider their role in relation to promoting research across all clinical grades. Managers and supervisors could review the aims of junior meetings and journal clubs in order to support appropriate CPD and research activities.

By reviewing the induction process and mentoring processes a workplace will develop where newly qualified physiotherapist are encouraged to be an active participants in their socialisation to the workplace and be prepared to be an active participant in their professional development.

*6.1.3 Implications for professional and statutory bodies*

The CSP provides *Guidelines of Good Practice for New Entrants to Physiotherapy* (CSP, 2003). The findings from this research suggest that for these participants many of the guidelines were not being followed, for example the provision of an induction programme, and structured educational programmes. In the current climate the guidelines need reviewing especially in respect to 'a planned programme of rotations' (p.5). It may also be appropriate to review how these guidelines are implemented in practice. The adoption of a form of CEDP's and induction tutor could be considered as a part of CPD portfolios and mentoring.

The requirement for 1,000 hours in supervised clinical education during an undergraduate programme has recently been reviewed and deemed appropriate (CSP, 2002). However, the approach adopted in that review was to consider what was required to educate a student physiotherapist and how much supervision is required and not how appropriate the levels of supervision are when compared to the reality of practice when qualified. The profession could consider reviewing its expectations of supervision of students on placement in relation to the reality of the current workplace. It may be that either levels of

supervision on placement are too high or that there is not enough supervision of newly qualified physiotherapists.

Consideration could be given to a review of the rotational system for newly qualified physiotherapists (Archer, 2006, Masters, 2006). Some non-rotational junior posts have been developed (Limb, 2006), and it will be important to review the experience expected at Senior level if a non-rotational post has been completed. The transferable skills gained in a non-rotational post need to be clearly identified. This review could also cover the variability between rotations with particular reference to supervision and CPD activities (sections 4.7.3, 4.7.4.1, 4.8.1). This is important as there is evidence from this research to suggest that some managers believe it is important to complete a rotational system that includes the core rotations and achieve a number of clinical hours before a junior physiotherapist can apply for senior posts (see page 182). The benefits of assessing junior physiotherapists' competencies and transferable skills could be evaluated so that juniors do not have to just 'do their time' before applying for their first senior post.

The expectations of inclusion of newly qualified physiotherapists in research early in their career could be reviewed. One of the outcomes of the *Curriculum Framework for Qualifying Programmes in Physiotherapy* (CSP, 2002) is that newly qualified physiotherapists should be able to demonstrate their capacity to engage in research and evidence-based healthcare. This Framework outcome is linked to bench marking statements (QAA, 2001a) and graduate attributes (QAA, 2001b). The outcome is further sub-divided and requires newly qualified physiotherapists to be able to work with others

and contribute to research projects. There is an expectation from the profession for newly qualified physiotherapists to be involved in research and to be able to evaluate evidence and apply this, where appropriate, to their practice. Some participants expected to be involved in research, but the experience was different. Research was not perceived an important part of their workload (sections 4.7.3, 4.8.2, 4.8.3). It would be unreasonable to expect newly qualified physiotherapists to be involved in their own research projects but given the emphasis on research skills at undergraduate level it is wasteful if these skills are abandoned completely until later in their career. If these skills are not used until later this may lead to a reluctance to become involved in research as the skills taught in the academic environment at undergraduate level may be perceived as being out of date or 'rusty'.

The use of research and research skills needs to be part of the agenda for newly qualified physiotherapists. For participants in this study the journal clubs were where they reviewed literature. These clubs were organised at junior level and across all juniors in a Trust. One participant reported that the journal club had ceased to exist due to lack of interest (Georgina 03). Consideration could be given to organising journal clubs within rotations and across professions and levels of seniority. In this way all staff could be exposed to research from different professions. If these clubs were led by senior staff involved in research then more junior staff would become more aware of research active staff within a Trust. Juniors may then feel more able to volunteer to be involved in or, at the very least, be aware of research being untaken within their own Trust. Such a process would help with the dissemination of evidence into practice. The issue of how research is

disseminated into practice was identified as a problem for the profession in Chapter two (see page 65).

It is important these implications are considered primarily by the programme from which these newly qualified physiotherapists graduated. If this is not done then there is a risk that graduates from this programme will not progress into senior posts in the NHS and the resource will be lost. As these newly qualified physiotherapists were working at 10 different Trust then there may be some value in other programmes, supervisors and managers considering these findings in relation to their programmes if their graduates find themselves in similar circumstances.

**6.2 Limitations of the Research**

Authors such as Krefting (1991), Ritchie (1999), Ballinger (2004), and Hammell & Carpenter (2004) argue that qualitative researchers need to produce high quality research that can be rigorously reviewed by standards relevant to its paradigm and not by the standards set by quantitative researchers, which are inappropriate. All research has its limitations, and the following limitations are based on the ones pertinent to this research.

Great care must be taken not to generalise these findings to all newly qualified physiotherapists. Ten newly qualified physiotherapists working in ten different Trusts participated in this study and there is no evidence to suggest their profile was very different from the cohort. However, these findings and implications are unique to this

group, especially as they graduated from one School of Physiotherapy. However, it may be possible to transfer some of the findings and implications to other physiotherapists or occupational therapists in similar situations as reported by other researchers (eg: Rugg 1999b, 2003, Lee & MacKenzie, 2003).

This was a self-selected sample, which could mean the participants had more interest in the issues being researched and were therefore more likely to reflect on their experiences, influencing their perceptions of their first year in practice more than non-participants in the research. They may also have been more prone to reflect positively on the experience as they had a sense of professional pride and wished to present a good view of their professional career. The results of this study could therefore be seen as the best picture of expectations and experiences of newly qualified physiotherapists during their first year of work (Sweeney et al., 2001a).

The interviews were conducted between July 2002 and September 2003 and since then the NHS has changed. As identified in Chapter five (see page 187), newly qualified physiotherapists cannot expect to find a job easily in the NHS and some may never find work as a physiotherapist. Many of the newly qualified physiotherapists in this study experienced a job market where they could make choices about where they wanted to work (section 4.6). However, the implications suggested in section 5.1 are still relevant to newly qualified physiotherapists as when they do find work they will find themselves working in a busy constantly changing environment. Many of today's graduates will take longer to find posts and therefore will need more support in their early careers when they

do find work. Although many graduates may not go into the traditional 'core' rotation schemes which were the norm for the participants in this research, the findings are still relevant as again newly qualified physiotherapists entering environments they many not have experience in their undergraduate placements will need more support as they beginning their professional roles.

### 6.3 Further Research

As identified by the literature review, research involving newly qualified physiotherapists is very limited. Areas for further research involving newly qualified physiotherapists are identified below.

Cusick et al. (2004) reported on a piece of action research within an occupational therapy department in Australia, which aimed to develop strategies to support newly qualified occupational therapists. Such an approach could be developed within physiotherapy departments in this country. In this way all levels of staff could be involved in the research process, thereby not only improving the experience for newly qualified physiotherapists but also fostering a research culture within the department (Clemence, 1998). Such an approach may be more applicable within a busy NHS which is constantly changing. One of the main barriers to research has been identified as time (Metcalfe et al., 2001) but if research was perceived as part of the process of changing things within a department and part of normal working activities then staff may find themselves involved and value the process. It may also be possible to extend the research to include other

departments, such as occupational therapy thereby widening the experience for all those involved. With the financial constraints within the NHS there is a danger that research will be considered a low priority, which was suggested by Clemence (1998), before the current round of cuts and rationalisation.

Another area for research is a longitudinal study of career pathways of newly qualified physiotherapists especially in non-traditional or non rotational posts, fast tracking comparing experiences and also comparing these experiences to the more traditional core rotation posts. The research should also include the views of managers who will decide on the suitability of juniors applying for senior posts who have not had traditional core rotations (Hunt, 2004).

Research is also needed to investigate the meaning of 'fitness for purpose'. What are the expectations of newly qualified physiotherapists from managers' and supervisors' perspectives? As discussed in the literature review there may be a gap between theory and practice. This needs to be explored to find out if it is an issue of universities and managers expecting more generic skills, and supervisors expecting more professional skills and what value each group places on such skills. The research could focus on what skills and knowledge newly qualified physiotherapists should possess. Focus groups could identify the skills and then assess the importance of these skills.

In order to undertake these areas of research, physiotherapists will have to consider more fully the role of qualitative studies within their evidence base. The literature review has

revealed why there is little qualitative research published in the physiotherapy literature and the final section discusses this issue with particular relevance to the research presented in this thesis.

### 6.4 Significance of the Research Within the Research Community

The dominant research paradigm within physiotherapy is the 'medical' model of practice and the RCT is perceived as the 'gold standard' for research (Shepard et al., 1993, Carpenter,1997, Ritchie, 2001, Johnson & Waterfield, 2004). This study is

> placed firmly within the naturalistic paradigm ...(and) grounded in the context in which the study participants operated (Sweeney et al 2001a, p.338).

Although some authors (Bithell, 2000, Parry, 1997, Ritchie, 2001) acknowledge that qualitative research has an important role to play in the development of the evidence base for the profession, as yet few qualitative studies have been published (Gibson & Martin, 2003) or the value of qualitative research recognised by the profession (Bithell, 2000, Johnson & Waterfield, 2004).

So how will this study be judged within physiotherapy? Is it only one of a few qualitative studies in physiotherapy or is it one of many qualitative studies that do not get published as they are not judged as 'best evidence' by the dominant medical model? Parry (1991),

Ritchie (2001), Johnson & Waterfield (2004) have all expressed concerns over how qualitative research is judged within physiotherapy. Various authors discuss 'the levels of evidence' (Clemence, 1998, Hammell & Carpenter 2004, Ritchie, 2001) where the RCT is rated at Level I and qualitative methods are either rated at Level IV or V, the lowest point on the scale. As the levels of evidence are based on the medical model of research the rating of qualitative approaches towards the lower end of the scale is unsurprising. However, such an approach means that the individual or patient's voice is lost in the research process and therefore valuable 'evidence' is lost (Hammell & Carpenter, 2004). As Clemence (1998) contends

> Physiotherapy is a profession seeking to establish its own theoretical base; while evidence-based health care can improve the quality of clinical interventions, the profession itself will have to decide if it shares doctors' views regarding the order if a hierarchy of evidence which puts RCT's at the top and personal experience near the bottom (p.257).

It is important for qualitative research to be reviewed using criteria relevant to its philosophical assumptions. Then physiotherapists may begin to recognise its value in researching questions which have previously been regarded as 'unresearchable'. Participants in physiotherapy research need to be given 'a voice' and not reduced to mere numbers and statistics.

This piece of qualitative research has identified some important findings and implications. Exploration of the lived experiences of these newly qualified physiotherapists provide a valuable insight to their first posts working in the NHS and the development of their professional role. Programme leaders, managers and the professional body should consider the use of CEDP's and review the induction and mentoring processes for newly qualified staff particularly in the light of the continuing changes within the NHS and the current employment situation for newly qualified physiotherapists.

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# APPENDICES

## Appendix I

## Newly qualified occupational therapists' perceptions of their first posts

## Appendix I

### Newly qualified occupational therapists' perceptions of their first posts

More literature was found in occupational therapy (16 research studies) than physiotherapy on the views of newly qualified occupational therapists. This may reflect the psycho-social model which underpins the occupational therapy profession in contrast to the medical model of research which dominates physiotherapy practice (Barnitt, 2004).

Table 1 summarises the occupational therapy literature in this area. Of the 16 research based studies only half of them were conducted in this country and 3 of them were conducted by Rugg (1996, 1999b, 2003) at a single school of occupational therapy. Indeed single cohort studies are a feature of the literature (Rugg, 1996, 1999b, 2003, Atkinson & Steward, 1997, Hummell & Koelmeyer, 1999). It should also be noted that the majority of the studies are pre-2000 and therefore may not be relevant to the current NHS context.

As with physiotherapy many of the studies utilise questionnaires to collect data. There are some excellent response rates (Leonard & Corr 1998), which are achieved because of the researchers' close contact with the students and newly qualified occupational therapists (Rugg 1996, 1999b, 2003).

Table 1 A summary of the relevant occupational therapy literature

| Author(s) | Date | Country | Cohort | Area of research | Participants | Method(s) | Pilot | Response rate |
|---|---|---|---|---|---|---|---|---|
| Bailey | 1990 | USA | 1986 | Reasons for attrition | 696 | Questionnaire | No | 60% |
| Parker | 1991 | UK | 1986 | Needs of newly qualified | 94 | Questionnaire | Yes | 54.3% |
| Atkinson & Steward | 1997 | UK | 1994 | Experiences and needs of newly qualified | 25<br>3 | Questionnaire<br>Interviews | No | 92.5% |
| Adamson et al | 1998 | Australia | 1991-4 | Perceptions of preparation for first posts. | 114 | Questionnaire | No | 28.7% |
| Leonard & Corr | 1998 | UK | 1995 | Sources of stress and coping strategies | 62 | Questionnaire | Yes | 78% |
| COT | 1995 | UK | 1994 | Selection of first post | 426 | Questionnaire | No | 51% |
| Rugg | 1996 | UK | 1990/1 | Transition into practice | 177 | Questionnaire | No | Not given |
| Rugg | 1999b | UK | 1992/3 | Continuity of employment | 206<br>39 | Questionnaire & Semi-structured interviews | No | 98% |
| Rugg | 2003 | UK | 2000 | Expectations & Stress | 65 | Questionnaire | No | 73% |
| Hummell & Koelmeyer | 1999 | Australia | 1991 | Perceptions of first 6 months | 74 | Questionnaire | Yes | 69.2% |
| Spalding | 2000 | UK | 1997 | Professional development | 2 | Semi-structured interviews & essay | No | 8% |
| Sutton & Griffin | 2000 | Australia | 1997 | Role of met expectations and job satisfaction | 295 | Questionnaire | No | 72% |
| Sutton & Griffin | 2004 | Australia | 1997/8 | Expectations & experiences and job satisfaction | 235 | Questionnaire | Yes | 72 & 84% |
| Tryssenaar & Perkins | 2001 | USA | 1996 | 'Lived' experiences of newly qualified | 3 PT's<br>3 OT's | Reflective diaries | No | 5% |
| Lee & Mackenzie | 2003 | Australia | Not given | Exploration of experiences | 5 | Semi-structured interviews | No | Not given |
| Steenbergen & Mackenzie | 2004 | Australia | Not given | Exploration of professional support | 9 | Semi-structured interviews | No | Not given |

*Newly qualified occupational therapists' perceptions of their first posts*

The earliest study found in occupational therapy was Bailey (1990). She investigated why female occupational therapists left the profession. Although this was not specifically directed at newly qualified occupational therapists, it is cited in most of the literature reviewed in this section. Although recently qualified occupational therapists (0 to 5 years post qualification) were the third largest group of respondents (19%) to the questionnaire, the majority of the respondents (56%) had been working 5 to 15 years. Most cited multiple reasons for leaving including re-location, unable to find a job, excessive paperwork, better job/salary opportunities outside occupational therapy, stress and concerns over their professional role and lack of recognition by other health professionals. The findings were not specifically related to the newly qualified, for example, 63% of Bailey's respondents were taking time off to raise a family. However, there is no indication as to how many of these were newly qualified and how many were 'lost' to the profession, as some may intend to return to work as occupational therapists once their children were older. However, these occupational therapists did express concern about being out of date when they returned from their career break. Although this was a large survey with a 60% return rate, generalising the findings to groups not specifically accounted for in the study must be viewed with care. Concerns over their professional role and lack of recognition by other Allied Health Professionals are identified by other occupational therapy authors (Hummell & Koelmeyer 1999). This is in contrast to physiotherapy, although Richardson (1999a) claimed there was a crisis of confidence in the profession in that physiotherapists no longer had a true sense of professional identity. No evidence has been found in this review to support her view.

An early piece of research cited in most of the occupational therapy articles is Parker (1991). Parker surveyed newly qualified occupational therapists' needs during their first posts. The research was prompted by the experience of lecturers who had observed

> enthusiastic, hardworking students enter the profession with commitment and zeal and, within 6 months, find the same people disillusioned and unhappy with their work (Parker 1991 p.164)

Ninety-four questionnaires were distributed to newly qualified occupational therapists who had been in post for approximately 6 months. The researchers made 9 recommendations mainly about support and supervision of newly qualified occupational therapists based on the 2 broad findings of the research. These findings were that newly qualified occupational therapists had a lack of confidence in professional skills and had difficulties in relationships with other staff. Parker (1991) also reported that some students had suggested that the course could provide better preparation for the 'real' world. The recommendations suggested ways in which the newly qualified occupational therapist could be supported in practice, for example – self-help groups, encouragement for newly qualified occupational therapists to demand more support, an in-depth induction process, structured one to one sessions with an experienced senior occupational therapist, meetings between different grades of staff and staff training for staff who supervise newly qualified occupational therapists. All these recommendations are included in the CSP Guidelines of Good Practice For New Entrants to Physiotherapy (2003). This could be perceived as evidence of interprofessional working but there is no

evidence to support this view as the CSP guidelines do not reference any other research or guidelines from other professions. This piece of research was conducted on students qualifying with a diploma, and today both occupational therapists and physiotherapists qualify with an Honours degree and as a consequence problems encountered in first posts may have changed.

A survey (COT 1995) sent to all qualifying occupational therapists in 1994 had a 51% response rate. This survey has been widely criticised. There was a poor response rate, possibly due to the timing and method of distribution of the questionnaire. There were also problems with the representativeness of the sample (3 Schools of Occupational Therapy) and some of the questions were ambiguous which may have affected the response rate (Rugg 199b). The survey found that the two major influences on selection of first posts by occupational therapists were chosen field of work and geographical location. These results were different from Warrinder & Walker's (1996) survey of physiotherapists where location was ranked 6$^{th}$ in the list of factors influencing the choice of first post. The field of work does not apply to physiotherapists as most graduates initially work in the NHS and, for example, social care settings are generally not an option for physiotherapists (Masters, 2004).

Atkinson & Steward (1997) published a preliminary report of a longitudinal study of newly qualified occupational therapists from a British school of occupational therapy. Twenty-seven students were sent a questionnaire about their expectations of their first posts and 26 replied. Three participants, 3 months after starting work, were interviewed.

A second questionnaire was distributed when the occupational therapists had been working between 2 and 6 months. The findings concentrate on 3 areas – choice of first post, preparation for practice and continuing education. These newly qualified occupational therapists were working predominantly in the NHS, as this was where they perceived posts to be available. The authors reported that although it could be expected that most occupational therapists would be working in the NHS, they were surprised by so few graduates working in the community or social services.

In comparison most newly qualified physiotherapists do not work in the community. Atkinson & Steward (1997) and Masters (2004) suggest that it is based on the belief within the profession that more experience is needed before undertaking community work. Other influences on the choice of first post were family ties to the area and placement experiences whilst students. Twenty-five per cent of these newly qualified occupational therapists were working in non-rotational junior posts. In physiotherapy such posts are unusual and not recommended by the professional body (CSP, 2003).

The second area covered by the findings was preparation for their first posts. The newly qualified occupational therapists felt adequately prepared in their academic skills, which enabled them to find information to support the areas they felt less prepared in, for example, some specific assessments. The third finding was related to continuing education. Most of the newly qualified occupational therapists had participated in some continuing education but often this was needs led rather than being part of a long-term development plan. However, this research was conducted before the development of a

more structured approach to continuing professional development (CPD). Now all qualified therapists are expected to maintain a CPD portfolio, the structure of which is provided for physiotherapists by the professional body (CSP 2005b).

Adamson et al. (1998) investigated Australian occupational therapists' perceptions of their preparation in the undergraduate course for their post graduation posts. The research used a survey technique and the questions for the questionnaire were developed from a group of allied health professions. The authors acknowledge the used of a group of allied health professions in the development of the questionnaire rather than a sample of newly qualified occupational therapists as a limitation of their study. They attempted to improve the validity of the questionnaire by asking teaching staff and workplace supervisors to complete the questionnaire and then compared the results. A purposive sample of graduates from 4 cohorts from an Australian University was used. The response rate was poor (28.7%) when compared to other research reviewed. The authors felt this was a reasonable response for such a sample and compared it to response rates for similar populations. However, they did not consider that the relatively poor response rate may also be due to other factors such as stress in the workplace and lack of time or interest. More care might have been taken when drawing the conclusions especially when the authors attempted to generalise to all occupational therapists and even all health professionals. The study does identify various areas where newly qualified occupational therapists' perceived themselves to be well prepared for the workplace, for example, essential tasks, confidence in clinical role, and communication with clients. Various factors where the graduates were poorly prepared were also identified such as

communication with other health professionals, workplace management, and knowledge of the health industry. These findings are similar to those of Hunt et al. (1998a). The authors concluded by claiming that, even with such a poor response rate, the findings have international significance relevant to other health professions. Although there are similarities between the education of occupational therapists and other health professionals there are differences particularly when comparing countries and healthcare systems.

Leonard & Corr (1998) studied stress and coping strategies in newly qualified occupational therapists. They focused specifically on stress and the literature available in occupational therapy was extremely limited. Their literature review concentrated on reporting the general literature on stress, then stress in health professions and then specifically on the limited work in occupational therapy. Most of the cited work is pre-1990 and its relevance to current practice is questionable. The tool for the research was a questionnaire developed from issues identified in the literature review. There was a small pilot study and the final questionnaire was sent to 80 newly qualified occupational therapists. The method for selecting the sample could not be used today, as it involved randomly selecting graduates from the list produced by the professional body and then finding the graduates' addresses on the Council for Professions Supplementary to Medicine Register (the statutory body before the HPC). Such information is not available today. However, the advantage of such a sample was that it included newly qualified occupational therapists from across the country and from numerous Schools. The response rate was very good (80%), especially when compared to other studies reviewed

in this chapter (Parker, 1991, Adamson et al., 1998). The authors acknowledged the high response rate and cited literature that indicated high response rates may be found when the issues under investigation are important to the respondents.

In this case the newly qualified occupational therapists felt that stress was an issue in their jobs and therefore wished to participate in the study. The stressors identified reflect closely the literature reviewed for the study. This is a limitation of the study as there was no scope for other stressors to be explored and the respondents were given no opportunity to rate the amount of stress caused. So, for example, supervision was one of the most frequently experienced stressors, but for many it might have been mildly stressful but for others very stressful. The stressors were categorised into 3 groups – professional values, organisational issues and client/patient contact. The highest rated stressors for the professional category were 'transition from student to therapist' and 'conflict between the idealism in college versus the reality of the job'. This 'theory-practice gap' is discussed in the literature by both physiotherapy and occupational therapy authors. There were 4 highly rated organisational stressors – 'too much paperwork', limited resources for patient/client care and 'staff shortages' and 'too much work to do in a limited time'. None of these featured in the physiotherapy literature. In the final category, client/patient contact, 'making mistakes' was highly rated, and was also reported by Parker (1991). Previous research with students also reported this as a fear when first working with patients (Harris & Naylor, 1992, Walker & Naylor, 1991). The main coping strategy identified by Leonard & Corr (1998) was support offered by others either via formal supervision sessions or informally by colleagues. Some of the findings were different

from previous research (Parker, 1991), but this might also demonstrate the changes in the working environment for occupational therapists. Leonard & Corr (1998) participants only lowly rated a perceived poor professional status, whereas Parker's (1991) participants felt that poor recognition by other professions undermined job satisfaction. Parker (1991) had recommended making more support available to newly qualified occupational therapists and from Leonard & Corr's (1998) findings it could be claimed that this was being achieved.

Rugg (1996, 1999a, 1999b, 2002 & 2003) considered issues relevant to the transition of newly qualified occupational therapists into the workplace. The first article (Rugg, 1996) was a report of a preliminary study of 177 occupational therapists who had completed two questionnaires (one pre- and one post-qualification). There were two phases to the study, the first phase involved one cohort, which essentially piloted the questionnaire as the questionnaire was revised based on their comments. The second phase involved the subsequent cohort, who completed the revised questionnaire that was now based on a rather old American checklist of problems encountered by occupational therapists (Allen & Cruickshank, 1977 cited in Rugg, 1996). This checklist was revised for the British participants and items from the original questionnaire were added. The author argued that as there was no significant difference between the demographic data of the two cohorts, the two cohorts could be treated as one, despite having completed two different questionnaires. The results showed that these occupational therapists found the same areas of difficulty as the original 1977 checklist (Allen & Cruickshank, 1977 cited in Rugg, 1996). These areas related to success of patient care, time, working with others and

occupational therapists' authority in the working environment. As the results were similar it could be argued that the method was a valid research tool. However, many things had changed between 1977 and the 1996 study and the checklist may have limited the responses of the participants. The study was able to compare the expected and actual experiences of the participants and in some cases there were some statistically significant differences. As found by other authors (Tryssenaar & Perkins, 2001, Rugg, 1999b), there was a perceived gap between newly qualified occupational therapists' expectations and the realities of practice. The discussion related many of the findings to pre 1980 literature and Rugg acknowledged that this may not be relevant to the climate of rapid change experienced by these participants.

Rugg (1999a) reviewed the literature on factors influencing newly qualified occupational therapists' continued employment. The literature review identified the lack of research in this field but also included many pre-1990 articles, which, as the author again admitted, were difficult to apply to the context of practice in the mid nineties, and have not been considered for this review. Atkinson & Steward (1997) had previously stated that there was "limited information in the public domain about the experiences of newly qualified occupational therapists during the early years of professional practice" (p.388). Rugg (1999a) concluded that the factors influencing occupational therapists' continuity of practice remain unclear and recommended further research.

In the same year Rugg (1999b) published a study to address the issue of continuity of employment for newly qualified occupational therapists in their first year of work. Again

data from two cohorts were included in the data analysis as no statistical difference was found between the cohorts' profiles. This time both cohorts were sent the same questionnaire and thirty-nine of the 206 respondents to the questionnaire participated in semi structured interviews. There was an excellent response rate, much of which has to be attributed to the author's close contact with the participants before graduation. The study found a 7% attrition rate one year post qualification but of the remaining occupational therapists who were working 24% reported they were likely to leave occupational therapy permanently in the next year. As in Bailey's (1990) study both personal and environmental issues influenced the continuity of work. The variables measured by the quantitative part of the questionnaire, such as age, level of trait of anxiety and gender were found to influence withdrawal from practice. The variable, which related the discrepancy between expectations and the realities of practice, was significantly linked to attrition and turnover.

The qualitative findings emphasised the importance of good supervision for the newly qualified occupational therapist. Rugg (1999b) attributed the expectation of newly qualified occupational therapists of many hours of supervision to the undergraduate requirement of 1,000 supervised hours whilst on clinical placement, which may give newly qualified occupational therapists unrealistic expectations. The same 1,000 hours supervised clinical practice is required for approval of physiotherapy programmes in this country (CSP, 2002). Other issues found by Rugg (1999b) were CPD opportunities, levels of autonomy, client relationships and responsibility. Positive experiences were linked to retention and negative to attrition. She recommended changes to student support

on clinical practice to more clearly reflect the reality of practice when qualified. However, some of the recommendations were not clearly linked to the research. For example, she suggested that data should be collected on the profile of the international occupational therapy workforce to assist policy making, but why the data needed to be international is unclear. She also recommended international research into newly qualified occupational therapists' early work experiences. Why this research should be international is not argued but it would be difficult to compare occupational therapists in different countries due to different models of healthcare. Rugg's research reviewed here is based at one school of occupational therapy in England and not generalisable. Clearly there is a need to widen the study to all schools of occupational therapy in England.

In 2002 Rugg published another literature review, which considered expectations and stress in junior occupational therapists. The second literature review forms the rationale for the study published in 2003. The emphasis of the second literature review is far more on the link between stress and expectations and therefore more relevant to this review as it does not focus on attrition. Again some old references are included but some more recent studies are reviewed, and most of these are relevant to other healthcare workers and not directly to occupational therapists or the newly qualified. Again Rugg identified that little research in this area has been completed in occupational therapy and the 'theory-practice gap' was once again highlighted.

Rugg (2003) investigated links between expectations of their new posts and their levels of stress and the age of newly qualified occupational therapists. Despite previous

recommendations for further research to be international (Rugg 1999b), this study is again based at the same school of occupational therapy. This time 65 graduates participated in the study, 73% of the cohort of graduates. A quantitative only approach using a questionnaire, as in 1996, was used to collect the data. Although the questionnaire was specifically designed for this study, elements had been used in her previous research. The participants were divided into two groups, depending on their age. The only statistically significant correlation was between younger occupational therapists' expectations and their levels of stress. Rugg (2003) felt this may be due to younger occupational therapists, who were mainly single, having less personal support than more mature therapists, and therefore finding the experience more stressful. She acknowledged the limitations of the study, particularly in relation to the timing of the questionnaire very early in their first posts when the participants may not have had enough time to assess whether or not their expectations had been met or not. Lacey (1977 cited in Clouder, 2003) suggested there may be a 'honeymoon' period early in first posts when newly qualified people feel more satisfied than a few months later. Rugg (2003) recommended again that clinical educators on undergraduate programmes should ensure that the placements reflect the reality of practice. However, there are some problems if the number of supervised hours are reduced then the student may not be able to achieve the learning outcomes. Perhaps instead the needs of the newly qualified therapist should be assessed by both the supervisor and the newly qualified occupational therapist and then appropriate support offered. It should also be noted that Rugg (2003) focussed on stress of occupational therapists in the early months of professional practice rather than the whole first year experience.

Taking a slightly different approach Hummell & Koelmeyer (1999) focussed their research on new graduates' perceptions of their transition into their first posts. Again the authors identify the limited research in the area and therefore reviewed pre-1985 literature and available anecdotal evidence. One cohort of students at an Australian University participated in the study. Although single cohort studies are a feature of the literature in this area (Rugg, 1996, 1999b, 2003), it does seem to produce good to excellent response rates and, if the limitations of the approach are acknowledged, is a valuable approach for exploring issues relevant to newly qualified therapists. The design, piloting and administration of the questionnaire is clear and includes information on how consent was obtained from the participants, which was not given in previous studies. The questionnaire was sent to the newly qualified occupational therapists 6 months after graduation but there is no information given about how long they may have been in their first posts. The results are presented in the same five sections that were used in the questionnaire. One of the sections (transition) contained open-ended questions and the other sections primarily consisted of closed questions. The study found that 89% of the newly qualified occupational therapists believed that the transition from student to newly qualified occupational therapist had been stressful but 85% were satisfied with their first posts. As with other studies (Parker, 1991, Rugg, 1996b) good supervision provided support for the newly qualified occupational therapists at a challenging time. Induction programmes were also rated highly, which is also supported by Parker (1991). CPD activities were perceived to be helpful in the transition, as also identified by Atkinson & Steward (1997). As with previous research (Bailey, 1990, Rugg, 1999b), professional knowledge was identified as an issue for these newly qualified occupational therapists.

The recommendations regarding the support and supervision by more experienced occupational therapists made by Hummell & Koelmeyer (1999) were similar to previous research (Parker 1991). However, they did present new ideas such as new graduate support groups and stress management courses for newly qualified occupational therapists.

Sutton & Griffin (2000, 2004) presented a longitudinal study of occupational therapists pre- and post-qualification conducted by non-occupational therapy researchers, their background being strategic management. The first report covers pre-qualification expectations, and relates these to personality traits. This research provided the baseline data for the longitudinal study reported in 2004. In the 2000 report the literature review found the need to develop more sound methodologies than those used by previous researchers. The sample for this study was much larger than any of the previous studies and was also multi-centered and gathered data from participants representing all Australian states. There were 295 participants (72% of the total final year students from the represented universities). A questionnaire was utilised, which collected demographic data, used Likert scales to assess expectations of first posts, a previously validated inventory to assess personality and another previously developed scale to assess work aspects of the job. The demographic data is presented and related to previous cohorts in Australia and other countries, which is more explicit than some other research reported in this review. The results showed that the personalities of the sample were similar to a normative sample. The participants were shown to have inflated expectations of their first posts, which were in common with other new workers to an organisation. This supported

Rugg's (1999b) view that undergraduate clinical experience should be more realistic. The authors claimed that the research measured expectations at entry to workplace from an organisational and an occupational viewpoint. However, the occupational aspect is more difficult to justify. The questionnaire was designed around previously validated tools, some not specially designed for occupational therapy or even health professionals. This may have influenced the results, as the research reviewed in this chapter (Spalding, 2003, Lee & MacKenzie, 2003, Tryssenaar & Perkins, 2001) identifies professional skill acquisition as an important expectation of newly qualified therapists, something not reported in the findings of Sutton & Griffin's research. Perhaps this is the influence of the authors' non- health professions background, although it could be argued that this provided a 'neutral, unbiased' approach to research in this area.

Sutton & Griffin reported in 2004 on the longitudinal study of the same cohort of occupational students. A second questionnaire was completed 14 months after the first one. The 2 questionnaires utilised by Sutton & Griffin were based on structured interviews with both newly qualified and more experienced practitioners. The main finding was that pre-entry expectations of support did not match experience. The authors postulated that this might be because on student placements more support is provided and therefore the newly qualified therapist expects the same level of support once qualified as suggested by Rugg (1999b). However, they also felt that this mismatch when compared to the other areas explored, those of pay and overall job content, was influenced by interpersonal relationships and was therefore less predictable. The results also showed that 'contract violations', which were defined as a "psychological contract (when one

party believes) that perceived promissory obligations have not been met" (p.495), were related to un-met post-entry expectations rather than pre-entry expectations.

Spalding (2000) interviewed two newly qualified occupational therapists six times over the period of one year post qualification. Her study focussed on a particular model of skill acquisition (Dreyfus & Dreyfus, 1986 cited in Spalding 2000) of these occupational therapists. She found these participants progressed quickly through the model by using their good reflective skills, which were possibly enhanced by the research process itself. Being interviewed 6 times in their first year post qualification may have facilitated a more reflective practitioner than other newly qualified occupational therapists and could explain why they moved through the model so quickly. Reflective learning is an important element of CPD. However, neither newly qualified occupational therapist reached the final stage of 'expert' but had reached levels of proficiency that would be expected in a practitioner 3-5 years post qualification. The main limitation with this study was that the analysis was strongly influenced by the model of skill acquisition. The choice of the model was decided upon because the researcher was 'familiar' with it. The model provides 5 stages for skills acquisition from novice to expert and assesses individual skills rather than overall achievement.

Tryssenaar & Perkins (2001) explored the experiences of 3 occupational therapy students and 3 physical therapy students in a North American study. The authors adopted a phenomenological approach to explore the 'lived experiences' of the participants via reflective journals written during their final placement and first 12 months of work. Of

the 120 students initially contacted about the study, 6 students completed the requirements of the reflective journals. The lived experiences were divided into 4 consecutive stages (Transition, Euphoria and Angst, Reality of Practice, and Adaptation). The themes identified within the stages were 'great expectations', 'competence', 'politic', 'shock', 'education', and 'strategies'. The journals reflected the highs and lows of the experience. Great expectations were reported towards the end of the course and at the beginning of their working experience. These were linked to trepidation about work. The competence theme was linked to periods of self-doubt about their skills. This theme covered issues of paperwork, as identified by Leonard & Corr (1998) and Bailey (1990), and the system in which they worked also identified by Adamson et al. (1998). These 2 issues caused high levels of frustration and at times anger. As claimed by other authors (Rugg, 1999b, Sutton & Griffin, 2004) this was related to the 'theory-practice gap' where the academic/clinical curriculum protects the students from the reality of the workplace. The early stages of employment reflected the theme of shock which related to standards of care, attitudes and relationships. When the newly qualified occupational therapists reflected on their undergraduate programme they particularly valued the transferable skills they had learnt as they had prepared them for work and the future. However, they did identify some gaps in their practical skills. The final theme was the strategies the newly qualified occupational therapists adopted to cope with the working environment. These strategies started emerging 4 to 6 months into their first posts and may have coincided with a change of rotation – although the authors do not suggest this. Examples of strategies adopted were participation in courses, seeking out more support from a variety of people (both these were identified by Leonard & Corr, 1998), and developing

strategies that limited the influence of their professional life on their personal life by keeping to their working hours and prioritising tasks. The authors concluded that their analysis showed that these graduates were experiencing a process of socialisation and mentors were extremely important in this process. The authors acknowledged the limitations of this study, which included the self selected female sample and their involvement in the process. However, the research did show that for these participants their first year post qualification was successful and any problems encountered were predictable.

Lee & Mackenzie's (2003) study also utilised qualitative methods to explore the experiences of newly qualified occupational therapists. Like Hummell & Koelmeyer (1999) they focussed on the transition between student and practitioner, but their emphasis was on the importance of attracting and retaining therapists in posts in rural Australia. The problems of recruitment and retention are similar to community posts in England (Masters, 2004). However, in Australia newly qualified therapists represent a third of rural therapists, and although no figures could be found for this country, this is unlikely to be the same in community practice in this country. Lee & Mackenzie (2003) used semi-structured interviews to explore in depth the experiences of the newly qualified occupational therapists. The themes related to the choice of rural posts, the transition from student to practitioner, professional practice in a rural environment and their attitudes towards their first posts. The choice of first posts was addressed by the COT (1995) survey and in a physiotherapy study by Warrinder & Walker (1996) but their findings were different. Newly qualified occupational therapists in Lee & Mackenzie's

(2003) study made their choice of rural first posts based on previous experience of rural life before starting their degree and for personal reasons were committed to working in rural areas even before they began their studies. Any comparisons with COT (1995) and Warrinder & Walker's (1996) studies are difficult as their samples were much larger and perhaps if Lee & Mackenzie (2003) had surveyed all the graduates from the cohort, not just those working in rural areas, then more reasons for the choice of first posts may have emerged.

The transition from student to practitioner was defined by times of initial low self esteem about their clinical skills, including an awareness of gaps in their knowledge and therefore the fear of making mistakes (also reported by Leonard & Corr,1998) professional identity (Parker, 1991), and the importance of support from other therapists. As time went by the newly qualified occupational therapists developed more self confidence in their own skills and realistic expectations of practice. The remaining 2 themes, professional practice in a rural environment and their attitudes towards their first posts, relate directly to rural practice in Australia and are therefore not discussed in this review. These newly qualified occupational therapists reported that good experiences were related to good supervision and support groups. In this study access to support was often by telephone or email, and interaction with a variety of different clients (Tryssenaar & Perkins 2001, Spalding, 2000). Poor experiences were related to limited resources, which caused stress. The authors acknowledged that a longitudinal study of these 5 therapists would provide more in-depth information about therapists' transition into the workplace.

Steenbergen & Mackenzie (2004) developed the study by Lee & Mackenzie (2003) and focussed on professional support experienced by newly qualified occupational therapists again in rural Australia. The recruitment of the participants was the same as in the above study. Here nine newly qualified occupational therapists were interviewed, two by telephone. The study identified a lack of structured professional supervision as an important issue for these newly qualified occupational therapists, although support from colleagues was an important part of the job. Without professional support these occupational therapists found it difficult to establish their professional identity, an issue which is highlighted in the occupational therapy literature (Bailey 1990, Lee & MacKenzie 2004).

*Experienced occupational therapists' perceptions of newly qualified occupational therapists including research which involves both newly qualified occupational therapists and more experienced occupational therapists*

Four studies involving both newly qualified therapists and more experienced staff were also found in the literature search.

Kenyon & Ilott (1997) evaluated an occupational therapy course in Britain. Three groups of stakeholders were consulted – the newly qualified occupational therapists, the line managers and representatives of the sponsoring authorities. This study was part of a larger longitudinal evaluation of the whole course. However, for this part of the study a brief questionnaire was distributed to members of the groups mentioned above who were

asked to comment on the skills of the graduates in relation to the Professional Body's Curriculum Framework (COT, 1993). Descriptive statistics based mainly on Likert scales were used to analyse the data. As the authors acknowledged, the number of participants (46) was small and therefore the findings cannot be generalised. However, the evaluation was positive and the graduates were rated as competent at entry to the profession. Some areas were reported as weaker, such as newly qualified occupational therapists' management skills which supported previously reviewed research in physiotherapy by Clouder & Dalley (2002) and Lopopolo (2004).

As in physiotherapy, other occupational therapy researchers have concerned themselves with the issue of 'fitness for purpose' of the newly qualified occupational therapist. Barnitt & Salmond (2000) reported on the 'fitness for purpose' of newly qualified occupational therapist from the perspective of one manager and one educator of occupational therapists. Three themes were developed from the findings of previous research by Wiles et al. (1999 cited in Barnitt & Salmond, 2000) for discussion by the 2 participants. Wiles et al. (1999 cited in Barnitt & Salmond, 2000) surveyed therapists, supervisors, and employers. Later they interviewed a sample of the original survey respondents. The study found some discrepancies between the expectations of each group. The first theme was related to admissions to the undergraduate programme and therefore not relevant to this literature review. The other 2 themes, expectations of their first posts and transition, are relevant. The gap between undergraduate education and the realities of work was recognised as being inevitable but more stakeholder involvement in the delivery and the development of the curriculum were seen as ways of reducing the

gap. It was also reported that the development of undergraduate community placements was important in addressing the gap between undergraduate and postgraduate experience. Wiles et al. (1999 cited in Barnitt & Salmond, 2000) had found that there were differences in expectations of the skills required by newly qualified therapists. For example, managers focussed on more generic skills and supervisors felt profession specific treatment related skills were more important, which in some cases led the newly therapist to abandon their research skills due to the pressures of work in the early part of their career. The educator in Barnitt & Salmond's (2000) research felt this might be because supervisors might be inexperienced in new areas of practice. The employer felt that the demand to deliver services on a very limited budget led to an emphasis on treatment skills and that there was little time for research and development of reflective practice by the provision of 'library time' or participation in research.

Cusick et al. (2004) tried to combine the views of both newly qualified staff and more experienced staff in a piece of action research. The research was based in an acute hospital and aimed to develop strategies to support the newly qualified occupational therapists. The authors recognised that new practitioners often need high levels of supervision from an already stretched team of more experienced occupational therapists. Informal discussion in the department, before the research started, had identified the high number of newly qualified staff and the turnover of these staff as being the greatest challenges. The advantage of using action research was perceived to be that not only were the staff participants in the research but they also learnt about the research process. The research initially involved 24 members of the department who identified issues that were

important for newly qualified therapists. A Delphi study technique was then utilised to prioritise the original issues. These issues were then used to inform and develop departmental strategies. The authors recommended the use of action research as it allowed the problems and priorities, relevant to the newly qualified occupational therapist, to be addressed by all groups and this certainly worked in this way. For example, support was identified as an issue and a new graduate peer support group was established along with a peer review process. Another issue, which has also been identified in this review, was the quality of supervision. The action research approach allowed more streamlined supervision arrangements to be implemented alongside a new protocol for supervision. Although the authors mainly concentrated on a discussion of the value of action research, some of the findings are relevant to this research.

Adamson et al. (2001) reported on managers' views of managerial skills required by newly qualified occupational therapists. The most important skills were related to the management of the future (time management, interpersonal skills, prioritising tasks and goal setting), organisational practices (being an advocate, interpersonal skills) and team leadership. The authors suggested that rather than participating in time management courses, it was more important for newly qualified occupational therapists to receive support from other clinicians in the clinical environment to help develop time management strategies. Also highly rated were interpersonal skills, which were perceived as being important in resolving conflict issues with colleagues and for the newly qualified physiotherapist to work effectively within a team. Although the research indicated the importance these managers placed on these management skills, it did not evaluate these

skills in relation to other skills that might be expected of a newly qualified occupational therapist. This research supports research in the physiotherapy literature by Lopopolo (2004), but as with the Adamson et al (2001) there was no attempt to find out if newly qualified physiotherapists demonstrated these management skills.

# Appendix II

## Literature Search – The Method

## Appendix II

### Literature Search – The Method

A literature search of the computerised databases AMED, CINAHL, Embase, OVID, PubMed, MEDLINE, *Ref Works*, Blackwell Synergy, Academic Search Premier, Australian Education Index, British Education Index, ERIC, IBSS, Science Direct, Springerlink, and the Web of Knowledge was conducted. The following combination of keywords was used.

1. Professional identity formation, professionalism, nature of experience, novice to expert practitioner.
2. New graduates, graduates, novice practitioner, beginning practitioner, newly qualified, first posts / jobs, transition, preparation for the work, expectations.
3. Physiotherapy or Physical Therapy.
4. Occupational Therapy.

A $ was used at the end of appropriate keywords to utilise the 'wild card' option. Also text alerts were set up on all searches so relevant new papers could be included in the literature review. Relevant results were imported into a reference manager (*Ref works*). Also for each article found the reference lists were checked for further references and a 'cited' search was also performed on articles of particular relevance to this review.

## Appendix III

**A table to summarise the criteria for professional status as described in the literature**

## Appendix III

## A table to summarise the criteria for professional status as described in the literature

| *Criteria* | *Authors* |
|---|---|
| *Performs a unique and essential social service* | Lieberman (1956 cited in Kim 2001), Popkewitz (1994), Cant & Higgs (1999), Holye & John (1995), Nixon & Creek 2006. |
| *Founded on intellectual techniques* | Lieberman (1956 cited in Kim 2001). |
| *Long periods of specialist training/education* | Lieberman (1956 cited in Kim 2001), Downie (1990), Popkewitz (1994), DuToit (1995). |
| *Formal educational requirements* | Cant & Higgs (1999), Hoyle & John (1995), Hunt et al. (1998b). |
| *Responsible for judgements made and acts performed within the scope of practice* | Lieberman (1956 cited in Kim 2001), Popkewitz (1994). |
| *Both individual and group autonomy* | Samuels (1987), Popkewitz (1994), Hoyle & John (1995), Richardson (1992), Hunt et al. (1998), Nixon & Creek (2006). |
| *Commitment to expand and develop expertise* | Eruat (1994) DuToit (1995), Hunt et al. (1998). |
| *Emphasis on the service performed rather than financial rewards* | Lieberman (1956 cited in Kim 2001), Downie (1990), Eraut (1994), Popkewitz (1994) |
| *Self-governing independent organisation of practitioners* | Lieberman (1956 cited in Kim 2001), Downie (1990), Eraut (1994), Popkewitz (1994), Cant & Higgs (1999), Hoyle & John (1995), Hunt et al. (1998b). |
| *Knowledge base/professional culture* | Downie (1990), Richardson (1992), Popkewitz (1994) Cant & Higgs (1999), Helders et al. (1999). |
| *Operates a code of ethics* | Lieberman (1956 cited in Kim 2001), Downie (1990), Popkewitz (1994), DuToit (1995), Goodson & Hargreaves (1996). |
| *Able to speak publicly on broad issues relevant to the body of knowledge* | Downie (1990). |
| *Period of professional socialisation* | DuToit (1995), Hoyle & John (1995), Clouder (2003) |
| *High social standing and earning* | Hoyle & John (1995), Saks (1999). |

# Appendix IV

## Participant case profile

**Participant's Case Profile**

Name: Lauren
Contact number:
First post:
Start date: 2/9/02
Profile of participant: Age, Gender, Admission profile, Exit profile.

22yrs, F, 3 Alevel, 2:1

**First interview date and time:** 18/7/02 2.30pm
Consent form completed: ✓
Comments:

My office
Excited but worried
about skills

**Second interview date and time:** 3/3/03 2pm
Arrangements: Directions, car park and cost, quiet room with socket, Manager's permission, contact numbers. → tube
Comments:

2/1/03 Left message on mobile
7/1/03 Doesn't rotate until early Feb
18/2/03 Left message on mobile
19/2/03 Interview arranged
Enjoying herself

**Third interview date and time:**
Arrangements: Directions, car park and cost, quiet room with socket, Manager's permission.
Comments:

3/7/03 Rang left message
11/7/03 Rang left message
12/7/03 arranged for 29/7

As bubbly as ever.

## Appendix V

## Interview record sheet

## Interview Record Sheet

| Name | Hospital | 1st Interview | Start Date | 2nd Interview | 3rd Interview |
|---|---|---|---|---|---|
| Jake | | 18/7/02 | 7/02 | 4/12/02 | 4/4/03 |
| Brian | | 1/10/02 | 7/10/02 | 9/4/03 | 9/8/03 |
| Philip | | 18/7/02 | 7/02 | 29/1/03 | 12/7/03 |
| May | | 25/7/02 | 2/9/02 | 5/2/03 | 11/6/03 |
| Nathan | | 3/9/02 | 23/9/02 | 18/3/03 | 14/7/03 |
| Georgina | | 22/7/02 | 12/8/02 | 6/1/03 | 13/6/03 |
| Linda | | 4/9/02 | 10/9/02 | 27/1/03 | 10/6/03 |
| Lisa | | 23/7/02 | 1/8/02 | 5/2/03 | 25/6/03 |
| Kath | | 17/9/02 | 23/9/02 | 9/7/03 | 4/12/03 |
| Lauren | | 18/7/02 | 2/9/02 | 3/3/03 | 29/7/03 |

***My numbers:*** **w- 020 8891 0121 ext 2542**
**m- 07754**
**h- 01895**

***Questions:***

1. **Room + socket**
2. **Directions**
3. **Permission from manager**

H/eddoc/subjectrecordsheet

# Appendix VI

## Informed consent form

## CONSENT FORM

*Title of the Study:*
Newly qualified physiotherapists' expectations and experiences of their first posts: A qualitative study.

*Invitation to Participate*
You are being asked to take part in this research project. The information below explains, in ordinary language, what will happen to you if you agree to take part; it describes any risks or discomfort you may have, and it also explains what I hope to learn as a result of your taking part.

You are invited to participate in a research study of newly qualified physiotherapists' expectations and experiences of their first posts.

*Basis of Subject Selection:*
The reason you are invited to participate in this study is because you are a newly qualified physiotherapist who is just about to start your first post.

*Purpose of the Study*
The purpose of this study is to explore newly qualified physiotherapists' expectations and experiences of their first posts.

*Explanation of Procedures*
You will be interviewed on three occasions. The first being before you start your first post, the second not less than four months into this post and the third not less than eight months into the post. The total time that is required of you is approximately one hour for each interview. Each interview will be taped. At a later date you will be sent a summary of the findings and you will be asked to complete a short questionnaire, which will ask you if the findings reflect your experiences or there are any omissions.

*Potential Risks and Discomforts*
There should be no potential risks or discomforts.

*Potential Benefits*
You will derive no direct benefit from participating in this study. This study may reveal aspects of newly qualified physiotherapists' expectations and experiences of their first posts. This information, in turn, may help future newly qualified physiotherapist.

**Assurance of Confidentiality**

Any information obtained in connection with study will be treated as privileged and confidential and will not be released to any unauthorised person(s) without your consent. Any information obtained in this study may be published in appropriate journals or

presented at professional meetings. In such publications pr presentations, your identification will not be disclosed.

## In Case of Injury

Brunel University has public liability insurance cover for persons such as yourself who are authorised to be on their property. Further, you are covered for any negligence on the part of the University. You are not covered for accidents caused by your own negligence.

## Withdrawal From the Study

You should not take part in the study if you do not wish to do so. You may also withdraw at any time during the research, without giving a reason.

## Any Questions?

If you have any questions please do not hesitate to ask. If you think of questions later, you should contact me at the address below.

You are voluntarily making a decision whether or not to participate in this research study. Your signature certifies that you have decided to participate having read and understood the information presented. Your signature also certifies that you have had an adequate opportunity to discuss the study with the researcher and you have had all your questions answered to your satisfaction. You will be given a copy of this consent form.

------------------------------------------------ --------------------

Signature of Subject Date

My signature as witness certifies that the subject signed this consent form in my presence as his/her voluntary act and deed.

------------------------------------------------ --------------------

Signature of Witness Date

In my judgement the subject is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this study.

------------------------------------------------ --------------------

Signature of Researcher Date

(The above informed consent form is taken (as amended) from :
Bork, C E, (1993) Research in Physical Therapy
Philadelphia, J B Lippincott Co.)

H:/Eddoc/consent