

Exploring the lived experience of Osteopathy students making the transition from working in student clinic (8 hours per week) to working full-time (40 hours per week) during the summer holiday break

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Declaration

Name of candidate: Daniel Garelja

This Thesis/Dissertation/Research Project entitled “Exploring the lived experience of Osteopathy students making the transition from working in student clinic (8 hours per week) to working full-time (40 hours per week) during the summer holiday break” is submitted in partial fulfilment for the requirements for the Unitec degree of Master of Osteopathy

Candidate’s declaration

I confirm that:

- This Thesis represents my own work;
- Research for this work has been conducted in accordance with the Unitec Research Ethics Committee Policy and Procedures, and has fulfilled any requirements set for this project by the Unitec Research Ethics Committee.

Research Ethics Committee Approval Number:

Candidate Signature:Date:

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List of Abbreviations

Master of Osteopathy – MOst

Abstract

Introduction: The transition made from being a novice to having greater expertise has been discussed since the late 20th century in the field of nursing. However, recently the focus of research has widened to study transitions in all forms of healthcare. Osteopathy, a form of manual healthcare, has limited research into its techniques and philosophies, and the transitions made by students when studying and practicing osteopathy. In New Zealand, Unitec and the ARA Institute of Technology are the providers of education in osteopathy, with students completing an undergraduate degree and Master of Osteopathy (MOst) Postgraduate Diploma of Osteopathy, respectively. This research project investigates the lived experiences of student osteopaths as they make the transition from full-time students and part-time practitioners to full-time practitioners in a supervised work environment at Unitec. During the MOst programme at Unitec, students complete eight hours of clinical work experience per week during the semester. During the summer break of the first year, the students are immersed in a clinical experience where they complete 40 clinical work hours per week for one month.

Methodology: An exploration of the transition that students make during this immersive experience was conducted through focus group interviews. To analyse the data, a descriptive phenomenological research method was used. This method allows the researcher to analyse the data, extract the essence of the discussion and create a fundamental structure of the phenomenon (making the transition). Preconceptions and biases held by the researcher are recorded and acknowledged to mitigate external influences acting on the data. Colaizzi's (1979) method was used to analyse the data. In this method, the information gathered is read and reread and clustered into themes before the essence and fundamental structure of the phenomenon is recorded and checked by the participants.

Results/Findings: The themes and subthemes that presented themselves were: 1. *"Confidence from Validation"* with subthemes including the effects of validation on i. clinical skills; ii. professional identity; and iii. comparison with others. 2. *"Immersion and groundedness"* (which is described by the participants as being mentally present and able to adapt their own style of osteopathy for each patient) with subthemes including the changes to i. sense of self and confidence; ii. New patient management; and iii. environmental effects: tutors, chores and reception. 3. *"Stress from clinical and extra-curricular commitments"*, with subthemes i. financial burden; ii. positive and negative reactions to stress; and iii. rewards from immersion.

Conclusion: The students felt nervous and unsure going into the month, expecting very difficult clinical scenarios to come up throughout the month. The clinical tutors played a large part in building the students' confidence during the experience. As there is no objective measure of improvement, the students sought validation of their clinical skills from the tutors and compared their skills to those of other students. After being immersed in the experience,

the students built a sense of self confidence and groundedness. The environment that the students worked in, from the tutors and receptionists to the chores and clinical maintenance, had a large effect on their experience of this transition. Stresses such as financial strains and relationship burdens added to the pressure on the students, as the month of clinical work is unpaid, leaving students without income for a month during a time where they could have equivalent, paid employment (the summer break period). Some students felt that the stresses improved their clinical confidence and competence as they learnt to manage themselves and their time effectively. By comparison, other students felt that these stresses took away from the experience. There was consensus that the month-long immersion was essential for helping the novice osteopath find their own style of osteopathy that they hope to employ in the future and helping in the transition that is entailed in acquiring greater expertise.

Chapter 1 – Introduction & Review of Literature

Osteopathy is a patient-centred form of manual therapy. Like other forms of manual healthcare, osteopaths practice osteopathy to the constraints of their physique and personality (Davidson, 2009; Kleinbaum, 2009). The formal education and clinical experience guides the osteopath in their diagnosis and treatment, which classically does not use medical jargon (Grace, Orrock, Vaughan, Blaich, & Coutts, 2016). In New Zealand, each student of osteopathy is required to complete a qualification accredited by the Osteopathic Council of New Zealand. Between 1999 and 2018, this consisted of a Bachelor of Applied Science (Human Biology) and a Master of Osteopathy (MOst) degree at Unitec Institute of Technology ('Unitec') (Kleinbaum, 2009). As of 2018, the ARA Institute of Technology in Christchurch, New Zealand offered a pathway to registration as an osteopath, where the students undertake a Bachelor of Musculoskeletal Health, followed by a Postgraduate Diploma of Osteopathy, the latter being offered in 2021 ("Postgraduate Diploma of Osteopathy," 2016).

Literature on the development of expertise is extensive, with many academics offering theories on the pathway from novice/beginner to expert (Benner, 1982; Lewin, n.d.; Peña, 2010; Sargent & Schlossberg, 1988). The term 'Novice' is used to describe someone with little or no experience in the field that they are expected to have knowledge of, or who follows rules context-free (Benner, 1982; Greenfield et al., 2014). 'Expertise' is described as having an extensive background knowledge in the chosen field and being able to apply intuition to guide practice rather than following analytical rules and tools regardless of context (Benner, 1982; Pereira & Aziz, 2015). Benner (1982) described the stages between novice and expertise, labelling them 'advanced beginner' - where the individual has some experience and improved performance; 'competency' - where the individual is able to perform actions while considering the long term plan appropriate and has gained more experience (approximately two to three years); 'proficiency' - described as the ability to see the situation as a whole, how to act in response to modification of plans, and understands the important aspects in decision making, which have been developed through experience.

In the literature, there appear to be only two studies of transitory stages for osteopaths, from student to practicing osteopath and why osteopaths choose to leave the profession (Davidson, 2009; Kleinbaum, 2009). This study examined the transition that the students make from novice to advanced beginner while at Unitec. For one month, each student is required to enrol in an immersive full-time clinical work experience. This month of unpaid, immersive education is the first full-time work the

students experience as osteopaths. The pedagogy of immersive environments is not fully developed, however, the experience does improve student competence and confidence (Hand, Cavagnetto, Chen, & Park, 2016; Pliego, Wehbe-Janek, Rajab, Browning, & Fothergill, 2008). Approaching the immersive month through the eyes of the students experiencing it, being mindful of bias and prejudice, will help the reader understand the changes and transitions that are made by the students.

Introduction to Literature Review

In order to register as an osteopathic practitioner in New Zealand, students at Unitec must complete a three-year Bachelor of Applied Science in Human Biology degree followed by a two-year Master of Osteopathy (MOst) degree. Following the three-year Bachelor of Human Biology degree and a minimum achievement of a B grade average in the third year, students must attend an interview before being accepted into the two-year postgraduate MOst degree. Students must complete the MOst programme to become registered as an osteopath. The requirements of the MOst degree are that the students must reach a passing grade in all papers, carry out a 90-credit thesis and undertake 1000 hours of recorded clinical work.

The Bachelor's programme focuses on practical techniques and the theoretical aspect of the profession while the MOst programme aims to help students make the transition from 'paper to person', i.e. developing skills in clinical proficiency so that following graduation, the new osteopaths are experienced practitioners with a strong sense of professional identity (Greenfield et al., 2014). During the first year of the MOst programme, each student has two four-hour clinical shifts scheduled per week that contributes towards the required 1000 clinical hours. During the summer break, between fourth and fifth year, each student must participate in a month of full-time (40 hours per week) clinical work. A review of the literature shows that only one study has focused on the transition from student to practitioner in the field of osteopathy (Davidson, 2009). However, that study used questionnaires and interviews to document the changes that occurred during this transition rather than seeking to understand the lived experience of the transition itself. Another study by Subramaniam et al., (2014) used quantitative data collected from survey results to assess feelings of stress and competence in new graduates. However, to date, there have been no qualitative studies of the transition students make when going into full-time work in a controlled environment.

A recent study of student osteopaths who were making the transition between the undergraduate and postgraduate programmes at Unitec explored how students develop as first-time osteopathy

opinion practitioners (Gaddes, 2017). This study was conducted on fourth year osteopathy students at Unitec using qualitative interviews and thematic analysis to explore the transition between the two education programmes. A sample size of 13 participated. Thematic analysis was used to analyse the collected data, and found that students were initially lost and unsure how to conduct themselves in postgraduate programme, however, over time and with the help of tutors the students became aware of their shortcomings and how to correct them (Gaddes, 2017). Gaddes' study offers important insight into topic of this thesis, as the transition from undergraduate to postgraduate level study comes shortly before the transition made from part-time practice, to full-time practice in a teaching clinic. Moreover, Gaddes' study and this thesis involved the same population, but different samples (Gaddes, 2017).

This study collected data relating to the human experience of what it is like to be fully immersed in a teaching clinic. In previous studies of osteopathic transitions, data revolved around the changes experienced when making the transition from undergraduate to post-graduate studies in osteopathy (Gaddes, 2017), when first entering the workforce (Davidson, 2009; Subramaniam et al., 2015), or when leaving the osteopathic workforce (Kleinbaum, 2009) rather than understanding the experience of being fully immersed in osteopathic practice. Using descriptive phenomenology to study this event allows the observers to understand the human experience involved in the transition within the osteopathic education framework (van Manen, 2016). Kleinbaum (2009) used a mixed method design to investigate attrition rates of osteopaths leaving the profession in New Zealand, Australia, United Kingdom, and the USA. The main finding was that osteopaths leave the profession due to extrinsic factors (those the participant had no control over), intrinsic factors (such as person's personality and suitability to the practice of osteopathy), or a combination of both. This study appears to be the only one in the field of osteopathy and is important as it identifies factors that affect the transitions that osteopaths make while working through interpretive descriptive methods based on phenomenological methodology (Kleinbaum, 2009).

Gaddes' (2017) and Kleinbaum's (2009) use of qualitative methods contrasts with a quantitative approach that would use objective measures, such as surveys and questionnaires, to study the same phenomenon. Quantitative methods allow insight into common feelings that a sample group may have about a topic, which can then be generalised to the wider population. For example, using a robust, standardised questionnaire to gauge changes in clinical competence or business orientated knowledge before graduation and after a year of professional work as an osteopath (Subramaniam et al., 2015). Whilst comparable data may be collected, and conclusions can be drawn about cause and

effect, there are a variety of statistical parameters that must be met in order for the data to be valid, reliable and generalisable to the wider population. Furthermore, the emphasis on objectivity detracts from a deeper understanding of the experience and the reasons for the potential variation in the data over time does not explore the reasons for any observed changes. Therefore, a phenomenological methodology allows the description of the lived experience to be gathered from the view point of the students and provides insight into how individual changes are experienced (Davidson, 2009; McPeake, 2014; Wojnar & Swanson, 2007).

Additionally, the timeframe that the transition to full-time supervised clinic occurs in does not correlate with any current transition theories. There are many different theories that have been created to categorise the types of transitions and what occurs in different stages of a novice's development to expertise (Benner, 1982; Burnes, 2004; Evans, Forney, Guido, Renn, & Patton, 2009; Peña, 2010). Therefore, rather than using a theory to understand the transition, the goal of this study is to understand the individual experience of the transition, minimising the effects of any biases or prejudices. It is important to have some understanding of the background of different transition theories, in order to understand the different ways that people can experience change.

Dreyfus' Model of Skill Acquisition

The Dreyfus 'Model of Skill Acquisition' (1980) was developed as a theory to describe the transition a student or practitioner makes as they develop from a 'Novice' to an 'Expert' in their chosen field (Peña, 2010). This theory of transition was developed using chess players and pilots, with the view for it to be applied widely in different fields such as medicine, sport, gaming and education (Benner, 1982; Dreyfus, 2008). The acquisition of experience (for example clinical hours or number of patients seen) defines the transition from novice to advanced beginner, but in both, the student or practitioner follow rules context-free and take no responsibility for their actions outside of the rules (Peña, 2010). Competence follows when the student or practitioner can use some pattern recognition when identifying situations, where rules can be easily interpreted but still strictly adhered to (Field, 2014). Proficiency follows and is where intuition is expected to be used when interpreting situations (Dreyfus, 2008). During proficiency, the student or practitioner is more experienced and can adapt rules and their strategies depending on the context of the situation. This is compared to the final Expert stage, where the student or practitioner can intuitively adapt to the situation needing small amounts of explicit knowledge, as their pattern recognition and clinical knowledge is vast (Field, 2014; Peña, 2010).

In a critical review of Dreyfus' model by Peña (2010), potential problems with the 'Model of Skill Acquisition' have been highlighted. This review addressed the complexity of learning problem-solving skills and how implicit and explicit forms of knowledge are important to consider. Peña (2010) did not offer methods or information regarding how the Dreyfus' model was critiqued. Field (2014) also critically reviewed Dreyfus' model, however, did not present methods for how the model was reviewed. Both Peña (2010) and Field (2014) were conducted in university healthcare settings in America and England, respectively. Both offer extensive review of Dreyfus' model and the implications of its application in educational healthcare scenarios.

Patricia Benner – Novice to Expert

In 1982, Patricia Benner expanded on the Dreyfus model, specifically for nurses and their development (Benner, 1982). The five stages describing the transitions made to becoming an expert are the same as in the Dreyfus Model of Acquisition, however, Benner aims to use her model as a basis for career progression in nursing. Rather than solely describing the differences between stages, the Dreyfus model was applied to nursing with the general characteristics of the stages made specific to the development of nurses in practice (Benner & Tanner, 1987). The original article (1982) contends that expert practice is difficult to describe as the expert's performance is intuitive and holistic; fluid and able to work outside of context; understanding and is able to be guided by theory; has an efficient and intuitive grasp of a scenario and is able to apply analytical tools seamlessly without wasteful consideration of other possible scenarios (Benner & Tanner, 1987). Therefore, Benner's adaptation of the Dreyfus model uses a more interpretive description, where expert practice is shown in separate scenarios, from the expert's viewpoint, rather than attempting to define it with a rule (Benner, 1982). Davidson (2009) comments that there is little research into expert practice in osteopathy. Further research into different levels of experience and osteopathic practice would provide a base for creating a model for osteopaths as Benner's has done for nursing.

Benner's research is important as it defined transition in a specific medical profession; something which had not been done before. Although it specifically refers to nurses, this transition phenomenon is important because it outlines the characteristics that each individual can measure themselves against to get a sense of how they compare with experts. It can also be used by education and workplace institutions to give nurses an idea of the performance or knowledge that is expected of them (Benner, 1982). The phenomenon in question in this thesis is the experience that students had during the full-time month of working and the transition from part-time to full-time clinical practice.

Benner's work is important to review in the context of this study as an argument can be made for utilising Dreyfus' development theory to evaluate how osteopaths develop as practitioners during this transition.

Benner's adaptation of Dreyfus' model provides an effective guide for developing a tool to measure the change in skills of a nurse (the Nursing Professional Values Scale) (Weis & Schank, 2000). There has been research into utilising assessment tools to measure the clinical skills of an individual osteopath, however, to date, there is no comparable progression model specifically for osteopaths (Gimpel, Boulet, & Errichetti, 2003).

Schlossberg's Transition Theory

In 1995, Nancy Schlossberg, a clinical psychologist, developed a transition theory that defines a transition as any event or non-event that results in a change in relationships, routines, assumptions, and/or roles (Evans et al., 2009). Schlossberg's theory is based on the collaboration of more than fifteen authors and described how transitions are unsettling no matter whether they are positive or negative and they change the way they we experience our existence whether the individual is aware of the transition or not (Killam & Degges-White, 2017; Powers, 2010). This transition theory is similar to Benner's adaptation of the Dreyfus model as it is described interpretively with the participant describing the lived-experience of the transition through their own understanding. This is a classic example of hermeneutic phenomenology (Benner, 1982; Evans et al., 2009; Wojnar & Swanson, 2007).

Schlossberg categorised the types of transitions that one may experience as events and non-events, where events are divided further into anticipated or unanticipated events and non-events are either personal, ripple, delayed or resultant non-events (Evans et al., 2009). Non-events are events that are expected but do not occur (Sargent & Schlossberg, 1988). There are also four factors that determine how one may cope with a transition. The first is the 'Situation', which describes the timing, trigger, duration, previous experiences and role changes that occur with this transition. The second is 'Self', which is the personal and demographic characteristics plus the psychological aspects of the individual that determines how they cope. The third is 'Social Support' which includes any support from family, friends, partners, institutions, or communities. The final is 'Strategies of Coping' which is divided into categories based on whether they modify the situation itself, the meaning of the transition or help with managing the stress post-transition (Evans et al., 2009).

The timeframe during which this study was undertaken was relatively short when compared to progression models of transition such as Dreyfus' and Benner's models. Due to this short timeframe, any changes that occurred were expected to be between the Novice and Advanced Beginner stages (Peña, 2010). The potential of events to cause a change in methods or routine and the durability of the changes may be seen in this study, however, any development of intuition or pattern-recognition skills was unlikely to be seen within a month. Schlossberg's event-based transition theory may be more effective in describing causes of the experiences the students may have over this month, however, the overall transition of an osteopath throughout their career is expected to follow Dreyfus' universal Model of Skill Acquisition (Field, 2014).

Kurt Lewin's Force Field Analysis and Change Theory

In the mid-20th century, Kurt Lewin developed change theories around organisational development and designed a three-step change model (Burnes, 2004, 2017). These ideas have been studied, appraised and built up in the literature, and are now a field of study in themselves (Yu & Frempong, 2016). 'Force Field Analysis' (FFA) was part of his 'Field Theory' that looked at the changes occurring in a broader group, as he felt that it was necessary to understand the conditions or forces acting upon a group or situation. The behaviour of an individual was stipulated to be a product of the group environment (termed 'field'), and, therefore, any change in the individual behaviour was due to a change in the field (Burnes, 2004).

FFA is notable in change theory development because it shifts the focus from the individual towards the 'field' that the change is occurring in (Burnes, 2004). Group dynamics was another notable term as Lewin discussed how the dynamic of the group and its relationships with other sections of the whole influenced the behaviour of the group members (Zand, 2009). Lewin also studied which aspects of the group characteristics were influenced by the forces acting upon them, how these changes subsequently affect the members and, more importantly, if the forces acting upon the group can be controlled. The aim of FFA was to produce a more desirable group traits in different settings, for example an osteopathy student clinic group (Burnes, 2004, 2017; Zand, 2009).

The three steps of Lewin's change model are 'unfreezing', 'moving', and 'freezing' (Zand, 2009). These steps are part of the organisational change model developed to influence the characteristics of a group and put the analyses of the field into action. The first step 'unfreezing' refers to breaking down a current situation so the ideas and old behaviours can be analysed. The stability of the present situation

is maintained by an equilibrium of human behaviour and, therefore, different methods must be applied to make changes in different groups. Next is the 'moving' step where the new skills or ideas are learnt, however, it is important to note that the unfreezing step only provides a base for moving and after unfreezing the moving stage can go in any direction. The forces acting upon a group must be understood so that organised change can occur here, where the forces are altered to produce the desired characteristics of the group. Lastly the 'freezing' stage occurs where the equilibrium in the new situation is aimed to be maintained so there is no regression to the previous state. Therefore, there must be change to the organisational culture, policies and practice (Burnes, 2004; Levasseur, 2010; Zand, 2009).

Similar to previous critical reviews, Burnes (2004) offers a review and critique of Lewin's FFA and provides his scholarly opinion on the theory, however, does not include the methods or methodology used to come to the conclusions and critique developed throughout his study. Similarly, Burnes (2017) and Zand (2009) also offer review and further discussion of Lewin's work. All articles cover a large breadth of information and produce a clear review of Lewin's transition model. Levasseur (2010) discusses the practical use of Lewin's FFA model, however, was conducted in a similar manner to Burnes' (2004, 2017) and Zand's (2009) opinion pieces. The studies were conducted in educational institutes across the USA, and UK.

Road to Excellence

The acquisition of expert performance across many different fields was detailed by Karl Ericsson in 1996. In his book 'The Road to Excellence' (1996), he describes the common pathways that one would take to achieve excellence in any field and how the achievements of an expert stand out when compared with those of their peers. However, in this book the psychological processes leading up to that point are not scientifically recorded (Ericsson, 1996). In medicine, the distinguishing factor between novices and experts is the organisation of their knowledge, reasoning strategies, pattern-recognition capabilities and metacognitive abilities (Ericsson & Smith, 1991). The novice-to-expert continuum is recognised here with expertise broken down into specialist and general expertise. General expertise is gained from studying, internship, and practicing as a physician. Specialist expertise is gained when a physician (or expert in another field) chooses to specialise in a specific category or field. These types of expertise overlap and specialists may still develop their general expertise when working outside of their specific field (Ericsson, 1996; Patel & Groen, 1991).

To become an expert, Ericsson (1996) discusses how 10 years is considered the estimated amount of time required to become an expert. However, 10 years in a single field does not guarantee expertise. Expert performers engage in more deliberate practice with the intent to improve performance through specified tasks that are designed to enhance different skills needed for expert performance. Compared with the other individuals who partake in a similar activity, experts practice with focus and deliberation rather than enjoyment, and are commonly supervised by a coach to ensure training can be targeted at any skill deficiencies (Ericsson, 1996). The 10 years of preparation is broken down further to 10,000 hours of deliberate practice with the aim to refine execution of the task (Ericsson, 1996). This includes the time it takes for skill acquisition, maintenance of deliberate practice, feedback and review of current practice, planning and mediation of effective improvement and learning, all of which is specific to the domain. As this becomes a habitual practice, the lifestyle is difficult to maintain, especially into adulthood, as the expert practice and performance becomes mentally and physically demanding. Therefore, activities are specialised for the individual to constantly maintain and improve specified aspects of the performance (Ericsson, 1996).

Recent studies have challenged Ericsson's model of deliberate practice in acquiring expertise (Ericsson, 1996; Macnamara, Hambrick, & Oswald, 2014; Miller et al., 2018; Thomas & Lawrence, 2018). Differences in the measurement of expertise across different domains (eg sport, games, education, music, and professions) makes the analysis of expertise difficult. A 2014 meta-analysis of deliberate practice directly challenges Ericsson's claim (Macnamara et al., 2014). Macnamara et al. (2014) independently analysed 88 articles that investigated the results following deliberate practice across domains such as games, music, individual sports, education and professions, and found that the variation in performance explained, and not explained, by deliberate practice does not strengthen Ericsson's claim. Miller, et al., (2018) reviewed Macnamara et al.'s (2014) meta-analysis in context of the current literature. The study found that 14% of the variance in expertise can be explained by deliberate performance. Deliberate practice is important, but how important is still debated (Macnamara et al., 2014; Miller et al., 2018). Thomas and Lawrence (2018) investigated domain differences across professions including weather forecasting, auditors, livestock judges, clinical psychologists, polygraphers, and stockbrokers. Factors such as aids in decision making, difficulty measuring criteria, and substituting criteria with gold-standards influence how a domain differs in levels of professional competency. There is controversy regarding how expert-level knowledge and fast decision making relates to high level performance across all domains and also the issue of 'nature' (pre-existing abilities) versus 'nurture' (job-relevant experience) (Thomas & Lawrence, 2018).

Qualitative Approaches - Phenomenology

Phenomenology was developed as a philosophical discipline and research method by Husserl in the 19th century (Lopez & Willis, 2004; Wojnar & Swanson, 2007). Originally, phenomenology attempted to understand different 'phenomena' as experienced by the individuals who have lived through them (van Manen, 2016). Husserl developed his idea with the intent that any influences from bias or preconceived ideas can be reduced through 'bracketing'. Bracketing is a method where the researcher acknowledges their own bias and ideas prior to data collection, thereby, Husserl developed his idea with the intent that the effects of any preconceived ideas or influences can be 'bracketed' aside so that the participant can describe their lived experience of the phenomenon without any outside influence. Bracketing is a method where the researcher records their prejudices preconceived ideas prior to data collection so that during data analysis, influence from any preconceptions can be observed and kept in check, thereby, reducing the effects of bias (Lopez & Willis, 2004; Reiners, 2012). This methodology is termed 'descriptive phenomenology' and will be used in this study (van Manen, 2016). Bracketing was designed to improve the strength of phenomenological studies so that they could be considered scientific and generalisable. With this, Husserl developed his method to transcend subjectivity by abandoning his lived reality to describe the phenomenon in its pure, universal state (Wojnar & Swanson, 2007).

Descriptive phenomenology is different to hermeneutic phenomenology because it aims to create a description of the lived experience where external biases and interpretations are minimised (Matua & Van Der Wal, 2015). This type of research is commonly used in nursing and psychology and is effective for how the conscious mind understands (Davidsen, 2013). Knowledge of the lived experience without external influence allows for a more thorough understanding. This in turn aids future studies that investigate why a phenomenon is experience as it is, and how different interventions can be applied to the phenomenon for the improvement of individuals (Lopez & Willis, 2004)

In this study, descriptive phenomenology was chosen as its strengths play to filling the gaps in the literature. There are quantitative data in the osteopathic literature regarding the transition into full-time osteopathic work, however, only one study discussed transitions made as an osteopathy student develops towards becoming a practitioner (Gaddes, 2017; Subramaniam et al., 2015).

Lopez and Willis' 2004 scholarly opinion piece discusses the differences between descriptive and interpretive phenomenological studies and its application for nursing students and education. The article critically reviews both forms of phenomenology, and aims to stimulate dialogue regarding its application for nursing practice. Wojnar and Swanson (2007) review the differences between descriptive and interpretive phenomenological styles, how they can be applied, and the utility of both phenomenology styles in nursing science.

Background

A study conducted in 2015 by Subramaniam et al. of students completing a Master of Health Science (Osteopathy) in Australia and then making the transition into the workforce found an increase in confidence during postgraduate study. However, once the programme was completed and the students were in the workforce, confidence was much lower. The graduates felt that they were more confident and competent in the final months of the programme compared to 6 months into professional practice (Subramaniam et al., 2015). There are many potential reasons for this lack of confidence. However, one that is more likely is that the support that students have through the M0st programme suddenly disappears as they move into the workforce (Dornan, Boshuizen, King, & Scherpbier, 2007). Subramaniam et al.'s (2015) study was conducted using two surveys, one was conducted in the final year of Victoria University (Melbourne, Australia) osteopathy programme and the other six-months following registration as an osteopath. Of the 51 questionnaires sent out there were 25 responses. The questionnaires were developed for this study as there were no available tools specific to the osteopathic profession and therefore were not supported by evidence in the literature. Another study found the experience was similar for student nurses and midwives, (Fahey, 2006; Skirton et al., 2012). As only a single piece of research examines the changes newly graduated osteopaths feel going into the workforce, conducting further research pertaining to this topic could provide additional insight into how the transition from student to osteopath affects their pathway to expertise.

Osteopaths, once graduated and in full-time work, find that having access to an osteopathic support person can help build a sense of identity, help with clinical reasoning and diagnosis, and build a treatment or approach style (Davidson, 2009). Solomon and Miller (2008) found that a supportive workplace was the most desired aspect for job-seeking novice practitioners. Having supporting osteopaths was also ranked highly in Davidson's study (2009), and would help dampen the negative effects of the transition into full-time work that can be experienced by newly graduated osteopaths

(Subramaniam et al., 2015). Davidson (2009) used questionnaires and interviews to investigate the transition from student to practicing osteopath. The sample consisted of 20 participants (15 male and five female with a mean age of 33), all of whom had been working for 3-18 months as osteopaths. Davidson reported that participants struggled with 'transition shock' when entering the workforce, and strategies such as mentorship, guidance and self-care made students feel more comfortable.

Environmental Effects on Learning

Recent literature has investigated the effects of immersive environments and learning simulations in a healthcare education setting and found that a safe environment resulted in students feeling comfortable taking risks and accepting challenges (Pollock & Biles, 2016; Topping et al., 2015). Competence and skill acquisition were approached through exposing students to different learning opportunities both within and outside university settings (Meechan, Jones, & Valler-Jones, 2011). The simulations and immersive learning environments were shown to be positive tools for developing clinical skills and improving self-reported competence and confidence (Meechan et al., 2011; Moxham et al., 2017). Meechan, Jones and Valler-Jones' study (2011) investigated clinical skill acquisition of first year nursing students through a survey and examination results, demonstrating the effects of structured educational clinical simulations on skill acquisition. This study was conducted on 140 first year nursing students at the University of Worcester in England. Pollock and Biles' study (2016), used hermeneutic phenomenological methods and interviewed 10 students in the third semester of a two-year undergraduate degree to investigate their experiences of immersive patient care scenarios; a phenomenon similar to the one being studied in this thesis. Additional research supports the use of immersive environments in all forms of education due to positive results such as increased engagement and learning, however, it does not offer a gold-standard solution for the pedagogy required (Hand et al., 2016). While there is limited research into immersive learning environments in osteopathy settings, this is not the case with nursing, mental health and other medical fields where such research is more common (Davidson, 2009).

Another aspect of the environment that affects learning is the educator. Within education of osteopathy students, there is evidence of the effects that educators have, where critical thinking and use of evidence based medicine are influenced by the educators (Fryer, 2008). In 2016, Pollock and Biles (2016) conducted semi-structured interviews of undergraduate nursing students before using hermeneutic phenomenological methods to analyse the data. They concluded that it is the educator who creates a safe and engaging learning environment where students can take risks and reflect on

their performance and ability, in turn improving student engagement and success as they feel supported and encouraged regardless of any negative aspects of the simulation.

Postgraduate Study Influence on Workplace Competence

Studies conducted on the effects of postgraduate study on workplace performance in manual therapists shows benefits for the extended period of study. Improvements in clinical confidence and improved clinical reasoning were seen following postgraduate study (Green, Perry, & Harrison, 2008; Perry, Green, & Harrison, 2011). The Masters level study helped to deconstruct their existing cognitive framework and challenge the students to rethink and understand their topic, which in turn affects their thinking universally (Green et al., 2008). Dornan et al. (2007) found that medical students must develop both clinical competence and a confident state of mind and sense of identity to become effective medical practitioners. These qualities reinforce each other and will improve with time as there is further immersion in clinical practice. The increase in clinical confidence was a common theme that Masters students expressed which was experienced in professional and personal aspects of their life (Dornan et al., 2007; Green et al., 2008; Tryssenaar & Perkins, 1997).

In addition to a boost in confidence, Green et al. (2008) found an increase in accurate clinical reasoning and diagnosis. Those with formal specialist training were better able to clinically reason faster and solve problems with less error compared to similarly experienced physiotherapists with no formal training. In this instance, the formally trained physiotherapists expressed the analytical and critical thinking that postgraduate institutions hope to teach students. In a qualitative study of medical students, it was found that after the practical internship, those who had more time with patients felt more satisfied and found the transition into full-time work easier than those with less patient exposure (Prince, Van De Wiel, Scherpbier, Can Der Vleuten, & Boshuizen, 2000).

Green et al. (2008) investigated the influence of a Master's level qualification on physiotherapist's careers using a survey design. Questionnaires were piloted before being sent out to 77 physiotherapists that graduated from 'MSc Manual Therapy programmes' between 1994 and 2005. Only 48 responses were recorded. The study found that respondents perceived that a Master's qualification had a positive effect on aspects such as improving clinical skill and confidence, but was accompanied by factors that were perceived negatively such as increased management responsibilities, less free time and less clinical 'hand's on' time (Green et al., 2008). Using a different approach, Prince et al. (2000) conducted focus group interviews to investigate the transition from pre-

clinical to clinical phases of fifth year students in a medical school based in the Netherlands. Three focus groups made up of seven, five, and eight participants respectively were carried out. Content analysis was used to analyse the data. The main finding was that students found it difficult to merge clinical and theoretical knowledge and experienced difficulty applying theoretical knowledge to clinical scenarios (Prince et al., 2000).

Full-time immersion: effects on competency and confidence

The effects of an immersive full-time work experience have been documented in recent articles that study the effects that the transition from student to practitioner has on confidence, competence, stress and mental health measures (McPeake, 2014; Robins, Roberts, & Sarris, 2018; Wright et al., 2018). Within the transition, the changes to confidence were not constant. For example following immersion in a physiotherapy clinical setting, confidence was built, however, these improvements were lost once they left the full-time setting (Wright et al., 2018). This was also seen in other studies of transitory periods, where student health professionals felt unprepared prior to the full-time clinical experience (Levett-Jones, Pitt, Courtney-Pratt, Harbrow, & Rossiter, 2015; Rugen, Harada, Harrington, Dolansky, & Bowen, 2018). An investigation into senior nursing students' confidence and competence following an intensive clinical course found that students were able to utilise their theory knowledge in the practice, and that practicing common clinical skills improved levels of self-confidence and competence (S. Park, 2018). However, a lack of confidence and feeling of being unprepared may stem from the students not practicing all the techniques of the clinicians role, either due to technical difficulty or a low likelihood of the scenario occurring in practice (S. Park, 2018). A year-long clinical simulation for nursing students resulted a large increase in self-reported patient care and inter-professional teamwork, however, throughout the year the students shifted their priorities towards professional and clinical development (Rugen et al., 2018). Rugen et al.'s, (2018) study also focuses on the development of post-graduate students and utilises open ended questions across three time points (one, six, and twelve months through the post-graduate training year). A 2014 meta-analysis of 15 studies into 'boot camp' style of education in medical fields found that all had positive results on clinical knowledge and skills and also confidence (Blackmore, Austin, Lopushinsky, & Donnon, 2014). Results from Mori, Carnahan and Herold's (2015) systematic review found similar results following simulation learning experiences in physiotherapy students. The boot camps were held during career transitional periods, either from post-graduate to residency or residency to speciality. The duration of the camps was shorter compared to other studies of transitional phenomena. The meta-analysis

found the duration of the boot camps ranged from four hours over 2.5 days to 160 hours over eight weeks with some being eight hours over a single day (Blackmore et al., 2014).

Focus Group Data Collection

Focus group methods are common in healthcare qualitative research (Foley & Timonen, 2015; Nyumba, Wilson, Derrick, & Mukherjee, 2018; Wilkinson, 1998). In a review of the use of focus groups as a method, Wilkinson (1998) describes how focus groups aim to explore people's attitudes and beliefs and how they are held in a social context. Similarly, in a recent exploration of the methodology by Nyumba et al. (2018), focus groups were described as drawing from the personal experiences, beliefs and attitudes of the participants (Nyumba et al., 2018). Therefore, it can be important to reflect on the socio-economic status of the participant's as this can influence how they interact and discuss sensitive topics. Wilkinson's study from 1998 could be considered outdated and there is more recent literature (such as Nyumba et al.'s study from 2018) that provides a new best practice guideline, however it is important to consider as Nyumba et al. (2018) makes reference to Wilkinson results in their study. Nyumba, et al.'s (2018) review of the methodology screened 170 studies done between 2011 and 2017 from different populations and identified how previous studies did not include a rationale for, and information regarding, the focus group design. This led to the development of suggested best practices. Nyumba et al. (2018) had similar findings to Wilkinson's (1998) and Guest et al.'s (2017) that participants are more likely to share sensitive information (such as substance abuse, sexual abuse, mental illness, homelessness and criminal activity among others) in a focus group setting. Guest et al.'s (2017) original hypothesis, based on three empirical studies, was that people are more likely to share sensitive information in a one-on-one scenario, however, the power imbalance in a research-participant situation detracts from the openness. Guest et al.'s (2017) study compared the differences between the results of focus group and individual interviews. Although the sample size was large (350 participants) the sample comes from a specific part of the population (African-American men living in Durham, North Carolina) and therefore must be considered in context of the study. The researcher or facilitator in a focus group plays a large role in the effectiveness of the focus group and skills relating to developing a rapport, listening, communication, flexibility (regarding the flow of the discussion) and impartialness are important for this (Nyumba et al., 2018; Rabiee, 2004). This aspect of the focus group is not commonly reported according to Tong, Sainsbury and Craig, (2007) meta-analysis of an item checklist of qualitative interview and focus groups studies.

Colaizzi's Method of Data Analysis

Colaizzi's method of data analysis was created to establish a reliable method for conducting phenomenological research (Colaizzi, 1973; Dowling, 2007). The steps employed by Colaizzi's method aim to break down the data into units, cluster and transform the units into meanings understood in phenomenological terms and then create a description of the phenomenon from these units. An aspect of his method that is different to other phenomenological styles of analysis is that it recognises some interpretation in the creating of the description, therefore, the data analysis is presented to the participants for checking before completion. Using Colaizzi's method enhances the rigour of the study by increasing the credibility of the findings (Abu Shosha, 2017).

Colaizzi's method is considered dialogal, where the research is done through dialogue with the participants, however, he stresses that dialogue occurs only between equals (Beck, 1994). Differentiating or stratifying the individuals due to social or professional cues diminishes the ability for dialogue, reducing the insight into the phenomenon as the individual experiences it. This is compared Van Kaam's phenomenological research who calls for expert opinion on the research findings, risking interpretation of the results whereas Colaizzi takes the results back to the participants to ensure validity (Beck, 1994; Reiners, 2012; Van Kaam, 1959). By taking the research findings to experts, the interpretation of data can be affected by biases that come from the expert's opinion (Reiners, 2012). Although the approaches to methodology are otherwise similar, this variation in methods affects the validity of results. More recent research argues for an extension of Colaizzi's methodology to allow for non-verbal communication to be used during research (Edward & Welch, 2011). The goal of phenomenology is to give a scientific value to 'expressions of life', which is the understanding and experience of phenomena. Edward and Welch (2011) described how art, music, poetry and metaphor are vehicles of expression in one's everyday life. This article, uniquely, offers an extension to Colaizzi's method of phenomenological research, however, this addition to the method has not been employed in any manual therapy transitional studies to date.

Conclusion

Theories of how individuals make the transition from novice to becoming an expert and the influencing factors have been developed and studied to understand what characteristics define an expert (Benner, 1982; Lewin, n.d.; Peña, 2010; Sargent & Schlossberg, 1988). The process of becoming an expert follows deliberate and repeated practice, 10,000 hours of repeated practice is referred to classically.

However, later studies have found that the environment that one works in influences the development of confidence and skills (Levasseur, 2010; Lewin, n.d.; Meechan et al., 2011; Moxham et al., 2017). Immersion in a full-time work environment is an educational method to accelerate the time it takes to reach expertise and is a common teaching tool in healthcare (Blackmore et al., 2014; Pollock & Biles, 2016). The clinical skill and confidence that develops from these experiences influences the practice of each practitioner and, combined with the practitioners personality and intuition, creates a style of practice unique to the practitioner (Langridge, Roberts, & Pope, 2016; McCutcheon & Pincombe, 2001; Walton, 1968). An exploration the experience of participating in full-time immersive clinical training will help to elucidate what the transition into a full-time setting is like and what changes the students undergo as practitioners. By using Colaizzi's data analysis method to investigate a description of the transition as experienced by the student practitioners, the immersive learning experience and transition that students make to become a unique osteopath can be better understood.

Chapter 2 - Methodology

Introduction

This study approaches the topic of osteopathy student transitions in a way that has not yet been employed. An understanding of the transition from part-time to full-time clinical practice within the MOst programme at Unitec will be developed here, with the methodology used catering to building an understanding of this lived experience. Previous studies on transitions that osteopaths make focussed on the changes experienced when first entering the workforce, initially entering the clinic or on reasons for leaving the profession rather than understanding the experience of being fully immersed in osteopathic practice (Davidson, 2009; Kleinbaum, 2009; McCollum, 2014; Subramaniam et al., 2015).

Phenomenology, a methodology designed to understand a phenomenon has two schools, descriptive (also known as Husserlian – named after its creator) and interpretative (also known as hermeneutic) (Wojnar & Swanson, 2007). The research question posed here is best answered by descriptive phenomenology as this school works towards building a detailed description of a phenomenon, which in this instance is making the transition from part-time to full-time work. This chapter discusses this type of study and the school of phenomenology, how focus groups are used to collect data for analysis and the model used for the analysis of the data. Discussion of how the rigour of the study is addressed in addition to the details of how the focus group was carried out.

Qualitative vs Quantitative

Quantitative and qualitative studies employ widely divergent methods of data collection and analysis (Yilmaz, 2013). This research question aims to investigate the 'lived experience' of the phenomenon, which is the transitional period moving from semester two to summer clinic. To answer the question, the interpretation and concepts behind the participant's experience of the transition is analysed. Qualitative work aims to achieve depth of understanding regarding subjective data (for example a phenomenon or experience) while quantitative studies aim to achieve breadth of understanding of objective numerical data while being generalisable to a population (Palinkas et al., 2015). The two styles of research can complement each other, as a qualitative study can answer 'why', 'how' and 'what' about human behaviour while quantitative methods suit 'when', 'how many' and 'who' research questions. Qualitative studies may highlight issues for further objective examination using

quantitative methods. Together the research styles can analyse a topic from different perspectives (Neergaard, Olesen, Andersen, & Sondergaard, 2009)

The schools of phenomenology

The nature of this study lends itself to qualitative methodology, as it examines the 'why' and 'how' of a phenomenon. In phenomenological studies, the object of the study is the phenomenon, while the research aim is to understand the phenomenon as experienced by the person (Wyer, 2015). It is especially useful in this instance as qualitative research approaches aim to describe a perception and experience of the world (Kim, Sefcik, & Bradway, 2017; Neergaard et al., 2009). Phenomenology is a research method, founded in the 19th century by Edmund Husserl, developed for the descriptive investigation of a phenomenon in its entirety (Davidsen, 2013). Phenomenology aims to capture the essences of a phenomenon and organise the subject experiences in such a way that they can be analysed in as objective a manner as possible (Lopez & Willis, 2004).

The phenomenological methodology was derived from two schools, descriptive and interpretive/hermeneutic. Hermeneutic or interpretive phenomenology was developed by Husserl's student named Martin Heidegger (Davidsen, 2013). Heidegger's phenomenology was developed to explore how people experience a phenomenon, however, the interpretation of information cannot be avoided as the philosophy of hermeneutics presumes prior understanding (Wyer, 2015). He believed that the way an individual understands life is determined by their culture, social situation, personality and past experiences which in turn leads to a unique interpretation of an experience (Wojnar & Swanson, 2007). Heidegger's method analyses what prejudices and biases influence the experience of a phenomenon in addition to the experience of a phenomenon itself. All unique aspects of a person are influential in how they experience reality and, therefore, must be considered when extracting the essence of the phenomenon. (Davidsen, 2013; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016; Wojnar & Swanson, 2007).

Descriptive phenomenology aims to capture the essence of a phenomenon in its purest form (Davidsen, 2013). To Husserl, the reality experienced is objective and there are aspects to the experience that are common to all those who experience it (Lopez & Willis, 2004). The essence of the phenomenon is extracted from the data to create a detailed description of the phenomenon as experienced by the participants. When using descriptive phenomenology it is important to acknowledge any prejudices or biases that may influence the researcher and record these, this is

known as bracketing (Chan, Fung, & Chien, 2013). The bracketed biases are acknowledged during the data analysis phase, allowing the researcher to develop an understanding of the phenomenon as it was experienced by the participant (Wall, Glenn, Mitchinson, & Poole, 2004; Wojnar & Swanson, 2007; Yilmaz, 2013).

Why descriptive?

In this study, descriptive phenomenology was chosen as the object of the study is the phenomenon of the transition from part-time to full-time work. The aim was to understand the experience of making this transition through the eyes of the participants rather than exploring personal influences behind how it was experienced. Using descriptive phenomenology to study this phenomenon allows the observer to understand the human experience of making a transition within learning osteopathy (van Manen, 2016). The goal is to build a descriptive understanding of how the transitional phenomenon is experienced by the student osteopaths, without delving into what has influenced each student's unique experience of the transition. The participants are invited to describe their experiences using descriptive language while the researcher records information and facilitates discussion to evoke a deeper reflection on the experience.

Descriptive phenomenology was chosen over interpretive phenomenology as the study investigated the phenomenon rather than the reality of the phenomenon. Using descriptive phenomenology allows the phenomenon to be experienced on its own terms through the shedding of preconceptions via bracketing (Lopez & Willis, 2004). Wojnar and Swanson (2007) discuss the concept that "the goal of hermeneutic inquiry is to identify the participants' meanings from the blend of the researcher's understanding of the phenomenon, participant-generated information, and data obtained" (Wojnar & Swanson, 2007, p. 3). While this research method is utilised in healthcare, as it takes a more personal and reflective approach to data collection it would be inferior for understanding the fundamental essence of the phenomenon (Jackson, Vaughan, & Brown, 2018). This is because it also considers the personal aspect of the phenomenon, whereas the fundamental essence is created in order to be as objective as possible. To extract the true fundamental essence of a phenomenon, all subjective influences must be as far removed as possible, which in descriptive phenomenology (and this study) is done through bracketing.

Discussion of Prejudices

In phenomenology, the biases of the researcher are made transparent to minimise the effects of prejudices (Tufford & Newman, 2012; Wojnar & Swanson, 2007). The researcher's experience with the phenomenon (here, the transition from part-time to full-time practitioners in a supervised clinic) gives them insight into potential findings before the study had commenced, and may allow for biases to be recognised during analysis. A diary of the experiences had by the researcher within the full-time clinical month is provided as Appendix 1. The candidate is both a participant and researcher of the phenomenon and personally experienced the transition with the cohort under study. The clinical environment and others involved in the experience were familiar to the researcher and details of these are documented in Appendix 1.

Ethical Considerations

As the candidate experienced the phenomenon alongside the participants of this study, there were several ethical considerations to consider. To minimise the possibility of any ethical infringements the following steps were taken:

Reduction of and observation of biases

To help reduce the effects of bias, a bracketing diary of the experience was maintained by the researcher. This was done so the researcher could identify preconceived ideas regarding the transition phenomenon during data collection and analysis. Additionally, students attending summer clinic are allocated into one of three groups, each group attending one month during the summer holiday break. The researcher opted to participate in the final summer clinic group (February) so as to avoid the potential bias of their own clinic experience to the first and second focus groups. Communication over the first two clinical months was restricted to organisation of the focus groups.

Anonymity

The identities of participants were known to the researcher before the study, as he is also a member of the cohort being studied. Therefore, anonymization could not be achieved during data collection and analysis.

An online transcription service (<http://www.scribie.com>) was used to transcribe the audio recordings of the focus group interviews. The service ensures anonymity of the recorded parties to the transcribers and this is guaranteed using a signed non-disclosure agreement (NDA) (see Appendix 2).

Alongside a study proposal, a research ethics document outlining what steps were taken to ensure proper ethical standards were followed was submitted to the Unitec Research Ethics Committee and all study procedures were approved before commencement. The ethics approval letter provided by Unitec Research Ethics Committee is included as Appendix 3.

Storage of Information

To ensure data security, various measures were taken to protect the confidentiality of the participants. All physical copies of the confidentiality and consent forms (see Appendix 4 and Appendix 5) and transcribed interviews were kept in a locked drawer in a lockable room at the researcher's residence. All digital files were kept in a password-protected laptop and also on a password-protected data storage device. Physical copies of the confidentiality and consent forms and the transcribed interviews will be destroyed according to the ethics application and relevant Unitec policy.

Previous relationship with participants

The researcher is a member of the same cohort of students that were studied and also went through the transition experience at the same time. To avoid any potential biases or coercion during the study period, communication was limited to discussion of the organisation of the focus group interviews.

Power differences between researcher and participants

As the researcher is part of the participating cohort with a pre-existing social relationship with them, there was little power difference between parties going into the focus groups. This was to the advantage of the study, as there is evidence to show that participants in focus groups are more likely to share sensitive information compared to individual interviews (Rabiee, 2004). Although sensitive information may have been more likely to be shared, the environment was chosen to ensure that the participants felt comfortable and safe when sharing their experiences.

Compensation

No compensation was provided for participation in the study. Refreshments were provided for the participants following the focus group.

Chapter 3 - Methods

Sampling Style

Purposive sampling (where the researcher selects part or all of a population as they have specific experience or insight into the topic of study) was used in this study as it allows the non-random selection of individuals with specific experience in the phenomenon being studied (Bernard, 2011). It also lends itself towards data saturation (Etikan, Musa, & Alkassim, 2016). Purposive sampling is commonly used during recruitment for focus groups as it elicits a collective view regarding a phenomenon (Ryan, Gandha, Culbertson, & Carlson, 2014). When searching for a population sample the quality of the sample is more important than the size (Wyer, 2015).

In this study, purposive sampling was used to include students from the MOst population due to their knowledge and experience of the month-long full-time work experience in the student osteopathy clinic within Unitec. All students in the population were invited to participate and describe their experiences of the phenomenon that is going from a part-time to full-time osteopathy working environment.

Participant Recruitment

Recruitment

Following ethics approval, a population of 16 students (all members of the Year 1 2017 cohort) enrolled in the Master of Osteopathy programme at Unitec were approached regarding participation in the study. Recruitment occurred during the month prior to conclusion of Semester 2, 2018. Information regarding the aim and nature of the study was provided on the osteopathy fourth year group Facebook page. This post was aimed at informing the potential participants of the study rather than as a recruitment strategy. Study information were provided to participants (see Appendix 4, Appendix 5 and Appendix 6) and collected prior to the focus group occurring. . A sample size of 13 students were able to participate in this study.

Inclusion Criteria

Inclusion criteria were: enrolled in the MOst programme, and completion of the full-time summer clinic month.

Exclusion criteria

Students were ineligible if they had not completed the full-time month, or if the summer clinic experience was completed over more than a four-week time period.

Data Collection Tools

Focus groups were selected as the data collection approach because the population being studied was homogenous and had well-established relationships prior to the study. This promotes equality among the participants which contributes to the openness of discussion among participants (Masadeh, 2012). There is some evidence that shows that too much homogeneity can limit the range of perspectives in the data collected (Masadeh, 2012), however, as the participants of each full-time working month chose the month to work in due to convenience rather than because of relationships and also the primary researcher's knowledge of the differing personalities and opinions, the potential limiting of perspectives during the discussion was reduced (Walton, 1968). As the aim of descriptive phenomenology is to understand the essence or essential structure of an phenomenon by creating a rich description of the phenomenon (Willis et al., 2016). Gathering a large amount of information aids in the development of a description of the phenomenon as more understanding into the essence of how the phenomenon is experienced.

Data was collected using two separate focus groups and in one case, because of a scheduling conflict an individual interview was conducted. Focus groups are common in qualitative studies and are considered an important health research technique (Flynn, Albrecht, & Scott, 2018). Focus groups help to facilitate detailed discussion and conversation to a level that may not emerge with other forms of data collection (Flynn et al., 2018). Focus groups were selected because small groups of participants made up of familiar peers, means the participants are likely to be comfortable engaging in discussion about their experiences (Rabiee, 2004; Ryan et al., 2014). Also, the smaller sample size favours a methodology such as focus group interviews as there can be deeper exploration into the phenomenon (Willis et al., 2016). An individual interview explored the phenomenon from a single point of view

Table 1 A seven step data analysis method for descriptive phenomenology developed by Colaizzi, (Colaizzi, 1973)

Title of step	Instructions for step
1. Familiarisation	Reading and re-reading the transcripts to gain a general understanding of the data
2. Identifying significant statements	For each transcript extract significant statements relating to the phenomenon in question. These are recorded on a separate document
3. Formulating meanings	The meanings of the statements are extracted and formulated
4. Clustering themes	The formulated meanings are sorted into, themes, and subthemes
5. Developing the exhaustive description	The findings should be integrated into an exhaustive description of the phenomenon
6. Producing a fundamental structure	The fundamental structure of the phenomenon is extracted from the exhaustive description and described in rich and detailed language
7. Seeking verification of the fundamental structure	Validation of the phenomenon is sought from the participants to compare the description of the phenomenon and their experiences.

allowing insight into how an individual perceived the month of full-time work. The individual interview was intended to be a focus group, however, due to other participants' prior engagements, only one participant could attend.

Data Analysis

The Colaizzi method of data analysis was employed for data analysis. This is composed of seven steps (Table 1.). Colaizzi's methodology was chosen due to its rigour during the theme analysis and how the steps lead to a condensed fundamental analysis of the experience as per the aim of descriptive

phenomenology (Abu Shosha, 2017; Morrow, Rodriguez, & King, 2015; Polkinghorne, 1989; Wirihana et al., 2018):

The seven steps include aspects of thematic analysis and coding, where the significant statements are separated from the bulk of the focus group transcripts for further analysis. This entails finding the meaning of the statements from which the themes are then developed (Liamputtong, 2009; Morrow et al., 2015).

1. Familiarisation

The transcriptions were read while listening to the audio recordings. This was done twice in order to become familiar with the content, and to correct any mistakes and omissions made during transcription. As the transcription service is based overseas, there may have been difficulty understanding and transcribing the New Zealand accent. Listening to the recording alongside the transcription allowed the researcher to overcome these difficulties and enhance the accuracy of the transcription.

2. Identifying significant statements

Following familiarisation, significant statements were identified by further reading of the transcripts (see Appendix 7).

3. Formulating meanings

Significant statements were read and reread while listening to the audio recordings to recognise the context and develop an understanding of their meaning. The statements were then read against the bracketing diary to check for any bias, and any statements that matched or went against the statements of the diary were marked and recorded separately. Once this was done, the statements were taken to the research supervisors for critical discussion. When a consensus regarding the meaning behind the statements was agreed, the meanings were recorded (see middle column of Appendix 7).

4. Clustering themes

The meanings formulated from the significant statements were analysed to understand the essence of each meaning. This was also done alongside discussion with the research supervisors, the essence of the meanings were extracted allowing the different themes to be clustered together in context of

when they appear in the focus group interviews allowing a narrative of the phenomenon to be formed (see right column of Appendix 7).

5. Developing an exhaustive description

A description of how the clustered themes represent the experience of the phenomenon was created, using the timeline of how the clustered themes are laid out. This was done with reference to the formulated meanings so as to create an exhaustive description of the understood phenomenon. The description was reviewed with research supervisors and once a consensus was arrived at, the next step was taken.

6. Producing a fundamental structure

To create a fundamental structure of the phenomenon the exhaustive description was read and reread alongside the bracketing diary to observe any underlying biases that may have influenced the description of the phenomenon. The descriptive words used in the exhaustive description were refined to reflect the narrative presented by the clustered themes so the lived experience of the phenomenon can be understood.

7. Seeking verification of the fundamental structure

Once the fundamental structure was developed, it was presented to the participants by email. Additionally, the fundamental structure was presented to the participants' Facebook group. Seven of the 13 participants agreed with the fundamental structure, the remaining 6 participants did not reply.

Bracketing

To improve the rigour of the study, the researcher maintained a diary of his experiences as he worked through the month of full-time work (Wall et al., 2004). Any personal biases or preconceptions that might skew the focus group discussions and the subsequent data analysis were recorded and acknowledged (Jackson et al., 2018). This process is known as bracketing and is common within descriptive phenomenological studies. The aim was to obtain a description of a particular phenomenon as free as possible from unexamined presuppositions (Matua & Van Der Wal, 2015; Tufford & Newman, 2012). Frequent meetings with supervisors and peers where the information was shared and read helped to improve the rigour of the study and reduced potential biases. Having additional readers of the transcripts is another way that the researcher can create 'distance' between themselves and the study and is another form of bracketing.

During the first focus group, a secondary facilitator was used to reduce potential bias in the questioning and discussions facilitated by the primary researcher. This was important as the primary researcher was a student in the MOst programme and relationships with the participants had already been established. Due to an unanticipated scheduling conflict, the secondary facilitator was present only during the initial focus group and not for the individual interview, or the second focus group.

Addressing Rigour

A framework for establishing rigour in qualitative studies has developed as researchers have sought clarity of purpose within qualitative methodologies (Begley & Tobin, 2004). A framework for ensuring rigour in qualitative research was proposed by Lincoln and Guba in 1989 aiming to achieve 'trustworthiness' of studies (Lincoln, 1995; Morse, 2015). This 'trustworthiness' is achieved through strategies described below to ensure the credibility, dependability, confirmability, and transferability of research (Cope, 2014; Houghton, Casey, Shaw, & Murphy, 2013; Ryan-Nicholls & Will, 2009).

Credibility, or the truthfulness of the data was addressed through step seven of Colaizzi's data analysis method where the findings are taken back to the participants (Cope, 2014; Morrow et al., 2015). Taking the research findings back to the participants allows them to verify that the information is truthful, contributing to the credibility of the research. Triangulation is a strategy where more than one method is used to research a single phenomenon; this is done to confirm that the data are true and complete (Houghton et al., 2013; Jick, 1979). One way that this study triangulates is through the use of different interview styles. Although unintentionally, focus group one and three differ from focus group two as the second focus group was an individual interview. The different styles of interview allow for different qualities of information to be gathered, i.e focus groups can gather a larger breadth and depth of information but may not gather an individual experience of the phenomenon (McLafferty, 2004). This study addresses the credibility further by undertaking multiple focus groups with different participants, which also addresses saturation.

Dependability improves the rigour of the study by addressing the steps that the researcher takes as conclusions are drawn from the data (Connelly, 2016; Houghton et al., 2013). It is important to make the rationale for the methods as well as data analysis transparent so that the study may be repeated. Dependability is addressed through the use of Colaizzi's data analysis tool and the explanation of each step of this process. Reflexivity incorporates the personal contribution that the researcher brings to

the study as in qualitative research, the researcher themselves are the research instrument (Houghton et al., 2013). The use of a reflective diary is important to improve dependability and details the reflexivity of the researcher. The personal opinions and predispositions of the researcher are recorded so that their effect on the data are transparent.

Confirmability is similar to dependability in that confirmability relates to the neutrality and consistency of the research (Grieb, Eder, Smith, Calhoun, & Tandon, 2015; Houghton et al., 2013). Methods to ensure confirmability include leaving an 'audit trail'. This is a detailed log of the decisions taken and conclusions drawn during the data collection and analysis process which is another method of bracketing (Connelly, 2016; Jackson et al., 2018). The confirmability of this study is addressed through the use of Colaizzi's data analysis method, which makes the steps of data analysis transparent. Also, the methodology section of this thesis outline the reasons and steps taken to carrying out this study. The bracketing diary is provided in Appendix 1 and the steps taken as per Colaizzi's data analysis framework is outlined in the methods section. Confirmability is also established through peer review. Having peers that are familiar with qualitative work review the research helps avoid bias that arises from having just one perspective on the data (Connelly, 2016). The usefulness of peer review or discussion in supporting rigour is argued in the literature (Morse, 2015; Munn, Porritt, Lockwood, Aromataris, & Pearson, 2014). Although peer review prevents a single perspective analysis of the data, there is a risk that the peer shares the same views as the researcher, and may be prone to a range of bias' including prestige or association bias, gender bias, confirmation bias, conservatism, bias against interdisciplinary, and conflict of interest, and thus reducing the positive effects that it has on the rigour (De Silva & Vance, 2017; Glonti & Hren, 2018; Lee, Sugimoto, Zhang, & Cronin, 2013). In this study, the peer reviewers were the supervisors of the primary researcher and come from different fields of scientific research. According to Park et al. (2018) this peer review process is likely to improve the rigour of the study.

Transferability is the ability to extrapolate the data collected to those not involved in the study (Connelly, 2016; Houghton et al., 2013). This required the study to include information about the participants and the context of the research, such as their age range, gender, how far through the degree they were, and if they had any prior manual therapy experience. The responsibility of deciding whether there is sufficient background information provided to make the collected data transferable or generalizable ultimately falls on the reader (Cope, 2014).

Data Collection

Preparation

The week before the first focus group was to take place, the associate supervisor and the primary researcher practiced the layout for how to organise the room that the focus group was to take place in. This included moving the practice tables out of the middle of the room, moving more chairs into the room and into place and setting up and testing the voice recorder. A mock interview was carried out to test for appropriate voice recorder placement and the most effective positioning for the focus group leader and secondary facilitator. This room was arranged so that the researcher and participants were in a circle to facilitate casual conversation while the secondary facilitator observed from slightly further back behind the group. The voice recorder was sensitive enough to record the conversation clearly from a small stool in the middle of the circle. An iPhone was set up as a back-up recorder against one of the walls of the room. The iPhone was tested and produced an audible recording, albeit not as clearly as the dedicated voice recorder.

Question Development

Question development was aimed at getting a description of any transitions that the participants made over the month of full-time work. Rather than making them reflect and interpret reasons for the transition, the questions aimed at eliciting a description of the transition (Englander, 2012). The questions used are seen in Appendix 8.

Focus Group Organisation

Focus group organisation began in the last week of each clinic group's month of full-time work. Two dates were proposed with the chosen date being selected depending on the number of people able to attend. The date was chosen when six to eight participants confirmed that they would be able to attend as this would provide diverse information from different participants regarding their experiences while being small enough for everyone to talk and describe their thoughts (Fusch & Ness, 2015). This was decided upon via online messaging applications, with discussion based on appropriate timing and confirmation of the location (Unitec's Clinic 41). Some refreshments (food and drink) were provided.

Location Selection

The location of the focus group was chosen as a place with which the students were comfortable and familiar. The clinic is where Master of Osteopathy students spend their time working throughout the course, refining their clinical skills and interacting with tutors.

Focus Group Commencement

The time scheduled for each focus group was one hour, however participants were able to discuss for longer if they felt comfortable and were able to do so. Focus group one had five participants; focus group two had one participant; focus group three had seven participants. The first focus group ran for 1 hour and 42 minutes; the second focus ran for 14 minutes; the third ran for 1 hour and 6 minutes. A secondary facilitator was present for the first focus group only.

Post-Focus Group Reflection

Immediately following the focus group, the researcher noted their thoughts on the themes that presented themselves. There was a general feeling of unity among the focus groups regarding the feelings about the summer clinic experience. Main topics of discussion included relationships with the tutors, communication issues between students, time management and patient management, emotional exhaustion following the month and coming out of the month with a general sense of improvement and recognition of what their future as a future osteopath will hold.

Conclusion

This qualitative study used two focus group interviews and an individual interview to investigate the lived experience of the transition from part-time to full-time osteopathic work. Using descriptive phenomenology methods and Colaizzi's data analysis tool, a description of the essence of this transitory phenomenon was produced. Rigour was addressed through methods common in qualitative studies including self-reflective bracketing, peer review and discussion. Purposive sampling was utilised to select participants with experience of the full-time transitory month. Two focus group interviews and an individual interview were undertaken to achieve data saturation while the researcher reflected on each focus group to reduce any bias and improve the quality of the interview processes.

The results of the focus group interviews were analysed and presented in a table to illustrate how the themes were developed (see Appendix 7). The findings from the focus groups in this study were presented as quotes from the participants that illustrated the transition. The quotes were presented, with the theme described next to it before the essence of these themes were explored. Quotes from different focus groups and participants were clustered together to validate these themes.

Chapter 4 - Results

The information presented by participants covers a variety of topics relating to their experience of the phenomenon that is full-time work in a student osteopathy clinic. Problems and a short reflection on the focus group will be covered before presenting the discussions of the focus groups. The narrative that developed throughout the focus group interviews included the development of clinical confidence and competence, the lifestyle that surrounds full-time work, and the difficulties that working at the clinic entailed (see Appendix 1 for further details). This analysis reflects a description of the phenomenon of transition as experienced by these fourth year MOst students.

Focus Group Problems and Solutions

To mitigate any potential recruitment problems, the focus groups were scheduled outside of the Christmas/New Year holiday period, with the December 2017 group focus group planned for early January 2018. Communications regarding the scheduling were planned at the end of the month of full-time work to ensure that more people could attend the interview. This method worked well as five people attended and the discussion and conversation flowed naturally.

The secondary facilitator was useful in this first focus group as they provided feedback regarding the performance of the researcher. Things that could have been improved upon include being more specific regarding the details of the problems that arose during the full-time month and avoiding interrupting people in order to move on to a new topic. The secondary facilitator was unavailable to attend the focus groups two and three due to unanticipated scheduling conflicts, going against best practice as stated by Nyumba et al (2018) and limiting the reliability of the data collected.

Focus group two was expected to be problematic, as only three students worked full-time over the month. Therefore, there were not as many people available for the focus group and organisation was more difficult to ensure that all people were available. Organisation for this focus group occurred in the final week of the month of full-time work, however, two of the three people, at short notice, were unable to make the date. Therefore, the focus group became an interview of only one participant. The information gathered from focus group two was useful, however, it did not provide as much information as the other focus groups due to the lack of conversational flow. The researcher tried to ensure a more conversational style of questioning to minimise the effects of having only one participant. The data collected have not significantly affected the overall results but provide a more

individual perspective on the problems that arose throughout the month. By focus group three, the researcher had gained some experience in facilitating a focus group, however this session also went against best practice as suggested by Nyumba, et al. (2018) and did not include a secondary facilitator. Immediately following each focus group, errors were reflected upon so by focus group three, the researcher was more confident with facilitating the focus group and guiding discussions. Facilitation mistakes that were identified on reflection included interrupting the participants, changing topic too quickly, and allowing some participants to not contribute to discussion as much as others. Ways that these mistakes were minimised were i) waiting until a participant had finished speaking before following up with guiding questions; ii) not asking new questions until the discussion starts to get off topic; and iii) using the question guide to get each participant's response to multiple questions before moving on.

One participant from the February full-time work month was unable to attend, reducing the number of participants down from six to five. From an organisational standpoint, the focus group was planned far enough in advance so that all participants from the February full-time month were able to attend the focus group. Conversation was not as easy flowing as it was in the first focus group, however, after some time discussions began to flow more easily.

Table 2 Themes and subthemes that emerged from thematic analysis of transcripts from three focus groups that considered the lived experience of osteopathy students making the transition from working in a student clinic (8 hours per week) to working full-time (40 hours per week) during the summer holiday break

Themes	Subthemes
Confidence from validation	Clinical Skills
	Professional Identity
	Comparison with others
Immersion and groundedness	Sense of self and confidence
	New patient management
	Environmental effects: tutors, chores and reception
Stress from clinical and extra-curricular commitments	Financial Burden
	Positive and negative reactions to stress
	Rewards from immersion

Theme 1: Confidence from Validation

Subtheme i) Clinical Skills

Discussion of how interactions with tutors made each participant feel came up frequently, with all participants stating that tutor interactions had a significant effect on their summer clinic experience. Positive tutor remarks had a positive snowballing effect on confidence in clinical skills and emotional management. The student practitioners confirmed the powerful effects of positive tutor remarks and being trusted to continue treating without discussion with the tutor. Clinical skills such as time management, choice of appropriate techniques and examination rigour were self-reported to improve and by the end of the month-long period the student practitioners felt more confident. There had been variation throughout the month with regards to the above clinical skills due to feelings such as emotional burnout. However, towards the end of the month-long experience these feelings were replaced by confidence:

“backing from the tutor really just skyrocketed me in terms of confidence, and also like what someone touched on before, like don't come out”

“...it was really good to have someone to trust and empower you as a clinician to go, "Do you know what? I got this. I can go in, I can do this and I can do this examination. I'm going to come out and do that”

“I think because I had been in clinic longer and I had learned more, I think that boosted my confidence”

The student practitioners' time in the MOst programme aims to develop their skills as an osteopath. The month-long full-time experience immerses the students in osteopathic work with the tutors providing guidance for the development of their clinical skills. Having the tutors provide support and validating the students' clinical skills in turn leads to a boost in overall competence. The relationship between tutor comments and clinical skills shows how a boost to confidence also improves clinical competence. This aspect of the tutor-student practitioner relationship was a very powerful tool for building confidence and competence.

Subtheme ii) Professional Identity

The scope of practice for an osteopath is broad, therefore, the development of each student's skills is not straightforward. The opportunity for each student to develop a personal approach to their practice arises because so much time is spent in clinic with patients and, thus, having positive feedback on their work helps to confirm that their approach is effective. This validation is key to building each student's own professional identity as an osteopath. The tutor's remarks are more powerful as a student-teacher relationship has already been formed during the undergraduate Bachelor of Applied Science (Human Biology) course. Therefore, each tutor is able to use the relationship to help develop aspects of each student's practice that they think are required.

"Everything nicely starts to come together and then you get what being an osteopath means. I mean it's almost like hooks at the end of the year, so you're like okay this is what we do"

"Three of my tutors asked me what my goals were for summer clinical and they all took it really seriously. Throughout the four weeks they really helped me focus on them"

"In order for me to notice improvement, I usually need some sort of validation from a tutor, to be like, "Well done." Or, "you get this mark." Or something like that. And I'm probably focussing on that cause that's what I got quite consistently throughout the whole experience"

"These experiences that you've had, do you find that they relate to becoming and effective practitioner or osteopath?"

[In response]: "Yes, I think so"

"I know this is what I'll do when I'm an osteopath, and this is the first time I've had an opportunity to actually do it, and it made me so much better because I did something and I could see instantly it didn't work and then I could do something else, and then it worked"

The importance of having a clinical tutor around for guidance was repeatedly confirmed by the student practitioners as it was reported to be difficult to develop a sense of professional identity. Having the

tutor present for guidance and validation of skills helped to develop and confirm the sense of being an osteopath that the students strive for over the MOst course.

Subtheme iii) Comparison with Others

As there is no objective measure of any improvement over the month, the students compared themselves with their peers to measure improvement. Throughout the month-long experience, the students' feelings about their own progression were mixed. Some students felt that their progression was linear and improved week by week, while others felt that improvement was inconsistent throughout the month. These other students remarked that when they compared their improvement with others, they felt some jealousy and a desire to have the same linear progression. For some students whose time in clinic started part way through other's month-long experience the comparison with others led to negative feelings of self-consciousness and intimidation.

"I was probably a bit embarrassed because I entered and my first week... In the last week of the December shift. So, I was in everyone else's week four. So, I was quite a bit self-conscious of my skill level"

"Our tutors, were also like... They said to all of us, you guys have improved so much over these last few weeks. We can tell that you're going into fifth year prepared and I think just even having the reiteration that we're actually better was like a really nice thing to be able to get that confidence"

"Like knowing where I started in the first of the summer holiday, where I finished at fourth year, and we're beside the fourth year, compared to now where I am"

When seeing a patient for the first time, observing the previous student practitioner's notes validated the student's thoughts on their own progression. Another tool for comparing skills between practitioners was observing the patient's improvement following another practitioner's treatment compared to the treatment that they had provided. Whilst this tool is not reliable as it does not provide an objective measure, its use can affect the student's confidence and competence.

As the summer clinic experience is very long compared to any other time in clinic, it was difficult for students to manage themselves physically and emotionally over the month. Some students in the MOst programme were involved in manual therapy work before entering the student clinic and had

experience in manual therapy, while others had only the experience from working two four hour shifts per week in the fourth year of study. This led to feelings of burn-out in those with less experience and in turn feelings of a lack of improvement as the burnt-out student saw their peers managing patients and improving their clinical skills while they were currently lacking empathy and motivation. These indirect ways that the students compared themselves to others had a significant effect on motivation and feelings of confidence within the clinic. Students that saw their peers improving felt less confident in their own skills, however a direct comparison between skills such as note taking and effectiveness of treatments increased self-confidence.

Theme 2: Immersion and groundedness

Subtheme i) Sense of self and confidence

The routine that developed from being totally immersed in clinical work, built efficiency in each student practitioner's routine and also a sense of ownership and grounding in their osteopathic practice. The month-long experience aimed to immerse the students in clinical work. Groundedness is described by the participants as being able to stay present in your mind and body while calmly treating, feeling and adapting with your hands rather than carrying out a routine. It is also described as knowing the style of osteopathy that the student works with and adapting it to bring a personal approach to their practice. The feeling that the student refined their techniques according to osteopathic principles developed through immersion and improvement of time management. The way the student practitioners examined, treated, and managed patients was individualised during the month in a way that reflected their attitudes towards osteopathy.

“More grounded, more able to bring some of the stuff that I've always wanted to into my treatments for the patients”

“...because I had been in the summer clinic so I had better confidence. I had a much better appreciation of looking at that patient, and in my head going, “What would I be doing?” And then what did they do that was different, which is not necessarily that I'm wrong and they're right or the other way, but it's just like adding to the picture”

“I don't fragment or disassociate from myself. I don't end up flustered. I don't disassociate. I stay with the patient. I can actually feel what I'm feeling when I'm treating”

After experiencing a month of full-time work, the student practitioners felt more confident and more grounded in their practice. As they had experienced more challenges, their clinical and emotional management improved and became more efficient. Being able to be present and aware in the situation at hand developed towards the end of the month-long experience with each participant beginning to take ownership of the unique way that they practice osteopathy.

Subtheme ii) New patient management

An aspect of the experience that several students found difficult was the management of patients unfamiliar to them. Trusting other student practitioner's work, reading almost unintelligible notes and managing several new patients in a short time-frame had a significant impact on the students' experience.

"Some people wouldn't write a diagnosis one week, or they wouldn't even write their treatment, or they would copy the same diagnoses week after week. Some people, it wasn't just handwriting, it was the quality of their notes was just horrendous"

"You were essentially trying to catch up and get to know this person, get to know their problems of some pretty bad notes, some good notes but a lot of bad notes"

"There's follow through and I can see from the patient notes what the other areas that I was wanting to [treat]. So, it's kind of really getting into that prioritising"

The students found that managing many new patients in a short timeframe was stressful. Reading notes, judging where the patients were in their recovery plan, and inter-practitioner trust were aspects that made new patient management difficult. Inter-practitioner trust was reported to be low and the students felt that tests must be repeated to ensure confidence in the working diagnosis and management plan. Additionally, the students also found they were able to use note taking as a means of comparing themselves with their peers and determining their trust of other student practitioners.

"So I didn't rely on their notes. I just looked through to make sure there was no reflex, seeing what was positive and negative to see what might have changed this time instead of relying on the notes, I just started fresh through a patient I was seeing"

This method of new patient management developed a sense of groundedness in the student practitioners, as the reduced timeframe to work in meant the students' routines had to be refined in a way that was effective for their style of treatment. With a lack of intelligible notes, the students had to repeat the essential safety and diagnostic tests before following through with treatment and a revision of the management plan. In the summer clinic, each student received more new patients as there was no long-term weekly schedule, therefore, the student practitioner's routine had the most opportunity to be refined during this month of immersion.

Subtheme iii) Environmental effects: tutors, chores and reception

The learning environment that the students spend the month in had a great effect on the students' experience. Extra-curricular stresses such as work, family, traffic and financial burdens played a large part in how each student experienced the full-time month. Aspects of the clinical environment such as tutor expectations, chores, and reception work were also found by the students to influence their experience of the month.

Failure of tutors to appreciate pressures on students

An aspect of the experience that the students found difficult was how the tutors did not understand the reality of the situation that students had to deal with. Students had to work additional hours and expend time and energy outside of clinical hours to meet financial needs. The students described how the tutors did not understand how life outside of clinic became very busy due to the month-long experience and this made the month frustrating. Other obligations such as additional work in evenings, living with reduced finances (due to less time able to work in a paying job), less free time, increased stress from clinical demands, more theoretical knowledge demands (and therefore more study outside of clinic), house maintenance (cooking and home chores) all added to the stress felt throughout the experience.

"It's a complete disconnection from our experience as students. You've got tutors saying oh I know it looks stressful. You're like yeah because there's a lot of compounding factors"

"I hypothesized at the start of my month going in with my boss that I would work a Saturday, but when I got in there, I realized it was completely unrealistic... I was stuffed"

“So I would finish clinic and then I would go and massage for an hour, hour and a half, type thing, which would mean that I was normally not be getting home until like nine p.m. from work. So I've literally been at clinic from 7:30 am, getting home at 9 p.m., but at least it wasn't much, but it was still bringing in some money”

“I don't think I could have got through summer clinic as well as I did without the group of people we had as well. The group of the people we had was a major support network”

The students thought that the stresses that came from outside life compounded with clinical stress were not appreciated by the tutors who also expected more from the students. The additional work done to afford to live affected the full-time experience as the students were often tired and stressed. This disconnection between the students experience and the tutors led to negative feelings about the month of work, however, the support network created between the students made the experience more manageable.

Chores and Reception

Part of the clinical environment included doing chores such as laundry, dishes, general cleaning and reception work. These tasks were not always shared evenly between students which created tension between peers. The students were expected to maintain the clinic, however, the additional work that this created took time away from learning, especially from those who felt that the responsibility should not land upon them. This was a result of staffing challenges at Unitec, hygiene requirements for a clinic (needing clean bedding and pillow cases every shift) and individual student practitioner patient lists. Less busy students took up some responsibilities of clinical upkeep when able to, however, when this didn't occur others felt frustration about having work reception and ensure clinical upkeep in addition to a busy patient list and regular chores. Students felt that they should not be responsible at all for manning reception as a receptionist for the clinic is employed by Unitec. One student recognised the benefit of this even though it took away from clinical obligations, however, the majority of students had strong negative feelings toward this.

“I get very fed up with having to do reception... I'm not paying 18 grand a year to be manning reception”

“There's this whole culture of whenever people are on shift, they have to do all the dishes and like a lot of people... At the end of the day [participant 6] did a lot of dishes a lot of the time”

*“The amount of cleaning I do in this place is ridiculous. If everybody did that amount, this place would be spic and f***** span”*

“You know what though? I wouldn't mind it because sometimes you have to do that in your clinic, not every clinic has a reception. So, in that respect, some people need to learn how to answer the phone and have that customer service skill because a lot of people don't”

The opinion that working the reception was good for development as a clinician was not shared by the majority of the focus group. Most participants felt that the month of full-time work entailed a lot of additional stresses such as financial burdens, additional work and strained professional relationships already. Having responsibility for the state of the clinic was more work that took away from the clinical experience which was already negatively impacted upon. As there were Unitec employees to cover these responsibilities, the consensus was that the work should not fall on the student practitioners.

Theme 3: Stresses from clinical and extra-curricular commitments

Subtheme i) Financial Burden

The financial burden created by being unable to do paid work over the month created an additional stress for the participants. StudyLink [government funding for tertiary students] does not provide student allowance payments during this month of full-time work as the clinical course is only one paper and, therefore, technically part-time study, which is not covered by government funding. Each participant was working during weekends and evenings over the month, which took away time that could have been spent studying or preparing (mentally and physically) for clinic. Having the additional stress was a controversial discussion as some students felt that it added to the learning experience while others disagreed. However, there was a consensus that during the month of full-time work, the financial burdens that were experienced took time away that could have been spent on clinic work.

"Then I was struggling in having no money still because StudyLink doesn't even cover rent. It's covered our rent and bills and then a tiny bit [of money] left for food"

"It didn't affect me but the Unitec Study Link needs to be sorted because people don't have the time and the energy to do it that kind of crap, and money is a big issue"

"It was like, "Oh you're leaving early, but the clock." And I'm like, "Yeah, but I have to go earn some fricking money because I'm working"

The stress put on the students from financial hardship over the month and the tutors seemingly not understanding the stress the students felt because of this negatively affected the experience for many. Time that could have been spent on clinically related topics was spent working outside the clinic and, due to contractual obligations it was difficult to manage time around extra-curricular work. The difficulty organising this with the government student funding body led to additional stress that the students struggled to effectively manage. Having the other students as a support group helped students to deal with these hardships, however, the students felt that their experience suffered due to financial pressures, regardless.

Subtheme ii) Positive and negative reactions to stress

The students experienced a range of positive and negative aspects of full-time work and the consensus was that the stress experienced helped develop skills such as time management, emotional management and efficient clinical routines. Undergoing the rigour that accompanies a full-time working schedule, where there is less time to organise yourself clinically and to organise life outside of the clinic was instrumental in refining the student practitioner's skills.

There was contention regarding whether the extra-curricular aspects of full-time work such as dealing with traffic, clinical chores (laundry, filing, reception work and dishes) and financial difficulties helped build clinical skills. Participant 1 from focus group 2 felt that it hindered their learning, and that having these other commitments drew attention away from improving clinical skills. However, participant 8 from focus group 3 felt that having these other commitments meant that clinical skills had to be more refined to be able to dedicate time to all aspects of full-time work. This in time improved technical skills, patient management and emotional management.

Negative feeling towards additional stresses:

“Well maybe not having to work would have definitely helped and actually have a break ... I had no energy ... Definitely financial wise”

“[Regarding how the participant felt that they would have come out of the experience more confident and effective if there were no issues] Yeah, definitely”

“You could focus on the patients rather than Unitec”

For these participants, having more problems added to their routine outside of the patient interactions diminished their experience. They felt that being able to fully commit to working with patients and the tutors would provide the best outcomes for clinical confidence and competence. Aspects such as course enrolments, financial hardship due to having to do unpaid full-time work compounded by StudyLink problems, second jobs, and clinic maintenance took time that could have spent learning. The participants felt that if these problems were solved, they would have come out of the month-long experience as more effective osteopaths.

Positive feeling towards additional stresses:

“[Regarding how the participant felt that they would have come out of the experience more confident and effective if there were no issues] No. Because it’s almost as if like the problems make you better”

“It doesn't matter what happened in that month, I would have come out on the top of my game because if I had fully booked patients, they would have been awesome”

“It’s all part of the learning”

On the contrary, others felt that being exposed to these problems improved the outcome of the full-time month. Having financial difficulties, extra-curricular hardships and additional clinical maintenance allowed the participants to experience what is an almost accurate experience of full-time work. Additionally, the stress that resulted from other commitments meant that being able to function effectively within such scenarios would not be as stressful once graduated and working.

Although it didn't directly improve clinical skills, it was important to understand what full-time work can entail.

Clinical skills such as technique efficiency, emotional management and time management were refined over the month of full-time work as the phenomenon includes dealing with clinical chores. As these 'distractions' took time and attention away from clinic work, the students felt that this challenged their expectations of the experience. Some were grateful for the additional work as it forced clinical skills to be refined and appointments to be streamlined, however, others felt that it took away from the time that could have been spent practicing and studying to become a better osteopath.

Subtheme iii) Rewards from immersion

The students identified that one of the most difficult aspects of the experience was balancing the full-time workload and extra-curricular roles. However, this difficulty was rewarding where the student practitioners felt that they reaped the rewards of this difficulty at the end of the month-long experience. The difficulty of the adaptation was due to the increased expectations that came with the responsibility of working in the clinic while having less time to manage life outside of clinic. The role of the student practitioner was the same in the full-time month as in the semester time clinic (including managing patients including those not familiar to them, reading and writing notes, doing laundry, dishes, and general cleaning, participating in tutorials and studying new topics). In contrast to the semester clinic, however, all these responsibilities fall on the participants without having other students nearby for help. The expectation of the students was that the experience would be very difficult and challenging, however, these challenges improved confidence.

"This is exactly what I need. You need a good kick up the ass. It makes you harder that month. Like it makes you so much harder"

"There were so many of us there that there was, unfortunately, not enough patients to go around but I agree with what they're both saying that we came in thinking it was horrible and came out and everyone was okay. I came out with confidence and I came out actually thinking it wasn't actually that hard"

"It's something that comes up and I was expecting to come up more, just chores and extra things"

“It's like we own clinic now”

The rewards of the month of full-time work were as the participants described, they felt accomplished and more able to deal with the stresses that will accompany full-time work. They also described feeling more competent and better able to manage themselves as healthcare practitioners as they can manage their emotions and be aware of the situation at hand. The expectations of the full-time month did not match the experience, as the participants described the feelings at the end of the month positively and the expectation was that the month would be “very difficult”. Ownership of the clinic, their work and their progress were the results of the challenging experience.

Development of the Exhaustive Description

The month-long work experience began with hardship and without direction for the students. There was no way to self-measure improvement and therefore, the comments made by the tutors had an important effect on the students' confidence. The students could compare themselves with their colleagues, however, this was less powerful than tutor comments. After some time in the clinic and experiencing stressful scenarios (relating to both clinic and life), the students felt that they had improved and there was an increased sense of professional identity and groundedness. The immersion meant the students could explore different methods and techniques and develop a unique art to their practice that expressed how they would like to work. This led to increased confidence and enjoyment of the practice. This was shown in how some students felt about the first week of the month - anxious, stressed, intimidated, nervous and exhausted, compared to how they felt at the end of the month – confident, self-managed (emotionally and clinically) and grounded.

The feelings expressed at the end of the month were difficult to refine, as the immersion in the clinic was challenging but rewarding. Some participants felt that the stresses brought on from life, for example relationship and financial strains and a lack of free time made the time in clinic less rewarding as it took attention away from osteopathy, whereas others felt that the stress further refined the experience. There was a collective agreement that seeing the results of the work was satisfying and made the experience worthwhile.

Those who found it difficult to enjoy the experience towards the end of the month felt that they had overcommitted themselves emotionally and were experiencing burnout. They experienced a lack of empathy and sympathy and found it difficult to relate to patients as people. This feeling was not

widespread among the participants. However, it indicates how some flourish under stress while others find it difficult to manage themselves.

Fundamental Structure

The experience of full-time immersion was emotionally challenging due to financial, time and relationship management whilst also being clinically challenging due to a lack of experience, time pressures within consultations and unfamiliar clinical scenarios. Participating in the immersive experience was rewarding, with enjoyment found in becoming grounded and students seeing their clinical skills and patient management improve. Students felt an increase in their confidence when their work was validated by tutors, which improved their self-reported clinical skills. Several students found that the collective clinical and outside life pressures were valuable in refining professional identity, whilst others felt that these demands took away from the experience and lead to emotional burnout. All students found that once the immersion was complete, their self-confidence as future osteopaths had increased.

Chapter 5 - Discussion

The results of the study confirm that an immersive workplace experience is an effective method of improving clinical competence and confidence. Throughout the experience, there were fluctuations in feelings of emotional and physical burnout due to the stress that accompanied an unpaid, full-time work experience, however, some participants welcomed these stresses and described how they improved their outcome of the transitory experience (regarding clinical confidence and competence). The student participants experienced a transition from being a novice to an advanced beginner, and, in turn, felt confident in their skills and personal approach to osteopathy.

An increase in clinical confidence and competence has been reported in studies investigating how postgraduate study influences clinical workplace competence (Blackmore et al., 2014; S. Park, 2018). Clinical confidence, professional identity and skills such as clinical reasoning and diagnosis are all shown to improve following study at a postgraduate level which corresponds to the findings of this study (Dornan et al., 2007; Green et al., 2008; Perry et al., 2011). In this study of postgraduate students, the increase in clinical skills of the participants may be linked to the increased use of palpation in patient-practitioner interactions. Palpation is the key way student osteopaths inform clinical reasoning and improve technique efficacy (Davidson, 2009; Fryer, 2008). By increasing the amount of palpation a student carries out, clinical reasoning and technique efficacy also improve. This increased volume of palpation appears to be an important aspect of the full-time working month experience that makes the students feel more confident as osteopaths.

Intensive clinical skill courses, not including patient-practitioner interactions, have a positive effect on self-reported self-confidence and competence. The results of clinical immersion are also seen in the transition into full-time work, where practical internships lead to a smoother and easier transition (Prince et al., 2000). Interestingly, a study in physiotherapy students (another form of manual healthcare) found that an increase in confidence following immersive clinical work was lost once out of the full-time setting, however, increases in clinical competence were consistent (Wright et al., 2018). Wright et al.'s (2018) study investigated a six-day full-time immersion experience for healthcare students, where each day was spent on a different topic. Confidence was gained following immersion in one topic but was lost when beginning a new topic. This may indicate that confidence can be linked to a sense of familiarity within a workplace environment rather than to the hours spent immersed in practice. This can also be seen in a study of the transition to full-time work in Australian osteopathic students, which found that they were more confident in their final months of study compared with

when they first went into the workforce (Subramaniam et al., 2015). The findings of this study underline the findings of other researchers, as the fundamental structure of this transitory phenomenon highlighted how the students felt more confident in themselves as osteopaths towards the end of their immersive full-time month compared to the end of the fourth year of study.

In this study, 'groundedness' was described by participants as "being able to stay present in your mind and body while calmly treating, feeling and adapting with your hands rather than carrying out a routine". The participants also view groundedness as knowing the style of osteopathy they work with and adapting it to bring a personal approach to their work. Groundedness as a concept has not been studied in the context of bringing personality to clinical practice but some literature exists relating to how personality can affect the way a practitioner practices (Walton, 1968). In a study of doctors treating psychiatric patients, it was shown that the personality of doctors effected their style of treatment (Walton, 1968). For example, the study found that age influenced practice style, also the practitioner's ability to deal with ambiguity or uncertainty in clinical situations affected the style of treatment, for example, doctors less tolerant of ambiguity had greater tendency to prescribe pharmaceuticals (Walton, 1968). Although, Walton's study is now 50 years old, and the results sometimes questionable, the nature of his findings, ie the differing practice style with differing personality traits, are important to note.

In a study of how emotions can affect clinical reasoning, intuition (which is often associated with expertise, as per Dreyfus' and Benner's transition models) is described as a combination of expertise, knowledge, personality and environment (Benner, 1982; Field, 2014; Langridge, Roberts, & Pope, 2016; McCutcheon & Pincombe, 2001). In a recent systematic review of cranial osteopathy and its reliability, the personality of the practitioner was one of the factors influencing treatment efficacy (Guillaud, Darbois, Monvoisin, & Pinsault, 2018). A distinguishing feature of osteopathy compared with other forms of manual healthcare is that osteopaths use clinical reasoning to guide treatment rather than standardised treatments for particular named conditions (Grace et al., 2016). Clinical reasoning is influenced by many aspects of the patient-practitioner interaction, including the practitioner's values and beliefs towards health (Grace et al., 2016; Higgs, Jones, Loftus, & Christensen, 2008). The personal values and professional beliefs of the osteopath influence their clinical reasoning and, therefore, the practitioner's unique style of osteopathy is influenced by their personality.

In a recent study of students in nursing, occupational therapy, social work and psychology courses, participants reported feeling most 'burnt-out' towards the end of their studies, with these feelings continuing into the workplace environment (Robins et al., 2018). These feelings of burn-out were also highlighted in this study, where a number of students felt physically, mentally and emotionally drained after the second week of the immersion experience. This may be due to a rapid increase in responsibility required from being in the full-time clinic and less time and energy available for other responsibilities. This is illustrated by one student describing their working day and financial difficulty over the month:

“So I would finish clinic and then I would go and massage for an hour, hour and a half, type thing, [paid work] which would mean that I was normally not be getting home until like 9 p.m. from work. So I've literally been at clinic from 7:30 am, getting home at 9 p.m., but at least it wasn't much, but it was still bringing in some money”.

Burn-out has been shown to be more common in students involved in placements or full-time work scenarios than in those already in the workforce. This may due to a lack of confidence, a lack of familiarity, and an increase in responsibility with a lack of resources (energy, time and emotional availability) (Robins et al., 2018).

The environment that the students were immersed in resulted in a positive outcome with regard to clinical skills, confidence and professional identity. Immersive environments are shown to be effective in a variety of settings, however, Hand et al.'s (2016) study into education through immersive environments questioned the pedagogy behind such methods. Hand et al. (2016) discussed different ways to develop the pedagogy behind immersive educational environments. The different methods to improve immersive teaching environments include modifying the classroom settings, modifying the discussions had during class, and varying the teacher beliefs (Hand et al., 2016). This thesis showed that these modifications do improve the outcome of immersive environments as the participants felt that the transition into full-time work positively affected their learning. Modification of classroom setting was done by student's conducting all their work and study in the osteopathy clinic, discussions were modified to be based around the clinical work being done, and the varying of teacher beliefs was achieved by having many tutors with different styles of practice supervise the participants. As this study only highlighted specific information regarding how students engage in a full-time work environment, it did not confirm the findings of Hand et al. (2016), and more research is required to develop and evaluate the most appropriate pedagogies for immersive teaching environments.

Each participant reacted differently to the stress of being in a full-time working environment. Some students reacted positively to the added stress while others reacted negatively. This stress stemmed

from responsibilities additional to the clinical work, including financial management (which was heightened in the experience due to unpaid full-time work), relationship management, time management, clinical hygiene maintenance and reception work. Stress in response to clinical placements in nurses has been recently documented where nursing students feel unprepared, nervous, anxious, and worried about the practicality of clinical work before entering a full-time scenario (Levett-Jones et al., 2015). However, there is limited evidence for how students perceived stress as a positive factor in their education. The relationship between stress and burnout has been established and stress management has been shown to be a useful skill in preventing burnout (Blackmore et al., 2014; Kleinbaum, 2009; Robins et al., 2018; Skodova & Lajciakova, 2013), however utilising stress as an education tool has only been seen in one study (Pliego et al., 2008). The study conducted here has similar findings to Robin's et al (2018) and further strengthens the argument that burnout and stress is prevalent in university students studying in the health professions (Robins et al., 2018). One method of preparation for stress management, termed 'stress hardiness', has been incorporated by a single boot-camp style immersive educational experience (Pliego et al., 2008). Blackmore et al.'s (2014) meta-analysis of immersive postgraduate medical education highlighted the study where some participants felt that clinical immersion helped improve their 'stress hardiness' and prepared them for what is to come when entering the workforce. On the contrary, others felt that the nervousness and anxiety that accompanied the additional responsibilities of the experience took away from their education. Of the 15 studies included in the meta-analysis, all showed improvement in clinical skills, however, only a single study investigated the effects of clinical immersion on 'stress hardiness' (Blackmore et al., 2014; Pliego et al., 2008). These findings are similar to those of the present study as some students felt that the stress that accompanies full-time clinical work helps them in the transition to becoming a competent osteopath, while others felt that the accompanying stress took away from their learning opportunities. Reasoning for the discrepancy was not investigated in this study, but future research could usefully examine this discrepancy.

The transition made from novice to becoming an advanced beginner is described by the participants here, although not in direct terms such as 'advanced beginner' and 'expert'. Karl Ericsson's (1996) 'Road to Excellence' describes how expertise is reached following 10,000 hours of focused and deliberate practice of a task. The Osteopathic Council of New Zealand (OCNZ) requires 1,000 hours spent in student clinic as a prerequisite for graduation with a MOst degree, however, not all 1,000 hours are spent in interacting with patients. Of these 1,000 hours, 160 of them are spent in the immersive full-time experience that is the focus of this study. This full-time month of work accelerates the acquisition of experience by immersing the student in a safe environment surrounded by

educational opportunities such as patient-practitioner interactions, patient-tutor interactions, and clinical tutorials. Dreyfus' model of transition and Benner's adaptation of the model would argue that the students have left the novice stage and have made the transition to being an advanced novice (Benner & Tanner, 1988; Peña, 2010). The study did not investigate what level each student felt they were at regarding transition models, however, the competence and confidence the participants describe is reminiscent of Benner's description of 'Competence' – "[the clinician] begins to see his or her actions in terms of long-range goals or plans. The competent nurse lacks the speed and flexibility of the nurse who has reached the proficient level, but the competency stage is characterised by a feeling of mastery and the ability to cope with and manage the many contingencies of clinical nursing" (Benner, 1982, p. 4). This may provide some evidence that Dreyfus' model of skill acquisition could be applied to osteopathy in a similar way that Benner has done in nursing, however more research would need to be undertaken to support this statement.

In addition to the increased patient-practitioner interactions, the participants spent more time immersed in an education setting. Aspects of the educational setting include observing other patient-practitioner interactions, clinical tutorials (on subjects chosen by the participants) and participating in discussions with clinical tutors. Education into osteopathy theory included in the experience may potentially have more of an effect than the patient-practitioner interactions that the students had. The re-education of osteopathy theory (introduced early in the degree) could have led to the described increase in clinical competence, as the students may feel more confident integrating theory into their practice (S. Park, 2018).

As Hand et al., (2016) have stated, a pedagogy utilising immersive environments for education has not yet been standardised. The aim of this study is not to develop this standard, however, it supports the use of immersing student practitioners in a workplace environment. Increasing the patient-practitioner interaction time and therefore increasing the amount of palpation each student does improves their clinical skills and confidence (Davidson, 2009). Perhaps the continued education of theoretical knowledge and how to apply it is more instrumental in the students' transition to becoming an osteopath, however, regardless of the specific aspects of the experience, both theoretical and practical knowledge benefit from an immersive educational environment.

A limitation of this study was the experience of the researcher during the focus groups. The benefits of running a focus group for data collection largely depend on how well the focus group is facilitated, and how the researcher directs conversation to obtain deeper insight into the topics (Nyumba et al.,

2018). As the researcher was inexperienced at facilitating focus groups, the information gathered did not achieve the depth or breadth that an expert researcher may have obtained.

A second limitation of this study was that a secondary facilitator was not included in the second and third focus groups. This is a large limitation to the study as the inexperienced primary researcher carried out the interview without support. Any biases that the primary researcher has from their time in the experience go unchecked in these focus groups, potentially influencing the questioning and discussions. Having the secondary facilitator reduced bias as they could bring discussions in line with questioning and ensure neutrality of the questioning, while providing support and also feedback to the primary researcher regarding the focus group. This limitation goes against best practice for focus group methodologies, reducing the reliability of the discussions had during the individual interview and focus group three (Nyumba et al., 2018).

This study offers a pathway to different avenues of research. An increase in clinical confidence and competence following the month-long transition was observed, however, investigating which aspect of the experience caused statistically significant improvements in students' performance and confidence may provide further insight. Aspects of the experience that were not recorded include time interacting with patients and tutors and the total number of patients seen during the month in clinic. These may influence the outcome of the experience. Complimenting this study with quantitative methods would allow for greater insight into the relationship between the specific aspects of the clinical immersion and the overall transition that the students' experienced.

How each student responds to the stress of the experience is a point for further study. Having additional responsibilities similar to those that the participants will experience in the workforce, while managing relationships with tutors and peers led to positive or negative feelings towards the experience. Additional research could investigate aspects that enhance the educational utility of the experience, and/or, methods of analysing why a student reacts positively or negatively to different stressors.

Osteopathy in itself has a limited body of research relating to it and without further study, the pedagogy of developing expertise in osteopaths will not advance. The study conducted aimed to investigate the effects of immersing student osteopaths in a clinical work environment and found evidence that it improved the development of clinical competence and confidence. Aspects of the experience that detracted from participants' abilities to attend to clinical work was perceived by some

as reducing the benefits of the immersive experience, regardless of its likeness to workplace realities. However, despite a general increase in self-confidence and clinical competence following the month-long experience among the students, there remains scope for refining immersive education in osteopathy.

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Appendices

Appendix 1 – Bracketing diary conducted by primary researcher over their month of full-time work

Bracketing for Thesis – Summer Clinic 2018 (Jan 30th – Feb 23rd)

Day 1 (30/1)

The beginning of my month of full-time clinic will be strange compared to the others. The previous Wednesday (24th January) I underwent surgery to remove to pilonidal abscess. As it was so recent I am not able to treat patients and am stuck to observations. I'm disappointed because this month is meant to be a full immersion into osteopathy and I was hoping to learn a lot and become very motivated to study and learn and become more of an osteopath however this will have to wait. I will discuss the plan for the summer (at least the first two weeks) with Stella and Philipe and see if it is wise for me to be in clinic at all.

Day 2 (Wed 31/1)

Today was much of the same as yesterday. It was very tiring just observing all day and I feel like I'm not getting as much out of the month as I could so far. Watching my peers allows me to practice my clinical reasoning however it is not the same as having the pressure of being responsible for the patient and having more patients before and after.

Day 3 (Thurs 1/2)

Today I am coming to terms more with how observing is being more beneficial for my learning. I am feeling like I am making more use of my time, practicing how I would write notes as if the patient was my own and trying to spend the time thinking in less linear patterns and trying to challenge myself. It is still difficult to concentrate all throughout the day however I am seeing the use. I am jealous of the others and the learning they are getting compared to mine, and the relationships they are building with the tutors as they are being challenged to learn. I am excited for my time when I am treating as my relationship with the tutors and the peers will improve as I will be less excluded. I have to practice being patient and try my best to learn as much as I can from observations.

Day 4 (Fri 2/2)

Today is the last day of observations and I am happy that this week has come to an end. I feel like my relationship with peers and tutors is increasing but I still do not feel challenged. I am restless both in and out of clinic as I am not able to exercise or strain myself. Therefore I am beginning to get bored in clinic, and observing is becoming more tiring and more difficult. For the end of the week I am trying to push through and learn as much as I can by carrying a notebook with me and writing down tips and comments that the tutors make that can be beneficial for my learning.

Day 5 (Monday 5/2)

Today is the first day that I will be treating a patient. I am looking forward to seeing them and I am hoping it will go well. I am slightly nervous about seeing the tutors when treating as this is my first patient and I am behind the other classmates in terms of clinical experience. The tutors have been able to get to know them and their strengths and weaknesses. In comparison I have not been able to have that yet so this will be a hard first week as the tutors are able to test me and find out where I am. This excites me and makes me nervous.

I am happy to be able to move on from only observing. My lower back is still a bit uncomfortable and some positions are difficult for me to move in but I am hoping I will be able to work around that. I want this a lot to help my learning as I feel that observing is not as efficient as treating for my learning.

Day 6 (Tuesday 6/2)

Today was pretty difficult getting back into it. I only had a couple of patients but I'm not as able yet as I would have hoped. I'm getting better but I still find myself really tired throughout the day after my surgery and I want to be as mentally and physically active as I can be. I feel torn between two sides of how I feel. In terms of my clinical learning I want to be pushed and challenged as it helps me learn, however on the other hand I want to take it easy as I still don't feel quite up to it and I want to take clinic easy until I'm feeling more capable. I was okay with the people I saw and the tutors weren't too challenging on me which I'm grateful for but soon I think I will have to ask them to challenge me a bit more and not to go easy on me (as I think they're holding back cause of how I'm feeling post-surgery)

Wednesday (Wednesday 7/2)

Today has been a good day in terms of my clinical learning. I felt more competent with the patients and talking to the tutors has been easier. I feel that I am getting into my stride, however I know that my days are not very busy or that difficult compared to others. There is some jealousy from my behalf when talking to my classmates as I am hoping to be challenged and experience some tough days over this month and so far I am nowhere near to being properly challenged. I know I am still recovering however I would like to be properly challenged before the month is over. I would like this because I feel like I could prove myself to the tutors and then also be able to build my relationships with my classmates by sharing this experience. Today was also interesting as one of my three patients (compared to the others who have seven or eight) was a minor and therefore I had to be extra thorough with consent. This was a challenge that I enjoyed as I ended up making the

right decision on the spot (consent through the parent not the student) and I am hoping that I will have more situations like this in the future.

Thursday (8/2)

Today was similar to yesterday, I feel like I am slowly getting more and more comfortable treating and being responsible. I am feeling better in terms of my surgery and I am more capable in being active throughout the whole day. Later in the morning was difficult as I struggled with answering the tutor's questions. I have to study up on discs and facets and the differences in aggravating and relieving factors. This was hard to deal with as it should be something I know (tutor described it as our 'bread and butter'). I felt that both tutors (the one I was presenting to and the other one nearby) were disappointed in me as I have been better than this and it did not look good for myself.

Friday (9/2)

Compared to yesterday, I do not feel as confident. With my first patient they have had a lot of headaches and problems and I felt like I helped them. I was hoping that the tutor would be more helpful with this case however they came into the examination and therefore I did not have a chance to have an in-depth discussion because we were in front of the patient. Also the tutor did not provide much guidance with the case as I was hoping. This was the first time that I felt short-changed by the tutor and wish that they could have been patient and helped more. This is because the patient was

Monday (12/2)

Today has been quiet as I have only treated one patient. As last week I was not able to treat any patients I have no patients lined up for appointments this week. I am frustrated as I still would like the 8 patient day challenge and prove my skills to myself a bit. So far I feel that my relationship with the tutors is building. They are becoming more friendly (breaking down the purely professional barrier) and know how to push and challenge me. I am glad that this is finally happening as I feel that I am lacking behind the other students as they have had more patients, are learning more, and growing as Osteopaths. I know that this will come and I just have to be patient.

There are still some parts of my practice that I struggle with. My notes are not as clean as I would like them to be, and my time management is still lax. I feel like I can get through a case history and examination quickly (in around 25 minutes) however I make my treatments take longer and end up taking the full hour. This is something that I want to practice as I would rather treat people and be done before the hour. I will practice making my appointment times 45 minutes max.

Thursday (15/2)

The last few days have been very good. Yesterday was the first day that I was really challenged by the tutor about a patient. My new patient for the morning shift has some systemic issues and my questioning and case history was not specific enough to make sure that the patient was safe to treat. I was not able to think critically, streamline my questioning and step up in my clinical skills. The tutor said that I need to step up and they expect more of me as we are about to go into fifth year and I'm still acting like a fourth year student.

This challenge was hard as I was disappointed in myself as I was not able to step up and I felt like I was floundering throughout the appointment. The tutor recognised this and I was glad that they did because it identified some parts of my practice that I was not addressing. I feel like my relationships with the tutors were challenged and I have not yet been able to prove myself, which can only happen when another complicated patient books in.

There are some parts of my practice that I am finding myself improving in. Straight-forward patients I am confident in treating, however there are still parts that I can improve even more with. I do want to be the best Osteopath that I can but to do this I need to sacrifice more time. There is much more that I can do to improve, however at the moment I am struggling to find more time to sacrifice. Between fencing, relationships, a social life, and my recent surgery I am not making the time that I need to step up and this is reflected in my practice.

The simulation of full-time work is enjoyable, as this is what I want to do, but it is only now that I am starting to see how difficult it is to have a life and keep on top of being an effective and safe osteopath. There is always more that I can do to improve on and finding the balance between being an Osteopath and everything else – plus while I am studying having work in addition to everything else to be able to afford to live.

Friday (16/2)

Overall this week has been good. I feel like I am starting to find my feet and my style of treatment. I am happy with how my appointments are going, however my relationships with the tutors are not where I would like them to be as my theoretical knowledge still needs work. I found this week that I need to sacrifice more and commit myself to study and Osteopathy if I want to be the best that I can be. I am a step behind everyone else due to my surgery and the fact that I did not start treating patients until the second week and my schedule did not become busy until week 3 of summer clinic. This frustrates me as I feel like I've missed the best opportunity for learning that the course provides. I am grateful that the tutors are supportive and have accommodated for my condition over the last few weeks but I feel that it has impaired my learning and that the tutors are babying me still. I would like a chance to really prove myself but I am yet to have an opportunity. I hope that next week I have a busy day with 6-8 patients but I realise that this is not likely. I feel like my clinical skills have improved from last week where I felt that they were where they should be. Due to missing out on practicing on patients, it took a while for my clinical skills to get back to where they were before my two month clinical break, however at this stage I am happy with my skills.

Monday (19/2)

Today I feel like I am coming into my stride with my clinical reasoning and thinking. I felt like I am slightly better at drawing different aspects of the patient's complaint together to create a coherent picture in my mind. So far this is to impress the tutors and my classmates, rather than myself, however either way I feel that I am improving. My relationship with the tutors has become better over the week except today one tutor was tough on us and gave us a reality check in regards to our practice.

I really want to be competent at putting together the different pieces of patient complaints and examinations but there is so much that each day I am missing new things that I hadn't thought about. Additional questions or examinations in regards to more lifelike aspects of their complaint (eg instead of asking about swelling, ask about difficulty putting on or taking rings off. Instead of asking about neck pain and sleeping, asking about things such as reading at night or watching tv/device usage). This will give a more human appreciation to the complaint. I understand that this aspect comes with being experience but I would like to up my game as the tutors have reminded us that we are now fifth years. As we are in our final year they will stop holding our hand through the appointment to ensure that we are safe and expect that we are thorough with our questioning and testing to ensure all aspects of the patient's complaint has been considered.

Today was difficult and I felt that my relationship with the tutors took another step backwards as they called out the class on our weaknesses and what we are doing wrong. They expect much more from us and that we are pulling together all aspects of our knowledge and implementing it with our Osteopathic principles. It is time to look wider and deeper when treating patients to be more effective.

Tuesday (20/2)

From now on I have to try harder to fill the gaps in my anatomy and pathology knowledge so I have a good base to work from as this area still lets me down (for example, muscle attachments and all the causes of coughing). Phil grilled me in the seminar room and it reduced my confidence a lot. I am trying to fit the pieces together but it is still difficult. He asked if I have more difficulty learning the information or recalling it and I think it is recalling the information. I know that this will take a lot of time to practice and get good at but I want to get it right before I finish uni. The expectations on us are greater now as we enter the fifth year and I want to prove to myself and the tutors that I can be more than competent.

Wednesday (21/2)

It feels funny to think of myself as being so close to fifth year now. I'm still a little nervous about clinical work because of what happened yesterday but otherwise I am ready to focus and practice my information recall with flash cards and asking the tutors to quiz me a bit more. I know it will make being in clinic more difficult but I think the extra stress will help me develop as an Osteopath.

I'm a little frustrated that last couple of days working in the clinic this morning isn't fully booked. It would have been nice to be very busy and be hands on all the time and interact with the different tutors and learn as much as possible. In the meantime I will try to observe different other classmates to see how they work but otherwise I will practice my memory recall as I'm feeling motivated. This month has been good but not as busy as I would have liked so for the last couple of days I want to make the most of it. I've had a couple of patients book into today which is good. I'm happy to be working but right now I want to get as much as I can out of this month

Thursday (22/2)

Today my motivation dropped a bit after feeling good yesterday. I think it is the early morning start and late finish and I am struggling to want to learn as I was feeling tired. After feeling good yesterday I'm trying to keep on making the most of each shift but today wasn't great. I did some flash cards and saw my patients that were booked in but I felt like I was following the routine. On one hand I'm happy with that as I enjoy the routine and am looking forward to getting into the routine of working, being in the routine contributes to me feeling like an Osteopath, but on the other hand I know I should be making an extra effort to learn in this environment because it is almost up and is the most osteopathy I will experience until I leave university and enter the work force.

It was a little difficult today as some of the tutors weren't that invested in challenging me, but again this is the same as before. Some tutors want to push and challenge me and I like that, but others feel that as we are so close to being fifth years now we should be comfortable pushing ourselves and finding our own paths which is what I'm finding difficult.

Friday (23/2)

Today is the final day of the experience. I'm finding it difficult to think that this is meant to be the best learning experience of the clinical aspect of the course. The month of full-time work has shown me what working as an Osteopath will really be like. It is difficult but I enjoy it. However aspects of the experience have made it more difficult to appreciate. Not being busy is very frustrating as the whole idea behind this month is that we are immersed in Osteopath but not being able to treat people means that we can't actually practice what we want to do. It has been good to be able to learn a lot of new techniques from the different tutors but we haven't been able to put these into our examinations or treatments. I want to be able to implement them into my style, but this will have to wait until I am further into fifth year to experiment with different techniques.

Having the many different tutors available meant that we could soak up so much information but when these views conflicted it made work tricky to navigate as some tutors were less accepting of opposing views. This again is good on one hand as this is what life will be like but it made it harder to approach some tutors and then presenting the case to them was harder as I felt like I was being judged. Especially from the tutors who expected more from me "as we are fifth years now". When the tutors pushed me it made it hard to present to them again as I didn't want to be challenged like that out of embarrassment and/or pride. Lots of this is disjointed thoughts that I'm trying to piece together. With the tutors who were tougher I appreciate it now looking back but in some instances the ways that they test us could be refined to not feel like such a put down, but it's the same kind of shame as failing at anything but we are just in front of our peers. It was motivating but at the time that was hard to see.

I feel like this has been a good experience overall, there are definitely things that I would change about how it is managed but I enjoyed it. I appreciate the stress that accompanies the month from clinic and outside life, regardless of difficult it can be. This month was hard but good and I hope to keep up what I've learnt from the different tutors and my peers. I feel like I'm closer with the people that were in the February group because we've been through the same stress. I wish there were more opportunities like this as it was such good learning but I'm glad that the month is over so I can focus on other things. I'm a little mad that I didn't get to work as much as I wanted because of my finger injury and surgery, the experience would have been even better if I could have been fully invested the entire time but it's okay. If this is what life will be like after I graduate then I think I will enjoy it.



<https://scribie.com>

Confidentiality Letter

TO WHOM IT MAY CONCERN

I, Rajiv Poddar, on behalf of Scribie.com, agree to treat in absolute confidence all information that we become aware of in the course of transcribing the interviews or other material connected with the files which we receive for transcription. We agree to respect the privacy of the individuals mentioned in the interviews that we are transcribing. We will not pass on in any form information regarding those interviews to any person or institution. On completion of transcription we will not retain or copy any information involving the above project.

We are aware that we can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if we disclose identifiable information contained in the audiotapes and/or files to which we will have access.

Signature:  Date:.....October 2, 2017.....

Appendix 3 – Unitec Research Ethics Committee approval letter



10 December 2017

Dear Daniel Garelja ,

Your file number for this application: **2017-1077**

Title: *Exploring the lived experience of osteopathy students making the transition from working in the student clinic to working full time*

Your application for ethics approval has been reviewed by the Unitec Research Ethics Committee (UREC) and has been approved for the following period:

Start date: 3 November 2017

Finish date: 3 November 2018

Please note that:

1. The above dates must be referred to on the information AND consent forms given to all participants.
2. You must inform UREC, in advance, of any ethically-relevant deviation in the project. This may require additional approval.

You may now commence your research according to the protocols approved by UREC. We wish you every success with your project.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'N. Adams'.

Nigel Adams
Deputy Chair, UREC

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New Zealand

Appendix 4 – Participant Confidentiality Agreement



Research Project Title:

Exploring the lived experience of Osteopathy students making the transition from working in student clinic (8 hours per week) to working full-time (40 hours per week) during the summer holiday break.

Researcher:

Daniel Garelja

Ph – 0211300230

email – daniel.garelja@gmail.com

Participant's Name:

Phone number:

Email:

I _____ *(full name - please print)*

Agree to treat in absolute confidence, all information that I become aware of during the course of participation in the above research project. I agree to respect the privacy of those involved and will not divulge in any form, information with regard to any participating person or institution and agree to not retain or copy any information involving the above project.

Discussions and information recorded will be transcribed by a professional transcribing service that has agreed to treat all information with confidence, where names and identifying factors will be removed. This is accordance with the professional transcribing service's terms and conditions.

I am aware that I can be held legally liable for any breach of this confidentiality agreement and for any harm incurred by individuals or organisations involved, should information be disclosed.

Signature: Date:

UREC REGISTRATION NUMBER: 2017-1077 This study has been approved by the UNITEC Research Ethics Committee from 3-11-2017 to 3-11-2018. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the

UREC Secretary (ph: 09 815-4321 ext 8551). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix 5 – Participant Consent Form

Researcher: Daniel Garelja
Ph – 0211300230
email – daniel.garelja@gmail.com



Participant Consent Form

Project Title: Exploring the lived experience of Osteopathy students making the transition from working in student clinic (8 hours per week) to working full-time (40 hours per week) during the summer holiday break.

I have had the research project explained to me and I have read and understand the information sheet given to me.

I understand that I don't have to be part of this research project should I chose not to participate and may withdraw at any time during the research project. Should I wish to withdraw and revoke the information given during the focus groups, the information will be excluded during data analysis and questioning.

I understand that everything I say is confidential and none of the information I give will identify me and that the only persons who will know what I have said will be the researchers and their supervisor. I also understand that all the information that I give will be stored securely on a computer at Unitec for a period of 10 years. All physical copies of any data will be destroyed following acceptance of the thesis.

I understand that my discussion with the researcher will be taped and transcribed.

I understand that I can see the finished research document.

I have had time to consider everything and I give my consent to be a part of this project.

Participant Name:

Participant Signature: Date:

UREC REGISTRATION NUMBER: 2017-1077

This study has been approved by the UNITEC Research Ethics Committee from 3-11-2017 to 3-11-2018. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 8551). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix 6 – Participant Information Form

Information for participants



Project Title

Exploring the lived experience of Osteopathy students making the transition from working in student clinic (8 hours per week) to working full-time (40 hours per week) during the summer holiday break.

Synopsis of project

To date there is limited information regarding the development of Osteopathy students. There have been quantitative projects that research the transition into the 'real world' and qualitative projects that research the transition from undergraduate to postgraduate study, however there are none that investigate the development of student osteopaths. This project aims to understand what transitions occur within the students during the month of full-time work and why they have the feelings that they have. Coming together at the end of the month to discuss the experience of summer clinic will allow for a deeper understanding of the full-time clinical experience. This can later be used to refine the teaching process and ensure that students are able to make the most out of summer clinic.

What we are doing

Using focus groups to get a rich description of the lived experience of the transition into simulated full-time work through the eyes of Master of Osteopathy students.

What it will mean for you

Coming together with your peers in a group at the end of the month and discussing how you feel the month has gone. Refreshments will be provided and questions will be asked to get an idea of what this experience was like for the individuals. All that is required from you during the focus group is to answer the questions based on your experiences over the month of full-time work. The focus group is planned to run for up to 90 minutes with refreshments provided following the completion of the focus group, however you are free to leave at your will following the focus group.

If you agree to participate, you will be asked to sign a consent form. This does not stop you from changing your mind if you wish to withdraw from the project. If you wish to withdraw consent from the study you may choose to have all information provided discarded and not included in the collected data.

Your name and information that may identify you will be anonymised and kept completely confidential. All information collected from you will be stored on a password-protected file and only you, the primary researcher and the supervisors will have access to this information. The information and data collected will be kept for 10 years then subsequently destroyed.

Please contact us if you need more information about the project. At any time if you have any concerns about the research project you can contact our supervisor:

My supervisor is Dr William John Waugh phone 815-4321 ext. 7527 or email jwaugh3@unitec.ac.nz

Researcher:

Daniel Garelja

Ph – 0211300230

email – daniel.garelja@gmail.com

UREC REGISTRATION NUMBER: 2017-1077

This study has been approved by the UNITEC Research Ethics Committee from 3-11-2017 to 3-11-2018. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 8551). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix 7 - Thematic analysis of three focus group transcripts of osteopathy students who discussed making the transition from working in a student clinic (8 hours per week) to working full-time (40 hours per week) during the summer holiday break.

Thematic analysis of three focus group transcripts of osteopathy students who discussed making the transition from working in a student clinic (8 hours per week) to working full-time (40 hours per week) during the summer holiday break.

Focus Group Number & Profile	Initial Analysis	Emerging Themes	Essence of Phenomenon
<p>Focus Group 1. Transcript Profile</p> <ul style="list-style-type: none"> - 5 people - 5F - 2 in 20-30 age range. - 3 in 30-40 age range - 3 people with prior manual therapy experience - Current fourth years. - December group - Focus group was conducted in room 410-1016 	<ol style="list-style-type: none"> 1. Stressed when comparing self with people already through the experience – Participant 1 2. Weather made work difficult [too hot] – Participant 2 3. Reality check – getting used to time management and organisation – Participant 5 4. Exposure to more material as in clinic more – Participant 3 5. Difficult adjusting to 5th year role – better work in less time – Participant 4 6. Exhausting being immersed with new patients and info – Participant 5 7. Anger at continuing others work (incl working diagnoses) and reading badly written notes – Participant 4 8. Enjoyed seeing results of work- Participant 4 9. Have to go through difficult experiences to learn – Participant 5 10. Quick to burn out when providing a lot of empathy and compassion – Participant 3 	<p>Comparison to others leads to stress.</p> <p>Clinical environment (weather, building conditions, relationships, etc) had a large influence on the feelings towards being in clinic.</p> <p>More exposure lead to awareness of efficiency and exhaustion that comes with full-time work.</p> <p>Anger with dealing with conflicting professional views and skills.</p> <p>Pleasure with seeing results of treatments and being immersed in the clinical experience.</p> <p>Burn out and emotional fatigue early in clinic before learning how to manage personal and emotional barriers.</p>	<p>Environment affected learning.</p> <p>Collaborative learning and goal setting</p> <p>Immersion difficult to adapt to but rewarding.</p>

		Variability in personal development, ups and downs for each person regarding enjoyment of osteopathy.	
<p>Focus Group 2 Transcript Profile</p> <ul style="list-style-type: none"> - January group - 1 person - 1F - Participant in 20-30 age range - Participant had no prior manual therapy experience - Current fourth year. - Started part way through January with others who had been in for 2 weeks already - Done in practice room of clinic 41 osteopathy 	<ol style="list-style-type: none"> 1. Comparison to other students – lead to embarrassment when pushed by tutor and confronted about theory knowledge 2. Strengths did not show as expected and were questioned 3. Intimidation from tutors 4. Taking control of situation 5. Confidence with difficult situations 6. Easier adaptation to full-time routine than expected 7. Validation of clinical skills relate to feeling of efficacy 8. Grounded, clinical skills and emotional management came with clinic immersion 9. Extra-curricular stresses hindered learning – better to just focus on clinic (contrasts with point 16 from focus group 1) 	<p>Comparison with other students and being put down by tutor. Embarrassment in front of students who are half way through the experience already.</p> <p>As strengths were questioned by the tutor this led to being intimidated by the tutor.</p> <p>Confidence in practice and dealing with difficult situations.</p> <p>Validation of skills enhanced confidence.</p> <p>Immersion lead to becoming grounded and feeling confident in clinical skills.</p> <p>Dealing with more patients built better management emotionally and clinically (notes, time management, building rapport).</p> <p>Stresses from the outside life distracted from learning and reduced the ability to learn from clinical immersion.</p>	<p>Comparing against others as mark of improvement.</p> <p>Validation affects confidence.</p> <p>Immersion leads to groundedness.</p> <p>Outside life reduced clinical skills.</p>

<p>Focus Group 3 Transcript Profile</p> <ul style="list-style-type: none"> - February Group. - 7 people - 5 people in 20-30 age range - 1 person in 30-40 age range - 1 participant had prior manual therapy experience - 2M:5F - Current fourth year - Conducted in clinic 41 room 1005. 	<ol style="list-style-type: none"> 1. Reaffirmation of knowledge. Confidence in clinical knowledge and skills (repeatedly mentioned) - Participant 2 2. No longer relying on clinical tutors – Participant 2 3. Anxiety with having less tutor support – participant 4 4. Perfectionism related to over thinking and anxiety – participant 4 5. Feeling trusted to do their practice – participant 5 6. Nervous about having 2 months off – Participant 6 7. Nervous about first time working full-time – Participant 7 8. Expecting difficulty and bad experiences but this wasn't true –Participant8 9. Freedom but the responsibility that came with this – Participant 7 10. Timing became smoother and more confident as not having to check in with tutors – Participant 9 11. Accelerated learning from immersion – Participant 9 12. Not relying on others notes, making your own informed decisions; positives and negatives of this (called out if you don't know all info especially safety info) – Participant 2 13. Enjoyment and excitement to be doing the work – Participant 6 14. Difficulty having to be in clinic and take time off paid work and not having 	<p>Confidence. Feeling trusted to do their practice.</p> <p>Anxiety. Wanting to be in control but anxious about responsibility.</p> <p>Appointments became routine and details became smooth – time immersed improved clinical skills</p> <p>Regarding #14 disconnect between tutor's ideas and student's experiences – expectations to put all time and energy into clinic, however students cannot commit all this time due to financial and relationship responsibilities.</p> <p>Immersion time stopped outside life experiences but stress helped develop professional identity as osteopath.</p>	<p>Confidence from validation.</p> <p>Groundedness.</p> <p>Stress built better osteopathic skills and professional identity.</p>
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	money or annual leave for the year – Participant 7 15. Changing relationship between tutor to mentor and peer – Participant 6. 16. Stress from extra-curricular life helped become better osteopaths		
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Appendix 8 – Question guide used during focus groups

- Think of something that stood out during the first week of clinic, it could be something puzzling, frustrating, embarrassing, satisfying, anything that really stood out from the first week
- Think of something that stood out from the final week of the clinic and that experience. What was it and what had changed between these two events?
- What changes have you seen or you think that will become more apparent now that the month of full-time work is over?
- Do these experiences match what you expected coming into the full-time month?
- If all the problems that arose during the month, including clinical problems and extra-curricular difficulties, were solved, do you feel like you would have come out of the experience a more effective osteopathic practitioner?

Full name of author: Daniel James Gardy's

ORCID number (Optional):

Full title of thesis/dissertation/research project ('the work')

Exploring the lived experience of Osteopathy students making the transition from working in student clinic (8 hrs per week) to working full-time (40 hrs per week) during the summer holiday break.

Practice Pathway: Osteopathy

Degree: Master of Osteopathy

Year of presentation: 2019

Principal Supervisor: John Waugh

Associate Supervisor: Julia Hollis

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Signature of author: 

Date: 01/10/2019



Declaration

Name of candidate: Daniel James Garelja

This Thesis/Dissertation/Research Project entitled: Exploring the lived experience of Osteopathy students making the transition from working in student clinic (8 hrs per week) to working fulltime (40 hrs per week) during the summer holiday break is submitted in partial fulfillment for the requirements for the Unitec degree of MOST

Principal Supervisor: John Waugh

Associate Supervisor/s: Julia Hollis

CANDIDATE'S DECLARATION

I confirm that:

- This Thesis/Dissertation/Research Project represents my own work;
- The contribution of supervisors and others to this work was consistent with the Unitec Regulations and Policies.
- Research for this work has been conducted in accordance with the Unitec Research Ethics Committee Policy and Procedures, and has fulfilled any requirements set for this project by the Unitec Research Ethics Committee.

Research Ethics Committee Approval Number: 2017-1077

Candidate Signature: [Signature] Date: 01/10/2019

Student number: 1417282