

A critical analysis of practice education in
health and social care: Integrating disabilities
studies, the capability approach and the
International Classification of Functioning,
Disability and Health.

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ABSTRACT

Practice education forms an integral part of the curriculum for higher education students on pre-registration programmes in occupational therapy, physiotherapy and speech and language therapy. Given the increasing number of students with a disability in higher education, support for their needs is paramount particularly given the challenges of off-campus-based learning and the need for healthcare students to adhere to discipline-specific and regulatory body standards. An examination of the literature in this area reveals an under theorisation of the issues. This thesis seeks to address this through an in-depth exploration of practice education, through the views of those involved: students with a disability, practice educators, visiting tutors and clinical learning environment leads. In-depth qualitative interviews were the main research tool used, and the interview notes were subject to layered, thematic analysis.

Two core themes were identified from the findings which are pivotal to understanding the experiences of students with a disability in practice education: work context and practices and public perception of disabilities and management of identity.

The International Classification of Functioning, Disability and Health and the Capability Approach were the two key theoretical approaches used for understanding constructions and narratives of disability, along with key ideas from critical disability studies, in particular the critical realist approach. These theoretical approaches have the potential to trigger transformative knowledge and social justice in terms of providing a better practice education experience for students with a disability. Integration of students with a disability within the workforce is critical in facilitating an enabling environment and institutions including key players involved in practice education have a responsibility to work together to play their part in operationalising a paradigmatic shift in supporting such students during their practice education experience.

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CHAPTER 1: INTRODUCTION

1.1 Personal narrative

Good morning / afternoon, it's really nice to meet you. My name's Jane Hibberd, I'm a lecturer in occupational therapy from the University of East Anglia. Just to let you know, I wear two hearing aids and need to rely on sounds and lip-reading to help me hear. If you could ensure that you give me volume and clear speech and don't cover your mouth that would be really helpful. Also, if you do ask any questions or contribute any comments, which I am sure you will do, please raise your hand so that I know where to look to for the source of sound.

When meeting new cohorts or delegates for the first time, this is the usual patter I come out with, an open declaration of my personal disability. Being deaf is one of my disabilities which I routinely disclose, the one that perhaps is the most significant in terms of the challenges I face in daily life and the subsequent coping strategies I need to rely on, in an attempt to be part of a hearing world.

1.2 Students with a disability

A report written by Coleman, Sykes and Groom (2013) for the Equality and Human Rights Commission entitled *Barriers to Employment and Unfair Treatment at Work* asserts that people with a disability tend to be more disadvantaged than people without a disability for example, experiencing discrimination. Furthermore, this report suggests a work culture "that can be inflexible and not particularly welcoming of disabled people" (Coleman, Sykes and Groom, 2013:68). This is of concern particularly to healthcare students with a disability, and to those involved in training students to be the workforce of the immediate future. Indeed, Chacala *et al.* (2014) writing specifically about the profession of occupational therapy report that therapists with a disability are under-represented with the cause attributable to barriers in education and employment. The Widening Participation in Higher Education Agenda - a key initiative stemming from the Department for the Economy (2010) - is concerned with reaching out to under-represented

groups including students with a disability. According to the Higher Education Statistics Agency (HESA, 2016) the numbers of students in receipt of the disabled students allowance and categorised as studying subjects allied to medicine is on the increase. Figures for the period 2013/14 revealed that 7.95% of postgraduate students and 11.65% of undergraduate students were registered with a disability, whereas this increased to 8.28% for postgraduates and 12.34% for undergraduates for the period 2014/15. Current figures revealed an ongoing increase in numbers with 9% for postgraduate and 13% for undergraduates for the year 2015/16. Caution, however, needs to be exercised here as Vickerman and Blundell (2010) question whether the numbers of students with a disability in higher education have actually risen or whether they feel more comfortable with disclosing their disability than in earlier days? In any case, given the proportion of healthcare profession students with a disability in higher education, provision for improving their experience as students and identifying and improving cultures to integrate people with diverse abilities is paramount. Indeed, the Equality Act (2010:58) makes provision for disabled students in higher education in relation to Part 6 on Education, Chapter 2 Section 91 2(a) where it states that discrimination must not occur in the “way it provides education for the student” or 2(b) “in the way it affords the student access to a benefit, facility or service”. Therefore, the end goal concerning the transition from healthcare student to healthcare professional is pivotal and the needs of students with a disability must not be neglected. Vickerman and Blundell (2010:29) state that “employability and life skills should be incorporated into any disabled students’ participation in higher education”. The spectrum of stages from admissions through to employability prospects of the healthcare student is highlighted by Osbourne (2003:18) who cautions: “improving access is one thing, but ensuring progression both within and beyond higher education is another”.

1.3 Practice education

The particular focus of this study considers the challenges and coping strategies of healthcare students with a disability during their practice placement experience. Practice education forms an integral part of a

professional healthcare students' curriculum in higher education. The Quality Assurance Agency (QAA, n.d.) defines a placement as "a planned period of experience outside the institution (for example, in a work-place) to help students to develop particular skills, knowledge or understanding as part of their programme". The QAA UK Quality Code for Higher Education (2014:14), section B, chapter B4 on Enabling Student Development and Achievement, states "higher education providers pay particular attention to how these systems operate when students move into another learning environment, such as an employment-based placement".

Placement patterns in relation to duration and number vary according to the pre-registration programme the student is registered on. Students are placed in a range of health and social care settings to prepare them for eventual qualification as a registered healthcare professional. Pre-registration healthcare programmes embody distinct features signifying an additional level of complexity in that the discipline-specific body for example, the Royal College of Occupational Therapists and regulatory body for example, the Health and Care Professions Council, require adherence to the professional code of conduct and ethics along with achievement of professional competency standards. Thus the status of registered healthcare professional embodies many attributes and characteristics linked with professionalism. The potential challenge for all students, regardless of whether they have a disability or not, concerns their fitness to practise and in doing so, signals that they are registered as competent to practise in their chosen discipline.

Anecdotal evidence through my role as Practice Education Coordinator and Disability Liaison Officer demonstrates that students with a disability may often come across challenges during the practice placement experience solely as a result of their disability. For most, if not all, students with or without a disability, placements can be anxiety-provoking as they will not have previously encountered the allocated placement provider setting in the context of being a healthcare student in their chosen discipline. In addition, students are under pressure to succeed in unpredictable circumstances as working with vulnerable people in need of health and social care intervention

is not always straightforward. Indeed, Price and Gale (2006:22) asserted that “health care delivery is complex” with the decision-making process operating in an often fast-paced environment. Although not specifically related to disability, Walsh *et al.* (2010) conducted a study examining sources of stress in undergraduate physiotherapy students and stated that higher levels of stress are associated with clinical placements. Ijiri and Kudzma (2000) conducted a study on nursing students with learning disabilities and stated that in comparison to students without a disability, this group found transitions and higher levels of learning more challenging, therefore the need for additional reasonable adjustments is ever-present. For some students with a disability, being on placement can present an additional burden to contend with coupled with the need to work twice as hard to compensate for difficulties encountered as a result of the disability. The notion of working twice as hard resonates with a study conducted by Madriaga (2007:409) who explored the experiences of students with dyslexia in higher education; a student participant concluded: “disabled people have to work twice as hard”. This finding was echoed in other studies including Fuller, Bradley and Healey (2004b); Shevlin, Kenny and Mcneela (2004) and Denhart (2008).

Taking a student on placement inevitably represents an additional workload for practice educators due to the preparation required, provision of supervision, teaching and assessment of relevant skills and knowledge. Awang and Taylor (2005) asserted that for some placement providers, taking a student with a disability can be perceived as an extra burden. In tandem with this are legislative requirements to ensure that students with a disability, as far as reasonably practicable, have their needs accommodated within the practice placement environment.

The existing literature - covered in more depth in Chapter 2 (part II) - clearly indicates that students with a disability are more likely to face challenges that may compromise an otherwise positive placement experience (Baron, Phillips and Stalker, 1996; Hinerth and Mackenzie, 2004; Brown, James and Mackenzie, 2006; Hibberd, 2011). It is therefore imperative that students

with a disability are enabled and empowered to participate in practice education to a level commensurate with students without a disability. Hearing the voices and appreciating the lived experiences of not only students with a disability but also key persons involved in supporting practice education - practice educators, visiting tutors and clinical learning environment leads - indicates a critical area for investigation.

1.4 Study significance

My Masters of Science (Hibberd, 2011) afforded the opportunity to investigate the experiences of occupational therapy, physiotherapy and speech and language therapy practice educators who had supervised a student with a disability within the placement setting. I wanted to use my doctoral studies to expand on the findings from my Masters of Science in more depth and in doing so, to think about the importance of practice education and associated challenges for students and those involved in their learning experience. In addition, I wanted to apply disability studies as a critical framework for understanding the experience of disability and what this means for people who have a disability.

Given the increasing proportion of students with a disability as part of the healthcare workforce, we need to ensure that provision is made to accommodate their needs. This study is grounded in empirical evidence with the aim of identifying why such students encounter challenges in practice education and what we can do to mitigate these to enable them to engage positively in learning to be a healthcare professional. The need for empirical research stems from the paucity of existing literature on the subject of allied healthcare profession students with a disability and with reference to Shakespeare (2014:67) who so aptly states: “academics who want to make comments about the impact of impairment, might do well to base their analysis on empirical evidence about how disabled people feel about their embodiment”.

1.5 Outline of chapters

Chapter 2 - Literature Review: this chapter occurs in two parts with part I focusing on disability theory and concepts incorporating key contributions from a number of perspectives including materialist, critical disability studies and critical realist. The International Classification of Functioning, Disability and Health (ICF) and the capability approach are also covered. Part II focuses on empirical research encompassing the experiences of practice education for the student with a disability.

Chapter 3 - Methodology: a rationale for the methodological aspects of conducting this qualitative inquiry is covered within this chapter along with my philosophical standpoint and decisions taken about the design of the study.

Chapter 4 - Findings: this chapter presents the key findings from all 15 interviews with two core themes identified - work context and practices and public perception of disabilities and management of identity.

Chapter 5 - Discussion: this chapter synthesises key elements from the literature review and the findings and comprises four parts. Part I comprises composite narratives from the four key players in practice education (student with a disability, practice educator, visiting tutor and clinical learning environment lead). Part II explores the impact of disability conceptualisation and construction with reference to four key concepts - stigma and disclosure; work culture and practices; inclusivity; and relationships. Part III explores the contribution of two key theoretical frameworks - the ICF and the capability approach - in framing conceptualisations and constructions of disability. Part IV proposes suggestions for the enhancement of practice education for students with a disability.

Chapter 6 - Conclusion: this chapter draws the entire thesis to a close with a summary of the key findings arising and the implications for students with a disability in practice education. Suggestions for future research and reflections on my personal experiences of engaging in this doctorate are also included.

CHAPTER 2: LITERATURE REVIEW

For us, disability is the quintessential post-modern concept, because it is so complex, so variable, so contingent, so situated. It sits at the intersection of biology and society and of agency and structure. Disability cannot be reduced to a single identity: it is a multiplicity, a plurality (Shakespeare and Watson, 2001:19).

The above quote is a powerful statement and in essence, captures the salient connotations of what disability is all about - and why it must and should be viewed from a broader, rather than singular perspective. This chapter therefore discusses the critical framework of disabilities studies and its use in broadening this perspective for this piece of research.

This literature review focuses primarily on two overarching topics - practice education and disability studies, both of which collectively encapsulate the primary concern of this study. Part I focuses on disability theory and concepts incorporating a focus on definitions and conceptualisations of disability by exploring key contributions from a number of sources including different approaches to disability such as materialist, critical disability studies and critical realist. I also explore some key frameworks popular with disability researchers including the International Classification of Functioning, Disability and Health (ICF) and the capability approach. Part II focuses specifically on research on students with a disability within the practice placement setting.

2.1 PART I: DISABILITY THEORY AND CONCEPTS

2.1.1 Disability: an introduction

The Convention on the Rights of Persons with Disabilities (2008; CRPD) - an international treaty - was adopted by the United Nations General Assembly in 2006 and is concerned with protecting the rights and dignity of persons with a disability. The definition of disability according to the CRPD (2008:4), Article 1 is: “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”. In terms of the legal aspects of disability, a person with a disability according

to the Equality Act (2010:4) Part 2, Chapter 1 is defined as someone who “has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on the person’s ability to carry out normal day-to-day activities”. This thesis is concerned with how disability is played out in everyday life, particularly during episodes of practice education for healthcare students. I begin by engaging with the idea of disability in terms of the very different responses it can draw. An example is presented here, in 2005-07 the fourth plinth in Trafalgar Square depicted a sculpture by Mark Quinn entitled *Alison Lapper Pregnant*, featuring a woman born without limbs and pregnant - see Figure 1.



Figure 1: Marc Quinn, *Alison Lapper Pregnant*, 2005 (Fourth Plinth, Trafalgar Square)

Writing in *The Guardian* newspaper, the columnist Brendan O'Neill (2007: n. pag.) boldly asserted that Quinn's sculpture: "is profoundly patronising to disabled people" and furthermore, that it epitomises the view that "we value people for what they are rather than what they achieve". On the other hand, Waldemar Januszczak, *The Times* art columnist reflected that:

Marc Quinn's giant marble statue of the dysmelic Alison Lapper, rhyming her physical shortenings with the *Venus de Milo*, must be ranked as one of the most significant cultural moments in Britain's postwar art history. What a huge blow was struck for issues of disability by Quinn's moment of sculptural genius (Januszczak, 2017:18).

The stark contrast between O'Neill's and Januszczak's assertions challenge me in thinking about my own study and in turn encourage me to pose some embryonic questions: Can we (visiting tutors, practice educators, clinical learning environment leads) be guilty of patronising students with a disability, for instance seeing them for what they are rather than what they can achieve? Are we capable of striking a blow for issues of disability, and thus for the experiences of disabled students through our practice? In other words, how do we approach and conceptualise disability? And more specific to my research, how can the experiences of students with disabilities be supported and improved through a better conceptualisation of disability and its place within healthcare settings?

An undercurrent of negativity still exists today in relation to how disabled people are viewed and responded to. This is succinctly summed up by Morris (1991) - a disabled activist - who has written about society invalidating disabled people and the oppression of disabled people caused by misrepresentation. Nussbaum (2004) too spoke of the oppression and stigmatisation of disabled people. The idea that reactions of society towards a person with a disability are what magnifies - with (sometimes) negative connotations - the experience or impact of that disability on a person's life is therefore a crucial one in the context of this thesis. To an extent, misrepresentation still prevails today in the form of media stereotypes of disability. Sivanesan (2003) writes poignantly of her visual impairment and her journey towards becoming a qualified occupational therapist. She commences her paper by stating that the hardest barrier of all to overcome is one of attitudes. Attitudinal barriers towards persons with a disability echoes throughout the wider literature (Gitlow, 2001; Sanderson-Mann and McCandless, 2006; Marks, 2007; Miller, Ross and Cleland, 2009).

Stella Young's 2014 keynote lecture entitled *Inspiration Porn and the Objectification of Disability* further problematises attitudes to disability. It delivers a powerful message in challenging uncritical responses by asserting that living with a disability does not make that person exceptional in the eyes of able-bodied people. She refers to a picture of a child with prosthetic legs and calls this "inspiration porn" with a view that persons with a disability are

being objectified for the benefit of those without a disability. This “feel good” factor, Young (2014) says, allows society to feel good about itself without necessarily effecting change. In effect though, it is still a stereotypical view that patronises disability while appearing to be supportive. These complex ideas lead me to explore in a bit more depth the wider notion of stigma and its relation to those with a disability.

2.1.2 Stigma and its impact

Goffman (1963) has written extensively on disability and associated stigma and identity. He informs us that when a person has an attribute that is a deviation from which some people may perceive as a normality - such as a disability (Goffman uses the term “handicap”) for example - then as a consequence, stigma also becomes an attribute which is “deeply discrediting” (Goffman, 1963:204). Goffman (1963) explains that stigma arises from the close relationship between an attribute and a stereotype. The literature on stigma is vast and since Goffman’s seminal work, a number of authors have further developed and refined notions of stigma which, in essence, is socially constructed (Coleman, 1997; Kleinman and Hall-Clifford, 2009). Link and Phelan (2001) propose five determinants of stigma: namely, labelling (labelling human difference); stereotyping (linking labelled people to negative stereotypes); separation (labelling people according to distinct categories of ‘them’ and ‘us’); status loss; and discrimination (leading to unequal outcomes). Stigma, according to Link and Phelan (2001), is dependent on power and occurs within differing forms of power bases whether social, economic or political. The aforementioned authors give an example of the Nazi regime and their subsequent power towards stigmatisation of Jewish people. On reflection, this kind of stigma can be realised in social, economic and political forms.

The association of fear with stigma is an interesting notion posited by Coleman (1997), who observes that the level of fear experienced by the stigmatiser depends on the type of stigma. In relation to my study, this is epitomised in Evans’s (2014) work where nursing educators expressed concern that patient safety could be compromised because of nursing

students with dyslexia and the potential negative implications on their clinical practice. Furthermore, Coleman (1997) asserts that stigma is complex and comprises three components - fear (affective), stereotyping (cognitive) and social control (behavioural). She concludes that stigmatisation “occurs only when the social control component is imposed, or when the undesired differences leads to some restriction in physical and social mobility and access to opportunities that allow an individual to develop his or her potential” (Coleman, 1997:227). The phrase, *access to opportunities that allow an individual to develop his or her potential*, appears to align with the language of the capability approach (covered later in this chapter). This is significant as it reflects the influence of stigma as a potential barrier to a person’s aspirations, and therefore particularly important in a workplace context.

Pachankis (2007) in writing about hidden stigmas - specifically, conditions that if revealed, raise the possibility of stigmatisation, notes the consequences of concealing a hidden stigma in that the very act requires effort and can result in negative psychological consequences for the person concerned. Pachankis (2007) also observes that people with hidden stigmas have to face the pressure of a potential disclosure situation - in other words, the stress of having to decide whom to disclose to and the underpinning rationale for doing so. Pachankis (2007) proposes a comprehensive process model which illustrates the psychological consequences in relation to concealing a stigma with cognitive, affective, behavioural and self-evaluative elements having significant implications for the individual concerned. Tensions arise for those with both visible and invisible disabilities; according to Pachankis (2007:335) the former contend with the “emotional stress of being devalued” and the latter bear the additional stress of hiding their stigma. For both groups of disabilities, the possibility of engaging in “impression management” and working out strategies where the individual has to manage their disability are a constant threat (Pachankis, 2007:335). This can sometimes give rise to associated behaviours including social avoidance and isolation, the need for interpersonal feedback (in shaping behaviour) and maladaptive behaviour manifesting itself within close

relationships. Pachankis (2007) does espouse the benefit of disclosure, however, by explaining that it can lead to self-acceptance on the part of the individual if feedback on disclosure is positively received. Having explored the definition of disability and different responses including the real possibility of stigmatisation, which has hinted at the difficulties that may be present as part of a disabled students' experience, I now turn to some key ideas debated amongst scholars within disability studies subdivided under three main approaches - materialist, critical disability studies and critical realist.

2.1.3 Disability: social and materialist approaches

In 1976 the Union of the Physically Impaired Against Segregation (UPIAS) was formed by a group of people with disabilities (including Vic Finkelstein and Paul Hunt), the ethos of which concerned the relationship between impairment ("an attribute of the individual body or mind") and disability ("a relationship between a person with impairment and society") (Shakespeare and Watson, 2001:17). The social model of disability developed from the ideas of the UPIAS and was introduced by Oliver (2013) in the 1980s. In essence, the model proposed that causal inference of disability is socially orientated thus leading to social oppression. The social model triggered disability activism to bring about a change in societal attitudes towards disability and promoting rights for people with a disability. The social model is contrasted with the individual or medical model in which causal inference is pathology-driven, that is, biologically-oriented (Terzi, 2005a) and therefore located in the body of the disabled person rather than as originating in societal influences.

The social model has been subject to critique by a number of scholars including Shakespeare and Watson (2001:11) who likened it to "a sacred cow, an ideology which could not easily be challenged". Shakespeare (2014:26) notes impairment cannot be denied and says the social model "defines disability in terms of oppression and barriers, and breaks the link between disability and impairment". Shakespeare and Watson (2001:17) conclude; "people are disabled both by social barriers and by their bodies. This is straightforward and uncontroversial. The British social model

approach, because it ‘over-eggs the pudding’, risks discrediting the entire dish”.

Shakespeare (2014) explains that the materialist approach to disability focuses on the dichotomy between impairment and disability and societal influences and change can mitigate the impact of disability. The materialist approach does not recognise the criticality of impairment in the lives of disabled people, as Shakespeare (2014) argues the impact of impairment may be somewhat mitigated by an accessible environment. However, he cautions it does not level the playing field between disabled and non-disabled people.

2.1.4 Disability: critical disability studies approach

The Society for Disability Studies (n.d.; n.pag.) defines the disabilities studies approach as: “challenging the view of disability as an individual deficit or defect that can be remedied solely through medical intervention or rehabilitation by ‘experts’ and other service providers”. Disability studies is seen as exploring “models and theories that examine social, political, cultural, and economic factors that define disability” and “should work to de-stigmatize disease, illness, and impairment” (The Society for Disability Studies, n.d.; n.pag.).

Ferguson and Nusbaum (2012) identify some core concepts of disability studies, namely that it:

- must incorporate a social element; impairment is viewed at the pathological level, disability is not a personal attribute of the person with a disability but rather, it must be situated in context to understand what the lived experience means to that person.
- must be foundational; deepening our understanding of and exploring the meaning of disability in addition to understanding other aspects of human difference.
- should be interdisciplinary; using a range of disciplines to understand disability.

- should be participatory; research with rather than on participants.
- must be values-based; providing a clear direction for improving the lives of disabled people.

I have attempted to align my study with most of the above criteria. It is concerned with how disability is experienced in a social and organisational context. It follows a social constructionist view of disability, as created and sustained by society rather than only or mainly rooted in the body or mind of the disabled person. My study is about people with a disability and how they experience a particular aspect of their education (practice placement) which is often challenging. The study therefore incorporates the views and perspectives of disabled students themselves. I also hope that my study is perceived as being clearly values-based - it illustrates ways in which the experiences of disabled students can be improved, with implications for how organisations and professionals may need to relate to the idea of disability and indeed to disabled people themselves.

The term “critical disability studies” as opposed to “disability studies” has gained credence over the years. Meekosha and Shuttleworth (2009) ask whether the former is the preferred term now and if this represents a paradigm shift. They argue that critical disability studies is a shift away from the materialist approach to disability and ongoing debates concerning dichotomies between for example, disability and impairment. Critical disability studies explores not only dichotomies (Vehmas and Watson (2014:642) term this “anti-dualistic”) but also other concepts and in doing so, explores the deconstruction of disability identity. Shildrick (2012) postulates that critical disability studies is broadly aligned with a postconventional approach and in addition to challenging binary oppositions it also incorporates embodiment, cultural imaginary and emphasises the importance of emotion and affect on the disabled body. Furthermore, Shildrick (2012:35) rejects the social constructionist model of disability where disability is located “within the normative structures of mainstream society” and instead suggests that critical disability studies encourages a focus on the lived experience of disability.

According to Vehmas and Watson (2014) critical disability studies is concerned with an unsettling of existing concepts and perspectives on disability and impairment. Shakespeare and Watson (2001:22) argue, however, that there is not a stark divide between disability and impairment but disability instead “is a complex dialectic of biological, psychological, cultural and socio-political factors, which cannot be extricated except with imprecision”.

Kumari Campbell (2008) emphasises the importance of language in the context of disability when she discusses disablism and ableism as influential worldviews. Ableism is seen as a worldview which holds the (supposedly) perfect body and mind as the ideal around which the world revolves. According to Wolbring (2012:78) ableism concerns “prejudicial attitudes and discriminatory behaviours toward persons with a disability”. Disablism, according to Kumari Campbell (2008:152), concerns “assumptions and practices promoting the differential or unequal treatment of people because of actual or presumed disabilities”. Reeve (2012) explains that disablism concerns social oppression and can be manifested in one of two ways - structural (external to the person, for example, exclusion, discrimination, inaccessible environments) and psycho-emotional (barriers impacting on the person’s psycho-emotional well-being). According to Reeve (2012) psycho-emotional disablism comprises a direct form to do with relationships the person has with others and or introspectively and an indirect form stemming from the impact of structural disablism, for example, anger as a result of not being able to enter a building. Psycho-emotional disablism is an important concept in understanding the relationships people with a disability experience.

For people with a disability, achieving social justice is more than the removal of barriers, argue Vehmas and Watson (2014); instead, it concerns economics and the redistribution of goods and wealth. The authors cite an example of extra time for a student with dyslexia in examinations: albeit a seemingly small adjustment, it can make a significant difference in exam performance for that student. Davis’ (1997:9) powerful assertion that “the ‘problem’ is not the person with disabilities; the problem is the way that

normalcy is constructed to create the 'problem' of the disabled person" resonates with Vehmas and Watson's (2014) assertion that the lived experience of disability needs to be captured in context, thus acceding to normative dimensions and associated values. However, Vehmas and Watson (2014:647) argue that critical disability studies does not take economic factors sufficiently into account - instead, offering "tools of deconstruction and the abolishment of cultural hierarchies to eradicate economic injustice". Vehmas and Watson (2014) conclude their paper by asserting that critical disability studies in terms of deconstructing disability is insufficiently helpful from both a moral and political perspective.

2.1.5 Disability: critical realist approach

Gustavsson (2004), in examining the role of theory in disability research, proposed that the critical realist approach comprises differing strata of reality. Williams (1999:812), in his support of the critical realist approach, argues that this represents "real bodies and real selves as an 'antidote' to the playful deconstruction of postmodernism". You cannot, he states, bypass the body therefore, critical realism brings the "biological body, impaired or otherwise" back into play and considers societal influences coupled with a need to rethink questions of personal identity (Williams,1999:812). The sense of personal identity resides within the individual and notions of identity reconstruction have their limitations (Williams,1999).

Danermark and Gellerstedt (2004:341) emphasise that the way to understanding disability is "as a multifaceted phenomenon". Reality is multi-layered, and the differing levels of reality include physical, biological, psychological, psycho-social, socio-economic, cultural and normative mechanisms (Bhaskar and Danermark, 2006). Bhaskar and Danermark (2006:292) build on Danermark and Gellerstedt's (2004) concept of stratified levels and argue "all phenomena of disability need to be understood in terms of a necessarily laminated system". None of these mechanisms dominates hence critical realism is non-reductionist, thus acknowledging the complexity of disability as a phenomenon (Danermark and Gellerstedt 2004).

On the theme of critical realism Shakespeare (2014) calls for a holistic understanding of disability, advocating an interactionist approach which he claims is non-reductionist. The interactionist approach considers intrinsic and extrinsic factors impacting on the person's experience of disability. Impairment is an inherent part of disability so it is not only the manifestation of a person's bodily system contributing to the disability but also societal influences. My conclusion of this collective body of work on disabilities studies is that I maintain a critical realist stance in approaching my study because I recognise the complexity of the lived experience of disability and how this needs to be understood in relation to multiple dimensions.

I now turn to two frameworks - capability approach and the International Classification of Functioning, Disability and Health. I consider both frameworks as being relevant to my study, they have a connection with disability. The theoretical frameworks act as lenses for viewing the data, and making sense of the lived experience of the student with a disability during the practice placement experience - therefore helping me make sense of my data in particular ways.

2.1.6 Capability approach

The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993; it is concerned with human development, that is, "our capability to lead the kind of lives we have reason to value" (Sen, 1999:285). Key to understanding the capability approach are notions of freedom and functionings. Freedom, according to Sen (1999), is not just simplistically concerned with monetary matters but can depend on a number of interrelated factors including a person's rights as in political and civil rights and social and economic arrangements. Social arrangements include that which society makes provision for, including education. Freedom, argues Sen (1999:4), is "central to the process of development" and "enhances the ability of people to help themselves" (Sen, 1999:18).

Functionings are concerned with ‘the various things a person may value doing or being’ (Sen,1999:75). Functionings are “achieved outcomes” with capabilities being the “potential to achieve these functionings” (Walker and Unterhalter, 2007:4). Functionings therefore are also opportunities comprising “personal ability, resources, practical means, and knowledge” (Burchardt, 2004:738).

Capabilities enable greater ranges of functionings but, in turn, these functionings provide a platform for extending capabilities. Burchardt (2004) elaborates on the concept of functionings by explaining that the combinations thereof are referred to as the capability set. Functionings are states of being (such as being literate) or activities (reading a patient’s medical records). Burchardt (2004) goes on to say that in tandem with a consideration of what opportunities comprise, external circumstances come into play including the social, economic and physical environment. Capability then is construed as “the substantive freedom to be or do something” (Burchardt, 2004:745). Drawing upon Burchardt’s description of opportunities and functionings, Figure 2 illustrates my attempt to translate her description into a conceptual model; note the two-way arrow between internal and external entities.

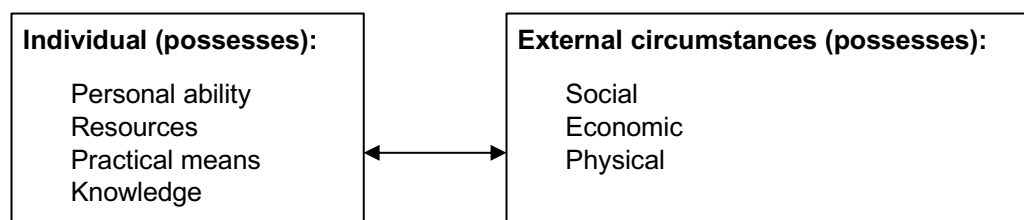


Figure 2: Burchardt’s (2004) description of opportunities and functionings

Regarding the term “capabilities”, Wolff and de-Shalit (2007:75) argue this is too vague as it is conditional upon the person or others performing some act, to turn capabilities into functionings. Instead, they propose that the term “genuine opportunities” (2007:172-3) be used to reflect conditions under which someone may have access to genuine opportunity and conversely acknowledging when someone has failed to take advantage of such

opportunity. Wolff and de-Shalit point out that there are internal (for example, talents and skills) and external resources (for example, income and support) that a “person has (or has access to) and what they can do with it”, these factors define the person’s genuine opportunities for functionings (2007:172-3). Use of these resources, say Wolff and de-Shalit (2007), is dependent upon structures both social and material such as traditions, systems, policies and culture. This notion is useful for thinking about the structures, social and material, that students with a disability on placement face such as the culture of the placement provider setting and expectations students are expected to conform to.

2.1.7 Disability and the capability approach

A number of authors have specifically employed the capability approach to analyse issues related to disability, for example, Terzi (2005b); Mitra (2006) and Welch-Saleeby (2007). Mitra (2006:240) provides a helpful explanation and illustration (see Figure 3) of the capability approach in defining disability as a deprivation of capabilities or functionings, with deprivation as an outcome of the interaction between personal characteristics, commodities or resources available and the environment. Note that I have added some examples under commodities and personal characteristics to reflect the context of students with a disability on placement.

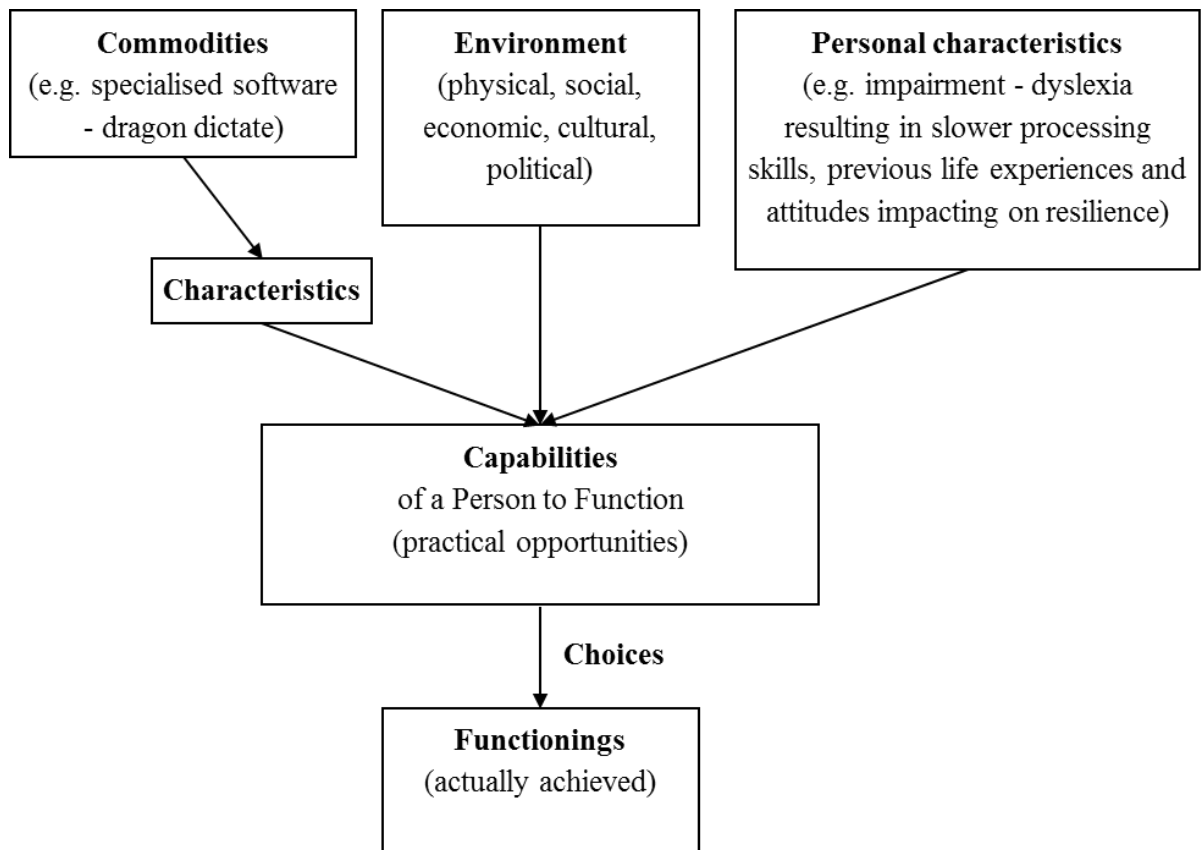


Figure 3: My adaptation of Mitra's (2006:240) illustration of the capability approach

Mitra (2006) highlights the value of the capability approach in delineating disability at the capability level (practical opportunities), and at the functioning level (what the person values and succeeds in doing or being), i.e. as potential or as actual disability. The concept of potential and actual disability is further elaborated by Mitra (2006) and I offer here an example to reflect the context of my research. Imagine a student with dyslexia on their practice education experience. The range of practical opportunities and hence the capability set for this student is potentially restricted as potential disability considers whether there are appropriate resources available to enable the student to complete patient documentation notes electronically? Actual disability occurs if the student's functionings are compromised, in other words they cannot do or be the things they value doing or being. An example is restricted access to information technology due to lack of appropriate software, which in turn compromises achievement of the placement learning outcomes.

Similarly, Walker and Unterhalter (2007:4) point out the difference between the two concepts of capability and functioning as the difference between potential and outcome - “an opportunity to achieve and the actual achievement”. It is clear that most authors emphasise the difference between potential and actual disability or potential and actual achievement as related to access or lack of access to either structural or internal resources.

In relation to the debates over disability (social) and impairment (physical) that this chapter started with, Terzi (2005a) suggests that the capability approach overcomes both biological and societal concerns. By refusing to prioritise one or the other perspective as more important in shaping the experiences of disabled people, it takes into account both and opens up instead an egalitarian framework. Terzi (2005a:215) emphasises that “the capability framework allows us to think of disability as inherently relational and multidimensional, as one aspect of human diversity”. Terzi notes how this is a critical consideration in relation to the political goal of social justice and argues that “the capability approach sets aside the debate over whether the causes of disability are natural or social, and promotes a direct concern with functionings and with providing the social bases of adequate capability to pursue valued ends” (2005a:215). Such a perspective echoes the holistic view advocated by Shakespeare and others aligned to critical realism. Once it is accepted that the holistic view necessarily invokes a critical view of structural arrangements in society, then the focus on education (and the experiences of students with a disability in practice education) takes a different kind of enquiry. Walker (2006) thus argues that institutions, including higher education, have a critical role in creating the right conditions to enable students to flourish in relation to learning and development, within a social justice, egalitarian framework.

Walker and Unterhalter (2007) state that within the context of education, in evaluating justice and equality, it is not simply a means of looking at the availability of educational resources, disposable income or the qualification pursued - and attained - but rather, an evaluation of the inter-relationship between capabilities and functionings. In other words, do educational

institutions improve access to resources and structural arrangements in a way that allows students to realise their potential and achieve outcomes, such that they have the capability to live a life they have reason to value? In the context of students with a disability on placement, using the capability approach ideas would mean that an important consideration is how different stakeholders (for example, student, practice educator, visiting tutor, clinical learning environment lead, etc.) as well as the organisational culture and practices must come together to ensure that student capabilities are realisable.

The “dilemma of difference” (Minow, 1985:163) is an important concept within the capability approach in understanding constructions of disability. It was originally coined by Minow (1985) and developed by others including Norwich (1994) in the context of education for children with special educational needs. Fundamentally, as Norwich (1994) explains, the dilemma of difference is manifested sociologically with regard to values and assumptions and concerns the tension between equality (provision for all) and individuality (attending to the needs of an individual with a disability). Either approach risks stigmatising and labelling the individual concerned as equality does not necessarily meet individual need and individuality may single out the individual. Terzi (2005b:448) powerfully asserts that “differences and diversity, therefore, instead of constituting a ‘dilemma’, have to be promoted and celebrated”.

Mutanga and Walker (2015:503) propose that the capability approach transcends the duality of framing disability - the dilemma of difference - by means of a “relational approach that considers both individual impairment and educational arrangements”. To address this dilemma of difference, Mutanga and Walker (2015) drew on capability lists created by previous authors including Walker (2006) and used this as the basis to interview students with a disability from two universities in South Africa. Their aim was to identify what students considered as critical valued freedoms and opportunities needed to access and succeed in higher education. Eleven key freedoms and opportunities were highlighted. According to Mutanga and

Walker (2015), these highlight the gaps that need addressing through, for example, the construction of disability policies to better the experiences of disabled students. Mutanga and Walker's capabilities list is further explored in Chapter 5.

Walker (2008:108) asserts that the very process of education is beyond mere acquisition of knowledge but has a role in shaping personal identity, that is, "becoming and being this kind of person". In the context of my study, this concerns the student's transition towards becoming a fully qualified healthcare professional and with this, the numerous responsibilities inherent in fulfilling this identity. The personal identity of the person with a disability can be compromised by how others view them. This is reinforced throughout the wider literature including Teschl and Derobert (2008) who, through the lens of the capability approach, reiterate the importance of people becoming who they want to be without being hindered by notions of what they should be and do.

The capability approach rejects the notion of utilitarianism and instead embraces the notion of human diversity. Utilitarianism, according to Sen (1999), is concerned with a person's well-being with utility representing a measure of a person's pleasure or happiness. He cautions however that happiness is hard to measure in the context of a utility based metric. Sen (1992:32) claims that a utilitarian perspective narrows the focus in terms of the freedom to achieve as being purely instrumental. In other words, Sen's (1992:31) idea behind the capability approach is less concerned with comparing assessments of individual happiness but is more concerned with "actual achievements" and the "freedom to achieve". Sen (1992:31), [author's emphasis] clarifies that this notion of achievement is "concerned with what we *manage* to accomplish, and freedom with the *real opportunity* that we have to accomplish what we value". In the context of this study, this can be interpreted as a call to understanding the challenges faced and coping strategies used by students with a disability on placement. Specifically, it is an exploration of what students manage to accomplish within the particular professional and social arrangements (placement) and

what freedoms or opportunities they have, to enable them to accomplish what is personally valuable to them, and how the educational establishment might enhance these opportunities in a way that facilitates a successful placement.

2.1.8 Valuing diversity and disability

Central to such an enquiry on placement practices and cultures is the perception of disability, particularly a reconceptualisation of disability through the avoidance of stigma and an altogether more positive valuation of people with a disability. Sen (1992) reminds us of the diversity of the human race, moreover, that each of us is diverse in different respects. In considering human diversity, Terzi (2005a) argues this is critical in addressing the demands in relation to equality. Life does not exist in a vacuum: human beings operate in a contextual world together with an interplay of social, personal, economic and political demands. Therefore in a diverse world, complete or blanket equality may not be possible or necessary. Instead, Terzi (2005a) reminds us that capabilities are context-sensitive and we need to consider the person's perspective on well-being - disability is not and should not be akin to a deviation from normality. Relevant to this concept of diversity is Swain and French's affirmative model of disability which presupposes that having a disability can be a benefit, that it is not necessarily a tragedy and can form part of a positive construct and identity:

In affirming a positive identity of being impaired, disabled people are actively repudiating the dominant value of normality. The changes for individuals are not just a transforming of consciousness as to the meaning of 'disability', but an assertion of the value and validity of life as a person with an impairment.
(Swain and French, 2000:578).

In Bevan's (2013) study where she interviewed occupational therapists with a disability, she concluded that greater diversity within the profession is needed. However, she cautions that given the increased prevalence of healthcare professionals with a disability entering the profession, people need to work as a collective to remove obstacles in areas of daily life including education and the work-place (Bevan, 2013).

2.1.9 Adaptive preference

Watts and Ridley (2012) examined the use of the capability approach (having rejected the medical and social model as being too restrictive) in the context of evaluating musicians with disabilities on the Drake Music Project. Their reasoning for using the capability approach was that it afforded an opportunity to acknowledge the biological determinants of disability in addition to the social construction of disability. Watts and Ridley refer to the notion of shame (associated with disability) and adaptive preferences, a concept explaining one's "tendency to limit aspirations in the face of adversity" (2012:362). Elster (1983:25) uses the term "adaptive preference" formation in terms of a person's transition from wants to possibilities, he emphasises that this is a "causal process occurring non-consciously". Elster (1983) uses Aesop's fable of the fox and the sour grapes as an apt metaphor for adaptive preference formation, where the voluntary imagination of the grapes as 'sour' are a way of minimising cognitive dissonance.

A Famished Fox saw some clusters of ripe black grapes hanging from a trellised vine. She resorted to all her tricks to get at them, but wearied herself in vain, for she could not reach them. At last she turned away, beguiling herself of her disappointment and saying: "The Grapes are sour, and not ripe as I thought" (Townsend, 1904:133).

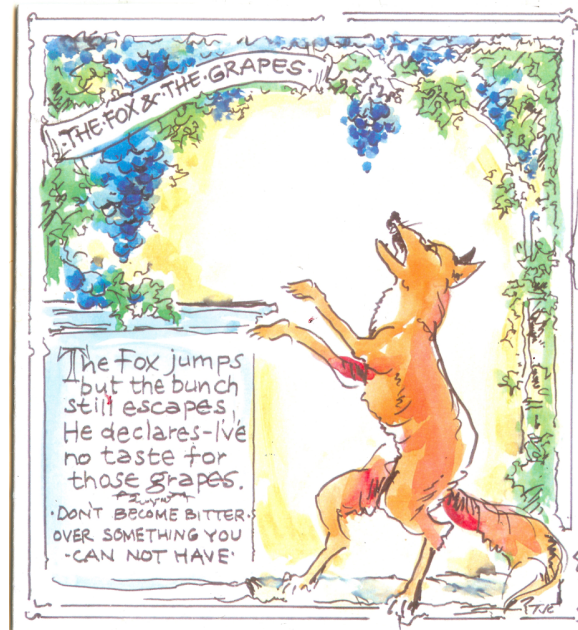


Figure 4: The Fox and the Grapes (Coppin, 2016)

Elster's ideas are reflected in a plethora of literature on the topic of adaptive preference formation – (Teschl and Comim, 2005; Watts, Comim and Ridley, 2008; Watts, 2013). A brief explanation is required here to appreciate the historical influence of adaptive preference formation and the competing diverging and at times converging views of two prominent authors - Sen and Nussbaum. Sen relates adaptive preference to limitation of freedoms and impact of adversity in the context of extreme deprivation and poverty whereas Nussbaum relates it to the need for realism - if something is unrealistic then it is not worth aspiring to, thus adaptive preference becomes a benefit (Watts, 2013). Watts's (2013) paper on adaptive preference captures the complexity surrounding this topic and furthers the work of Elster, Sen and Nussbaum. He describes four versions of the fox fable, each with its different outcome, and emphasises that the capability approach focuses on what someone has reason to value (Watts, 2013). Note here, Zimmerman (2003) presents the argument for three foxes and Watts (2013) argues the case for a fourth fox. Watts (2013) substitutes the fox for a student, the sweet red vermillion grapes become a metaphor for higher education, a particular form of post-compulsory education, specifically a degree known as vulpine psychology. The green grapes represent a non-

degree course known as viniculture. And finally the sweet edibles represent other forms of post-compulsory education. The four versions, using the fox fable, are (Watts, 2013):

- the fox prefers vermillion grapes and believes that green grapes are sour, they are out of reach therefore he mis-focuses and sees them as green thus concludes (falsely) they are sour - motivated perceptual error;
- the fox identifies the grapes as vermillion, they are out of reach therefore they must be sour thus he concludes all vermillion grapes are sour - motivated false general belief;
- the fox identifies the grapes as sweet and vermillion, he sees the grapes correctly, he changes his taste rather than his belief, he cannot reach the grapes thus now prefers sour grapes;
- the fox identifies the grapes as sweet and vermillion, he changes his taste not his belief, he cannot reach the grapes so now prefers sour grapes but still has a general preference for sweet grapes.

Two important points which are relevant in the context of my study include the role of character planning and rationalisation. Firstly, Elster (1983:119) posited the notion that whereas adaptive preferences concern the downgrading of inaccessible options, deliberate character planning (“intentional shaping of desires”) concerns the upgrading of accessible options. Watts (2013) captures this succinctly by explaining that the downgrading is akin to sour grapes and has the effect of combatting cognitive dissonance between desire and what one can have; upgrading, conversely, is akin to sweet grapes, the opposite and combats the cognitive dissonance between realistic and unrealistic aspirations. Secondly, rationalisation according to Elster (1983) is a means of shaping one’s perception of the situation to reduce frustration and dissonance.

Teschl and Comim (2005) state that adaptive preferences can arise from maladjustment to a situation and go on to state that the process of adaptation can impact on well-being. Indeed, in a similar vein Watts, Comim

and Ridley (2008) assert that embracing a state of adaptive preference has the power to erase an individual's self-awareness and the notion that what is occurring is wrong, then the person's sense of identity, they claim, is compromised. Both shame and adaptive preference are relevant in the context of this review in exploring the experiences of students with a disability on placement as they have the potential to limit the freedom to do what one wants to do or learn or accomplish thus creating a barrier to aspirations. This barrier to aspirations is reflected in a statement by Nussbaum (2006:283): "human preferences are highly malleable; they are particularly likely to adapt to expectations and possibilities. People often learn not to want things that convention and political reality have placed out of their reach".

The nexus between education and the capability approach in combatting adaptive preference is succinctly captured by Watts, Comim and Ridley (2008:19): "when educational resources are converted into educational functionings, they can enable the reflection and reflexivity that mark the shift from self-abnegation to aspiration". Education, according to Watts, Comim and Ridley (2008:13), challenges social injustice and "can empower the disadvantaged who might otherwise adapt their preferences and become accomplices in their own deprivation".

The higher education institute as a place of learning wields a powerful influence on the healthcare profession student in terms of an expectancy to conform to the standards of the discipline-specific and regulatory bodies, which in turn shapes or influences their thoughts, attitudes and behaviour. Nussbaum (2004) reminds us that capabilities have both inner and external dimensions. Inner dimensions consider the means of education and support, for example. The person needs to "be prepared to be engaged in the form of functioning" (Nussbaum, 2004:344). External dimensions pertain to whether a person who is prepared to voice their thoughts on an issue can be hindered by bad social and institutional arrangements. Nussbaum (2004) states a person's combined capabilities, that is, inner and external dimensions, must be enabled through the requisite tools and support including that of the institution. Continuing on the theme of institutions,

Pogge (2003:38) posits the notion of intrinsic and extrinsic discrimination on the part of social institutions, and how institutions can be biased towards those with natural endowments and that - amongst others - the “walking impaired” may be unjustly discriminated against. The distinction between overt and covert discrimination is also covered in Pogge’s essay (2003) and serves to reinforce my earlier thoughts within this chapter on notions of disability and the need for a paradigm shift in the way we think about disability. The link between Pogge’s assertions and Nussbaum’s inner and external dimensions is three-fold: firstly, students with a disability in my study are contextualised within the milieu of higher education which is an institution with embedded policies and procedures in respect of meeting competencies within a professional healthcare programme. This in itself will have a profound impact on the student experience of learning in the practice placement environment. Secondly, the importance of empowering such students through a supportive and positive learning environment during placement is vital in enabling them to achieve what they want to be and do and thirdly, societal expectations and attitudes towards students with a disability are hugely influential in shaping the lived experience of practice education. I now move on to another influential framework in thinking about disability - the ICF - before considering where the overlaps may lie between the capability approach and the ICF.

2.1.10 International Classification of Functioning, Disability and Health

According to Bickenbach (2012:55) the ICF “is the only game in town”! It is, he says, “a globally implemented statistical, clinical and scientific research tool - an international classification - as well as a conceptualisation of function and disability”. The current version of the World Health Organization’s (WHO, 2001) ICF (Figure 5) combines the medical and social models and builds on the foundations of the biopsychosocial model, developed by George Engel in 1977.

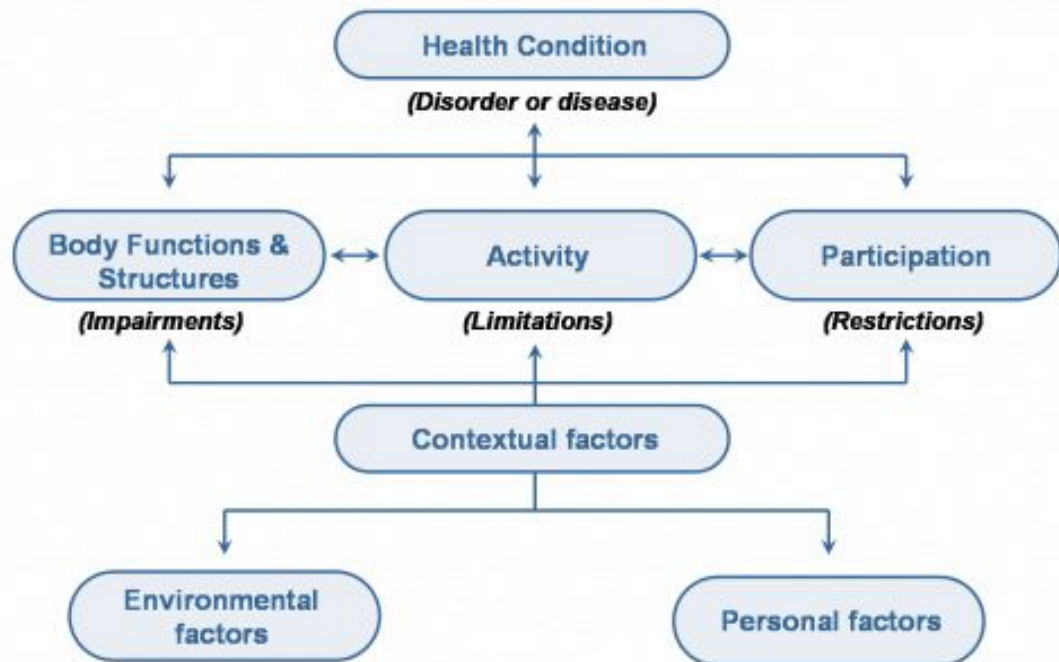


Figure 5: Conceptual model of the International Classification of Functioning, Disability and Health (WHO, 2001)

In essence, the ICF provides a comprehensive description of a health-related state. It comprises two parts, each with two components (in brackets): namely part 1: functioning and disability (body functions and structures; activities and participation) and part 2: contextual factors (environmental and personal) (WHO, 2001). Each component can be expressed in both positive and negative terms with functioning being the umbrella term encompassing all body functions, activities and participation versus disability, which is the counterpart umbrella term for impairments (a problem in body structure or function such as a significant deviation or loss), activity limitations (execution of a task or action) or participation restriction (involvement in life situations) WHO (2001). An important point in relation to contextual factors is the influence on functioning and disability with environmental factors being external to the person and personal factors internal (Welch Saleeby, 2011). Environmental factors encompass physical, social and attitudinal

considerations, more specifically, individual elements (physical and material features of the environment and direct contact with others) and societal elements (formal and informal social structures, e.g. work, rules, attitudes) (WHO, 2001). Moreover, the ICF codes environmental factors as facilitators or barriers which in turn impact on an individual's level of functioning. Personal factors pertain to the person's background or demographic considerations (age and gender for example), lifestyle and coping mechanisms (Welch Saleeby, 2011). As Figure 5 shows, the ICF clearly illustrates the dynamic interaction between all components thus illustrating the inherent complexity of disability as a lived experience. Furthermore, the ICF captures the interplay of a number of elements which in turn impact on the identified health condition and the extent to which activities and participation enable the person to function in terms of what they need and want to do. The ICF coding for activities and participation is based on "a causal model of disablement" (Chapireau, 2005:309) meaning that the environment impacts on the difference between ability and performance. This therefore is a critical component.

The ICF has shifted from that of disease consequence to an emphasis on neutral components of health (WHO, 2001); however, Bickenbach (2012) cautions that the arrows within the model (Figure 5) must not be interpreted as the components being causal or temporally sequenced. Instead, the ICF is etiologically neutral in that, with few exceptions, "there are no predictable correlations between health conditions and aspects of disablement" (Bickenbach *et al.*, 1999:1184). This is also reflected in the ICF's ethos of universalism as functioning and disability are not dichotomous, they are continuous - reflecting decrements of functioning in the context of the lived experience of the health-related state.

Bickenbach *et al.* (1999) refer to the concept of positive freedom and emphasise that participation encompasses enacting social roles and lifestyle choice. These can be compromised for people with a disability if resources and opportunities are not provided. On the theme of participation and in the context of the ICF, Baylies (2002:729) states that it "represents rights, capabilities and human development. Also environmental factors both social

and physical through which disability is contextualised". Here, she pinpoints the notion of disability as a social construction, influenced by the environment.

The ICF is not without its critics. Arvidsson, Granlund and Thyberg (2015) reviewed 16 studies and concluded the variable use of the terms activity and participation. Inconsistent use of the ICF principles, they caution, is confusing and thus challenging in relation to sharing of knowledge across different disciplines. Similarly, Bickenbach (2012) argues that activity and participation are accorded the same categories in the ICF yet although given different definitions, on a conceptual level, the distinction is unclear.

Terzi (2005a) argues that, unlike the capability approach, the ICF does not consider matters of justice for people with a disability and Chapireau (2005) asserts that it places more of an emphasis on understanding the impact of the physical environment on functioning than it does of the societal environment. I disagree with both Terzi and Chapireau. For the purposes of my study the ICF serves as a helpful and descriptive framework for situating students with a disability in the context of their practice placement experiences. In other words, it can be used as a tool for describing details of the person's abilities and challenges experienced in the context of their lived experiences. The ICF includes a broad spectrum of body functions and structures and activity and participation domains, thus truly embodying flexibility in consideration of the diversity of people's lived experiences. Of note, the ICF will not reduce stigma but can be used to highlight areas for action. Furthermore I argue that through familiarisation with the ICF framework, it can be used to communicate with other educational players in practice education to illustrate what roles they can play in reducing obstacles and providing support for students with a disability.

Thinking about impairment, it is a part of disability but having an impairment does not necessarily lead to activity limitation or participation restriction. This illustrates the importance of being aware of potential misconceptions surrounding the relationship between the consequences of the student's

disability and actual abilities which may on occasion be detrimental, for example, reinforcing stereotypical, negative views of disability. Table 1 illustrates my argument in context regarding four of the components of the ICF and the dichotomy between two different types of disability - deafness and past history of mental health. The WHO (2002) used a similar table and I adapted this idea by adding the fifth column to illustrate a holistic overview of the two disabilities. The second entry on mental health is based on the WHO (2002:17) table but amended here for brevity. Note, a more detailed application of the ICF in the context of my study findings is provided in Chapter 5.

Table 1: Using the ICF (WHO, 2002:17) to illustrate the difference between two disability types, adapted by Jane M Hibberd

HEALTH CONDITION	BODY FUNCTIONS & STRUCTURES (impairment)	ACTIVITY (limitation)	PARTICIPATION (restriction)	CONTEXTUAL FACTORS
Deafness	Most nerve cells in ear no longer functioning	Unable to use standard landline phone	Unable to make or receive telephone calls independently	<u>Environmental:</u> unawareness of specialised technology to enable telephone use <u>Personal:</u> now living alone, needs to be able to use telephone independently
Past history of mental health	None	None	Denied employment due to employers' prejudice	<u>Environmental:</u> attitude of interview panel unhelpful <u>Personal:</u> plummeting low mood as a result of denied employment

2.1.11 ICF and capability approach convergences and divergences

Having presented and explained above two key frameworks (ICF and capability approach), this section provides a brief précis of some of the key convergences and divergences in relation to the ICF and capability approach examined by a number of authors including: Baylies (2002); Burchardt (2004); Terzi (2005a, 2005b); Mitra (2006; 2014); Welch Saleeby (2007) and Bickenbach (2014). In doing so, I consider questions of accessibility and operationalisation. A critical consideration concerning perspectives on disability warrants exploration into how disability is socially constructed. Such a perspective affords an opportunity to understand the challenges and multi-faceted implications of living with a disability. For me, both the ICF and the capability approach lack an explicit appreciation and in-depth exploration of social constructions of disability. Instead, I suggest that the key tenets of a critical realist approach and critical disability studies need to be used in combination with the ICF and capability approach for the following reasons:

- critical disability studies brings in an application of theoretical approaches and ideas to aid an appreciation and understanding of disability for example, the complexity surrounding disclosure and stigma-associated behaviours.
- the critical realist approach illustrates disability as complex and multi-faceted, paying equal attention to the impaired body and to the environmental (social, political, institutional) context.
- the language of the capability approach is somewhat onerous (Burchardt, 2014); its theoretical foundations are complex, yet in contrast to the ICF, the capability approach for me yields a more strategic vision affording the opportunity to chart the student's journey towards realising their aspirations.
- the scope and scale of the capability approach are reflected in Walker's (2008:155) quote: "the capability approach locates education within a larger social and human development vision". This sense of vision is crucial in laying down the foundations towards achieving my earlier proclamation for

- a paradigmatic shift in relation to acceptance of students with a disability in practice education.
- Terzi emphasises the importance of establishing what she terms the “right conditions” (2005a:219). She says: “education enhances both well-being freedom and well-being achievements, and the capability approach captures the importance of providing the conditions for the development of capability in both of these senses” (2005a:219). What is not explicit within the capability approach for me is a sense of how we can create the right conditions, yet they are absolutely key in providing a conducive practice placement environment.
 - the ICF is useful in illustrating a comparative analysis between a range of health conditions including the interplay between impairment, activity and participation. In addition, the ICF breaks down - thus analysing - the inextricable link between the individual (student with a disability) and the influence of the environment with each element impacting on the other. The analytical component is, I argue, too superficial and does not afford in-depth considerations given the complexities and nuances that are inherent regarding notions of disability.
 - the ICF is easier to grasp than the capability approach in terms of understanding its key features yet is more descriptive in conceptualising disability.
 - in 2014 Bickenbach published a comprehensive overview of the ICF and capability approach and later that same year Mitra responded in kind - at times both authors have opposing views. Bickenbach (2014:19-20) presents a synopsis, grouped under three key concerns of the ICF posed by a number of prominent authors - the ICF does not “embody a theory of justice; incorporate choice and personal goals; distinguish resources and environments”. Bickenbach (2014) and Mitra (2014) conclude that the ICF and capability approach can feasibly complement each other and be used in tandem. However, Mitra sees the commonalities between the two approaches for different reasons to Bickenbach. Mitra (2014) argues that the descriptive element of the ICF is helpful for generating policies in the wake of challenges posed by a person’s disability. She also claims that the

ICF and capability approach are not theories but rather frameworks to enable conceptualisation of well-being and disability.

- Baylies (2002:725) points out the “parallels in language between the ICF and the notion of human development”. She goes on to assert that “the capabilities approach can become a powerful complement to a human rights approach and a social model of disability” (2002:735).
- Welch Saleeby (2007) argues that the capability approach and the ICF are complementary frameworks for social workers and goes on to provide a comprehensive justification and examples of their respective operationalisation. In essence, she says they facilitate a holistic perspective and understanding in context of the lived experience of the person with a disability. Accordingly, the ICF has merits in its classification properties, enabling social workers to implement interventions to facilitate capability development with the capability approach thus emphasising what the person can do rather than assessing their actual capacity or functional abilities.

Having explored two main theoretical approaches within the field of disability studies – the ICF and the capability approach – this opens up the possibility of applying these approaches as a framework to make sense of the empirical experiences of students during their practice placement experience. What must not be forgotten is the role of education in facilitating social justice. As captured by Watts, Comim and Ridley (2008:2): “education has a special place in the capability approach because of its transformative potential to enhance capabilities and empower individuals”. As well, the ICF complements the capability approach in providing a descriptive resume of the person’s experience of disability. Given the debates in the wider literature concerning impairment, the ICF and capability approach infuse a sense of the importance of viewing the person with a disability holistically and capture the importance of valuing the person as a human being. Models of disability are useful frameworks for situating the person with a disability in context and provide an important adjunct in thinking about students with a disability on placement. It seems fitting then that the next part of this

literature review explores the empirical evidence of disabled students' experiences of practice education.

2.2 PART II: PRACTICE EDUCATION - EMPIRICAL EXPERIENCES

The intention of this section is to explore what the current literature yields in terms of lived experiences of students with a disability in practice education. Admittedly, there is a paucity of literature specifically in relation to the disciplines of occupational therapy, physiotherapy and speech and language therapy, therefore reference to other healthcare disciplines will be included. The terms practice educator and mentor are interchangeable and depend upon the programme of study the student is on. Papers are also used both nationally and internationally with the year of publication reflecting the legislative influences at that time, for example, for papers based within the United Kingdom, the Disability Discrimination Act 2005 preceded the Equality Act 2010. Different legislations govern healthcare students with a disability outside of the United Kingdom but are not covered in any depth for the purposes of this literature review. This part of the review¹ has grouped studies under the themes of disclosure, reasonable adjustment, and support. These themes arose from engagement in three key activities - my experience in practice education, conducting a specific search of the literature and through extensive reading of literature in relation to disability, all of which led to a growing awareness of recurring patterns relating to the empirical experiences of students with a disability in practice education.

2.2.1 Disclosure

A worrying trend reported in the literature is the issue of disclosure. Students can be reluctant to disclose their disability because of, for example, a fear of negative repercussions from the practice educator, previous experiences where disclosure had negative repercussions and not wanting to be treated differently just because of a disability. Olney and Brockelman (2003:36) suggest several factors impacting on the decision to disclose, describing this as a “contextual act”, for example, disclosing on a need-to-know basis. The

¹ The literature search strategy entailed accessing a range of databases including Amed, Embase, Cinahl and Medline using key search terms mapped to medical subject headings. Truncation and boolean operators were applied to refine the search. Refer to appendix A for full details.

process of disclosure and the decision to do so can be complex due to the link with stigma and disability identity. This was illustrated in a study by Sheridan, Salmon and O'Connell (2016) who explored disclosure and students diagnosed with epilepsy in higher education or having recently graduated from universities in Ireland. Epilepsy was considered to be a concealable condition yet, if a seizure is experienced in public, it then becomes visible. Their findings indicated that perceived stigma acted as a barrier to disclosure yet disclosure enabled participants to regain a sense of control. Engaging the support of allies - such as fellow students - facilitated the process of disclosure.

Price and Gale (2006) caution that if a student is to disclose there is little point in doing so if the placement provider has no knowledge or understanding of how to help the student. Placement providers need to know if a student has a disability to enable them to plan a suitable programme of learning and to implement reasonable adjustments. In addition, these authors highlighted the need to consider accountability to management and staff and assessing the element of risk when working with patients (Rankin *et al.*, 2010). This is highlighted by Ashcroft and Lutfiyya (2013): their findings emphasised the frustration experienced by nursing educators when students do not disclose and the importance of gaining an understanding of how the student's disability may impact on their learning.

Mental health as a disability is reported in the wider literature and warrants a mention due to associated stigma and prevalence. Roberts, Warner and Trumpower (2000) conducted a longitudinal study using a survey to garner the opinions of medical students' perceived health needs studying at nine universities in America, the authors revealed that 38% of medical students reported mental health concerns. Furthermore, a proportion of students were not addressing their needs. Reasons cited included tension between the dual role of embodying both student and patient and with the latter, the risk of being treated by a doctor that knows them by virtue of being a student. An additional reason for students not addressing their mental health needs includes stigma associated with mental illness. Indeed, this is also reported elsewhere in the literature including Miller, Ross and Cleland (2009) who

conducted a study looking at medical students' attitudes towards disability. They are often not likely to disclose, particularly those with mental health difficulties. Givens and Tjia (2002) conducted a survey of 194 medical students in San Francisco and identified that 46 students scored eight or more on the Becks Depression Inventory and only 10 of those 46 students had accessed mental health services. Barriers to addressing the mental health concerns were similar to those reported in the Roberts, Warner and Trumpower study.

Dilemmas faced by students experiencing mental health difficulties on nursing and social work programmes was explored by Manthorpe and Stanley (1999) using surveys and focus groups across several academic disciplines including the caring professions in one British university. The findings revealed that faculty found students' resistance to accept help or lack of insight into their difficulty to be a significant barrier. The reluctance of students with mental health difficulties to disclose is also corroborated in a study looking at social work students by Quinn *et al.* (2009).

Issues pertaining to the identity of disability and the decision to disclose or not have been referred to as "passing" by Olney and Brockelman (2003:49). Goffman (1963:57) also writes about passing and reverse passing with the former being defined as "management of undisclosed discrediting information about self" and the latter defined as "concealment of creditable facts". The act of passing can lead to negative implications for people with a disability, for example, in the work-place, if the person is being assessed against competency standards. If the assessor is unaware of the person's disability and reasonable adjustments have not been planned, implemented and acknowledged, they may be more liable to form the wrong judgement of that person which could lead to the outcome of a failure to meet the required competencies.

Ragins (2008:195) in writing about invisible stigmas coined the term "disclosure disconnects" thus reflecting that disclosure is not an "all or nothing" situation but instead, is contextual in that decisions are made who to disclose to and why - both inside and outside of work. Indeed, Ragins (2008)

asserts that disclosure disconnects can be stressful for the person concerned. Social constructions of stigma and how this is perceived by others depends on four characteristics: controllability (individual is responsible for causing or perpetuating the stigma); peril or threat (mental health more threatening than diabetes); disruptiveness (degree to which stigma compromises social interactions) and course (the manner in which the stigmatised condition changes over time, can include the person's level of self-awareness and acceptance of stigma) Ragins (2008). The environment plays an important part in facilitating disclosure and Ragins (2008:202) identifies three types of support key to facilitating disclosure - social ("presence of similar others who have successfully disclosed their stigma"), instrumental ("presence of supportive relationships involving individuals who are not members of the stigmatised group") and symbolic ("institutional support that symbolises protection and support for the stigmatised identity"). Ragins's emphasis on the environment as key to facilitating disclosure is reiterated by Sanderson-Mann and McCandless (2006): the likelihood of the student disclosing if they have not done so is by creating a supportive and welcoming atmosphere in the practice placement environment.

2.2.2 Reasonable adjustment

Reasonable adjustment concerns the principle of meeting the needs of the person with a disability and is an important consideration for students with a disability on practice placement. Nussbaum (2004:310) uses the term "reasonable accommodation" and says that the notion is "unclear and contestable". For example, if employers prove that the actual adjustment is proven to be too costly they may then not be accused of discriminating against the person with a disability. According to the CRPD (2008:4), Article 2 defines reasonable accommodation as the:

necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

Furthermore, the CRPD (2008:16), Article 24 on Education emphasises the right for inclusive education without discrimination. The principle of reasonable adjustment or accommodation is a grey area and one that is at times contentious, particularly when there is tension between what the placement provider can reasonably accommodate given existing work practices or the environment. Often there is a dichotomy between the level of support that the student receives in the university setting and what the placement provider can feasibly accommodate.

Price and Gale (2006) and Murphy (2011) in their respective studies found that learning in the university setting and coping strategies do not always readily translate into the clinical setting. For example, the provision of extra time in practical scenarios at university is not realistic given the demands of certain scenarios in the clinical setting (such as conducting resuscitation procedures) where extra time could jeopardise the well-being of the patient. Conversely, Sivanesan (2003) reports that although some of the specialist support she had at university including specialist software was not available on placement, this was compensated for by having a supportive team to work with to help her overcome the barriers to achieving the placement learning outcomes. Similarly, Kornblau (1995) points out the need for ongoing open dialogue between student and educator to enable reasonable adjustments to be met.

Crawshaw (2002) reminds us that students with a disability may need a longer period of time to prepare for and complete tasks; for example, a student who has a mobility impairment and is on placement in a hospital setting may take longer to get from the office to the wards. Crawshaw (2002) also emphasises the fine balance between provision of reasonable adjustments and the expectation that a student with a disability will be able to meet the competency standards to pass. Expectations she warns, must not be lowered as otherwise the student may not meet the competency standards. On the theme of competencies, Hinerth and Mackenzie (2004) interviewed six occupational therapy clinicians to elicit their experiences of having supervised a student with a disability on placement. Themes emerging included the challenge of balancing the student's need for

reasonable adjustments with the need to meet required professional body competency standards to enable progression on their respective healthcare programme. Another theme was around the extent to which professional competency standards need to be strictly adhered to, to pass the placement.

Some reasonable adjustments may not be feasible due to the hindrance of systems within the placement provider setting, including the use of electronic equipment such as using laptops as security may be an issue (White, 2007). Conversely, Marks (2007:73) believes that “people should be permitted to use a range of strategies and technologies to perform the essential functions of their jobs”. Marks (2007:74) goes on to say that “a student’s success is highly dependent on the availability of accommodations, not the type or severity of disability”. Indeed, Evans (2014) explored the perspectives of nursing educators towards students with dyslexia and concluded that they have a moral obligation to provide reasonable adjustments.

Student attributes play a role in reasonable adjustments such as working harder to compensate for the disability. This was highlighted in a study by Price and Gale (2006) who conducted two focus groups using a control group (students without dyslexia) and a group of students with dyslexia to explore how student nurses with dyslexia cope in the practice placement environment. This study revealed some important findings including student nurses’ overriding concern for patient safety which meant they worked harder to compensate for their skills deficits associated with dyslexia such as multiple checking of drug charts when administering drugs to patients.

Examples of avoidance behaviour to deal with a challenge rather than effective reasonable adjustment was highlighted in a study by Morris and Turnbull (2006) who explored implications of dyslexia amongst nursing students and the impact on practice. They found that some students used self-managing strategies including avoidance tactics such as not answering the telephone. The implications of avoidance tactics can be detrimental to student learning and achievement of placement learning outcomes.

Foster (2008) conducted a small study exploring the learning needs of student radiographers with dyslexia, including alternative strategies to written

assessments, and cautions against applying a one-for-all approach as students are diverse in relation to their disability and what works for one student in terms of reasonable adjustments may not necessarily be applicable to another. Similarly, Sharby and Roush (2009) state that reasonable adjustment is an individualised approach and can be challenging in the clinical environment as placement provider settings are variable in numerous respects, including accessibility of the built environment and the prevailing work culture. An understanding of reasonable adjustments and what is realistic in actual practice needs to be driven by subject specialist healthcare faculty at the university but in collaboration with university disability support services, the placement provider and the student (Griffiths *et al.*, 2010; Rankin *et al.*, 2010; Tee *et al.*, 2010). Additionally, reasonable adjustment needs to be considered in the context of the working environment and counter-balanced against existing staff skill-mix, staff availability and time constraints (Rankin *et al.*, 2010). The importance of planning reasonable adjustment emanates from a study by Baron, Phillips and Stalker (1996) examining the barriers to training for disabled social work students. Barriers included the practice placement environment with educators admitting they adopted a reactive rather than proactive approach to taking a student with a disability on placement with reasonable adjustments not necessarily thought through in sufficient depth. Finally, an interesting notion concerning the tension between the educator versus therapist role was highlighted in a study by Hinerth and Mackenzie (2004). Primarily, the educator role should be uppermost, however, when supervising a student with a disability, the therapist role sometimes came out.

2.2.3 Support

Support from the practice educator is pivotal in facilitating student learning during their practice education experience. Additionally, the need to recognise the contribution that students with a disability bring to the workplace is emphasised by Andre and Manson (2004) as is the need to focus on their strengths and not just limitations, as otherwise this can contribute to the pressure that students are already under in managing their disability and being on placement.

Specific learning difficulties including dyslexia are the most prevalent disability encountered in higher education. Colon (1997) conducted a study on nursing students in one university in the United States of America (U.S.A.) and asserts that a heightened awareness amongst faculty and students of available support for students with specific learning difficulties led to more students being diagnosed. Much of the existing literature on experiences of healthcare profession students with a disability refers to dyslexia and the particular challenges students may face during the practice placement experience. However, this means that other disability types are potentially neglected in research as indicated in a study by Gitlow (2001) exploring the attitudes of occupational therapy educators towards students with a disability on their educational programme in the U.S.A. 304 surveys were sent with a 55% response rate. Results indicated that although faculty were mostly positive in their attitudes towards students with a disability, they felt less comfortable with behavioural-type disabilities. Gitlow (2001) does acknowledge that this may in part be due to wider concerns regarding how such students would manage in the practice environment.

Murphy's (2011) study explored the clinical experiences and perspectives of student radiographers with dyslexia. Themes arising from 120 questionnaires and 10 interviews included staff and fellow students not always being understanding of the students' needs, the importance of a learning contract specifically addressing the students' needs and the need for a support forum for all students with dyslexia. Awareness-raising is critical as highlighted in a study by Brown, James and Mackenzie (2006:36) who interviewed five students with a disability from the disciplines of nursing and occupational therapy with participants emphasising the need to "instill awareness and understanding of students with a disability" amongst practice educators, the university and other students. Tee and Cowen (2012) assert that for nursing students with a disability, support from mentors is paramount and that there will be challenges inherent throughout their learning whilst on placement. The means to address this they say is through the provision of knowledge and understanding of the disability and how best to provide the support required. Similarly, Tinklin and Hall (1999) suggest that students in

higher education tend to adopt a more positive outlook if faculty are aware of their disability and the accommodations needed. This message could well be extended towards practice educators in the practice placement setting. Education and awareness for practice educators is also critical in mitigating the perceived burden of time, which was highlighted in a study by Nolan *et al.* (2015) where they experienced tension between allowing extra time for students with a disability against competing work pressures and demands. Indeed, Tee *et al.* (2010) point out the importance of university faculty working closely with university disability support services as recommendations made by the latter may not be entirely realistic given that they are not trained healthcare professionals.

The importance of students having their requisite support needs in place to compensate for their disability is illustrated in a study by Ansari (2003). Ansari examined (amongst other factors) the influence of a range of demographic variables (including disability) on undergraduate physiotherapy students' satisfaction with their curriculum in relation to teaching, learning and performance on assessment in one British university. 300 questionnaires were distributed; 1.4% of students reported a disability and although non-disabled students performed better than disabled students, this was found not to be statistically significant. Ansari (2003) does acknowledge that not accounting for practice placements is a limitation of the study. It is possible that for those students with a disability who had their immediate support needs in place within the university-based component of the curriculum, this positively influenced their satisfaction levels. The extent to which satisfaction trends would have altered within the practice placement environment where students also undergo teaching, subsequent learning and continuous assessment is questionable as they may not necessarily have the same support in situ that they have in the university setting.

A sobering message emanates from Vickerman and Blundell (2010) who caution that for students with a disability, successful integration into higher education depends on the competence of staff in providing appropriate support and with the right attitude, and that indeed this should extend into the practice environment. White (2007) reiterates the importance of mentors

receiving adequate information and support from the university to enable them to support the student with a disability on placement. Furthermore, she says, students must be equally proactive to ensure a collaborative and conducive working relationship with their mentor.

2.3 CONCLUSION

The main focus of this literature review was to explore definitions and conceptualisations of disability and key contributions associated within the disability movement including social and materialist approaches, critical disability studies and critical realist approach. In addition two key theoretical approaches to disability were explored (ICF and the capability approach) and their potential relevance to the practice placement experiences of healthcare profession students with a disability. The literature review concludes that further work is merited to answer my study questions in that:

- the paucity of literature has been evident particularly in relation to the target group of occupational therapy, physiotherapy and speech and language therapy students;
- the literature review helps to illustrate how culture concerns an implicit way of 'being' or 'doing', the norms, traditions, values, habits, expectations of the working environment and the people within;
- key contributions associated within the disability movement, ICF and capability approach open up the potential for their use as illustrative frameworks on which to a) situate key themes arising from my findings; b) contextualise trends in disability awareness and c) propose a way forward to ensure a better future for students with a disability in practice education.

Three research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability and / or environment make a difference?
- 3) What existing strategies (if any) are employed to improve the placement experience by both students and others, and how effective are they?

CHAPTER 3: METHODOLOGY

This chapter focuses on the methodological aspects of my research and includes a consideration of philosophical underpinnings and my researcher role within the context of my study. Critical evaluation of commonly adopted research philosophies underpinning most qualitative studies not only broadened my outlook as a researcher but also enabled me to appreciate how philosophical approaches framed my thinking and how these in turn impacted upon the study and its design.

3.1 Philosophical underpinnings

My research approach is grounded in qualitative inquiry, centred on a need to understand the lived experiences of students with a disability and the challenges they faced during their practice education. A useful starting point in considering the paradigmatic overview of beliefs which guide subsequent actions within the research process is to examine four central elements (Creswell, 2013; Denzin and Lincoln, 2013). The four elements are ontological, epistemological, axiological and methodological beliefs. These elements are considered here to enable the reader to follow my deliberations and explorations in relation to my own study. They are considered in the context of my research questions and subsequent influence on the design of my research.

3.2 Ontological and epistemological stance

Ontology concerns assumptions about the nature of reality. In the context of my study it raises the question - what is the nature of the student experience, specifically, a student with a disability during their placement experience? Thinking more closely about the nature of reality and the student's placement experience, I argue that nothing occurs in a vacuum. The environment comprises many elements including physical space, people's attitudes, culture of the workplace - all of which can influence and shape people's thoughts and behavior thus nothing occurs in a vacuum. The student experience and the environment are inextricably intertwined. Denzin and

Lincoln (1998:206) state that on a positivism-constructivism continuum, within the constructivism paradigm, ontology encompasses realities “apprehendable in the form of multiple, intangible mental constructions, socially and experientially based...dependent for their form and content on the individual persons or groups holding the constructions”. Denzin and Lincoln’s assertion mirrors my ontological stance; the nature of the student experience is socially and experientially based, held by the student and others working in practice education. The intangible mental constructions are accessed by me as the researcher, by tapping into the practice education experience.

Epistemology concerns debates about what counts as knowledge, how one comes to know reality. In the context of my study this is about asking how do students and others involved (the practice educator, for example) understand the student experience? In other words, how do they come to know that reality? Within the constructivism paradigm, Denzin and Lincoln (1998:207) state that epistemology is “transactional and subjectivist”, the researcher and research participant are “assumed to be interactively linked so that the ‘findings’ are *literally created* as the investigation proceeds” [authors’ emphasis]. Given that my research centres on a need to investigate other people’s experiences, I needed to find a way to access people’s narratives of their lived experiences, tapping into what I view as another world that I cannot claim to be an intimate part of (practice education). This for me reflects what Denzin and Lincoln are saying as I needed to rely on others involved in that ‘other’ world to tell me what meaning and representation that world holds for them. The reference to the researcher and research participants being interactively linked was - for me - a process of co-creation for the purpose of constructing some form of meaning and subsequent understanding about the research issues under investigation.

Braun and Clarke (2013:30) define social constructionism as a position where “the terms in which the world is understood are seen to be related to specific social, cultural contexts”. They caution however that “a critical stance tends to be taken regarding perceived truths and taken-for-granted knowledge” (Braun and Clarke, 2013:30). Gergen (1985) also shares this

view and states that researchers need to be critical, for example, in questioning commonly accepted views or knowledge. The point about social and cultural contexts is relevant in my research as practice education occurs in an off-campus setting. It is therefore critical for me to understand the influence of the environment (and its social and cultural features) in which practice education occurs and how this impacts on the student with a disability.

Gergen (1985) offers another definition of social constructionist inquiry as emanating from people who articulate how they understand the world. It is, he says: “principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live” (Gergen 1985:266). Gergen goes further in emphasising the co-creation of knowledge. It is, he says, something people do together as opposed to a state of solipsism, he terms this the “communal basis of knowledge” or “communities of shared intelligibility” (Gergen,1985:270-273). The process of co-creation in my study was implemented through one-to-one interviews - me as interviewer and research participant as interviewee. The act of co-creation was continued following the interviews - a copy of the interview notes was sent to each research participant to check contents for accuracy. The notion of *sui generis*, posited by Denzin and Lincoln (1998:240), succinctly captures Gergen’s view of social constructionism: “the world that people create in the process of social exchange is a reality *sui generis*” [author’s emphasis]. *Sui generis* is defined as “of its own kind; unique” (Allen, 1991:1220) and for me, reflects the uniqueness of data obtained in research, the reality of people’s experiences. I consider the notion of *sui generis* as pivotal in capturing the essence of social constructionism. It reflects for me the following points:

- the importance of maintaining a relationship that facilitates the research participants’ telling of their story and experiences;
- social exchange occurs through a process of co-creation of knowledge with knowledge residing within those who are part of the lived experience;

- the importance of situating in context those voices by means of judicious interpretation and meaning-making (knowledge-generation);
- semi-structured interviews were employed as a way of hearing the participants' narratives and thematic analysis was used to look across the narratives for knowledge-generation.

Brinkmann and Kvale (2015) emphasise the epistemological assumptions behind interviewing as a method. They liken the researcher to a miner or traveller in relation to interviewing with the former extracting data that already exists, in other words, adopting a positivist approach. The traveller approach resonated with my social constructionist assumptions concerning the interviewing of research participants, that is, "interviewing and analysis as intertwined phases of knowledge construction, with an emphasis on the narrative to be told to an audience" (Brinkmann and Kvale, 2015:58).

3.3 Axiological stance

This concerns the role of values - all researchers bring to their research a set of values or beliefs that have potential to influence the research process. My own values and beliefs stem from personal experience of disability and previously-held roles as healthcare student and healthcare professional with a disability, along with the role of practice educator for students on placement. My tripartite roles within higher education consist of Disability Liaison Officer, Visiting Tutor and Practice Education Coordinator. Embodying the lived experience of disability coupled with these roles enables me to position myself as a researcher in context. As well, my axiological stance leads me to consider what kind of knowledge is valuable in the context of my research - what is the experience of practice education from the perspective of a student with a disability? Through my academic role as Practice Education Coordinator, I wanted to delve deeper into the practice education experiences of students with a disability. Whilst recognising some similarities from my experiences and knowledge since commencing my career as an occupational therapist with that from this 'other' world, I was also aware of some differences too. I noticed some

students with a disability appeared to manage fairly well on placement whereas others seemed to struggle. In addition, my own personal experiences of having a disability in the work-place - albeit a different context from that of students on placement - on occasion resonated with theirs. An example here centres on issues around disclosure of disability and how the consequence of people's reactions can have an impact - negative or positive on one's performance within the work-place. I began to grapple with the question of why some students seemed to experience certain types of challenges on placement more than others, and I needed to hear the voices of these students and others closely involved in the practice education experience.

3.4 Methodological stance

My methodological assumptions also reflect the views expressed by Darlaston-Jones (2007). Her research - incorporating social constructionism - emphasises the value of multiple viewpoints in aiding the researcher to understand the phenomenon under investigation. Interviewing a range of research participants (students with a disability, practice educators, visiting tutors and clinical learning environment leads) enabled me to gain insight and knowledge as to *how* students with a disability experience practice education in this 'other' world. In other words, my commitment to social constructionism as a paradigm paved the way to understanding the construction of disability and situates this within the critical disability studies framework. My methodology is grounded in qualitative empirical data but based around the notion of narratives which relies on the idea of people narrating their realities and making sense of these realities through narrating them to an interested researcher (Schiff, 2012).

3.5 RESEARCH APPROACH

3.5.1 Narrative Inquiry

The use of narrative inquiry provided a natural extension to my quest for understanding the lived experiences of students with a disability during their practice education experience. The emphasis on social construction as an “artifact of communal interchange” (Gergen, 1985:266) led me to identify some tangible links between social constructionism and narrative inquiry:

- social constructionism has strong links with narrative inquiry in that it concerns “stories lived and told” (Clandinin and Connelly, 2000:20);
- the stories are constructed between researcher and research participant (Clandinin and Connelly, 2000);
- thematic analysis was used as a tool to seek wider patterns in data collected from the research participants.

I constructed a series of composite narratives from each of the four groups of research participants (presented in Chapter 5), the purpose of which was to communicate patterns emerging from the findings to enable their use as an educational tool to enhance the student experience, and to aid the reflective processes of key persons involved in practice education. The idea of composite narratives was adapted from the work of Blickem and Priyadharshini (2007) who used patient narratives as a learning tool for the education of healthcare staff in practice. They explain that these narratives were “a composite of many stories and therefore, were neither fully fact nor fully fiction but situated in the realm of plausibility” (2007:624). These allowed a distance from particular respondents (preserving anonymity) and also allowed readers to see at-a-glance, inter-related issues in their complexity as crafted within the brief narratives. The use of these patient narratives was primarily as a pedagogical tool and enabled healthcare staff to confront the (plausible) experiences of patients and their role as not just

professionals, but as a member of an inter-professional team that needed to work together (Blickem and Priyadharshini, 2007).

The narratives in my study include both minor (participant experiences) and major (themes that cut across several experiences) elements to enable a deeper understanding of the experiences of students with a disability on placement, in addition to drawing upon anecdotal evidence from my role as Visiting Tutor and Practice Education Coordinator. The actual construction of the composite narratives, in other words, the process, the 'how I did it' is perhaps best explained by Frank (2000:481) in her research: "None of the characters have an objective existence. They are composites and constructions – bits and pieces of myself, of the people that I have known in these settings...". This resonates with how I composed my narratives, based on what I heard directly or indirectly via others (including students, practice educators, visiting tutors and clinical learning environment leads) involved in practice education and also based on wider reading in relation to practice education. Therefore they were not drawn from any one participant and are not verbatim quotes, but adapted by myself to sit in this composite narrative. The actual process of writing the narratives was personally cathartic and creative and facilitated a means of familiarisation and new and deeper understandings of the interview data as well. I also wanted to capture the 'drama' of practice education, the impact of what it means to be a student with a disability and facing potential challenges during the practice education experience.

Appendix Q provides examples of narratives written to establish issues raised by each of the four stakeholder groups. Appendix R is an example of a briefer, composite narrative worked up to specifically illustrate difficulties with disclosure. It lends itself for use as a pedagogical tool to open up a conversation about disclosure amongst both students and staff.

An important point emphasised by Clandinin and Connelly (2000:124) is that narrative inquiry involves "re-search", in other words, repeated searching to enable an in-depth return to the research question as opposed to trying to

solve a problem. This is what I experienced in relation to writing the narratives as it enabled me to return to the field notes time and time again and in doing so, to repeatedly process the research participant's voiced experience. This not only enabled familiarity with the material but also served to help me understand the stories about lived experiences of students with a disability on placement. Wertz *et al.* (2011:2) assert that:

The composite first person narrative is a reflective story. It draws a composite picture of the phenomenon emerging from the informants. The composite is not a simple re-telling. It is interpretation by the researcher in several important ways: through her knowledge of the literature regarding the phenomenon under enquiry, through listening and hearing the stories told by the informants, and through her own reflexivity during the process.

Furthermore, Wertz *et al.* (2011) highlight the first person, in other words, the use of the word 'I' to facilitate the phenomenon as a contextual entity.

Brinkmann and Kvale (2015) appear to furnish a similar definition of composite narrative to that of Wertz *et al.* (2011) except that they use the term "narrative analysis". Narrative analysis, according to Brinkmann and Kvale (2015:254), is defined thus:

Narrative analysis focuses on the stories told during an interview and works out their structures and their plots. If no stories are told spontaneously, a coherent narrative may be constructed from the many episodes spread throughout an interview. The analysis may also be a reconstruction of the many tales told by the different subjects into a 'typical' narrative as a richer, more condensed and coherent story than the scattered stories of single interviews.

An additional point of note in relation to the use of narratives (Brinkmann and Kvale, 2015) is the need to remain within the vernacular and this is what I attempted to do; for example, trying to capture the way that a student with a disability might phrase a sentence such as *my educator was really horrible*. As well, narratives are powerful in that they add a temporal and social dimension with regard to context-setting according to Brinkmann and Kvale (2015). This then captures for the reader a sense of the *lived experience* of students with a disability during their time on placement. Indeed, Blickem and Priyadharshini (2007) comment on the use of the first person narrative

as eliciting an affective as opposed to a cognitive response which afforded deeper insights into patient experiences of being in hospital. What is also useful is the authors' claim of the patient narratives in enabling the healthcare professionals to recognise the interdependent nature of their 'team' practice which had not been foregrounded as strongly before.

It seems appropriate to conclude my paradigmatic beliefs thus far with the following quote by Gergen (1985:272-3) which illustrates the importance of being aware that no matter how rigorous my chosen methodology, any quest for the absolute truth to answer my research question will never be fully realised.

By the same token, social constructionism offers no "truth through method." In large degree the sciences have been enchanted by the myth that the assiduous application of rigorous method will yield sound fact as if empirical methodology were some form of meat grinder from which truth could be turned out like so many sausages.

My approach is not of a metaphorical meat-grinder but rather one of attempting to understand - through interviews, based on narrative inquiry, the worldview of students with a disability in the context of practice education.

3.6 RESEARCH DESIGN

Threaded throughout are boxed extracts from my reflective journal and analytic memoing which detail some of my thought processes where I wrestled with fundamental decisions in relation to the research design.

3.6.1 Sampling and recruitment

In conducting this research, I thought carefully about who I wanted to recruit as research participants in the context of my research aims and who would be best placed to help me answer my questions around the challenges that students with a disability face on placement. Naturally, I would recruit students with a disability, that seemed obvious, however I was curious to hear the voices of others directly involved in practice education and with

experience of working alongside or possessing knowledge about students with a disability on placement. I therefore employed purposive sampling (Creswell, 2013) which enables selection of research participants to address the specific research question. I employed purposive sampling to recruit from four distinct groups of research participants, these are listed below together with a brief explanation of their context.

- students with a disability on pre-registration programmes within the School of Health Sciences at the University of East Anglia including the disciplines of occupational therapy (OT), physiotherapy (PT) and speech and language therapy (SaLT);
- practice educators - registered healthcare professionals (OT, PT and SaLT) from one local acute hospital setting within East Anglia which provides placement experiences for students;
- visiting tutors - OT, PT and SaLT university faculty who have contact with students during their placement experience;
- clinical learning environment leads, employed by Health Education East of England via the Local Education and Training Board. Part of their role is to work in partnership with placement providers and Higher Education Institutions in developing suitable practice placement learning environments and supporting and guiding practice educators. Clinical learning environment leads are not linked solely to any single discipline as they operate within a multi-disciplinary, health-related role.

My next step was to consider inclusion criteria - known as criterion-based sampling. Table 2 illustrates the inclusion criteria for each of the key participant groups.

Table 2: Key inclusion criteria for all four research participant groups

Students with a Disability
<p>Must be a current student on one of the following pre-registration programmes:</p> <ul style="list-style-type: none"> • BSc (Hons) Occupational Therapy • BSc (Hons) Physiotherapy • BSc (Hons) Speech and Language Therapy • MSc Occupational Therapy • MSc Physiotherapy
Must have experienced at least one practice placement block
Must not be currently intercalating
Practice Educators
Must be an occupational therapist, physiotherapist or speech and language therapist registered by the Health and Care Professions Council
Must have completed an approved practice educators course at any university
<p>The supervised student must be one that is (or has been) registered at the School of Health Sciences at UEA on one of the following programmes:</p> <ul style="list-style-type: none"> • BSc (Hons) Occupational Therapy • BSc (Hons) Physiotherapy • BSc (Hons) Speech and Language Therapy • MSc Occupational Therapy • MSc Physiotherapy
Must have had experience of supervising a student with a disability (from their own discipline), on placement within the last two years from date of initial contact with the researcher
Visiting Tutors
Must have fulfilled a role as visiting tutor for a student with a disability within the last two years
Clinical Learning Environment Leads
Must be employed by Health Education East of England
Must have supported practice educators taking students with a disability from the School of Health Sciences

The first step to recruitment was to send out gatekeeper letters (appendices B, C, D, E) in order to seek permission to recruit participants from the four distinct groups. These included the Head of School in the Faculty of Medicine and Health Sciences for access to visiting tutors (B), the Course Directors in the School for access to students (C), the Director of Clinical Learning Environment Leads (CLEL) for access to CLELs (D) and finally to the Head of Therapies (E) in the local acute hospital in the region for access to their clinicians.

Whilst awaiting responses from the gatekeepers I needed to consider carefully how I would target practice educators to increase the likelihood that they would meet my inclusion criteria. Consequently I decided to target potential participants independently rather than send out a general flyer invitation. A nominated administrative person from the School of Health Sciences was given access to the database of students registered with a disability (held by me in my capacity as Disability Liaison Officer). The administrative person also had access to placement allocations from the previous two years and used this to create a database depicting potential key research participants from the local hospital. This method of matching was only used to identify relevant practice educators to ensure focused recruitment given the work demands of this group of research participants and the fact that they are not an easy group to recruit.

Letters (appendices F: student with a disability; G: practice educator; H: visiting tutor; I: clinical learning environment lead) were e-mailed to potential key research participants and those meeting the inclusion criteria were invited to contact me. Upon receipt of an e-mail from a participant expressing interest in being interviewed, a participant information sheet was e-mailed (appendices J: students with a disability, K: practice educators, L: visiting tutors, M: clinical learning environment leads) and a date agreed for interview.

The process of recruiting participants was varied, in that students and clinical learning environment leads were the easiest groups to target and recruit.

Visiting tutors and practice educators were the hardest to recruit and on reflection, this could be attributable to a number of reasons. Firstly, the demanding nature of their jobs may have impacted on recruitment. For example, practice educators are likely to hold significant clinical responsibilities such as holding a caseload of patients which will tend to be their key priority. Students require clinical exposure during their placement experience therefore they are more likely to be placed with those holding predominantly clinical as opposed to managerial responsibilities. For visiting tutors, some hold a dual clinician / university lecturer role whereas others may hold a lecturer role only but nonetheless are likely to be contending with a busy schedule of academic related responsibilities including teaching, marking, administrative, enterprise and engagement and research related activities.

Secondly, it is possible that some individuals may have been uncomfortable with the notion of discussing the topic of disability. Disability can be a highly sensitive area and people may well fear the interview situation as a potential 'minefield', where they may 'get things wrong' with potentially serious consequences for themselves and their careers. This perception of being vulnerable can be a significant barrier to research in this area and while I have no evidence that this was felt by the target population, it is not implausible that these fears can hinder participation.

It is also possible that feelings of discomfort could have been related to me personally given my personal disabilities, one of which is clearly visible (deafness) coupled with my simultaneous roles as researcher, placement coordinator and disability liaison officer. Worries about saying the wrong things or tripping over their words in this situation may have added to the anxiety / discomfort. In addition, some participants may have had concerns about jeopardising an existing harmonious working relationship with me which could be triggered during an interview topic on disability. Finally, given the proximity of the workplace for practice educators to the University, research related activity will be prominent and some practice educators and visiting tutors may have experienced an element of research fatigue with

regard to being a research participant, being engaged in research themselves or not being interested in my research topic. While there is literature offering guidance on recruiting and retaining participants for sensitive topics, most of them focus on vulnerability after a traumatic experience (abortion or sexual violence for instance) rather than vulnerability in their role as non-disabled professional talking about disability. But Tregaskis (2001:351) as a disabled researcher interviewing non-disabled people about their disability-related attitudes points out the chasm that needs to be bridged. She doubts if there are any existing methodologies that offer solutions:

I suspect that in terms of the disabled-non-disabled dyad there may in fact be a need to find new, non-threatening, equalising ways of talking as a 'first step' before we can 'hear' what it is that we actually have to say to each other.

While no solutions are offered in that paper, upon further reflection, I believe it would have been useful to open up a conversation about these fears directly by a) discussing them as not usual, and b) reiterating my intentions to hear without judging how people might talk or think about disabilities, and c) reassuring potential participants that talking aloud about some of their anxieties and focusing on possible solutions, would have alleviated concerns and improved participation.

The results of the recruitment process are detailed in Table 3.

Table 3: Recruitment process

Students with a disability	Practice Educators	Visiting Tutors	Clinical Learning Environment Leads
<ul style="list-style-type: none"> • 12 targeted • 3 no reply • 1 declined • 8 interviewed 	<ul style="list-style-type: none"> • 8 targeted • 2 replied stating did not meet inclusion criteria • 4 no reply • 2 interviewed 	<ul style="list-style-type: none"> • 4 targeted • 1 replied stating did not meet inclusion criteria • 1 no reply • 2 interviewed 	<ul style="list-style-type: none"> • 4 targeted • 1 replied stating did not meet inclusion criteria • 3 interviewed

3.6.2 Participant Profiles

All 15 research participant names are pseudonyms and their status is indicated in brackets; for example, Lillian is a student thus 'Lillian (ST)'. To give the reader some context regarding the research participants, Table 4 denotes their respective profiles; in the case of students, the programme of study they were on and their declared disability.

Table 4: Research participant profiles

Students with a disability (ST)	Practice Educators (PE)	Visiting Tutors (VT)	Clinical Learning Environment Leads (CLEL)
Lillian <ul style="list-style-type: none"> • SLT • Year 3 BSc • Musculoskeletal 	Peter <ul style="list-style-type: none"> • Qualified as an OT 39 years, worked in higher education since 1993 • OT Lecturer • Visiting tutor for an acute hospital 	Mary <ul style="list-style-type: none"> • OT for 20 years • Works in an acute hospital, managerial experience, now working in remote ward 	Dennis <ul style="list-style-type: none"> • Qualified as an OT • CLEL since 2008
Mark <ul style="list-style-type: none"> • PT • Year 3 • BSc • Specific learning difficulty 	Andrea <ul style="list-style-type: none"> • Qualified as a PT 24 years, worked in higher education since 2002 • PT Lecturer • Visiting tutor for an acute hospital 	Veronica <ul style="list-style-type: none"> • OT for 23 years • Works in an acute hospital 	Jim <ul style="list-style-type: none"> • Qualified as a PT • CLEL since 2014
Sharon <ul style="list-style-type: none"> • OT • Year 2 BSc • Specific learning difficulty 			Keith <ul style="list-style-type: none"> • Qualified as a Learning Disabilities Nurse • CLEL since 2014
Aurelia <ul style="list-style-type: none"> • OT • Year 2 MSc Specific learning difficulty 			
Claire <ul style="list-style-type: none"> • OT • Year 2 MSc Specific learning difficulty 			
Kerry <ul style="list-style-type: none"> • OT • Year 2 MSc Specific learning difficulty 			
Gillian <ul style="list-style-type: none"> • OT • Year 2 MSc Specific learning difficulty 			
Nancy <ul style="list-style-type: none"> • OT • Year 2 MSc Specific learning difficulty 			

My intention was to achieve a wider variation across the participant groups I recruited, known as maximum variation sampling. The reality however with students recruited, with the exception of one, they all had a specific learning difficulty. A disability analysis (see appendix N), which depicts students registered with a disability for OT, PT and SaLT within the School of Health Sciences since 2014, illustrates that the most prevalent condition is 5.3% for specific learning difficulties with the next most prevalent being 2.5% for mental health conditions. The high prevalence of specific learning difficulties in higher education is also corroborated in a study by Fuller *et al.* (2004a) who interviewed students with a disability. Therefore, much of the participant data in this thesis relates to this particular disability. However, when interviewing the staff (practice educators, visiting tutors and clinical learning environment leads), their responses were drawn from their experience of students they had supported, who had a range of disabilities. This data therefore relates to a wider variety of disabilities and have been included wherever they fit the theme under discussion. I achieved variation in terms of the differing programmes of pre-registration the students belonged to. Indeed, Mason (2002) suggests that sampling in qualitative research is an organic process in that it evolves over the duration of the research. My *modus operandi*, echoing Mason's suggestion of an organic process came into effect as I utilised an iterative process of participant recruitment, data collection, memoing and analysis, this ensured that I was able to monitor the appropriateness of participants recruited. This became apparent following an interview with a student (third interview with this participant group) during which the student struggled to answer some of my questions which were based on the experience of a face-to-face visit with the visiting tutor during placement. This particular student had not yet experienced a face-to-face visit, but a virtual visit with the visiting tutor in a telephone conversation. Face-to-face visits offer a more in-depth and personal interaction between student and visiting tutor than can be achieved through a virtual visit. For example, noting a student's body language or non-verbal communication can prompt the visiting tutor to probe more than they would otherwise without a face-to-face interaction. Consequently this resulted in an amendment to the inclusion criteria for recruitment of students.

The two visiting tutors are from two different disciplines and finally clinical learning environment leads were recruited from Norfolk and Suffolk - partly for the pragmatic reason of proximity. The most challenging group to target were practice educators. Despite repeated e-mails and letters sent to the targeted persons, I only managed to recruit two participants in this category. To address this, the Therapy Lead at the placement provider setting was contacted and I was subsequently invited to attend the Therapy Lead meeting to talk about my study. The meeting comprised Therapy Leads from each of the professions of OT, PT and SaLT. All persons present took copies of the participant information sheet and were given names of specific practice educators to chase up on my behalf. An e-mail was sent following the meeting to put into writing what was said during the meeting. Unfortunately this approach, whilst useful in highlighting the worth and benefits of my study, did not yield any further participants. On reflection, direct participation in the discipline specific staff meetings for both faculty at the University and for practice educators would have afforded the opportunity for me to talk more about my research and piqued interest. It may also have dispelled any hesitations that potential participants may have had about taking part.

3.6.3 Data collection: interviews

Data collection occurred through a process of face-to-face, one-to-one semi-structured interviews from the four distinct categories of key informants depicted in Table 3. Brinkmann and Kvale (2015:4) claim that “it seems so simple to interview, but it is a fundamental assumption of this book that it is hard to do well”. Although I acknowledged the value of focus groups and have used them in previous research studies, my rationale for interviewing as opposed to focus groups was that I wanted to gain an in-depth understanding of each participant’s narrative and experience. Interviewing seemed the best method to enable co-construction of knowledge between interviewer (me) and interviewee coupled with the opportunity for gaining the depth and richness of information I was seeking. As I was seeking personal information about placement experiences, I was concerned that participants

may not be so forthcoming in a focus group situation. In addition, interviewing as a method of data collection offered me flexibility in that I was interacting with one person at a time. My choice seemed to be a sound one as in the event, clinicians and visiting tutors were the hardest to recruit for one-to-one interviews, and aiming for a focus group would have entailed considerable organisation and time.

Cohen and Manion (1994) caution that although interviewing allows for in-depth exploration of issues – more so than other methods - they can also be prone to bias. Such bias can emanate from interviewer characteristics, respondent characteristics and the questions asked. A pilot interview and a reflective journal all played a part towards counteracting bias in addition to enabling me to reflect upon my skills as a researcher.

I decided to conduct a pilot interview for the purposes of testing out my proposed research questions to ensure that they would make sense - both to me and the person being interviewed (Carpenter and Suto, 2008). The pilot also afforded an opportunity for me to practise my interviewing techniques in readiness for starting the data collection phase. I ensured that the interviewee I selected had a disability as this would mean they should have sufficient insight and knowledge concerning the questions being asked of them. An extract from my reflective journal illustrates the value of a pilot interview:

24.2.15: I conduct a pilot interview on a recent graduate of our School, this person has a disability so they meet the inclusion criteria apart from not being a current student. I am so nervous, nervous that the interviewee will think my questions are daft / inappropriate and nervous because the interviewee is now doing their own research which makes me feel a tad inferior. I use the student version questions. Following the interview, the interviewee makes some valuable suggestions for tweaking some of the questions for example, some were double barreled thus too complicated and wordy and also feedback on my interviewing technique - for example, I need to allow more time for the interviewee to respond. What is incredible is that the interviewee tells me things I never knew before, this makes me realise that I need to release prior expectations of what the interview will yield in terms of data otherwise I am guilty of being blatantly biased. I also learn the importance of being an active listener, if I miss something then the nuances of interviewing are lost in that moment - forever.

All interviews took place from April 2015 to October 2015. What can be gleaned from the participant profiles in Table 4 is that the two practice educators I interviewed both worked within the acute hospital setting, therefore their responses in the main tended to focus on this particular environment. In addition, the same was true of the visiting tutors - they tended to focus on their visits within the acute setting. All the students made some reference to the acute setting as did the clinical learning environment leads.

Attention was given to the setting and conditions of the interview. Up to one hour was allocated for the duration of all interviews and participants were given the choice of being interviewed in a venue of their choosing. Thirteen participants were interviewed on the university campus and two at their place of work. One interview posed a challenge location-wise as it had to be conducted within a very noisy and busy open plan-space (commonly used to conduct meetings) due to the practice educator being unable to book a private room. All other interviews were conducted in a quiet, private room. Before the interview, the research participants were reminded about the study and then asked to sign a consent form (appendix O).

For the target group of students with a disability, I periodically changed the format of the interview guide in the wake of emerging findings from preceeding interview notes. My argument for change was threefold:

- this group comprised the highest number of participants recruited (8 in all);
- it was my most relevant group of interviewees in that the participants were directly experiencing the very phenomenon I wished to research, students with a disability in practice education;
- following data analysis of the first two interviews with students, on reflection, because I had so many questions to ask of them, my interview guide was perhaps too overwhelming - not only for me to deliver but also for the recipient too.

Initially, I was concerned that my interview guide was too highly structured (appendix P illustrates the differing versions which cover the four different target groups of interviewees), but Birks and Mills' (2011:75) advice was reassuring: "you can use an interview guide...but expect that it will evolve as your study progresses". Braun and Clarke (2013) advise on the importance of structuring the interview questions carefully and where appropriate to include prompts and probes. This combination of highly structured or rather, detailed interview guidelines alongside an expectation that this needs to be used flexibly in response to each participants' narrative worked well. I recognised I needed to simplify the guide without compromising the

information I needed to gain from the participant. Consequently the interview guide and questions were amended for the third interview with a student. However, challenges were encountered as illustrated in my reflective journal extract below:

12.10.15: The interview with Sharon [Student] the other day didn't go well I felt as the questions did not seem to flow:

- Are there consequences for a student with a disability on placement over and above that of a student without a disability?*
- In your experience, are there differences in the learning capabilities between students with and without a disability?*
- What are the core attributes that you feel are necessary for:*
 - a student with a disability?*
 - the visiting tutor?*
 - the practice educator?*

I can still analyse the data but Sharon seemed to struggle to answer them. Added to that, the student had not yet experienced a face-to-face visit from the visiting tutor due to the stage of practice education reached so had to base their response on a virtual visit. What was interesting was that Sharon mentioned the importance of awareness several times. Perhaps the problem lies with the phrasing of the questions? Perhaps a better way to phrase them is by changing the first two questions:

- Can you describe the nature of your disability?*
- Does having a disability have an impact in any way on your placement experience?*

As can be seen from the above extract, the interview guide was amended following the third interview for all subsequent interviews with students. None of the interviews was audiotaped and my rationale is illustrated in the following reflective journal extract:

1.3.15: I am reading Glaser's (1998) 'Doing Grounded Theory' and in Chapter 7 entitled 'Taping', he adamantly states that the researcher should not use any form of electronic taping during interviews. I was both excited and persuaded by the concept of no taping, I felt a sense of – in one word – freedom. Freedom from the shackles of having to wait for my support worker to transcribe the interviews (I cannot enact this skill due to hearing impairment), ploughing through endless transcripts and coding before I can even begin to decide who to sample next. Glaser makes sense on this taping conundrum when you read the entire chapter, his arguments are persuasive. I wonder if this is what brainwashing feels like? I realise that I need to temper my current views with some colleagues.

Birks and Mills (2011:76) postulate that “it is not always necessary to tape interviews”. Indeed, in a study by Devers and Robinson (2002), they did tape some of the interviews however, on one occasion, circumstances meant it was inappropriate to tape (it was a study on after-death communication). Birks and Mills (2011:76), however, caution that where possible interviews should be taped and more so for those new to research. In addition, interviews should be taped as a “back up” and for access to “verbatim quotations that can be used to defend your coding and illustrate your final theory”. As a counter-argument to Birks and Mills (2011), Manion, Cohen and Morrison (2011) postulate that audiotaping may lead to the interviewee being reticent in coming forth with information and feeling hindered by virtue of being recorded. This suggests that not audiotaping potentially means that interviewees may feel more relaxed.

At this point, it could be argued that not recording the interview may lead to the interviewer not remembering the salient features of what was said in the interview. A powerful counter-argument is furnished by Kvale (1996:161) who argues that “the interviewer’s active listening and remembering may

ideally also work as a selective filter, retaining those very meanings that are essential for the topic and purpose of the study". Kvale (1996:161) also espouses the interviewer's immediate memory of the interview in capturing "the visual information of the situation as well as the social atmosphere and personal interaction". Not taping enabled me to capture and hone in on the spatial, temporal and social dimensions inherent within the interview context (Kvale,1996). In addition to contemporaneous (within 12 hours of interview) typing up of the interview notes I also produced a free-flowing synopsis, using my own words, of each interview. In effect, each interview was captured twice.

Data is not only to be judged as accurate, trustworthy or reliable within a process which produces verbatim words that flow from a participants' mouth into a recorder and transcribed word-for-word. The disadvantages of transcribing for me are that I cannot verify the outcome of the transcript nor can I hear the recording.

MacDonald and Sanger (1982) in their paper entitled 'Just for the Record' advise the following: "it is only a partial record of the interaction and the communication – the sound component, and even this partial record will be reduced if, as usually happens, subsequent use of the record is based on the transcript-words only". As a deaf person, I cannot listen to the recordings unless I entrust the whole to a transcriber who has not been present at the interview and will be prone to transcribe only the sound component recorded.

Guest, MacQueen and Namey (2012:96) add weight to the argument for not taping by stating "the benefits of audiotaping are obvious, but just because an interview or focus group is recorded does not necessarily mean a verbatim or useful transcript will result". Indeed, Manion, Cohen and Morrison (2011:426) question the value of transcripts and state they are "decontextualised, abstracted from time and space, from the dynamics of the situation, from the live form and from the social, interactive, dynamic and fluid dimensions of their source; they are frozen". The concept of decontextualised transcripts is captured in an analogy furnished by Kvale

(1996) who likens a transcript to a topographical map - it is not, he says, representative of the actual landscape in reality, the translation from paper to actual reality is far removed. According to Kvale (1996), a transcript is an opaque screen between the researcher and what happened during the interview. Freedom from transcripts resonated with my experiences of conducting the interviews, as a researcher and interviewer I expended due diligence and attention to what was being said, knowing that I did not have the safety blanket of a tape recorder. An added benefit of not recording meant that the speed of concurrent data collection and analysis enabled me to recruit participants fairly quickly as I was not having to wait for the interviews to be transcribed.

My reflective journal concludes:

16.2.15: After all this wrangling and torment what is the verdict? To tape or not to tape, I am convinced...in the words of Glaser (1998:107): 'DO NOT TAPE INTERVIEWS'.

Given that I have espoused interviewing as a method, what of (if any) the downsides to interviewing? In my personal experience, it was time-consuming conducting 15 separate interviews in total. Brinkmann and Kvale (2015) provide a useful list that constitutes quality criteria in relation to interviewing. For me, one of the key points which I did not adhere to consistently was the need to follow up with the interviewee the meaning of what they were saying, in other words, to encourage the interviewee to expand or clarify what they said. Potentially, this may have enabled me to acquire a more consistent and robust set of data. Brinkmann and Kvale (2015) list 10 standard criticisms of interviews of which two relate specifically to interviewing and analysis - the insertions in brackets are my responses:

- not trustworthy but biased (methods to counteract bias have been covered in this chapter);
- not reliable because it rests on leading questions (interview guide initially piloted and consequently monitored and reviewed after each interview. Brinkmann and Kvale (2015) positively encourage the use of leading questions to help verify what the interviewee is saying).

Upon completion of each interview, the typed notes were sent to the research participant to ensure that it was a fair representation of what had been said. All participants apart from one practice educator checked the notes of their respective interview.

3.6.4 Reflexivity and Positionality

Two key concepts of any qualitative research are attention to positionality and reflexivity. According to Carpenter and Suto (2008:93), “This role brings with it the responsibility of fully locating ourselves in the research (positionality) and engaging in disciplined self-reflection (reflexivity)”. Given that notions of reflexivity and positionality permeate all stages of the research process, for ease of reading I have straddled this section between the sections entitled data collection and data analysis.

Carpenter and Suto (2008) emphasise the notion of reflexivity where embracing this as a researcher will contribute to the quality of the research in that potential bias is acknowledged and facilitates a state of transparency. Memoing can be used as form of engaging in reflexive practice (Dunne, 2011). Memoing, according to Lempert (2007:249), is the “fundamental link between data and emergent theory”. Guest, MacQueen and Namey (2012:123) define memos as “short narratives” supplementing raw data. Memoing as a technique was used throughout the entire research process, including data analysis; the added value of memoing means thoughts captured form part of the writing up of the thesis. Analytic memos are a useful adjunct to the iterative process of data collection and analysis (Dey, 1993; Saldana, 2009) and afford the opportunity to engage reflexively with the development of issues emerging from the data. Saldana (2009) asserts that analytic memos can be used as part of the data corpus, they can form part of the data set to be analysed as they may in themselves generate codes and categories. This did occur in several instances within my own analytical memoing and data analysis activity. An example of an analytic

memo within a reflective journal extract highlighting the need to revise the interview guide follows:

27.1.16: It's been a while since I have added to this. I am 3.5 days into a 4-day study leave. This period has been truly gruelling...I have had to review my methodological approach and am using thematic analysis. I started all over again with the analysis:

- looking at each set of interview notes independently;
- combining interview notes by sample groups.

I think what has been beneficial is that these few precious days have enabled me to become familiar with the data, repeated reading of the interview notes and thinking about the data all the while.

I now need to consider, what are the emerging themes? It appears to be support. Support manifests itself in many formats and if this is not tapped into nor delivered effectively then it can have consequences for all concerned with practice education. Let's explore some examples....

SUPPORT...

Enablers to support mechanisms:

Disclosure; facilitating positive learning environment; culture of placement (positive); support for practice educator.

Barriers to support mechanisms:

Time pressures; staffing pressures; acute setting - fast and busy.

Need for self-management on student's part - insight, awareness of impact of how they present.

Starting to re-read the literature on critical disability studies, one paper refers to the capability approach, have I come full circle?! Perhaps all my prior reading on capability theory is not to be wasted after all.

Braun and Clarke (2013:9) highlight the importance of what they term “qualitative sensibility” and define this collectively as attributes that a researcher must possess including “the ability to reflect on, and step outside, your cultural membership, to become a cultural commentator - so that you can see, and question, the shared values and assumptions that make up being a member of a particular society”. These authors also comment on the importance of ensuring that assumptions do not interfere with the research process. Being a cultural commentator is an interesting notion and for me represents a means of mitigating the influence of potential bias and has personal resonance due to my close working relationships and connections with all interviewees. Interestingly, there were times during my research journey when I had indeed made assumptions and wrongly so, I had to learn to put these to one side and to listen to what the interviewee / data was saying. An example was during data analysis: after two colleagues independently looked at a set of interview notes I realised that, by comparison, I had not achieved the depth of analysis in parts of the interview notes required at doctoral level due to making assumptions about what I thought the data was saying. I had to work hard during the interviews too - particularly with students to ensure that I remained objective, in the sense of being open-minded, and to not interfere or infer more than what was being offered in the interview. Braun and Clarke (2013) state that in qualitative research you cannot hope to eliminate all possible sources of bias, in other words, an element of subjectivity creeps in. The manner in which I carried out all stages of the research process - recruitment, collection of data and subsequent analysis - was therefore, inevitably influenced by my existing knowledge of disability and practice education, in addition to my personal beliefs and values. Braun and Clarke (2013:21) state that “qualitative research does not treat this subjectivity as *bias* [authors’ emphasis] to be eliminated from research, but tends to involve contextualised analysis, which takes this into account”. The insider / outsider status in terms of identity with a particular group is also alluded to and therefore another critical reason for engagement in reflexivity (Braun and Clarke, 2013).

In section 3.3 regarding my axiological stance, I described my tripartite roles within higher education comprising Disability Liaison Officer, Visiting Tutor and Practice Education Coordinator. There is a need to acknowledge another important characteristic, the very embodiment for me of being disabled and being a researcher on disability. I offer some reflections here by way of acknowledging the potential impact and influences of these overlapping roles and relationships with students and staff.

These roles and relationships may have affected the nature of the data that was generated, in both good and more problematic ways. For example it is possible that the research participants (in particular, the students with a disability) spent more time talking about the 'problems' they faced on placement because I am disabled. They may have felt that the 'right answers' were about issues/problems that my research may then 'solve'. Getting around such expectations is a thorny issue in qualitative research and upon reflection, I would have tried to 'set the scene' in a more exploratory way, that allowed students to talk about experiences, good or bad, and making it explicit that I was there to hear these in an unconditional way. This is perhaps what Tregaskis recommends as the "non-threatening, equalizing ways of talking" (2001:351). In some ways, this is hard to do because research information packs designed to show adherence to ethical research practices may inadvertently signal that the research seeks specific kinds of information over more exploratory conversations. Using ice-breaking activities that allow participants some room to relax into the interview would have been another option – for instance, asking students to take a moment to draw a timeline of their time on the course, to pick 'high' points and 'low' points on this timeline, or to draw a visual representation of their placement site as a way of educating me about its contours, and then moving into talking about particular spaces and experiences within it may have all led to different kinds of conversations. While none of these are guaranteed to overcome the problem identified, they may have alleviated it or at least signaled my desire to hear about a range of matters rather than just 'problems' that need solutions.

On the other hand, some participants may have felt 'liberated' by this overlap in experience with a disabled researcher and found it easier to talk to me than they might to a non-disabled interviewer, because of a sense of commonality between us. This too holds dangers as experiences of disability are diverse, subjective and quite personal to each body, each impairment and each context that this may simply engender a false sense of commonality that can lead to misunderstandings or missed understandings. This is another 'obstacle' to hearing the uniqueness of different experiences. One possible solution may be to be attentive to moments of dissonance (where the assumed commonality is broken) and to focus the conversation on dissimilarities in experiences such that a wider range of experience may be able to be communicated.

Another perspective to consider is that the research participants may have simply seen me as 'staff' (not researcher) and felt compelled or inclined to stress how they have to "get on with it" or "just have to work harder", as they felt they needed to impress upon me that they were coping, and should be given credit for that. Because interviews are also social situations, respondents may try to adhere to what is socially desirable or sanctioned (Polkinghorne, 2007) and this is particularly so in the case of students being interviewed by lecturers/teachers. For students I interviewed, there may have been a sense of being 'assessed' or 'appraised' by me in connection to my role as placement coordinator. While I made an effort to distance myself from my other roles and stressed the research as a distinct process, I cannot be sure that this was fully accepted and that this did not colour the nature of the conversations. These matters also pose dilemmas for data analysis, discussed in subsequent sections of this chapter.

An example of outsider status illustrated in the following reflective journal extract led to a pivotal moment which gave cause for reflection and emphasised the frustration of knowing that I cannot always be fully cognisant of the practice education experience from both practice educator and student perspective.

24.10.15 Reflecting on the interviews, I realised I had completed an interview with a practice educator and the timing of the interview happened to coincide with having one of our students on placement. Whilst I was waiting in reception, the student in question came up to me to say hello and acknowledged that I was there to interview their practice educator and not as visiting tutor. Interestingly, I interviewed that same student at a later date. From analysing both sets of interview notes, a few scenarios recounted from both parties did not corroborate from the perspective of practice educator nor student. This experience served to reinforce my status as an outsider. Even though I hold the role of practice education coordinator I am too far removed from the practice educator and student roles to be fully cognisant of the nuances of practice education.

As this section has emphasised, engaging in reflexive practice through the use of a reflective journal and analytic memoing goes some way in exposing and situating the position of the researcher and the context within which decisions may have to be taken. To conclude, an important consideration is the researcher / participant relationship. Carpenter and Suto (2008) state that this is open to influence dependent upon interviewee expectations of the research and the researcher. To combat this, the researcher should aim for a position of transparency (Carpenter and Suto, 2008:126) - which can be achieved through a reflexive attitude and cultivating “a genuine presence”

and “self-disclosure”. The following reflective journal extract demonstrates an occasion where genuine presence and self-disclosure were exhibited.

23.10.15 Reflecting upon my interviews, I feel they have gone okay. I feel pleased at the way I come across as an interviewer in that my personal attributes come into play for example, putting the interviewer at ease and the skill of active listening. I remember empathising with one research participant who became rather ‘heated’ in relation to the need for equality for people who have a disability. I was able to acknowledge what they were saying without disrupting their flow and briefly self-disclosed my own disability and the impact of this.

3.6.5 Data analysis

Elo and Kyngas (2007) distinguish between two approaches to analysis - deductive and inductive. Data analysis in this study comprised both approaches - deductive in that the framing of the interview questions was influenced by my personal curiosity and exposure to relevant literature and inductive as characterised by themes emerging from the data. Braun and Clarke (2006:12) capture the essence of inductive analysis by saying that “data are not coded in an epistemological vacuum”.

The process of thematic analysis enables inferences to be made from data generated to examine the phenomenon in depth (Elo and Kyngas, 2007). Thematic analysis has been criticised by some for being apparently simplistic by virtue of the fact that there is no right way in which to apply this method of data analysis (Elo and Kyngas, 2007). However, Braun and Clarke (2013) caution that although such flexibility is embedded within this method, there are some limitations. I have highlighted some of these below with my counter-argument alongside in italics:

- interpretation of data can be compromised without reference to an existing theoretical framework - *theoretical frameworks are introduced in Chapter 2 with regard to existing literature and applied to the findings in Chapter 5;*
- inferences in relation to use of language cannot be made - *the nuances of language per se were not a critical consideration for the purposes of my research.*

Guest, MacQueen and Namey (2012:11) postulate that “thematic analysis is still the most useful in capturing the complexities of meaning within a textual data set”. These authors state that thematic analysis is commonly used and offers reliability as more effort is expended in relation to interpretation of data as opposed to word-based analyses. Most importantly, Guest, MacQueen and Namey (2012:15) argue for the term “applied thematic analysis” thus representing an amalgamation of methodological approaches and techniques such as “grounded theory, positivism, interpretivism, and phenomenology - synthesized into one methodological framework”. It may appear that a research method based on an amalgamation of techniques typically used in one particular approach lacks rigour yet Guest, MacQueen and Namey (2012:15) assert that the applied thematic approach is “rigorous, yet inductive”. Guest, MacQueen and Namey’s assertions provide a useful counter-argument to Braun and Clarke’s earlier statement concerning the limitations of thematic analysis. Guest, MacQueen and Namey (2012) go on to produce a comprehensive table comparing applied thematic analysis with that of other methodological approaches, namely phenomenology and grounded theory. An example of how my data analysis incorporates elements of other methodological approaches includes the use of memoing - commonly used in grounded theory - as an adjunct to interpretation of data.

Guest, MacQueen and Namey (2012:124) purport that “qualitative data analysis is both an art and a science” and emphasise the importance of being creative in this process. The meaning of data is a critical consideration as part of the analytic process. At this juncture it is appropriate to put into context what is meant by codes, categories and themes as these can, on occasion, be used synonymously by researchers. To start, in terms of

thematic analysis, Hsieh and Shannon (2005) describe three different approaches to content analysis. The one that applies to my approach is termed conventional content analysis in that codes are defined during data analysis and derived from the data itself. Categories according to Saldana (2009:11) “may contain clusters of coded data”. A theme is defined by Saldana (2009:139) as – [author’s emphasis] “a *phrase* or sentence that identifies what a unit of data is *about* and / or what it *means*’.

An additional technique used to help make sense of the data collected was the production of a free-flowing synopsis, in my own words, of what the interviewee had said following each interview. I produced a summary for each interviewee upon several readings of each interview and incorporated it alongside the analysis of data. This technique helped me to retain the content of each interview and adopted a less rigid format to that of the interview notes. In other words, it was not produced in the order that things were said.

Guest, MacQueen and Namey (2012:70) propose six steps inherent within applied thematic analysis and these are reproduced (in part) word-for-word below with my personal commentary alongside in italics.

- Read the text and propose themes - *I used coding as a first step to break down the data and to gain an overview of what the ultimate themes might be.*
- Refine the themes into codes with well-developed definitions - *this step was not followed in my research. Instead, I viewed codes as the smallest units of data which then developed into categories and ultimately themes.*
- Have two or more analysts read a sample of the text again and identify segments that reflect specific code definitions - *Guest, MacQueen and Namey (2012: 89) describe the process of intercoder agreement but do so in the context of the coders referring to a codebook and then assessing agreement using “subjective assessment, percent agreement and Cohen’s Kappa statistic”. Albeit not on such a formal basis, my primary supervisor independently coded two of the interview notes and in addition, a fellow*

researcher colleague also independently coded a set of interview notes, in all cases, following comparison with my coding, results were broadly similar. Specific code definitions were not produced as part of my analysis.

- Compare the way each analyst coded the text sample - *results of the independent coding exercise were discussed with the primary supervisor and fellow researcher, resulting discussions enabled me to develop further insights into my data.*
- If the result are the same, continue coding with periodic re-checks - *the two people that independently coded did so at differing time points within my overall data analysis period.*
- If the results differ, identify why - *as explained earlier, my coding labels were broadly similar to that of the two people who independently coded a set of interview notes.*

The above steps are comparable to the steps adopted as part of using applied thematic analysis and are outlined below.

Step 1: each set of interview notes was read through several times to gain an overall sense of what the interviewee was saying in addition to an interpretation of the meaning behind what was being said.

Step 2: each interview was individually analysed by examining small portions of the data. A series of headings was reproduced to begin the process of detailed line-by-line analysis. An example is taken from an interview with Lillian and is reproduced in Table 5. Note that within the incident column, this captures, in chronological order, parts of the actual data so L13 is taken from line 13 onwards. The parts in italics represented what I considered at that stage of the data analysis to be potential quotes for use in the findings chapter. This part of the coding process mirrors what Guest, MacQueen and Namey (2012) refer to as structural coding - using segments of text from the interview notes that reflect the research participant's response to the research questions. Interestingly, Guest, MacQueen and Namey (2012) say that this technique will also highlight how well the researcher conducted the

interview: for example, whether questions were asked consistently across all interviews and whether sufficient probing questions - where warranted - were asked. As a counter-argument, Braun and Clarke (2013) assert that research and interview questions are not the same. The issue of interviewer technique was pointed out to me when my primary supervisor independently coded two of the interview notes and suggested that I needed to return to two of the research participants to ask them to elaborate more on parts of the interview. In other words, richness or thickness of parts of the data was lacking (Braun and Clarke, 2013).

Table 5: Initial breaking down of interview data with Lillian

Question	Incident	Highlight exact words from interview that capture key thoughts / concepts	Meaning
What challenges – if any – did you encounter during your practice placement experience?	L13: the hospital environment (year 3 placement) is much easier in that you can take breaks, <i>staff naturally take breaks it's an environmental thing</i>	Hospital practices involve taking breaks <i>Staff naturally take breaks, it's an environmental thing</i>	Taking breaks is an unquestioned (to the point that appears 'natural' as a given) part of hospital working culture

Step 3: all the interview sets according to each of the four groups of interviewees were amalgamated to permit comparison of data across groups. An example from the CLELs is given in Table 6; in the left-hand column the category here is depicted as clinical environment, a subsequent code belonging to this category is culture. The purpose of this step of analysing the data was to group together similar responses from the interviewees according to their respective groups, which then enabled categories and ultimately themes to emerge. So for example, clinical environment or environment is a theme.

Table 6: Comparison of data by interview group - CLELs

	03CL	06CL	07CL
Clinical environment			
Culture	Culture is a major factor. The health service (organisation) does not have a good record of supporting students with a disability.	Other providers are driven by quality standards and with more private providers coming on board and their financial incentives; the working environment is not likely to be so inclusive.	I think this tends to be reactive rather than a proactive situation. The work environment needs to be individualised.

Step 4: this involved making sense of the themes and use of thematic schemas or maps to illustrate conceptual models. One such example is illustrated in Figure 6 below:

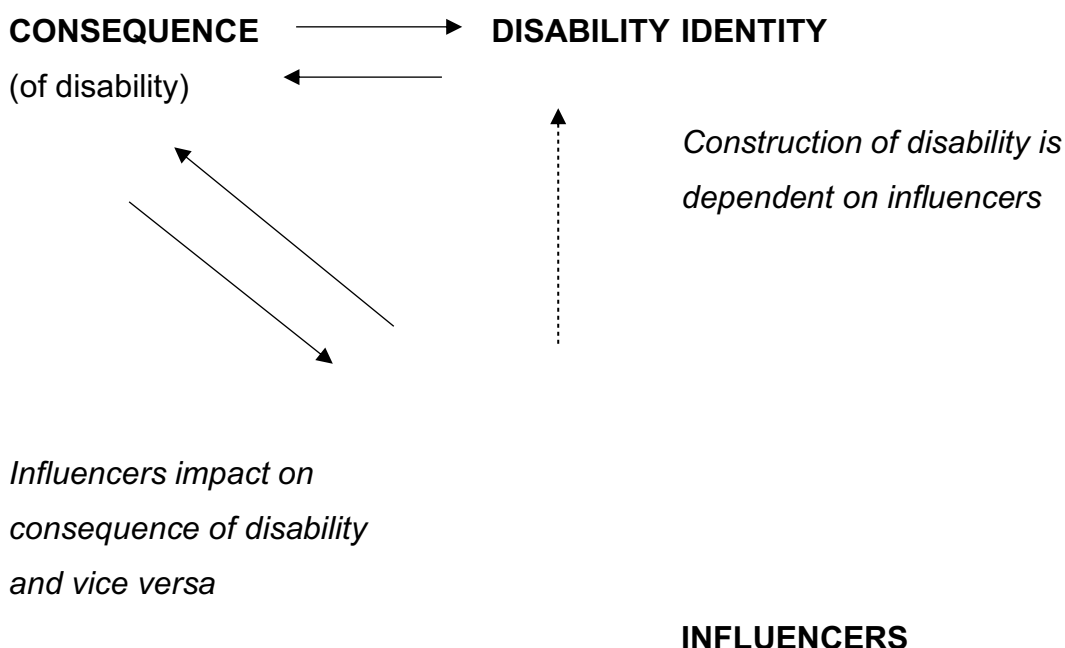


Figure 6: Consequence of disability impacts on disability identity and vice versa

Reflecting on the process of data analysis, on three occasions I followed up on points within the interview notes to seek further clarification. With one of the interview notes, I experienced ethical tensions as I had interviewed a student with a disability and needed to liaise with a colleague over a technical matter which had arisen from something the interviewee had said. The incident is discussed on pages 103-4 in more detail. I found myself revealing who the interviewee was to help my colleague fully appreciate the context of what was written in the interview notes. My colleague then revealed some information about the interviewee which meant that my original interpretation - based on what I was reading and based on what the interviewee had said - was apparently incorrect. This made me feel uncomfortable and my colleague sensed this. We worked out a response that I could feasibly incorporate into the findings chapter to help interpret and clarify the matter. This made me realise how challenging it is to not only analyse data but also derive a meaningful and logical interpretation from it without breaching confidentiality.

The interpretation of data findings highlighted several tensions which I needed to reflect upon, if not address fully. The most difficult judgement to make was in how readily I might accept what was being said to me. Earlier in this chapter, there was a discussion on the difficulties in any interview situation and how it is not simple to create a context in which interviewees will say what they mean and mean what they say. The professional roles we all played, the fact that I was a visibly disabled researcher, the tendency to reveal only partially, experiences or stories, or to prevaricate or offer what might be seen to be the 'right answers' in this context all complicate the matter of arriving at trustworthy interview data. Most often I did take the interactions and responses at 'face value'. This was partly out of a desire to have a respectful relationship with the participants who had so freely given their time. It was also partly because some of their words 'rang true' in relation to previous research as reported in literature. For instance, where students insisted that they felt they were working 'twice as hard' (as non-disabled students), this is a common theme that has arisen in previous research (referenced on page 4). Where they spoke of difficulties with

practice education, this too echoed pre-existing literature (reference in Part II of the literature review). Another reason I felt compelled to take most of what was narrated to me at face value was that my research was not attempting to get to the bottom of the 'truth' as it were, it was to draw out perceptions of students/staff and their version of their experiences as they relayed them to me. The inter-view (Kvale, 1996, 2007) was a process of hearing narratives and making narratives. While for the most part, I felt reasonably sure that I was hearing what participants experienced and narrated as trustworthy stories, there were still moments where there were 'anomalies' in stories revealed by the different actors which were troubling in relation to making one unambiguous sense of what was being told (as illustrated on pages 80 and 87). Where there were discrepancies in accounts between staff and students, I returned to the two interview accounts to reflect on what may have contributed to these differences of perspective. Often these were related to the particular roles they were playing within the context – that is, I did not feel either student or staff were 'lying' but that the differences underscored the difference of perspective and role they each played in the situation.

At this point, it may be helpful to unpick both accounts. The first account on page 80 was unsettling in that I found it challenging to grapple with two unseemingly disparate set of interview notes. This was a situation in which the student and practice educator had been working together during one of the placement blocks. I had already completed the interview with the practice educator who presented a positive account of working with students with a disability. Yet when I interviewed the student, their experience seemed – on the face of it – somewhat negative. An example was when the practice educator spoke about providing an aid as a reasonable adjustment and said it was simple to do, yet effective and seemed to solve the challenge the student was experiencing. Yet the student's version was that the aid was only useful in certain contexts and did not serve to mitigate the particular challenge they were contending with. In this situation, it is possible to read and accept both accounts as narrated. The practice educator did indeed believe the experience was well supported but the student felt that it could

have been better. I read this discrepancy as a difference in experience and roles. The second account on page 87 was also unsettling and frustrating too because what the student was saying did not square with my personal knowledge of placement allocations. She claimed she was told by the university that there was no way she could take a particular placement because her disability would not allow her to get on her hands and knees, which would be crucial to this type of placement. This was an instance where I had to check the student's version of events with that of a colleague. The colleague was clear that this would not have been the advice of the university as there were other students with similar conditions who were able to undertake that placement. Did the student then misunderstand what the university had advised? Or did I misunderstand what the student had told me? Could the student have got this mis-information from non-official channels, and did the staff not realise this? Did the student give me a version of events that she perhaps thought I would want to hear – a problem I could solve? Both these accounts have taught me that analysing data is challenging. Particularly when people have differing perspectives, in other words, when their version of events are unique and personal to them and stemming from values or perceptions they may or may not be aware of. I have taken the stance that as a researcher, I have to respect what participants say and use my judgement in the interpretation of data, thinking through more deeply, the reasons why participants might think in a particular way or why their version of events may present in particular ways.

In such cases, trying to 'triangulate' or member check could not have offered me a 'truth' common to all parties. I could though, have returned for further rounds of interviews as recommended by some researchers, to feel confident that I was reading the data, the situations and the people appropriately. On reflection, this would have been ideal. On the other hand, recalling the extremely busy nature of staff and student lives, I am ambiguous about whether this would have increased or decreased goodwill towards my research.

3.6.6 Ethics

Ethical approval for the research idea and processes of access and basic methods of research was granted by the School of Education and Lifelong Learning Research Ethics Committee. Additional approval to recruit practice educators - by virtue of their being employed by the National Health Service - was sought from the Research and Development Office of one acute hospital, R&D Reference Number 2014HPP04S (137-09-14). Ethical tensions and dilemmas are threaded throughout this entire chapter, while the more straightforward mandatory aspects of ethics inherent in any research are covered directly here.

Informed consent: a participant information sheet (appendices J-M) was e-mailed to potential research participants declaring an interest in the study. At the point of face-to-face contact with me, the principle of consent was reiterated and another copy of the participant information sheet and consent form (appendix O) were given to the participant with an opportunity to ask any questions. Signing the consent form indicated that the participant had read and understood the terms and conditions of the study as detailed in the participant information sheet.

Confidentiality and anonymity: all information in relation to research participants, data collection, memos and analysis was safeguarded and kept confidential using secure password access to the computer. Pseudonyms have been used throughout this study. Research participants were asked not to divulge the name of any actual persons during the interviews. The administrative person involved in initially collating information of potential research participants signed a confidentiality form.

Coercion: the consent form and participant information sheet stated that research participants could withdraw from the research at any stage without repercussion, which was also reiterated at the point of face-to-face contact. All participants agreed to be interviewed and none withdrew at any stage. With regard to participant well-being and duty of care disclosure, appropriate safeguards were in place and no issues arose.

In concluding this chapter, I have explained my philosophical perspectives in which my research is rooted within a social constructionist framework to explore the lived experiences of students with a disability in practice education. I have also explained the methods and rationale for sampling and recruitment, data collection and thematic content analysis. Threaded throughout this chapter are extracts from my reflective journal and analytic memoing which reveal my thinking and growing insights behind methodological decisions and actions taken.

CHAPTER 4: FINDINGS



This chapter presents the findings from all 15 interviews under core themes, sub-themes and categories within them. Through the process of data analysis - as outlined in Chapter 3 - two core themes emerged: work context and practices and public perception and management of identity. A discussion of disclosure is weaved throughout the two core themes as a concept (rather than a standalone theme) and reflects its influence on practice education for all stakeholders involved. Table 7 provides a summary of the core themes and their respective sub-themes and categories. Appendix S provides an additional level of detail with descriptors and location of sub-themes and categories.

Prior to the presentation of the two themes, this chapter commences with a contextual description of acute versus non-acute environments. This is important in capturing the atmosphere of the work setting and illustrates the contrast between the two. In addition, there is a short description on the essence of on disclosure and the complexities inherent within the decision to disclose or not disclose.

Theme I relates to work context and practices and covers three key sub-themes including the environment, skills and roles and relationships.

Theme II relates to public perception and management of identity and covers three key sub-themes including public perception, management of identity and supporting student learning.

Table 7: Brief overview of key themes, sub-themes and categories

THEME I: WORK CONTEXT AND PRACTICES		
Environment <ul style="list-style-type: none"> • Speed / pace of work • Noise • Space <ul style="list-style-type: none"> - Space: community setting - Space: acute setting 	Skills <ul style="list-style-type: none"> • Multi-tasking • Information management <ul style="list-style-type: none"> - Technology - Note-writing - Processing - Verbal communication 	Roles & Relationships <ul style="list-style-type: none"> • Attitude: Practice educator <ul style="list-style-type: none"> - Role conflict • Attitude: Visiting tutor • Attitude: Student
<div>  DISCLOSURE  </div>		
THEME II: PUBLIC PERCEPTION AND MANAGEMENT OF IDENTITY		
Public Perception <ul style="list-style-type: none"> • Stigma • Disability: visible and non-visible • Disability type 	Management of Identity <ul style="list-style-type: none"> • Disability identity • Inclusivity • Awareness-raising 	Supporting Student Learning <ul style="list-style-type: none"> • Support: making contact • Support: learning • Support: adjustments

4.1 CONTEXT: EXPERIENCES

4.1.1 Experiences: acute hospital

For an academic definition of acute care (although not specifically in the context of a hospital setting but nonetheless still appropriate), I refer to a bulletin published by the World Health Organization, where the authors Hirshon *et al.* (2013:286) state: “Standard medical definitions for acuity emphasise the singular attribute of time pressure” (the authors attribute this part of the quote to Oxford Dictionaries Online). “Acute services therefore include all promotive, preventive, curative, rehabilitative or palliative actions, whether orientated towards individuals or populations, whose primary purpose is to improve health and whose effectiveness largely depends on time-sensitive and, frequently, rapid intervention” (Hirshon *et al.*, 2013:386). Furthermore; “As a clinical service, acute care responds to immediately life- or limb-threatening health conditions, regardless of their ultimate cause” (Hirshon *et al.*, 2013:387). The temporal aspect in acute care is emphasised in that “acute care is driven by a temporal element - i.e. responding to immediate threats to life or limb” (Hirshon *et al.*, 2013:387). Here, the sense of urgency is a key characteristic, and alongside that, rapid intervention. The temporal aspect is interesting as this determines the outward manifestation of behaviour related to speed and rapidity - such as working quickly, thinking quickly and a sense of hustle and bustle. Fitter (n.d.), an occupational therapist, provides a personal account on her Trust’s webpage of what it is like to work in an acute hospital setting:

In an acute setting there is rapid turnover of inpatient beds, so therapy is often undertaken within a short time. The rapidly changing environment means occupational therapy skills are used quickly and to their full in order to facilitate treatment pathways for individuals.

Following on from Fitter's description of working as an OT in the acute environment, I asked one of my students who had sustained an injury to their lower limb to write a brief account of her experiences of being on placement in an acute setting. Here is the student's account:

As a first year student who sustained an injury at the beginning of the school term that left me with limited movement, the idea of being in an acute setting at a stroke intensive rehabilitation ward frightened me to no end.

I vividly remember the first day stepping into the pristine germ-free hospital ward that had a faint smell of disinfectant. I was hyper aware of the beeping sounds of various machines and devices that were hooked up to each patient's bedside. In the common room, therapy groups were held all day with healthcare staff bustling about with their patients. Equipment such as 'Mo-Lift', RotaStand, hoist and similar equipment were being used on the ward by nursing staff.

I remember thinking to myself even though we were shown how to use some of the equipment at university, due to the limitations caused by my injury I was not comfortable about my abilities. I felt relieved that my educator and the entire team were understanding and supportive of me. They made sure to explain the importance of each of the actions they took and made allowances such as letting me 'voice out' the actions I would take in each appropriate situation. This helped me to achieve the goals set by my educator and myself despite my limitations. The very nature of working in an acute hospital setting means the work can be unpredictable, and requires an ability to be able to think 'on your feet', under pressure and at some speed.

4.1.2 Experiences: non-acute environments

In contrast to acute environments, the non-acute environment or healthcare in the community carries - in part - different practices, cultures and protocols. To help convey a sense of what it is like to work within the non-acute environment, I present the account of an occupational therapist:

“Community services are provided outside of hospitals in community settings, including in people’s homes and in community clinics. Community services have a number of objectives, including promoting health and healthy behaviours, supporting people to manage long-term conditions, and providing treatment in a person’s home or in the community to avoid hospital or residential care where possible” (Monitor, 2015: 12).

By the very emphasis of this definition, it can be seen that the essence of community care is to support people to remain in their own homes and avoid admission to hospital. In contrast to the urgent, rapid pace of an acute setting, with its high patient turnover, community services operate at a slower pace given both the logistics of community working (travel) and the often long-term nature of input. Community working allows professionals to establish greater rapport with patients and families as time can be afforded to more in-depth assessment and intervention.

The challenge of community services however lies in the nature of lone-working; in the face of an unexpected or unpredictable incident, professionals are required to respond immediately and appropriately often without the support of other professionals within the vicinity. In some respects, the sense of professional responsibility can be heightened in the community. Patients are not supported within a staffed healthcare setting – and with this comes complex risk management.

4.1.3 Experiences: disclosure

“To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where”

(Goffman:1963:53). Goffman’s seminal work on stigma so eloquently captures some of the dilemmas and inherent complexities that people with a stigmatised condition may face regarding the decision-making process related to disclosure.

Following recommendations from my placement coordinator, I made the decision to notify my educators about my condition in advance. This is something that I found quite difficult to do, but would really recommend any student to do the same. I’ve always been an actress when it comes to my health and always pretend that I’m fine even when I’m not. Throughout this academic year, I’ve learnt that nobody is superwoman and setting ridiculously high standards for yourself can be really detrimental. It was much easier on the first day of placement to walk in and know that your educator was already aware of the condition rather than keep pretending for 8 weeks.

The above piece is a personal account from a graduate therapist with a disability who contributed this piece to place on the School’s virtual learning portal to benefit other students with a disability. Whether a student discloses their disability or not is much written about in the wider literature and more specifically, referred to in the literature review chapter in the context of healthcare students with a disability on placement. For example Olney and Brockelman (2003), Price and Gale (2006), Sanderson-Mann and Mccandless (2006). A number of factors hinging on the decision to disclose is revealed in the findings and point to important implications for placement providers to be aware of in relation to this phenomenon. The decision to disclose or not to disclose is not as straightforward as it appears. I will keep returning to this issue of disclosure, as it related to the participants, in the rest of this chapter.

4.2 THEME I: WORK CONTEXT AND PRACTICES

The findings presented under this theme of work context and practices concern the placement experiences of the student with a disability with specific reference to the setting and its influence. Differing placement settings offer differing experiences for a wide range of reasons. Students are allocated to a range of placements throughout the duration of their programme: for example, an acute hospital setting as opposed to a non-acute hospital setting such as a slow-stream rehabilitative mental health setting with a slower pace of work or working in the community including visiting patients in their own homes. Within this theme, consideration is given to the specificities of any environment as an enabler. That is, attention is paid to the particular nature and elements of the work environment which facilitate or support the student with a disability towards developing competence in the requisite skills and knowledge during their practice education experience. Similarly, elements and practices of any environment that constrain student learning or are experienced as a barrier are also considered. Under the overarching first theme of work context and practices, four sub-themes are identified along with categories identified within each: specifically, Environment; Skills; Roles and relationships and Supporting student learning.

4.2.1 Environment

This theme covers the sub-themes of speed / pace of work; noise; and space - both within the community and the acute setting.

4.2.1.1 Speed / pace of work

This part of the findings will concentrate on the sense of speed and pace of work - from all four categories of research participants - and how in turn these can have implications for the learning experiences of students with disabilities.

To gain a sense of speed and pace of work within the acute setting, Mark (ST) illustrated the atmosphere of this setting when he said: "With the acute

hospital setting, particularly working with people with dementia, the atmosphere and work environment was intense, there is a lot to do work wise". In addition, Mark emphasised that: "The acute setting was very intense and busy therefore I had to work harder in this environment". Mark's comments help describe the hustle and bustle of activity; for example, staff milling about the work-place and being constantly busy with tasks to complete. In addition, a key word that Mark repeatedly honed in on was "intense" which would seem to imply working under pressure and in the context of a highly charged, dynamic and ever-changing environment.

Admittedly, working with people with dementia can present particular challenges particularly if the patient is presenting with multiple pathologies, for example, co-existing long-term conditions such as Parkinson's Disease, or if the patient has been admitted to hospital due to another acute condition. In addition, older people with dementia also have to contend with the challenges of the natural ageing process. If we examine this from a holistic perspective this incorporates natural, evolving changes - for example, biological, psychological, sociological and social - thus comprising a whole-body experience. If we just take one element as an example, reduced bone mass and muscle strength, this has the potential to impact on a person's mobility which will have a number of consequences such as not being able to get to the toilet. Being aware of the multiple consequence and implications when caring for patients with complex needs creates the intensity which Mark refers to - an intensity that encompasses care pressures, political pressures, emotional labour, coping with noise and multi-tasking. There is an added emphasis on discharge planning and the need for effective resource management, with pressure on staff to ensure sufficient bed capacity. Mark also said he had to work harder in the acute environment to compensate for his disability. This could be construed as reflecting the intense atmosphere and speed / pace of work in the acute setting. Dennis's (CLEL) statement concurs with that of Mark's regarding pace of work, multi-tasking and working with patients with complex needs: "The pace and complexity of work can be an issue plus working with patients with multiple conditions, this can be difficult if the student is only able to work on one thing

at a time”. Another student, Kerry (ST), said of the atmosphere on the ward where she was working: ‘the ward I was working on was very noisy, busy and fast’ thus reinforcing Mark’s assertion regarding the speed and pace of work in the acute setting. Kerry also said her practice educator in the acute setting bombarded her with information which she found to be overwhelming at times.

The speed and pace of work within the acute setting were commented on not only by students but also by visiting tutors, clinical learning environment leads and practice educators. In response to being asked what the impact is for practice educators having a student with a disability on placement, Peter (VT) said: “Pressure of work and time are huge factors. The responsibilities towards students with or without a disability should be similar. Perhaps for those with a disability more time is invested initially but then needs to taper off”. Note here that Peter advises on the need to ensure the student is supported initially but that this needs to be proportionate to their developing skill and knowledge accrued over the course of the placement duration. In other words, the support needs to be decreased to enable the practice educator to judge the student’s developing competence.

4.2.1.2 Noise

Noise as an imposition on student performance was mentioned earlier by Kerry (ST). The concept of noise as an imposition on student performance, particularly for those with dyslexia, was an interesting finding and perhaps not surprisingly so for the acute setting as background noise tends to be constant due to the vast space, echoing of sounds and sheer numbers of people moving around. Although there was no specific literature on the influence of noise in the context of my research, it seems appropriate to briefly refer to literature here to further an understanding of the link between noise and performance. According to Beattie, Lu and Manis (2011), people with dyslexia can experience difficulty in attending to visual or auditory signals and are unable to filter out extraneous information. This may help to explain why some students with dyslexia find the noisy environment in an

acute setting challenging. An opinion paper by Ahissar (2007:458) explains that people with dyslexia “fail to benefit from stimulus-specific repetitions. This deficit can account for phonological, working memory, visual and auditory difficulties, in addition to the greater sensitivity of dyslexics to external noise”. Furthermore, Ahissar (2007) uses an analogy of entering a noisy cafeteria - people with dyslexia may find it challenging to attend to the relevant stimuli such as the person who is talking to them. This resonates with the findings from some of the interviewees who found it difficult to concentrate in a noisy environment, as illustrated in the rest of this section.

Peter (VT) noted that in his experience students with dyslexia and dyspraxia can find it difficult to process information quickly, particularly within a noisy environment with the telephone ringing and patients calling out for the nurse. Mary (PE) also picked up on the implications of a noisy environment, saying:

The work environment presents challenges, for example noise. People with dyslexia can find it hard to maintain attention because of the noise levels. Actually, we can all experience problems in a noisy environment but this is amplified if someone has dyslexia. At my work place in the acute hospital setting, we had one office with 25 people. It's not the clinical environment that is challenging but it is the administrative setting for example not having your own office or the telephone going off and people interrupting you.

Some work environments have open-plan offices and a system of hot-desking which can be challenging for students with a disability who work better in quiet environments or perhaps need a particular set-up in terms of configuration of software and hardware elements in relation to computer use. Although Mary acknowledged that anyone can find a noisy environment challenging, in her experience this is amplified for someone with a dyslexia, which also means that, in turn, attention levels are compromised. Despite Mary's assertions, other interviewees have stressed that the ward environment is noisy too, not just the office environment.

Veronica (PE) had a student who was deaf and for whom it was difficult to follow what was being said in the multi-disciplinary team meeting as so many

people were talking and chipping in with information. Added to this, she said, there was a lot of background noise. Veronica also mentioned that as a practice educator she had to work harder on behalf of this student as she had to sit down with the student to work out how to adapt the meetings as the student was just not managing them at all. She asserted that the student was her responsibility so it was important to her to enable the student to seek some form of resolution in relation to their disability.

4.2.1.3 Space

Space was another factor identified which, for some students with a disability, impacted their performance on placement. Within this sub-theme, space in the community setting is contrasted with space in the acute setting. According to Peter (VT) who regularly visited an acute hospital where students are allocated placements, the sheer size of the acute hospital setting can make navigating a challenge for students, particularly if they have dyspraxia. Veronica (PE) reflected on her experience as a healthcare professional working in an acute hospital and said that the size of the place is a challenge in itself. Students with a physical disability become easily fatigued due to the amount of walking required: "In this setting you have to be able to keep up, things happen very quickly. There is a lot of walking upstairs and downstairs and walking along the corridors. In this setting the work is very physical". Veronica's statement really seems to capture the sense of constant physical movement, of urgency and unpredictability and that the healthcare professional needs to maintain a sense of constant readiness to be able to respond to events unfolding around them. The statement about things happening very quickly reflects the nature of working in an acute hospital setting as patient behaviour can be unpredictable due to the acute status of their health condition. In addition, staff are working fast to maintain capacity in respect of bed occupancy and patient discharge.

Veronica went on to say that you can make some allowances for the student with a disability. Here, she gives an example of using the lifts if a student with a disability is unable to use the stairs. This hints at the implication that

where the physical built environment cannot necessarily be changed for the student with a disability, the student needs to adapt. It could be construed that where the student is having to adapt their movements according to the physical space of the environment, perhaps the practice educator is also having to adapt their movements, alongside the student. Veronica's observations were corroborated by Mary (PE) who said in her experience fatigue is a significant problem for students who have a physical disability. For one student she had on placement, there were ten wards to cover in the acute setting which necessitated a significant amount of walking between the office and the wards. Mary explained that as she was team lead for a particular branch of medicine in the hospital, she was responsible for the therapy provision across ten wards. She herself worked specifically across two wards, but could be called to any of the ten to provide support, advice or sick/leave cover. The students usually worked her two wards with her, but would also come with her, if appropriate, at other times to cover the additional wards.

Lillian (ST) spoke about the paediatric setting and how this necessitated the need to get down to floor-level working with the child. Lillian's physical disability made this challenging. In addition, the impact of expectations of floor-level working for this particular student led to ongoing pain, resulting in fatigue which in turn impacted on her concentration levels. This is an interesting example of factors outside of Lillian's control in respect of the demands or expectations of a particular placement setting and how it is perhaps not always possible to accommodate the student's disability needs. Indeed, Lillian asserted in relation to this particular placement allocation in paediatrics that:

In paediatrics I knew that I had to be able to get down onto the floor in order to interact with the children. I just had to get on with it. The university had more or less said to me that if I can't get down onto the floor that I would not be able to do this placement.

The healthcare programme that Lillian was on meant that she could not avoid a placement in paediatrics as it was one of the key target groups for

this particular profession, thus she had no choice but to go ahead with this placement. In relation to employability prospects, students need to complete their practice placements in a range of differing health and social care settings thus demonstrating diversity of practice. Following my discussion with a member of faculty regarding Lillian's statement, I became aware that it is not essential to get down onto the floor as students may have mobility restrictions. Rather, they need to think about how to adapt their communication and general approach to compensate for not being able to get onto floor level. In other words, the student is taught, as part of placement preparation, to consider their therapeutic environment and to be aware of and identify enablers and barriers within the spatial arrangements and where they personally are situated in relation to the patient they are working with. This is interesting as Lillian's perspective of the placement expectations - getting down onto the floor - is not matched with that of the faculty member, thus creating a potential discrepancy in relation to expectations of the placement.

One student - Mark - did point out an advantage of the acute setting: being able to plan tasks for the day due to having a tangible, visual overview of all the patients on the ward and knowing what needed doing and when:

I liked the acute environment as I found that I could control my time better. For example, I could walk onto the ward and gain an overview of which patient was in which bed, I could observe what was going on and see the board where all the information was about the patient. This then helped me to manage and plan my time better. I could also take a quick break if I needed to.

Mark seemed to be saying that the spatial arrangement of the ward and the information board afforded him a sense of knowing where to find the right information and where to look to find the corresponding patient which seemed to help his mental map of the place. This in turn allowed him to feel in control of his time. If it all gets too much, he could take a quick break and this too helped him feel more in control of the situation. The last sentence in the quote above mentions the ability to take a quick break. This was also mentioned by another student, Lillian, who commented that: "The hospital

environment is much easier in that you can take breaks, staff naturally take breaks, it's an environmental thing". This same interviewee asserted that it was not so easy to take a break in the community when you are driving from one place to another and for Lillian, taking a break is important because of the consequences of her disability. The notion of "an environmental thing" in the context of the acute hospital setting is an interesting one and points to the culture and practices of the setting, and the norms in respect of human behaviour.

4.2.1.3.1 Space: community setting

The demands of the community setting necessitate significant amounts of driving, which imply a causal inference in relation to the impact on the student's disability. Lillian (ST) gave an example and said that the experience of a lot of driving for her led to pain and fatigue. She also said community working was very physical with lots of moving around, being constantly mobile, and driving from one patient's house to another to provide assessment and treatment. The culture of the community setting meant that Lillian could not take a break. This speaks of the behavioural or practice norms in this particular setting as opposed to the acute setting where it is easier to embed - from a logistical viewpoint - a break in the working day.

Aurelia (ST) found her community placement challenging from the perspective of her dyslexia as there was more to organise. For example, she cited the challenges of having to map read, driving to the patient's home and carrying lots of bits of paper around and not knowing what was for what. Working in the community can present additional challenges and highlights challenges from a spatial perspective. Aurelia (ST) revealed that she has both dyslexia and dyspraxia. For her, being dyspraxic meant that she had always been clumsy and had a tendency to trip over her feet if she is walking down a corridor. Aurelia explained that she noticed the dyspraxia more in her mobility than in her upper limbs: for example, fine motor movements although she cannot draw a straight line freehand without using a straight-edged implement. For Aurelia, she felt her dyspraxia did not have a

significant impact on her performance during placements, she said she just had to plan her movements a bit more. For example, with moving and handling patients she tended to get her right and left muddled on occasion. Right and left discrimination is characteristic of people who have dyspraxia.

4.2.1.3.2 Space: acute setting

Veronica (PE) felt that from her perspective, the acute setting is not at all inclusive: for example, the background noise was difficult for a hearing-impaired student she had and for another student with a physical disability, the amount of physical space to cover was challenging. In addition, she emphasised that the nature of the work is incredibly physical in respect of the amount of geographical space to cover in the acute hospital setting. As well, the physical aspect pertains to the energy expended during tasks including moving from patient to patient, assisting patients with washing and dressing and moving and handling. In contrast to Veronica, Mark (ST) felt that the work environment from his perspective is inclusive. He said that he was good at finding a quiet environment (space) as he needs this in order to write up patient notes as he cannot write and be distracted simultaneously.

4.2.2 Skills

This sub-theme covers a number of key skills identified by research participants that students with a disability may find challenging during their practice education experience. These include multi-tasking and information management, the latter of which covers technology, note-writing, processing and verbal communication.

4.2.2.1 Multi-tasking

The MSK (musculoskeletal) outpatient setting warrants particular mention in respect of speed / pace of work and was mentioned by a number of

interviewees in relation to the consequences it had on performance not only for the student with a disability but also for the practice educator supervising the student. The context and atmosphere of the MSK setting were captured by Jim (CLEL) who remarked:

In MSK there is a high number of patient throughput and extra time is tricky as you have to have time to write up notes, the process of clinical reasoning is a lot faster. Waiting lists are a big driver, particularly in MSK.

The sense of speed and pace of work is apparent in addition to the time element. Jim's view was echoed by Mark (ST) who said:

The appointments are time controlled usually 20-30 minutes. You can't afford to overrun as if you do you have patients waiting in the waiting room for their appointments and that stressed me out. You need to be quick and fast paced in MSK.

Here, the sense of urgency is conveyed, potentially a lot to do in a short space of time and a stressful environment in which to work. A particular feature of working in the MSK setting is described by Jim in relation to the culture of the work-place. The precedent, so to speak, is set in terms of expectations from clinical commissioning groups, management and patients attending the clinic. In the MSK setting, students often have to work against the pressure of external drivers such as waiting lists and keeping a high turnover of patients. They must also learn to multi-task in relation to actively listening to patients, whilst inputting to the patient notes, within the constraints of whichever information technology (IT) system the placement provider uses to manage patient records. This has the potential to cause enormous pressures for the student in question and may impact upon many elements of their performance, including rapport-building with patients, note-taking, data entry on the IT system, clinical reasoning, time management and prioritisation. This is all whilst continually being assessed by their practice educator.

Jim (CLEL) mentioned clinical reasoning. Clinical reasoning is one of a number of vital skills that students must learn and acquire to become a

qualified healthcare professional. It comprises the ability to be able to apply theoretical frameworks to underpin practice and involves cognitive processes including prospective (anticipatory), spective (in the moment) and retrospective (looking back) reflection (Fade, n.d.). Clinical reasoning permeates all aspects of the placement experience in addition to occurring during the face-to-face interaction with the patient and articulated through the process of patient documentation. Clinical reasoning is notorious for being challenging for any student to acquire and takes time to accomplish as it is a complex skill to enact, in part due to the need to articulate academic knowledge to justify thinking and actions. Some students may be fearful of coming out with the wrong information and being ridiculed by members of the multi-disciplinary team. In addition, students may be forgetful or unable to call on latent knowledge learnt during their time at university. For some students, the additional challenge of having a disability and the need to process information at speed is no easy matter.

Mark (ST) said of his experience in MSK: “it was challenging having to listen to the patient and write at the same time, it is difficult to do and initially I lacked in confidence”. This concerns the challenge of multi-tasking, completing more than one task simultaneously. On the face of it, this perhaps appears relatively simple to enact. However, if one listens to what Mark is saying, it would appear reasonable to assume that from a patient perspective, their expectation is the healthcare professional is listening to their ‘story’ and the information yielded will be retained / recorded in some format for subsequent reference. This is an example of what would appear to be a relatively innocuous skill, but in reality, demands a high level of skill as it draws upon all six domains that are formally assessed by practice educators - safety, professionalism, clinical reasoning, client management, interpersonal skills and information management.

Other students spoke in a similar vein to Mark about the challenges of multi-tasking in respect of their disability, particularly dyslexia. Gillian (ST) recounted her experience in relation to the challenges of multi-tasking:

In the acute setting I found it difficult to read the patient's notes then retain the information before going to conduct the initial assessment on the patient. It was challenging, having to read and remember the type of stroke the patient has had, their medical history and current status and so on. I got better with practice though with practice things do improve.

Gillian pointed out that with time and practice it is possible to improve. This is critical in relation to the learning process as well as acknowledging the pressurising conditions under which students are having to learn. The importance of dealing with information in the acute setting is prevalent here, having to read and assimilate information and to be able to retain that information as context-setting in preparation for the initial meeting with the patient.

4.2.2.2 Information management

It is pertinent to note that irrespective of the placement setting, a significant challenge identified by a number of interviewees pertained to information management, specifically patient documentation and the reliance on technology. As a skill, information management is woven throughout the practice placement experience, students are often overwhelmed with the amount of incoming data, both verbal and written, that they need to assimilate and potentially act on. For some students with a disability, information management is a key area presenting challenges for a number of reasons. This section covers: information: technology; information: note-writing; information: processing; and information: verbal communication.

4.2.2.2.1 Information: technology

Sharon said that IT access is crucial for placement. Of particular note is one student - Nancy (ST) - who has dyslexia. In relation to a placement in an in-patient hospital setting and not having access to a computer and having to handwrite for patient documentation, Nancy asserted: "This placement setting did not allow me to demonstrate my strengths, the things I am actually good at". Nancy therefore found this problematic as there was no

computer, the notes had to be hand-written therefore she did not have access to Word functions such as spell checker. She described how frustrating this was as feedback from her practice educator indicated she was struggling. Nancy's experiences hint at the reliance on technology to enable achievement of goals within the assessed area of information management. Computer access can help with patient documentation but needs to be a flexible system that permits editing of information. The question as to how user-friendly the current patient information systems are within the health service warrants further exploration - does the system cater for the varying needs of healthcare staff using them? Indeed, Jim (CLEL) argued that "IT is a major factor". Participation in this activity is potentially challenging for some students who have dyslexia as some IT systems such as 'SystmOne' have standard in-built mechanisms which allow for little variation and reconfiguration to meet individual user needs; for example, the background and layout cannot be changed, nor is there a spell checker / editing function. Consequently, this means it can be difficult to conform to the respective Trust-wide service standards.

Similarly, Kerry (ST) also talked about the frustrations of electronic means of patient documentation. For example, SystmOne, the facility to auto correct data entry was not available, she said:

On two of my placements I had to write the notes up on an electronic system. In one setting, I typed it onto Word then transferred it onto the electronic system. On another placement however, I had to type straight onto the electronic system. I prefer being able to transfer the information as this means I am more confident because I can edit it without any problems because it is not going straight onto the database.

Andrea (VT) stated that in her experience patient documentation is a challenging area for students with a disability, particularly in the out-patient setting due to time pressures and waiting lists. Although one student used Dragon Dictate software - this was beneficial according to Andrea - but also presented some challenges in respect of the compatibility and logistics of bringing in 'alien' technology into the work-place in addition to considerations

for confidentiality. Andrea also reflected on a student who used a dictaphone to assist with patient documentation thus recording the results of a verbal consultation whilst with a patient. Whilst this was helpful in one respect, the impact meant the student had to stay late to write up the notes as it was time-consuming having to listen to the recording again. Key here is the impact on time as the practice educator also had to stay late to supervise the student. This would appear to be a classic example of solving one challenge (for example, gleaning information about the patient via a dictaphone to enable the notes to be documented) but potentially creating another in respect of the process being time-consuming due to listening to the recording post-patient interview.

4.2.2.2.2 Information: note-writing

Kerry (ST), who has dyslexia said:

I found note writing challenging. The ward I was working on was very noisy, busy and fast. You have to be able to write up the notes, correctly, in a fast-paced environment. The process takes longer for me, my take on it is that I have a job to do and I have to just get on with it.

Note-writing appeared to be all the more challenging for Kerry as she experienced difficulties with sequencing and short-term memory. She mentioned the environmental setting as being very noisy, busy and fast and the importance of correct documentation regarding patient interventions. Kerry's experience hints at the importance of being aware that if the environmental conditions are conducive in terms of meeting the student's needs, in addition to the employment of the right strategies being in place, then it should be easier for the student to manage their disability. This in turn may enable the student to feel more confident in the mastery of a particular skill such as, in this case, patient documentation. What is also important to note in Kerry's interview is how pragmatic she appears to be when she stated she has a job to do and she has to just get on with it.

Claire (ST) too experienced challenges with note-taking and stated that if she does not have pen and paper to hand she simply cannot retain information such as what points she needs to action, contact details of the person she was talking to and so on. She has dyslexia and experienced difficulty with short-term memory and retaining information. Claire said it worried her that she may miss information and it will be her fault if she forgets something. Patient care, she said, is her responsibility. The speed of information processing and exchange of information within healthcare settings is phenomenal and contending with parallel, often unpredictable situations is challenging. Claire said she found new environments overwhelming and subsequently had to repeatedly ask questions of her practice educator and others as she could not always retain information. Claire also found writing patient notes challenging due to her poor spelling and scruffy handwriting, and worried that others may not understand what she had written. It is pertinent to note she also felt embarrassed by this admission.

4.2.2.2.3 Information: processing

Mark (ST) attributed the challenge of processing information down to his short-term memory, slow reading and writing speed because of his dyslexia. He described how, as a consequence of his disability, it was challenging when having to read patient notes. He noticed his practice educators were able to do this quickly in relation to assimilating information at speed. His exact words were that they were able to “skim read”. What is pertinent to note is Mark said he got better with practice, and that he viewed the practice educator as setting the standard for the level of skill that he aspired to, skim reading at speed. He cautioned it takes time to get used to new things such as IT systems on placement. This is important for practice educators to remember, that repetition and practice are important to enable the student to acquire the requisite skill to enable them to perform effectively on placement. Gillian (ST) also said with practice she got better at reading the patient's notes to gain contextual information and background and then retaining that information whilst providing interventions for the patient. Aurelia (ST), who has dyslexia and dyspraxia spoke at length about the challenges of her

disability. With the dyslexia, she struggled with phonics and reading and understanding, she said she could not always translate the written work nor understand it.

Sharon (ST), who has dyslexia in addition to another long-term health condition, said that she found organisation a challenge because she fatigues easily and having to take in so much information on placement is tiring in itself. Sharon went on to say that she had to work harder to compensate for her disability. Claire (ST) also cited a similar experience to Sharon and said:

I find new environments overwhelming, I don't know where things are or what their processes or ways of working are so I have to ask lots of questions, sometimes repeatedly as I cannot always retain information. All my practice educators noticed that I kept repeating the question.

Claire's experience serves as a reminder of what it is like to be thrown into an unfamiliar environment and the consequent search for a foothold to enable the process of familiarisation. On the theme of differing environments, Mark (ST) recalled his experience of working in paediatrics. He preferred this setting as he felt he had more time to observe children and to write up the results of their assessment and interventions. He also felt the same applied to community placements where he was less rushed and had more time to write up notes. Kerry (ST) also spoke about finding the community setting easier and explained she found her rapport with patients was at times compromised as she strove to process the incoming information. She described feeling like a nuisance at times; it impacted her confidence levels and it took longer to enact this skill. For Kerry, she found she could hide her disability in the community setting due to the slower pace of work. Kerry's experience is an interesting one and suggests the idea of 'being on show' or being more exposed in the acute setting as you are surrounded by more people therefore, as a consequence, more visible as a person as others can potentially hear and see what you are doing. This may help to explain why Kerry felt more in control of her disability and more comfortable with aspects of her community placement as opposed to her

acute one. In addition, Peter (VT) asserted that the community setting is easier for some students with a disability to manage as the environment tends to be quiet in addition to a reduced number of persons being present.

4.2.2.2.4 Information: verbal communication

It is useful at this point to reflect on what the purpose of a ward round or multi-disciplinary team meeting is and to gain some insight into why participation in a ward round tends to raise anxiety levels for students including those with a disability. A document entitled *Ward Rounds in Medicine* stated: “Medical ward rounds are complex clinical activities, critical to providing high-quality, safe care for patients in a timely, relevant manner” (Royal College of Physicians and Royal College of Nursing, 2012:1). This extract provides an interesting insight into the importance of ward rounds and how essential they are as a means of information exchange concerning patients. Decision-making is also critical and more so the need to do this on the spot.

The rapid exchange of information during the multi-disciplinary team meeting was considered to be challenging with one student recounting the experience as confusing as they were not always aware which patient was being talked about. Gillian (ST) spoke about initially adopting an avoidance tactic as she did not volunteer to write up the notes following ward rounds and morning handover as the high turnover of patients coupled with the rapid exchange of information was challenging. Paradoxically, however, Gillian said that despite the inherent challenges she liked the fast pace of work. Nancy (ST), who has dyslexia, said that the consequences of the fast pace of work had implications:

The multi-disciplinary team meetings were so fast paced, it was difficult for me to process information and to articulate my clinical reasoning. I tend to slur my words sometimes too so I was conscious of this happening because of the fast pace.

Similarly, Peter (VT) remarked that:

For those with dyslexia and dyspraxia, students can find it difficult to process information quickly, also in ward rounds, with a large team, it can be more challenging to have to listen, write notes and prioritise. Usually the information is delivered very quickly, running down the list, with the patient's name, date of birth, diagnosis and so on.

Here, we get the sense of a dynamic team meeting, a large number of qualified healthcare professionals in attendance, all seated round in a circle, the clock is ticking and everything is happening very quickly. Everyone is having to listen to whomever is speaking, the information is individually processed and then written down. You then have to prioritise the information, work out which patients you need to see first and what tasks you need to complete and in which order. Again, time and speed are of the essence as is accuracy of processing the information from the ward round as this will in turn inform subsequent actions to take with patients. Peter also went on to state that the size of the healthcare team dictates how inclusive the working environment is and that perhaps smaller teams tend to be easier for the student to manage in respect of verbal and non-verbal communication.

For Claire (ST), who also has dyslexia, the pressure of work had implications with regard to her experiences. She explained:

I am not good at working under pressure. If I am in a multi-disciplinary team meeting or talking to the family of a patient, I know the information, I know what I want to articulate but I go blank, I freeze. This happens in other areas of my life too though for example doing presentations here at university. The practice educator noticed this happening on one placement and saw that I was becoming flustered, so came over to assist me when talking to family members or other staff on the ward.

Nancy and Claire's experiences in respect of word slurring and freezing illustrate examples of their disability being visibly manifested in their behaviour and how easy it is for the student to potentially commence a journey on a downward spiral, thus impacting on confidence levels. Similar

to Nancy and Claire's experiences, Mark (ST) experienced challenges to information management and said he found he was sometimes mixing patients up as he had bits of information about all the patients but found it hard at times to relate the right bit of information to the right patient. He also experienced confusion with the multi-disciplinary teams as he was not always aware which patient they were talking about.

At this point in the findings, it is useful to summarise the sections on environment and skills given that they are closely intertwined. Key issues identified within the environment arising from the findings covered speed / pace of work, noise and space. Two key skills identified from the interviews were multi-tasking and information management. Over the course of the placement duration it is expected that students will gradually acquire and be at a level commensurate with the cultural norms of the setting in relation to the speed and pace of work and be able to complete tasks in a timely manner. Acknowledgement needs to be made that students need time to acquire the requisite knowledge, skills and attitudes to demonstrate competence to meet the placement learning outcomes. Andrea (VT) pointed out the importance of considering the stage of practice education reached where the demands and expectations of the student's performance will increase in complexity with the later placements. She spoke about the difference in performance demands and expectations in an out-patient setting between a year 1 and year 3 student, with the year 3 student being expected to meet not only complex learning outcomes but also doing so within a work culture where time pressures are paramount. This hints at the importance of ensuring that with each placement, the student's learning is appropriately facilitated and supported by the practice educator, and more so, pitched at the right level according to the stage of practice education reached. Andrea (VT) emphasised that the acute setting is challenging and that time is of the essence; she said that there is not so much time to communicate in this setting. Time is also a critical factor for the practice educator according to Andrea. The key points arising up to this point of the findings in relation to environment and skills appear to be particularly significant within the acute hospital setting and point to some interesting

findings particularly for students with dyslexia. This environment presents challenges not only due to the fast pace of the work but also due to the need to process information at speed. Time presents as a factor in driving the need to work quickly and this is succinctly summed up by Keith (CLEL) who stated “within the acute setting, it is all about the pressure of time”.

4.2.3 Roles and Relationships

Key here is a consideration of the influence of roles and relationships and how these in turn can impact upon the effective facilitation of support mechanisms and access to resources to support student learning during their practice education experience. The relationship between student and practice educator was mentioned by all interviewees and captures the importance of this as an integral part of practice education. Both student and practice educator are key players in respect of the practice education experience. There is a potentially intensive working relationship that may at times be fraught with tension due to the extra considerations to be borne in mind because of the student’s disability. The interplay of dynamics in the student-practice educator relationship is dependent upon a number of factors which will be explored within this section, including attitudes of the practice educator (and role conflict), visiting tutor and student.

4.2.3.1 Attitude: practice educator

According to all the students interviewed in this study, perspectives as to whether their practice educator adopted a positive attitude was variable. Mark (ST) cautioned that the relationship between student and educator is key and that the student needs to work out how to get on with their practice educator. Keith (CLEL) stated he has a disability himself and therefore feels able to empathise with students as he has knowledge of practice education from a student perspective. This potentially gives him an insider perspective and can be helpful as the level of understanding in what the student is experiencing is a powerful means of empathy. Without understanding and knowledge of what the student is going through, it is all too easy to make ill-

informed assumptions thus causing frustration for the student. In the case of Gillian (ST), her educator claimed to know someone who had dyslexia, and presumably some understanding of what it entailed, yet the practice educator had assumed Gillian could not read or write.

Indeed, Keith (CLEL) mentioned the act of disclosure can be a difficult thing to do and a supportive environment is required to facilitate disclosure. Despite this, Jim (CLEL) cautioned that “sometimes students feel scared letting you know about your disability”. This reinforces the importance of practice educators getting to know their student and, where appropriate, to provide the right conditions to enable the student to disclose - if they wish - without fear of repercussions.

Mary (PE) demonstrated pragmatism and forward-thinking when she spoke about the workforce and the need to support the student with a disability:

Exposure is important, if I have a colleague who is a new practice educator, I would not think, I can't allocate the student with a disability to that educator, they have to learn and the sooner the better. The practice educator can always get support from a more experienced educator and the university.

There is a sense here that Mary would not hesitate to allocate a student with a disability to staff who are new to practice education; she feels that exposure in relation to the experience of learning how to facilitate and support student learning - for those with a disability - is important and the sooner this happens the better. In essence, staff need to learn to work alongside students who have a disability. Furthermore, another interesting statement from Mary was:

I don't believe in complex patients. We always have a debate about this in my workplace. It's not that the patient is complex, it's about the skill of the therapist in unravelling or unpicking what their needs are. If I can't do it then it's up to me to refer the patient on to someone who can.

Although Mary is referring to patients in her quote above, she also said it was important not to view the student as a problem and remarked:

Having a student on placement enables you to revisit your own learning needs and raises your clinical reasoning to a conscious level. Help the student focus their learning, the student who has a disability is just another aspect, it's an exciting opportunity.

Mary appeared to be getting the point across that it is important to generate a culture where people, in society at large, including students with a disability are welcomed. This seems to infer the importance of getting to know the student and understanding their disability and how this may impact on their performance. Without that level of understanding on the part of the practice educator, their assessment of the student may be wrongly clouded. Mary also pointed out the benefit to the practice educator in having a student with a disability on placement, thus inferring that it need not be seen as burdensome.

4.2.3.1.1 Role conflict

The notion of therapist versus practice educator role is described in a narrative written by Sivanesen (2003) and in a study by Hinerth and Mackenzie (2004), all of whom write about the dual role that some practice educators find themselves in when they have a student with a disability on placement. Keith (CLEL) stated:

I would be worried if the therapist role was not coming out. I am a caring person by nature and I would have elements of the therapist role coming out for example, using counselling type techniques with the student if appropriate. Adopting the role of therapist is part of the process of supporting the student.

Dennis (CLEL) eloquently captures the challenges that practice educators may experience in relation to working with the student who has a disability:

Practice educators are not good at being objective. They struggle. You need to consider whether they get on well with the student, do

they like the student? If response is 'no' then they are going to struggle to assess the student. It is about developing appropriate professional relationships, this can be a problem. Are elements of the therapist role coming out, yes, with patients as you go through elements of the occupational therapy process with them. Good practice educators are able to apply elements of the occupational therapy process with the student. Practice educators need to work hard at their objectivity. Relating their work with the student to the learning contract and objectives, using the supervision process to review the student's performance. The practice educator can struggle to raise issues, they may be afraid of upsetting the student, however, they need to remain objective.

We can see from this scenario that the sense of maintaining objectivity on the part of the practice educator is important but not necessarily an easy thing to do. As mentioned earlier, the relationship between practice educator and student can sometimes be intense as they potentially spend considerable time working together in a highly pressurised environment for the placement duration. Dennis's point about maintaining a professional relationship is important as this helps maintain objectivity. Tools such as the learning contract and the supervisory process are important mechanisms in supporting the student and reviewing their performance, and both tools are used collaboratively between student and practice educator. The learning contract is a structured document enabling the student to identify their personal learning objectives which in turn feeds into achievement of the set placement learning outcomes. Construction of the contract identifies strategies and resources required to achieve the objectives in addition to a consideration of how they will be evidenced. The supervisory process is both formal and informal with formal supervision occurring for one hour per week of the placement duration. Supervision affords the opportunity for the student to reflect on the progression and development of knowledge, skills and attitudes acquired on placement and to receive feedback on their performance. The point about raising issues requires a modicum of sensitivity and Mark (ST) also made this same point about the practice educator needing to exercise sensitivity towards the student. Peter (VT) had a similar perspective to Dennis (CLEL) and said that he had never experienced the therapist role coming out. In his opinion this is not viable

because otherwise the student would pass the placement and the assessment process would not be rendered fair or objective.

The theme of therapist / practice educator role is continued by Mary (PE) who said there are commonalities between the two roles in working with patient / student in that the skills of identifying problems and solutions have some parallels. She asserted although it is her responsibility as practice educator to provide the learning opportunities, the student needs to do the work. This hints at the importance of ensuring the student is absorbed into the work-place team and culture and at the same time, it is helpful if they are open and honest about their disability as in turn this helps the practice educator to be more efficient in supporting their needs. Mary also voiced a sense of equality when she asserted that she views the student with a disability as a temporary member of the team. They are part of her staff group, she said, therefore she will make reasonable adjustments for them as well as her own staff.

Veronica (PE) also spoke about the therapist / practice educator role and said that when working with a student with a disability elements of the therapist role come out, particularly in the acute hospital setting as it can be a daunting environment in which to work. She cautioned, however, that there are advantages and disadvantages to bringing out the therapist role but it is important not to overprotect the student. Veronica went on to say if the student is struggling, sometimes you have to allow them to struggle to enable them to fulfil their potential. Here, it would seem that it is vital for the practice educator to get the balance right in implementing reasonable adjustments but in a manner that does not unnecessarily overprotect the student. The part about allowing the student to struggle is interesting and perhaps more about permitting the student to take 'risks' and to learn from their mistakes so that they can develop coping strategies to enable mastery of a particular task or skill. An example of a practice educator utilising their therapist role was furnished by Mary (PE) who had a student with a brain injury on placement. She said: "It was unfortunate that I had to adopt more of a therapist role towards the student as when they became fatigued their limbs would not

function properly". Here, the practice educator was in the position of having to straighten out the student's limbs thus adopting a therapist role.

An important part of the student-practice educator relationship concerns the visiting tutor, who plays an important part in mediating - where appropriate - between the student and practice educator, particularly at the interim stage of the practice education experience.

4.2.3.2 Attitude: visiting tutor

Sharon (ST) stated the visiting tutor needs to be not only understanding but also aware of context of the setting that the student is in and what the student is doing in their work. This is an important message as key here is an understanding of the situation that the student is in and how their disability may be impacting on their performance. Furthermore, Claire (ST) spoke about the need for the visiting tutor to be on the student's side. Poignantly, Claire said:

The visiting tutor needs to be on my side and to be understanding of any struggles the student may be encountering. Placements can be a lonely place to fight on my own if I am struggling. The visiting tutor needs to listen to the student and help to find a solution, to mediate with the practice educator.

Claire's statement emphasises the importance of ensuring that appropriate strategies and coping mechanisms are put into place to support the student with a disability, otherwise the challenges they encounter can be magnified out of all proportion. As well, the importance of support from the practice educator and visiting tutor is critical too.

Placements can be a stressful experience for both student and practice educator so the mediation role of the visiting tutor is a critical one requiring sensitivity in approach. Kerry (ST) cautioned though that the visiting tutor should not assume that if the student is struggling this is attributable to their

disability. Effective communication with and understanding of the student on the part of the visiting tutor therefore are paramount. Gillian (ST) felt the visiting tutor should ask the student if they are experiencing any challenges but not to focus on the disability nor to make a big thing of it but instead, she said, the emphasis should be on the actual placement and the student's experiences rather than their disability.

Peter (VT) spoke about the importance of knowing what the student's medical or healthcare background is, as he (Peter) once received communication from the practice educator querying why he did not know about the student's disability and this was consequently embarrassing for him. He also stated that "dyslexia is easy" meaning it tends to be straightforward in relation to understanding the implications and implementing strategies. However, he warned that students may have more than just dyslexia so it is important to be aware of what their needs are. Peter stated that the visiting tutor form is an important record for visiting tutors to refer to particularly if the student does have a disability. Although Andrea (VT) found the visiting tutor form important she asserted it will not always inform her if the student has a disability. Therefore, she says, it is important to ask the student if there is anything they want to talk about in particular or if they are struggling. You have to be explicit with the student, according to Andrea, in order to ensure you have given them the opportunity to say if they are struggling. This is an example where the visiting tutor has to rely on the student being honest if they are having any difficulties or if they have a disability that the visiting tutor is unaware of. Andrea emphasised the fact that it may not only be the student with a disability that requires support but also the practice educator may too. Interestingly, the importance of the student taking responsibility for their disability needs was highlighted by a number of students, including Aurelia (ST), who said that the student needs to initiate this when liaising with the visiting tutor if this is having a detrimental impact on their performance. Having considered the role of the practice educator and the impact for them of having a student with a disability, in addition to the role of the visiting tutor, key here is the tripartite relationship between the visiting tutor, the practice educator and the student. This was

referred to by both Keith and Dennis (CLELs) and potentially highlights the need for an explicit framework to illustrate the dynamic, interwoven relationship between all three.

4.2.3.3 Attitude: student

Personal attributes referring to the characteristic traits of students with a disability were highlighted as part of their identity. Of particular note was the determination of students with a disability in relation to their 'can do' attitude. This was illustrated repeatedly throughout most of the interviews conducted with students. An example was Lillian (ST) who asserted "I can do it" and, "I just had to get on with it" in relation to being able to implement floor-level working required for participation on a paediatric placement. Responsibility for the person's disability comes into play and Claire (ST) said it is her disability and her responsibility. Similarly, Kerry (ST) stated in respect of her dyslexia and writing up notes in the acute setting: "my take on it is that I have a job to do and I have to just get on with it". Kerry (ST) asserted that for her, in getting on with the job and doing things for herself, she found she cannot always make allowances for her disability: "I find that you can't always make allowances for your disability, I have to get on with it and do things for myself". This hints at this particular student adopting a 'get on with it' approach and being prepared to be realistic and compromise, not wanting to be seen (even to herself) as hiding behind her disability. Having said that, it is important to acknowledge that it is not always so straightforward for a student to adopt this approach as this will be dependent on many variables - for example, the extent of the disability, the student's existing coping strategies and effectiveness of these.

Some resolutions were identified as being part of the student's personal attributes. This included being organised - for Lillian, being organised was important to enable her to work around the physical pain as a result of her disability. Mark (ST) also spoke about being organised and that he has "to go over and over and over information in order to process it". It could be construed that being organised is an important attribute for managing the

consequence of having a disability. Sharon (ST) asserted she finds the skill of being organised challenging yet she uses a diary to help her achieve this.

In addition to being organised, some interviewees agreed that students with a disability have to work harder in order to compensate for their disability. Mark said that “working harder and longer (hours) is partly due to the dyslexia”. Sharon also spoke about having to work harder to compensate for her dyslexia and Jim (CLEL) too said this is true of students with a disability and that there is always an extra layer of things to do. Keith (CLEL) also subscribed to the notion of working harder if you have a disability. In addition he said for him personally, when he was a student with a disability, he did not realise the impact it would have on his performance such as taking longer to read and write up notes. This is he suspects, the same for students. This may indicate the need to implement appropriate strategies to mitigate the consequence of the disability or indeed to revise existing strategies if they appear not to be working. When asked if she felt that students have to work harder because of their disability, Mary (PE) responded by saying it depends upon the coping strategies that students utilise and whether these have been shared with the practice educator. Peter (VT) shared the same view as Mary and added, students have to adapt their way of working.

Both Kerry and Sharon said that students who have a disability need to be motivated to take responsibility for their learning needs. Kerry also said students need to be resilient. Given that the placement education experience is demanding and energy-sapping, more so perhaps for students with a disability, this is an important message regarding motivation and resilience as part of personal attributes for a student to embody. Kerry spoke about awareness, the need for the student to be aware if they need help or extra support and to seek that if required. She also spoke about the need for the student to be in control.

Gillian (ST) advised it was important for the student to know their own strategies and to be aware that people learn in different ways. Gillian also said it was important for students to prepare thoroughly for placements as it

helps with absorption of information. For example, completing preparatory reading so that the student is not necessarily encountering all new learning or information on placement for the first time. Gillian spoke about the importance of the student being proactive in asking for help and that sometimes she thinks that students hold back from this if they feel they are being judged by the practice educator. Gillian said: "I am secure in my disability, I know my coping strategies and I have no hesitation in asking for help if I need it". Obviously not all students with a disability are in this seemingly privileged position of being sufficiently self-aware about their disability and how this is managed. Sometimes, this process may evolve gradually as a form of awakening, for with experience the student becomes more secure in their disability and how they manage it.

Nancy (ST) described the in-patient setting as being "medical" and "rigid" in terms of the need to adhere to protocols. It was more of a tick-box approach, she said, therefore not exploiting her creative abilities. She said:

People say that those who have dyslexia tend to be strong on being creative. With two of my placements I was able to exploit this for example visiting someone in their own home, I am very visual so I was able to problem solve and think creatively as to how the home environment could be adapted.

Here, Nancy described how visual and creative she was. Ahissar (2007:464) suggests that people with dyslexia have the potential to be innovative and creative as "our perception is gradually tuned to hear and see what has already been presented". This same author goes on to say that "When such memory mechanisms are impaired, our expectations are less accurate yet at the same time might enable the detection of a broader range of stimuli, particularly those which are new and yet not too salient" (Ahissar, 2007:464).

Caution needs to be exercised here in asking the question, does a medical setting presuppose rigidity therefore it is not so flexible in allowing reasonable adjustments? Nancy's comment about the rigidity of the work is a reference to the fact that healthcare professionals work according to

standard protocols. An example is assessing a patient using a standard initial interview template to find out about the patient's functional abilities or perhaps having to adhere to certain criteria which dictate whether you carry out a home visit with the patient or instead assess the patient in the ward setting. The above scenario described a situation where the student's potential may not be fully realised in certain settings and an awareness on her part as to the reason why. Self-awareness or insight is an important attribute in that the student's innate ability in respect of knowing oneself affords them the opportunity to reflect on the consequences of their disability and how this might impact on their performance. This also describes a situation where the student is not enabled to exploit some aspects of their disability which are in fact a benefit, that is, her attributes in respect of her creative ability. This scenario hints at a state of critical consciousness on the part of the student with a disability. The need to know where one is situated in relation to wider society is important, in addition, being self-aware of the consequences of one's disability in the working environment is also key.

Referring back to Nancy's statement about demonstrating her strengths, this is critical and Dennis (CLEL) advised that it is important to view the student as a whole, not to single them out because of their disability. Dennis emphasised that practice educators need to acknowledge and recognise their students' strengths as well as weaknesses but that the former is more important. He also spoke about students being on a continuum, a visual representation of things they are good at and things they are not so good at. The practice educator needs to exercise skill in assessing where students are 'at' in relation to that continuum and intervene accordingly. Dennis appeared to be recognising that practice educators need to take into account both student strengths and weaknesses but to be aware a balance needs to be sought between the two.

The findings from this theme of work context and practices reveal that, in essence, no particular placement provider setting appears to be better or worse than another, students have differing abilities and needs and these are contextual in that the influence of the environment (placement provider

setting) will have some bearing upon the student's experience of practice education. For example, some participants seem to take the view of the medical model of disability in that they view the student with a disability as an additional burden or problem because of the way the disability is assumed to be purely 'resident' in the body of the student. In the next chapter I will discuss the problems that arise when this view is subscribed to, rather than a focus on how the disability may be the result of a social construction, where impairment may be particularly exacerbated by the acute hospital environment. This theme has also been instrumental in capturing the influence of attitudes within the tripartite relationship between student, practice educator and visiting tutor.

4.3 THEME II: PUBLIC PERCEPTION AND MANAGEMENT OF IDENTITY

The general culture invalidates me both by ignoring me and by its particular representations of disability. Disabled people are missing from mainstream culture. When we do appear, it is in specialised forms — from charity telethons to plays about an individual struck down by tragedy — which impose the non-disabled world's definitions on us and our experience [Morris, 1991].

The above quote by Jenny Morris, a disabled activist may, at first reading, appear somewhat outdated but looked at more closely, this is about representations of disability and how non-disabled people potentially impose a definition of disability onto those who have a disability. As a society, it is interesting to question how far we have progressed in relation to promoting inclusivity to enable better participation of disabled people in everyday walks of life. Notions of inclusivity from an environmental perspective were touched on earlier in this chapter particularly in respect of the acute hospital environment. This second theme comprises a number of sub-themes and categories including public perception - stigma, disability: visible and invisible, disability type; and management of identity - disability identity, inclusivity and awareness-raising.

4.3.1 PUBLIC PERCEPTION

4.3.1.1 Stigma

Some interviewees felt that students with a disability were inadequately understood, thus potential stereotypes or stigma concerning this population or category of people were being inadvertently perpetuated. How a person with a disability is perceived, that is, the ongoing construction of their identity is important in defining who that person is and how they function in life. In the context of students with a disability on placement, how disability is perceived by others can be key to influencing their performance on placement and ultimately their learning, particularly if they are being misunderstood by, for example, their practice educator.

The importance of not stigmatising students with a disability is mentioned by Dennis (CLEL) who said:

Organisations sometimes put up barriers, they make assumptions about the student. An example is, what if the student has to give cardiopulmonary resuscitation and they cannot do this on a temporary basis? This is very common, this is often used as an excuse not to provide a placement.

Dennis believed that the health service as an organisation needs to be better at supporting students with a disability on placement and that organisations sometimes put up barriers or make assumptions about the student to the extent of using this as an excuse not to provide a placement. Dennis furthermore asserted that culture is a major factor, he appears to be saying here that the organisation wields a powerful influence in terms of shaping the behaviour and thoughts of the workforce.

Mark (ST) also commented on stigma and said: “We are a health school and practice educators see people with a disability on a daily basis so I would hope there is no stigma”. Mark’s strongly worded statement hinges on the word “hope” and a kind of utopian ideology that as health school, we should practise what we preach, in other words, not displaying prejudicial attitudes towards students who have a disability. It must be acknowledged that stigma and prejudice are complex issues and resonate with the concept of unconscious bias.

Mark (ST) stated that he was quite open about his disability and had personally not experienced any negative attitudes from others in relation to his dyslexia. However, he surmised that with regard to others:

People have different expectations, they may not want to disclose and I can see why some people may be reluctant to do so. Dyslexia is so common. The practice educator still does need to be sensitive, this is very important, they need to have the right approach.

This student seems to hint at the fact that as a disability, dyslexia is perhaps less stigmatised, as it is now more common. It is also potentially easier to deal with since there is a greater awareness of the condition itself (even if the details of it are not as well understood). However, practice educators still need to be aware that some students may be reluctant to disclose this

condition for a variety of reasons. Indeed, Aurelia (ST) asserted: “I know some students with dyslexia won’t disclose due to feelings about stigma”.

The emphasis on the student being open and honest regarding their disability can, on occasion, have repercussions as illustrated in a scenario recounted by Lillian (ST) who said that she had disclosed her disability to the practice educator. But another member of staff had found out about this student’s disability and then advised that Lillian should have had an occupational health appointment prior to starting the placement. Lillian’s reaction was:

I felt a bit nonplussed as I know my own strengths and limitations and in fairness I had disclosed my disability [only] to the main educator. So for the other member of staff to come out with a comment like that was a bit disconcerting.

This scene contains overtones of bargaining and betrayal. Bargaining in that Lillian had taken the time and trouble to disclose her disability to the practice educator which in itself appears to be an act of being open and honest and also perhaps brave. By disclosing, Lillian would have been expecting the practice educator in turn to keep her disability confidential or to at least support her (Lillian) against adverse reactions from others. Possibly the sense of betrayal is directed towards the practice educator who told another member of staff about Lillian’s disability and subsequently came out with the comment about having an occupational health appointment. Lillian is clearly stating she knows her own person, her own body and what she can and cannot do, she is the expert yet appears to feel betrayed - and insulted - by the situation. Indeed, Dennis advised the level of disclosure needs careful consideration: “ensure that the level of disclosure is one that the student is comfortable with, and consider what is appropriate for example, who needs to know and why?”

4.3.1.2 Disability: visible and invisible

As a consequence of analysing the interview data and hearing - and learning - about the different types of disabilities that students experience, a disability can be broadly classified into two types - hidden and visible. Hidden disabilities such as mental health issues (for example, anxiety or depression) were the hardest to deal with, particularly if the student had not disclosed their disability. Mental health as a condition is well documented in the wider literature particularly in relation to stigmatisation and lack of understanding regarding how best to help someone experiencing mental health difficulties. Interestingly, a number of interviewees expressed concern that practice educators appeared to possess insufficient knowledge and understanding as to how to support such students during their practice education experience.

However, Keith (CLEL) cautioned that some students may not necessarily be aware of their disability until they are part-way through their university programme. The consequences of delayed diagnosis can be overwhelming for the student and a simultaneous burden to the stresses of dealing with the demands of the healthcare programme they are on. Andrea (VT) pointed out some practice educators are good at being vigilant in that through the process of cultivating a close working relationship with the student they may identify the student is struggling and as a consequence suggest the student explore this further through appropriate testing and support back in the university.

Dennis (CLEL) referred to differing levels of stigma attached to students presenting with a disability and said:

There are different levels of stigma attached to students presenting with a disability for example, someone with a mental health condition, this is a hidden disability. A visible disability is inescapable, it brings up the topic for you, naturally, and you can't really get away with it. If the disability is hidden it can be much more difficult to raise with the educator. Some disabilities are clear even if not straightforward. With mental health the tendency is that it is not clearly explicit nor evident.

Dennis's assertions raise some pertinent thoughts regarding the prevailing culture of disability and how society at large determines what is deemed acceptable or not. Remaining on the theme of visible and invisible disabilities, Jim (CLEL) felt that in his experience staff tend to be supportive towards students with a disability, this is easier if the disability is visible or obvious such as a hearing impairment as opposed to an invisible one such as dyslexia or one which the student does not disclose. This - in his opinion - makes it harder for the practice educator to be supportive. Jim also said the practice educator may need to rely more on the student in terms of understanding the implications of their disability in order to be in a position to support the student if the disability is a hidden one. Jim also felt there was less parity in general for students with a disability and also between the different types of disabilities. It is important to note the prevalence of students with a mental health condition upon entry to healthcare programmes in higher education is on the increase and therefore we (university and placement provider) need to accommodate their needs where appropriate.

Interestingly, a counter-argument in relation to disability being visible was provided by Mary (PE) who spoke about a student who wore leg braces over their uniform when the weather was hot and subsequently, this outward manifestation of disability became a visible as opposed to an invisible entity. The consequence of visible manifestation according to Mary was: "the patient's perception of the student was then based on their ability...due to their visible disability, this becomes a whole different challenge. I've only had one patient refuse to work with a student who had a visible disability". Here, it would appear the patient was potentially forming a personal viewpoint about the student because of the outward manifestation of disability. It is perhaps reassuring Mary said she has only had one patient refuse to work with a student with a visible disability but points to the dilemmas that can arise in an acute setting.

Further on in this section, patient perceptions of being treated by healthcare professionals with a disability and some of the factors that may figure in their

decision-making to refuse an assessment and subsequent intervention of their healthcare needs will be covered. Indeed, Jim (CLEL) cautioned that reactions of the patient towards the student with a disability can vary and they may not be so tolerant of the student's need for reasonable adjustment, for example, having to speak slower or repeat things. The student needs to have sufficient insight into their disability and the consequences that reasonable adjustment may have on others that they work with in addition to the patient's perception. As well, the connotations of the amount and type of support the student requires does need careful planning as it can have consequences. This was illustrated by Veronica (PE) who recalled one student who was going to come out with a support worker and this concerned her in that from a patient perspective, it could be construed as being surrounded by too many people and consequently impact on their well-being and cooperation to participate in the assessment / intervention being provided. The actual practicalities of this type of support were greeted by a modicum of concern on Veronica's part and entailed extra planning and thinking through on top of her existing workload.

4.3.1.3 Disability type

According to Andrea (VT), the type of disability in respect of associated challenges does make a difference. If for example, a student has multiple difficulties in relation to dyslexia, tasks such as spelling and processing information can magnify the challenges as the student may need to spend more time with the patient to assess them or explaining information to patients. In Andrea's view, settings where appointments are time-bound can make the practice educator anxious and this in turn can reflect on the student's assessment. Andrea's comment about slowing down the assessment process was mentioned too earlier by Jim (CLEL) who said in his experience patients can sometimes become frustrated because a student can slow down the assessment process because of their disability. If the patient is in pain or not feeling well this can exacerbate their symptoms. This hints at the fact that some patients may not be so tolerant of the need to

adjust to the student's needs - for example, to slow down the delivery of information that the student requires.

Further examples of the impact of disability type was provided by a number of interviewees, notably Keith (CLEL) who asked if a student in a wheelchair would be able to reach for dressings in a stock cupboard, and whether there would be good access to all parts of the built environment? Another unusual example was provided by Mary (PE) who recounted an experience when she had a student with a brain injury. She said this was so different to other students with a disability in that when the student became fatigued, their limbs had a tendency to contract. There were no coping strategies to manage this so the student was dependent on the team to straighten their limbs.

Lillian (ST) had an insider perspective of two contrasting disabilities - her own which was predominantly physical-based and a fellow student who had a mental health difficulty. Both students were allocated to the same placement. This is Lillian's experience:

I know one student who experienced a mental health difficulty and the challenges that they experienced were very different to the challenges I experienced. For one placement there was another student that I was paired with who could not drive for this particular placement duration. The student experienced mental health difficulties including anxiety and could not use public transport because of the anxiety. This was extra pressure for me on top of dealing with my own chronic pain and the subsequent impact on my placement as I felt under pressure to attend each day of placement, if I didn't then I was potentially disrupting the other student's placement. I also had to concentrate on driving and also listening to this other student's challenges that they were encountering because of their anxiety - this was very hard for me to deal with, it wasn't my responsibility to sort their problems out. I felt so responsible and it was extra pressure. I really feel that the university ought to think more carefully when they pair students together for placement...this other student really should have been paired with another student who did not have the same amount of pressure as me because of the chronic pain that I experienced.

Lillian emphasised the importance of the right allocation for the right student. She also recounted her relief at being allocated a placement in learning disabilities as due to the challenging behaviour exhibited with this client group, she worried that if she had been attacked this could have resulted in her previous injurious region of the body being fractured again. This to me expresses a hint of feelings of potential vulnerability.

Mark (ST) asserted that he managed his dyslexia on placements and did not encounter any major challenges. Furthermore he said: "It really is not a big thing to have a disability like dyslexia and I feel that my needs were easy and simple to accommodate". It is interesting to note that Mark's experiences of practice education on the whole appear to be positive ones yet by contrast, some of the students interviewed who also had dyslexia encountered negative experiences. Andrea (VT) revealed that:

The type of disability does make a difference for example, those with dyslexia, if it's just one problem such as spelling that is fairly straightforward and potentially they can adjust well to this but if they have multiple difficulties such as processing information that can be a challenge as they might need more time for assessments or explaining information to patients; settings where appointments are time-bound can make the educator anxious and can in turn reflect on the student's assessment. This can also impact on things like time management and organisation therefore making it a complex challenge for the student.

Here, Andrea is saying the experience of disability, the manifestation of the disability is unique to the student in that with any one type of disability, there may be a number of challenges they have to contend with such as processing information in addition to difficulties with spelling. This potentially means the student's disability may not present as being straightforward in mitigating the challenges experienced. The environment is also an influencing factor, according to Andrea, such as time-bound settings which add to the pressure of work. Another key point arising is the pressure on the practice educator; ultimately, they have some responsibility for the student's actions in terms of ensuring that delegation of tasks and expectations of the placement are clear. Nonetheless, if the student is experiencing difficulty

keeping to time, this may reflect and impact upon the practice educator's workload.

A final example is illustrated by Peter (VT) who said that in some instances, having a disability can be beneficial, he said: "for those with a mental health difficulty, if they are not emotionally stable then they may experience problems when treating patients with mental health problems but on the other hand, the student may be more empathetic". This resonates with the concept of insider perspectives on disability, having that deeper understanding of what the patient is experiencing because the student has been through that experience themselves, which can sometimes lead to better outcomes for the patient.

4.3.2 MANAGEMENT OF IDENTITY

4.3.2.1 Disability identity

The potential for misunderstandings regarding the student with a disability and the consequences thereof resonated strongly with some interviewees. For example, Lillian (ST) stated that one day, her practice educator suggested - several times - that she go home early as she looked tired. Lillian was also experiencing quite a bit of pain. The response from Lillian was that it should be her choice as to whether she wanted to go home earlier than planned and that people have good intentions but it can backfire. She explained that the visiting tutor may assume (rightly or wrongly) she (Lillian) was not coping with the demands of the placement and was down on her hours. This scenario seems to hint at the importance of the need for the student to be in control of their destiny, as Lillian stated: "I know I can manage my disability, I can manage it myself". This scenario highlights the need for the student to also control the public perception of themselves. They are aware of the stigma and of being perceived as not being able to cope. They wish to manage not just their disability in terms of how they function in the work-place, but also their reputation and public perception. Lillian

mentioned earlier her worries about being down on her hours and missing time off placement as a minimum number of assessed hours are crucial for evidencing performance in respect of the requisite skills, knowledge and attitudes to pass the placement. This scenario is potentially about the practice educator not recognising or acknowledging the student as being expert in managing their own disability. Sharon (ST) also voiced concerns about missing time from placement due to an additional disability (to her dyslexia) which results in fatigue as she then had less time to evidence performance which can increase the risk of fail. This is an important factor for practice educators and visiting tutors to be aware of as it demonstrates some of the associated burdens that students may be thinking about in relation to the consequences of their disability.

With regard to self-perceptions of disability, Aurelia (ST) spoke about her dyslexia being a part of her identity as it is a registered disability, and she identified herself as being a student with a disability. However, Aurelia also has dyspraxia but to her, at this point, she said, she is not a student with a disability because it is a part of her. She has always been clumsy and it is not a major problem on placement, she just had to work a little harder at planning her movements, for example, during a manual handling procedure. This is interesting as although Aurelia acknowledges her dyslexia and dyspraxia, the dyslexia is where she identified herself as being a student with a disability. In contrast to Aurelia, Claire (ST) asserted that she does not consider dyslexia to be a part of her identity and that she does not perceive herself as being different from others. Interestingly, she went on to say: "I don't let my dyslexia hold me back, I am at university and I manage very well. I don't find the label of dyslexia very helpful, it is negative, people think you can't read and that is untrue". Veronica too spoke about labels in the context of disability and said she does not believe in them as they can lead to making assumptions about the student in error. Thus, assumptions can be detrimental in creating misunderstandings about the student with a disability.

Claire (ST) also underlined the importance of recognising individuality when she said that disability affects people in different ways. Her frustration came through when she said that it makes her so angry the way some people with a disability are perceived. Claire further asserted:

I don't see dyslexia as a disability. When I read job applications and I see the quote about disability, to me, that is not applicable in my case. Yes, I 'have a disability' but I don't tell people unless I have to. I want people to see me for who I am, the label takes away the human element.

The statement about labels is powerful and potentially about objectifying people, in other words, seeing the disability first before the person. Claire's statement about other people making assumptions was shared by Gillian (ST) who said that one practice educator knew someone who had a severe specific learning difficulty and then wrongly assumed that she - Gillian - could not read or write. Gillian's following statement sends out a strong message:

I feel secure in my disability, I did not feel that I needed to defend or justify my abilities because I know that I am perfectly capable of reading and writing, with the right strategies in place I have no problems.

Gillian is someone who appears to be sure of herself and knows that she is capable - however, for that capability to materialise she needs to have the right strategies in place. Nancy too felt that dyslexia is not well understood and that people make assumptions, in her case she was told "oh, you can't be dyslexic because you are clever". This is a striking statement and seems to resonate with Jenny Morris's earlier statement regarding representations of disability.

Regarding perceptions of students with a disability, Nancy (ST) said it was important for practice educators not to view the disability as a negative thing but rather to be aware that the student may have coping strategies and, where feasible, to accommodate these. Indeed, Shakespeare (2014) says that labels can be stigmatising as they can lead to negative connotations or

consequences, but for some, however, diagnosis is important and can lead to the required support to mitigate the consequences of disability.

4.3.2.2 Inclusivity

Inclusivity concerns how well the culture of the setting or environment accommodates the needs of the student with a disability. Indeed, Dennis (CLEL) asserted that: “You need to ascertain if there is a culture of support, this is more important than the type of placement”. This is an important perspective, a powerful one too and perhaps alludes to the fact that it does not or should not necessarily matter where the student is allocated in terms of the placement setting, the culture of support is more important. Indeed, Lillian (ST) asserted that from her perspective, the work-place in general tends to be inclusive and that if it was not in respect of a person’s particular disability then it is important to use existing infrastructures to actively seek support or advice. Lillian said:

Yes, it is fine, it is inclusive I think. Re inclusive work environment: I think I meant that there are lots of different support structures available in the work environment for issues related to disability; if you felt that aspects of practice weren’t inclusive towards your disability there are lots of avenues to seek further support or advice about your concerns. I think now more than ever you don’t have to hide disabilities within the work-place; people are more aware of different disabilities and their impact and subsequently there tends to be less stigmatisation/bullying etc.

This is perhaps a naive comment given that for some, stigmatisation and bullying are still prevalent in the work-place. Lillian (ST) said that it is important not to bury one’s head in the sand and she advocates strongly for people with a disability not to be disadvantaged. Here, Lillian appeared to be saying that it is important not to hide your disability, to ensure that disclosure takes place and to ensure that you get the help and support needed to function in the work-place. Mark (ST) also felt that the work environment was inclusive from his perspective. Remaining on the theme of inclusivity, Jim (CLEL) said this depends. He cited an example of an MSK setting which

is time managed and the influence of external drivers such as waiting lists, particularly in MSK, he said:

Services are under a lot of time pressures and waiting lists as I mentioned earlier are key. The Clinical Commissioning Groups and people who sit on these are numbers driven - they are not interested in healthcare professionals as individuals nor those who might have specific needs because of a disability.

If this is true then it is an example of how commissioners may not necessarily be concerned with individuals with a disability per se but instead, are more concerned with achieving targets and perhaps assuming the workforce is capable of achieving said targets. Mark also mentioned waiting lists in MSK and the pressure to adhere to patient appointment times in addition to the fast pace of the work. The MSK environment is an example which for some people, is not inclusive and where the culture and expectations of the work need to be strictly adhered to.

Keith (CLEL) asserted that in relation to whether the work place is inclusive in his experience, it tends to be a reactive rather than proactive situation. Here he appears to be talking about the importance of planning and preparation for the student with a disability. He also goes on to say the work-place needs to be individualised as students have differing needs. Furthermore, Keith emphasised that support needs to be targeted not only towards the student with a disability but also for the practice educator too. He said we need the equivalent of the support mechanisms in higher education as well as in the placement provider setting.

Peter introduced the possible notion that students - whether they have a disability or not - may be construed by the practice educator as being an additional burden to contend with on top of their existing workload. However, he said, perhaps pragmatically, the duties of the practice educator should be the same for all students regardless of whether they have a disability or not thus suggesting equality for all students is important. The notion of equality is critical although it could be argued it is not about treating all students the

same as they are a diverse population but instead, ensuring that the individual needs of the student are met.

Lillian said that, for her, disclosure of her disability was beneficial and important to her as it meant that she received the right support from the university in respect of having a local placement to enable her to attend hospital appointments due to her disability. Lillian asserted: "I'm really glad I did disclose". Similarly, Aurelia (ST) said that she is not stupid and may sometimes need a bit longer to do things on placement because of her specific learning difficulties. She went on to say that this is the reason why she always discloses her disability to the practice educator because she does not want them to think she is stupid. This hints at the importance of perception control and how she - Aurelia - is perceived by the practice educator.

Nancy (ST) felt strongly that "the onus is on the student to disclose their disability and advocate for it". Disclosure according to Veronica (PE) is up to the student, she asserted that if the student does not disclose, it is not then her responsibility. This hints at the student's ability to control their destiny (knowingly or unknowingly). Another important point is that if the student discloses the potential expectation from their viewpoint is that the practice educator in turn will reciprocate by supporting their needs. Returning to Veronica's declaration that a failure to disclose on the part of the student is not her responsibility, this does appear somewhat overly harsh on the part of the practice educator. This points to the importance of practice educators ensuring that they regularly monitor their student's learning and the effectiveness of what they have learnt and to check if they have any particular needs. Sometimes, this form of monitoring may be the trigger to encourage a student to disclose if they have not already done so. Indeed, Keith (CLEL) discussed too the concept of time and equality on the part of the practice educator:

Time will have an impact on the practice educator however, if they have all the required information pertaining to the student with a disability including the nature of the disability and so on then the

impact of having a student should be minimal. The responsibilities are not any different towards other students without a disability.

Here, Keith hones in on the importance of the practice educator having the required information about their student, which is key to a conducive practice education experience for the student with a disability.

Andrea (VT) emphasised the need for clear communication between the student and their practice educator. She also went on to say that whether the student has disclosed or not may then depend on whether the practice educator is in a position to support them. This, according to Andrea is also dependent on the level of communication between both parties. It would appear that in this situation the practice educator really is the catalyst to supporting the student's learning.

Lillian (ST) emphasised it is important "not to bury your head in the sand". This is an important message about being visible, no matter what the disability, and the importance of seeking the requisite support to manage the practice education experience. Similarly Nancy (ST) also pointed out the importance of the student being able to communicate with their practice educator and to be confident in saying that they have a disability, what the implications are and subsequent identification of strategies. However, the idea of disclosure can sometimes be inadvertently turned into a virtue, with associations of 'openness' and 'honesty' and the opposite – those of 'covertiness' and 'dishonesty' - being associated with non-disclosure.

4.3.2.3 Awareness-raising

Dennis (CLEL) asked the question as to how experienced the practice educator and the team are in relation to supporting the student. This does have implications because if the team are inexperienced in practice education, it can be detrimental for the student concerned as in turn their needs may not necessarily be effectively supported. Dennis also questioned

whether the practice educator is aware of resources available within their own organisation which may in reality be helpful as an additional support mechanism for the student. An example of resources could be liaising with human resources or occupational health regarding advice on access to temporary counselling to manage heightened anxiety due to being on placement. Interestingly, support processes, according to Keith (CLEL), are explicit within the higher education setting - for example, access to the Universities' Student Support Services and visiting tutors' experience of pedagogical approaches in the context of higher education and more often than not, repeated experience of assisting students with a disability. These support processes, however, are not always so explicit in the placement provider setting which seems to indicate that there is a need to consider explicit support for students and staff. This potential lack of awareness on the part of the practice educator is concerning particularly as the CLEL voiced this and that they (CLELs) have a strategic role cutting across a number of healthcare professions. Indeed, awareness-raising with regard to supporting students with a disability is important according to Keith (CLEL) and this should be embedded into the training delivered for practice educators in preparation for taking students on placement. In relation to awareness-raising, this needs to encompass a plethora of topics, for example, how one's behaviour or attitude and general work culture may inadvertently be an example of prejudice towards the student with a disability. Dennis (CLEL) said that support for students with a disability should be good practice in any case. According to Dennis, in order to support the student with a disability, it is vital that the practice educator is able to identify their learning needs.

Sharon (ST) spoke about the need for the practice educator to be a good role model. Being a role model is an interesting notion and points to the fact that not only are students - including those with a disability 'in the limelight' that is, they are being constantly observed by those working around them but also practice educators are too. Being a role model carries with it important connotations as some students tend to model their behaviour on that of the practice educator, therefore the latter needs to adopt the right approach and level of support towards the student. Remaining on the theme of the practice

educator adopting the right approach towards the student, this was emphatically pointed out by Jim (CLEL) who said that being approachable was key to a positive learning experience.

Andrea (VT) said in her experience some practice educators feel that responsibility lies with the university in supporting the student with a disability and furthermore, the student already has identified coping strategies to manage their disability. This hints at the assumption that some practice educators may have that their allocated student arrives on placement as a 'ready-made' package thus reducing the burden of having to take a student on placement. An important point to make here is that some students may not necessarily have fine-tuned or even identified effective coping strategies as yet, particularly if they have only recently been diagnosed with a disability or if they have a yet as unknown disability. It seems to be an unfair expectation perhaps on the part of the practice educator that the student will be fully cognisant of their needs. It also suggests that whatever worked in a university context can translate into the hospital / care context, and therefore the practice educator does not need to provide any further thought or input. This illustrates a very different perspective on practice placements on the part of practice educators compared to the student with the disability. This reinforces the need for open communication between the student and practice educator and the importance of working together to agree upon and implement strategies to manage the disability. On the theme of unknown disability, Andrea said that some practice educators are good at being vigilant in picking up that a student is struggling and subsequently suggesting that they be tested for dyslexia for example.

Gillian (ST) said the practice educator should have adequate knowledge of the actual disability that the student has. She felt the university should have some information that is sent out to the practice educator in advance of the placement and this should also form part of their education and training in preparation for taking students on placement. She also emphasised the importance of the practice educator being open-minded and to judge students on their merits and not have pre-conceived notions such as "my

student has dyslexia therefore they won't be able to read nor write". Indeed, Mary (PE) reiterated the importance of not viewing the student as a problem. She said having a student enables the practice educator to revisit their own learning needs in addition to raising their clinical reasoning to a conscious level. Mary went further in her pragmatic approach and said: "Help the student to focus their learning, the student who has a disability is just another aspect, it's an exciting opportunity".

4.3.3 Supporting Student Learning

This sub-theme identifies three key factors collectively construed as instrumental tools in providing the right conditions to support student learning: making contact; learning; and adjustments.

4.3.3.1 Support: making contact

Mark commented that if the practice educator takes the time and effort to contact the student prior to the commencement of placement this can help to alleviate anxiety on the part of the student as the placement environment is construed as an unknown entity. Mark went on to say knowing the practice educator had read the student's letter of introduction and curriculum vitae was reassuring. This is an important part of the practice educator absorbing anticipatory information about the student in advance of meeting them face-to-face in addition to finding out about the student's disability if they have disclosed it in their letter. Jim (CLEL) also said that receiving a letter from the student is important and affords them, what he terms, an informal opportunity to disclose their disability. Anecdotal evidence in my role as practice education coordinator indicates that in some instances students do not receive a timely response to their letter prior to the placement starting. This can heighten anxiety on the part of the student as it leaves them conjecturing how prepared their practice educator is for taking on a student with a disability.

One would expect that a student would repeatedly disclose on each placement they are allocated to, yet Claire (ST) said that although she disclosed on two of her placements for one placement she did not feel she needed to. Instead, she alerted the practice educator that she might need to ask questions more than once due to the challenge of retaining information. This is an example where the student is not revealing a specific diagnosis - in this case dyslexia - but just explaining a consequence of their health condition. Non-disclosure for the third placement in Claire's case could be attributed to her feeling more confident by this stage of her abilities and having a better understanding of the demands of the placement setting. However, what is revealing is that in this interview, Claire went on to say that the practice educator on one placement also had a disability and from Claire's perspective, the impact of this seemed to make her own disability pale into insignificance and consequently she felt it inappropriate to share her own disability.

Kerry (ST) had a similar experience to Claire in that she too disclosed on two of her placements but wanted to 'test herself' for the next placement to see if she could manage without disclosure. In addition, she revealed that she did not feel entirely comfortable with the practice educator and this prevented her from disclosing. Also, the practice educator was away for the first week of placement so the moment - from Kerry's perspective - was lost. It would appear that an important implication arising from Kerry's experiences of disclosure is that certain conditions need to exist to facilitate disclosure - from a timing perspective and also from a perspective of the practice educator embodying the right persona to facilitate disclosure.

Jim (CLEL) too advocated for early disclosure as otherwise it can slow down the learning process. Time is needed, he said, to set up equipment or adaptations in order to implement reasonable adjustment. From Jim's perspective, practice educators need early warning about the student's disability so that they can "hit the ground running when they start placement". The student letter, he says, is an opportunity to disclose. He also advises that the practice educator needs to be approachable and that this is "key to a positive learning experience".

Dennis (CLEL) said that certain conditions are required to facilitate disclosure such as the need for the practice educator to create an environment in which the student feels comfortable to disclose. This is an important message to reinforce to practice educators as for some students, the decision to disclose or not may in some circumstances hinge on the right conditions being present. Furthermore, Keith (CLEL) stated that time is a critical factor in respect of taking a student on placement from the perspective of a practice educator, if they have all the key information regarding the student's needs and their disability then the impact of taking a student, he says, should be minimal.

4.3.3.2 Support: learning

Practice education is a learning experience, the student is learning how to be a healthcare professional. In doing so they need to acquire the requisite skills, knowledge and attitudes within a defined timeframe on placement and be simultaneously assessed. It is one thing to learn but how and where that learning takes place is a key consideration and this is where the practice educator plays a critical role in facilitating and supporting that learning.

Jim (CLEL) stated practice educators need to invest time in supporting the student and planning in advance to manage the workload. There is no need for pressure, he said. Jim suggested the impact of having a student with or without a disability should be minimal if the practice educator is able to plan and prepare in advance of the placement. Jim further acknowledged the time pressures within the musculoskeletal (MSK) setting and said:

Time pressures are challenging, particularly within an MSK setting. In my experience as a practice educator, I negotiated with my line manager to allow time for my practice educator role, we would always take two students at a time so that they could, between them, compensate for the reduction in my clinical time.

Jim's pragmatic approach is an admirable example of how he embraced the 2:1 model of practice education - that is, two students allocated to one

practice educator. Whilst this appears to be a reasonable solution to managing the pressures of time, consideration would need to be given to the logistics of student allocations in the placement setting to ensure that the benefits of time management are fully exploited. Like Jim, Peter (VT) asserted that for a student with a disability, extra time may need to be invested at the start of the placement but that over the duration of the placement this needs to be reduced, presumably because the student is deemed able to demonstrate autonomous working over time.

Listening and problem-solving are key to uncovering potential difficulties that the student and practice educator may be experiencing on placement. Indeed, Mary (PE) emphatically stated that: "You have got to be on the student's side otherwise there's no point. If the student is a little bit shaky it is going to be more stressful for them if the practice educator is not supportive". Mary's statement rings true in respect of ensuring that the student with a disability is appropriately supported in accordance with their required learning needs. The importance of acknowledging they may be under undue stress if that support is not there is a key consideration. Indeed, Gillian (ST) said that students will refrain from asking for help if they feel they are being judged by the practice educator, so the onus is on the latter to ensure they adopt the right approach towards the student. Kerry (ST) advised the practice educator needs to communicate with the student and to work together to think of strategies to compensate for the disability. She also cautioned the practice educator may need to invest more time in helping the student to learn. Mark (ST) stated "in my experience, practice educators need to be proactive in supporting the student". This is about practice educators having the skill to anticipate what challenges the student may encounter as a consequence of their disability and knowing when and how to support them.

Nancy (ST) emphasised all her practice educators were good at asking if she needed assistance and to say if she was struggling or needed support. Furthermore, Nancy said the practice educator should be open to accommodating the student's needs and not to see the disability as a

negative thing but rather that the student may have coping strategies and to accommodate these where feasible. Similarly, Gillian (ST) found one of her practice educators was very good in acknowledging and recognising her dyslexia; she had downloaded information on dyslexia from the internet and used this as guidance to support Gillian. Gillian concurred that this approach was most helpful as a means of supporting and facilitating her learning on placement. Aurelia (ST) echoed the experiences of Nancy and Gillian and said all her practice educators had been understanding of her needs in respect of her specific learning difficulties.

Mark also said what really helped on placement was when practice educators openly asked how they can support him in relation to his dyslexia. However, Mark cautioned the importance of practice educators adopting a sensitive approach, describing one practice educator who was patronising in constantly checking if he was okay and needed help? Similarly, Aurelia (ST) recounted a scenario from placement where she found a staff member's approach patronising. She said the staff member was trying to help her spell a word and used the phonetic style of spelling, which was unhelpful. This reiterates the importance of students being able to voice concerns if someone is trying to help them but in reality is counter-intuitive. Gillian (ST) recounted a similar experience to Mark and Aurelia where her practice educator kept pointing out her spelling mistakes on the IT system which did not have a spell checker function. Gillian said a more helpful strategy would have been to use the approach another practice educator used: furnish her with a list of words that she was commonly mis-spelling which she then could memorise and refer to.

Claire (ST) cautioned against practice educators assuming that they know how to help the student with a disability. They need to compromise and discuss reasonable adjustments; more importantly they need to ask the student, how can I help? Sharon (ST) emphasised the point that the practice educator needs to be adaptable because the student may do things differently - this could be anything from the way that they approach problem-solving to perhaps enacting a task or skill in an unconventional manner. She

said of the practice educator: “They need to be understanding and aware of the student’s needs”.

On the theme of disclosure, Sharon (ST) asserted that this to her is important but also is the need to be aware of one’s own learning and personal needs in addition to the expectations of the placement. This points to the importance of the student knowing themselves and the consequences of their disability, an awareness of their identity as a person with a disability in the context of practice education. Similarly, Aurelia (ST) said for her it was important to be very open about what she could and could not do. This is about being conscientious and working within one’s scope of practice.

Gillian (ST) posed some interesting thoughts in that for disclosure to take place, the student needs to acknowledge that they have a disability in the first place. She said that the two are linked - in other words you have to acknowledge the disability first and disclosure is linked to that acknowledgement. This appears to represent a conscious process on the part of the student, something about being prepared to acknowledge one’s identity and sense of who or what one is. This also hints at how far the student is prepared to go in terms of revealing themselves as an individual with a disability.

The following scenarios, illustrated by Peter (VT), emphasise that two-way communication and the relationship between the student and practice educator are key to increasing the chances of a sound placement experience. The juxtaposition between the two types of scenarios between student and practice educator perspectives are manifested as:

Student -

‘I have dyslexia and these are my strategies’

or

‘I have dyslexia, I don't have any strategies, can you do something to help me?’

Practice educator -

'you have dyslexia, we can work together on this'

or

'you have dyslexia, you need to get on with it'.

Peter stated that in both scenarios the first statement by student and practice educator respectively is positive and helpful with the second statement being the opposite. Anecdotal evidence asserts that students will often say 'it's the luck of the draw' when they speak about the practice educator allocated to them for the practice placement duration as this can have a significant influence as to how well the student is supported on placement. Peter stated that in his experience practice educators tend to be supportive, some more than others but in the main, supportive.

Mary (PE) made similar comments to Peter above in that you get students who openly disclose their disability in addition to demonstrating an awareness of their strategies and being able to articulate this to their practice educator. Potentially, this approach makes it easier for the practice educator to support the student and the challenge for the practice educator in trying to work out strategies with / for the student or suspecting that something is impacting on the student's performance but not knowing what is the cause is removed. Indeed, Mary went on to state that she finds it challenging as a practice educator when students hide their disability, thus illustrating that non-disclosure on the part of the student can manifest itself as a subsequent burden for the practice educator.

Gillian (ST) advised that practice educators need to be open-minded and not harbour pre-conceived notions concerning what the student may or may not be capable of doing. Gillian also said the university should have resources for the practice educator specifically in relation to supporting students with a disability and that the practice educator should possess adequate knowledge of the actual disability. This hints at expectations that students have of their practice educator, that he or she will possess some knowledge about their disability therefore they will be in a good position to support the student.

The findings so far point to some critical attributes on the part of the practice educator and the importance of really knowing the student and sensitivity towards their disability and respective needs. Some additional considerations were raised by Sharon (ST) who spoke about the importance of the practice educator having an awareness of what the student should be doing on placement and to provide regular constructive feedback to enable the student to adjust their performance. For Sharon, on one placement this did not happen and subsequently this led to frustration on her part and a sense of not progressing her learning as much as she would have liked. Poignantly, Sharon illustrated her frustration when she said:

I found that one educator was biased regarding my capabilities, the educator thought I was disorganised but I was not. It was fed back to me at the interim that I was not doing XYZ and that I was disorganised. If I had received earlier feedback I would have been able to moderate my performance.

Here, Sharon appeared to be saying that she was not being 'heard' by the practice educator who had misunderstood the consequences of her disability. A sense of injustice pervades and potentially sours the relationship between student and practice educator. Kerry (ST) also voiced a similar scenario where one practice educator was not clear in their expectations of what they wanted Kerry to do on placement and this in turn compromised her learning, Kerry cautioned: "Practice educators must be clear when they are giving information to students". Sharon and Kerry's experiences could possibly be attributed to a sense of compromised communication between student and practice educator. If expectations are unclear this is likely to lead to a deterioration in the practice educator's judgement of the student's performance. Indeed, Dennis (CLEL) cautioned "practice educators ought to be more specific re adult learning". Here, he was referring to the need for practice educators to apply the principles of adult learning in a manner which explicitly facilitates and supports student learning. Kerry advised on the importance of student and practice educator working together to manage the student's disability and to consider strategies that are workable in practice. Kerry also advised that time needs

to be invested on the part of the practice educator to help the student learn. Indeed, Peter (VT) goes further in saying that more time needs to be invested in the student initially, which is then expected to taper off.

Dennis (CLEL) proposed a number of practicalities the practice educator can utilise to support the student including the creation of a suitable learning environment and learning contract. The latter can be used to consider strategies and resources geared towards the students' needs in respect of their disability. Furthermore, Dennis said: "You have to set the conditions, establish rapport with the student and have knowledge of resources available to support the student". Critical here is the need to consider the invitational qualities (Billett, 2002) of the work-place setting and to allow sufficient time and planning for a thorough induction at the start of the placement.

Both Dennis and Keith (CLELs) mentioned the importance of the practice educator finding out how the student likes to learn and to establish what their learning style is. Awareness of the student's learning style is critical to ensure a conducive learning environment. Indeed, Mary (PE) said that "it's more about what the student needs to learn rather than the disability itself". Mary herself took steps to identify the student's learning style but asserted the student needs to be forthcoming in telling the practice educator how they learn best. Aurelia (ST) asserted the practice educator needs to have patience and to be aware of how the student learns. She went on to state all her practice educators had been good at matching her learning style as she learns best from a visual perspective. Peter (VT) spoke about grading the student's learning so that they build up the required skill or knowledge in addition to linking the learning with the placement learning outcomes. This is about contextual learning and the importance of pitching the learning according to the stage of practice education reached, in addition to gradually immersing the student into the learning.

4.3.3.3 Support: adjustments

In respect of reasonable adjustments, Dennis (CLEL) said there is a fine line between implementing reasonable adjustments versus unfair advantage. In his experience, practice educators do have anxieties about how far to go in respect of accommodating the student's needs in relation to their disability. Application of reasonable adjustments is a balancing act. Ultimately, if the practice educator goes too far it can advantage the student to enable them to pass the placement - unfairly - in some cases. The application of reasonable adjustments then is not necessarily straightforward and requires judicious implementation and skill in considering the stage of practice education reached and whether the student is being given a fair opportunity to be able to meet the placement learning outcomes. Practice educators have a critical role as gatekeepers to their respective profession so need to be confident in asserting whether their student is meeting the required competencies or not to pass the placement.

Mary stated: "Success on placement depends on how open the student is and the coping strategies they have. Some students use disability as a crutch". There are some interesting notions arising from Mary's comments, notably the importance of the student being prepared to have an open and honest dialogue with the practice educator regarding their disability. The second point concerns the type of strategies the student might already have or be prepared to try out in practice and how readily the strategies translate into the realities of day-to-day practice in the actual working environment. Another key comment from Mary is the assumption that some students use their disability as a crutch. This raises a number of questions as regards the meaning of this statement -for example, that some students may be using their disability as an excuse not to have to face up to the realities concerning the demands and expectations of the placement.

It is interesting to note that strategies utilised by students within the university setting do not always readily translate to the practice placement setting (for example extra time on course tests or use of specific software such as

Dragon Dictate). This view is also shared by Mary (PE) and also Dennis (CLEL) who said practice educators may not have as much time as they need to sit down and explain things to the student or help work out what their strategies are, as they are likely to be under a huge pressure of work. Not having time to understand the implications of the student's disability is of concern and potentially hints at a work-place culture that is not catering for the needs of a student with a disability as part of the workforce. Dennis cautioned the need to be aware of the following: "You need to consider the tension between the student's strategies in their personal and academic life versus being on placement for example, the need to write up patient documentation under time pressures".

The reality of strategies implemented within the university compared with those on placement is further illustrated by Andrea (VT) who recounted an experience where she visited a student on placement and because of their dyslexia they tended to misspell words. This was so significant that it had a negative impact on their placement performance. Andrea said she and the practice educator worked very hard to try and come up with appropriate coping strategies but it was not easy as the student could not complete their notes in a timely manner. This, she says, really was a difficult situation and illustrated that the reality of extra time for course tests in the university setting does not always readily translate into the clinical setting due to the need to complete tasks in a timely manner, under pressure. What needs to be acknowledged here is that some strategies are not necessarily transferable between university and placement settings nor between placement settings. This illustrates the inherent complexity involved in implementing strategies as each student should be considered as unique: what works for one may not work for another, for no two students with the same disability will have the exact same needs.

Nancy (ST) recalled a point during her practice education experience when her practice educator gave her an opaque notebook, which she said was to help her read and write notes simultaneously. However, Nancy explained

that this was helpful only for jotting down personal notes to aid her learning about the placement. The opaque notebook did not resolve the difficulties in being able to handwrite entries in the patient's notes as these comprise notes or folders which are legal, official documentation. This touches on an earlier statement in the previous section that some reasonable adjustments may only go so far in helping the student to mitigate the impact of their disability. Some strategies - either an adjustment in attitude or perhaps a piece of equipment or adaptation - may assist to some extent but the connotations of the adjustment require careful thinking through as it may not mitigate the consequences of the disability completely.

Aurelia (ST) said that for her acute placement the practice educator was helpful in suggesting she utilise a bullet-point format for capturing key points from patient interviews. This suggests the importance of practice educators working with students to identify strategies to compensate for the disability and perhaps that on occasion, a simple strategy has the potential to be truly effective in overcoming the challenge of processing incoming information and multi-tasking. Reasonable adjustment can occur on a number of differing levels ranging, for example, from the provision of tangible objects such as an opaque notebook as described by Nancy (ST) to more complex, nuanced subtleties such as attitudes of the practice educator towards the student with a disability.

This theme has highlighted the influence of public perception and management of identity. In addition, implementation of the basic infrastructure in relation to following policies and procedures within the practice education experience, such as a consideration of tools for learning, is critical in supporting students with a disability. What this points to is the importance of recognising and acknowledging that each and every student with a disability is unique and that a number of factors need to be implemented to support their learning. These factors will be explored in more depth in the next chapter.

4.3.4 CONCLUSION

This chapter has explored the challenges that students with a disability face during their practice education experience and in doing so, opens up new avenues of enquiry. What is important to note is that given the prevalence of student participants with a diagnosis of dyslexia, this has had some influence in the development of the themes in particular, work context and practices. However, these themes also include contributions from staff – practice educators, visiting tutors and clinical learning environment leads – who drew on their experiences of working with students with a range of disabilities – musculo-skeletal conditions, dyslexia, dyspraxia, hearing difficulties, physical immobilities, and those suffering from chronic pain and brain injuries. That such a variety of disabilities have a number of commonalities under the theme of work context and practices is interesting and poses a dilemma. While disability is experienced personally (is a subjective experience) and there is a real danger of erasing differences and thus homogenising disabled experiences, the data from students and staff show that there are also strong commonalities amongst differently abled bodies in work contexts and even more so the attitudes towards disabilities that they seem to experience. The thrust of the thesis and its contributions are therefore not reliant on any one type of disability in its entirety. There still remains the issue that while raising awareness of disability, reducing stigma, and addressing public perceptions remain overall, macro goals that will speak to anyone with a disability, specific measures (micro goals) that alleviate the student experiences related to particular disabilities must also be sought. Some suggestions that move in this direction are offered in the concluding sections of this thesis.

The place of critical disability studies in particular, the ICF, capability approach and the critical realist approach are useful frameworks for critically analysing and explaining the data findings. As I conclude this chapter, for me what is key is the importance of considering the contextual milieu in which the student with a disability on placement finds themselves in. This assertion resonates with a statement from Shakespeare (2014:75) who says:

The difference between my approach and what social creationists would describe as the medical model is that I do not explain disability as impairment, and I do not see impairment as determining. My approach is non-reductionist, because I accept that limitations are experienced as an inter-play of impairment with particular contexts and environments.

Shakespeare places an emphasis on the impact of impairment and how this depends on particular contexts and environments. A conceptual stance towards the notion of students with a disability on practice placement will be explored in depth in the next chapter.

CHAPTER 5: DISCUSSION

The purpose of this chapter is to synthesise key elements from the literature review and empirical findings leading to some key suggestions for practice education in the context of students who have a disability. There are four parts to this chapter:

Part I - a collection of composite narratives, the main purpose of which is to enable a reflection on the practice education experience from the perspectives of student, practice educator, visiting tutor and clinical learning environment lead.

Part II - explores the impact of disability conceptualisation and construction with reference to four key concepts - stigma and disclosure; work culture and practices; inclusivity and relationships. These concepts are then synthesised using the critical realist necessarily laminated layer approach.

Part III - explores the contribution of two key theoretical frameworks - the ICF and the capability approach - in framing conceptualisations and constructions of disability.

Part IV - gives some tentative suggestions for the enhancement of practice education informed by my findings with reference to key arguments from the field of critical disability studies, a critical realist approach, the ICF and capability approach.

5.1 Part I: COMPOSITE NARRATIVES

My rationale for using composite narratives is explained in Chapter 3 but the key points are repeated here. Using composite narratives is a means of conveying for the reader a sense of the lived experience of practice education for the student with a disability from the perspective of four narrators: a Student with a Disability, Practice Educator, Visiting Tutor and Clinical Learning Environment Lead. Using the first person narrative facilitates a deeper appreciation and understanding of the phenomenon being explored. These composite narratives (presented in appendix Q) reflect the central themes and issues from each of the perspectives of all

research participants. The narratives also combine my own personal experiences of being a Student with a Disability on placement, a Practice Educator, a Visiting Tutor and Practice Education Co-ordinator. Highlighted (by a process of underlining) within the narratives are words or phrases that are opened up for further discussion within this chapter.

The composite narratives play a critical part in illustrating key perspectives of the participants in this study in addition to allowing us to gain a sense of how the parties involved are all - in different ways - inter-dependent on each other. Indeed, these narratives possess pedagogical value in being used with key participants in practice education to raise awareness of issues that may impact on the student experience. Block and Weatherford (2013:499) state “narratives and storytelling are a good way to understand the personal beliefs and perceptions of having an impairment or disability”. The impact of using narratives is perhaps best described by Frank (1993:42), who writes about using what he termed ‘illness narratives’. He states that “people change their lives through telling them in narratives”. This for me weaves in a cathartic element for narrators and audience alike. Composite narratives can be adapted according to pedagogical aims and the specific needs of the delegates. The opportunities for flexibility is an essential part of their use. Haigh and Hardy (2011:408) write about the concept of storytelling and differentiate this from a narrative in that the latter is largely factual whereas stories are “reflective, creative and value laden...”. My argument is that narratives can equally be reflective, creative and value laden, and have been used as such in previous educational research. An example of how I have used this in this project is provided in appendix R. It is based on one of the concepts from chapter 5 – disclosure. The value of this particular composite narrative lies in its brevity and practicality, and it lends itself for use as a pedagogical tool, as there is infinite scope for debate and discussion on the related themes of stigma and disclosure.

To facilitate an understanding of the complexities inherent within these perspectives studied, I have taken the opportunity within this chapter to expand on some of the key issues arising from these narratives, some of

which resonate with themes picked up in the literature review. In doing so, I intend to argue the need for a paradigmatic shift towards an ethos embracing a positive culture and environment, one that enables students with a disability in practice education to flourish. An emphasis is also placed on the practice educator and visiting tutor who form an important part of the student's experience in practice education as they too have responsibilities in respect of contributing towards that paradigmatic shift.

5.2 Part II: DISABILITY: CONCEPTUALISATION AND CONSTRUCTION

This section focuses on a number of concepts concerning the conceptualisation and construction of disability emanating from Chapter 4. Firstly, I commence with a quote which encapsulates the wider debate in the existing literature in relation to constructions of disability: “liberation from disability is about having choices, not about living life in conformity to some pre-defined notion of normality” (Burchardt, 2004:742). For me, Burchardt’s words illuminate the need for choice and empowerment, in other words, a sense of social justice in the context of students with a disability in practice education. Her words also question societal perspectives on disability, indeed, what is normality? The realisation of how to embed choice and empowerment within the realm of practice education is deserving of attention to ensure that students with a disability have every opportunity to participate (to the best of their ability) in their practice education experience.

5.2.1 Stigma and disclosure

One of the major decision points that students in the study faced concerned disclosure of their disability. The process of disclosure is multifaceted and complex in that it is interdependent upon a number of stages which in turn are shaped by a perception of needs - on the part of the student, practice educator and visiting tutor too. A discussion on disclosure would not be complete without reference to stigma. As discussed in Chapter 2, stigma is a comprehensive and complex subject and has been much written about following Goffman’s (1963) seminal work on this topic. Stigma has a power basis supported by labelling, stereotyping, separation, status loss and discrimination. I argue that the reference to power, in the context of my findings, stems from the placement environment, its work culture and practices, as well as the relationship of the student with the practice educator.

In relation to disclosure, Pachankis (2007:335) paints a bleak landscape in describing the dilemma of those with invisible as opposed to visible

disabilities: “individuals with a visible stigma face the emotional stress of being devalued, individuals with a concealable stigma must choose between this stress and the emotional stress of hiding”. What is insightful about this quotation is that it shows that disclosure is a decision involving some degrees of stress - as the student may need to weigh up the possible benefits of disclosing their disability, thus relieving themselves of the strain of hiding their disability (and in the process gaining support to pass the placement) against the impact of potentially being devalued by colleagues who may or may not be able to provide the appropriate support needed. The outcomes are not clear-cut and the decision to disclose is therefore a risky one. Relevant here is the term “disclosure disconnects” (Ragins, 2008:195) discussed in Chapter 2 in relation to invisible disabilities and the need for contextual decision-making. I would argue here though that the concept of disclosure disconnects is also applicable to visible stigmas and indeed this was reflected in my findings where a number of interviewees reflected on decisions they wrestled with and their justification for disclosing or not and to whom. In my view, whether the disability is visible or invisible is less relevant for even if the disability is visible, the practice educator still needs to be cognisant of the disability and its implications within the practice placement environment.

The process of disclosure requires favourable conditions which may lead to the student making the decision to disclose. Triggers may include the practice educator exhibiting the right attitude, facilitating a supporting and non-judgmental environment and even asking the right questions to facilitate disclosure. For example, *‘is there anything you want to tell me to help me ensure that I create the right learning environment and support for you?’*. Attention also needs to be paid to how the practice educator comes across in terms of their approach to embodying genuine interest, concern and sensitivity towards all students, as anyone could potentially have a disability. The importance of exhibiting the right approach towards students on placement with a potential disability was illustrated by one interviewee who chose not to disclose because their practice educator had a disability themselves and had spent so much time talking about it that the interviewee felt

their own disability paled in comparison. On the one hand, a disclosure by the practice educator could potentially create an atmosphere of shared understandings of different types of disabilities, thus leading a student to disclose their own disability. On the other hand, as may have happened here, the student could have decided their disability was somehow lower in the order of disabilities and then chose not to disclose. This reveals how tricky the first moments of encounter between a student and practice educator can be. In addition, my findings stressed that for some interviewees timing is key with the decision to disclose hinging on the availability of the practice educator at the start of the placement. One said the practice educator was not there for the first week, and thus the moment was lost. Thus a multitude of pragmatic and more complex relationship issues come together to create a supportive environment that reduce the possibility of non-disclosure.

It is worth emphasising the need for sensitivity to each student's situation because it is easy for the practice educator to fall into the trap of assuming that they can explain the thoughts and feelings of other human beings (such as the student with a disability) by means of what I term 'related experience'. Put simply, related experience is the supposition that you know what the student is going through because you have experienced it yourself or the assumption you know the implications of their disability. If not accompanied by a genuine sense of insider perspective into the student's disability it can easily lead to stereotyping. Further complications and misunderstandings can then occur when labels are applied to particular individuals thus leading to misunderstandings and attitudes or even putting in place reasonable adjustments wholly inappropriate to that particular individual. Similar misunderstandings were cited by several of the interviewees in the findings.

Feelings of vulnerability (unconscious or otherwise) on the part of the student may also stem from a sense of bargaining or reciprocity and in doing so, an element of risk-taking. That is, the rationale for disclosure could for some students be about wanting or needing something from the practice educator. From the student's perspective, this may be about recognition and

acknowledgement from the practice educator about the student's disability and a need to negotiate the day-to-day logistics of how requisite skills and knowledge will be evidenced for the purposes of assessment.

Dilemmas inherent within the process of disclosure reflect the amount of pressure that students with a disability face during their practice placement experience with disclosure just one of a number of challenges they potentially face. Indeed, certain individuals may have developed coping strategies to deal with this kind of misplaced labelling and stereotyping (Velde, Chapin and Wittman, 2005; Brown, James and Mackenzie, 2006). Others though may have adopted the adaptive preference technique of modifying themselves and their desires or inclinations to fit in with the people surrounding and influencing them (Walker, 2006). Yet others may have given up altogether leading to behaviour which appears to represent a sense of withdrawal from life or general apathy (Roberts, Warner and Trumpower, 2000). This naturally exacerbates the situation when such behaviour is mis-read by the practice educator and consequently can perpetuate frustration on all sides.

The following quote by Pachankis (2007:339) neatly encapsulates the nexus between disclosure, adaptive preference, stigma and shame: "concealment often serves as an adaptation to hostile environments". Disclosure can also be linked to shame, as posited by Pachankis (2007), because retaining or concealing information concerning one's disability over time can result in feelings of shame. However, this same author espouses the benefits of disclosure in that for the person with a stigma-related condition, disclosure enables them to align their invisible sense of self with that of their outward presentation of self. Indeed, disclosure for some may be a way of influencing or controlling the environment (Ragins, 2008).

My findings indicate there is a positive side to non-disclosure in that it can inspire confidence in the student if they are able to manage the demands of the placement despite not disclosing. As well, if the environmental conditions are right, the student may feel that there is no need for disclosure

to take place as their disability is not having an impact on their performance. Additionally, non-disclosure can also be about agency on the part of the student. Agency plays an important role in that the student retains an element and sense of control in deciding what and how much to disclose (or not) and to whom. Control then can act as a management mechanism in that the student can use this to manage how others perceive them. Agency and empowerment then are important attributes for the student with a disability and consistent with my findings, reflect a sense of the need for the student to be in control of their destiny.

5.2.2 Work culture and practices

Kleinman and Hall-Clifford (2009) state that to combat stigma it is necessary to understand how it is created with reference to those who are stigmatised and the influence of social and cultural processes. Link and Phelan (2001:381) emphasise that “any approach must be multifaceted and multilevel”. Given the current debates in the existing literature and my findings in relation to the prevalence of stigma, this suggests to me the need for a major shift in societal attitudes and ways of thinking about and responding to disability. To address such a shift in the context of my study requires an understanding of constructions of disability and how these can be resolved or changed over time. Ragins (2008:207) poignantly asserts that it is “the perception of the stigma, rather than the stigma itself, that leads to different reactions...these perceptions vary by environment”. As a consequence, my findings go some way in addressing the question of how stigma is created in that the practice education environment plays a crucial part in shaping people’s behaviour, thoughts and attitudes. Even if the disability is visible, there are many facets to this and different situations on placement may expose differing expectations and feelings of vulnerability on the part of the student. Expectations of the student’s performance become progressively harder not only as the placement progresses but also as the student progresses from one placement to another.

The findings chapter highlighted how some interviewees (practice educators) seem to take the view of the medical model of disability in that they see the student with a disability as an additional burden or problem because of the way the disability is assumed to be 'resident' in the body of the student. While they engage with impairment, their relationship with the disabled person and their awareness of how the environment and their attitudes may contribute to the disablement are less evident. In addition, my findings and the existing literature suggest that people who have a disability are sometimes represented by their disability rather than being recognised and acknowledged for the 'whole' person they are. I have identified some of the key problems that arise when this view is subscribed to and I propose instead that there should be a focus on how the disability may be the result of a social construction, particularly exacerbated by the environment. In Chapter 2, I touched upon notions of how disability is constructed and formed. What is apparent from my findings is that, for the student, the effects of their disability appear to be shaped and influenced (in terms of thinking and behaviour) by the placement setting. The placement setting comprises a number of elements including culture and ways of working as influenced by the prevailing culture of the organisation and the physical setting.

An important point to cover here is that my findings highlighted how much pressure students feel they are under during placement. This pressure is identified in the context of having a disability and includes:

- having to embrace an unknown environment;
- achieving the placement learning outcomes within a defined timeframe;
- managing their disability, for example, deciding whether to disclose and/or trying out reasonable adjustments in a range of differing scenarios;
- having to work harder to compensate for the disability.

In Chapter 2 I referred to the concept of impression management (Pachankis, 2007). This resonates with and reflects the amount of pressure

students are under during placement in relation to managing their disability and the implications arising from, for example, concealing the impact of the disability if they have not disclosed or, even if they have, trying to give the impression that they are coping. As well, associated behaviours along with impression management include social avoidance and isolation, an increased emphasis placed on interpersonal feedback and maladaptive behaviour within close relationships (Pachankis, 2007).

Although it is a given that all students are under pressure during their practice placement experience, students with a disability can experience added pressure *because of* their disability. In educational management terms, this cannot be good for the learning that has to take place within the defined timeframe of the placement and in wider social justice terms, it is not good for the disabled person or the organisation either. There is an argument here to be made that at the very least, for the sake of optimising learning conditions, it is important to attend to the needs of students with disabilities. In addition, students need time to practise skills. Many participants stressed that, with practice, the student tends to experience an upward trajectory with the acquisition of requisite knowledge and skills. It may be important for organisations and key players involved in placement to acknowledge that, depending on the students' needs and capabilities, particularly where there is a disability, a different orientation / induction to the work-place may be needed where the appropriate amount of time and attention can be offered to them at the start.

Some patterns emerged in relation to the type of pressures that students find particularly challenging including multi-tasking, completing tasks within a defined timeframe and the pressure of being continuously assessed by the practice educator. A significant finding was the challenges in relation to information management - this comprised technology, note-writing, processing of information and verbal communication. Technology appeared to be one of the most challenging aspects, the student has to work with whatever data management system is used by that particular placement provider. Commensurate with the views of most interviewees, there is little

leeway for flexibility in reconfiguring the computer system to suit the student's needs.

A powerful statement from Wax (2014:255) on invisible disabilities is where she refers to Noelle-Neumann's 1974 spiral of silence emanating from within an organisation and the need to challenge the "systematic flow of ableism". I would argue that her statement also applies to visible disabilities.

Furthermore, Wax (2014) asserts the need for organisations as a whole (i.e. not just the individual practice educator or staff member) to take responsibility for addressing the issues around disability and doing so in a positive manner.

5.2.3 Inclusivity

Whilst the notion of inclusivity is critical, the question is how feasible is this in reality? Given the diversity of students with a disability, is the concept of inclusivity feasible for all in any given scenario? Shakespeare (2014:37) posits the notion of what he terms "barrier-free utopia" and associated problems inherent within this. It is not, he says, about removing all barriers and aiming for total inclusivity because such a situation is improbable. This points to the importance of targeting the individual student's needs, as one size does not fit all. An example (one which I have crafted, inspired by my data, combined with my own experience as a person with a disability and Disability Liaison Officer) that I cite in the context of students with a disability on placement but which resonates with Shakespeare's idea is this:

Imagine if you, as a practice educator, are running an induction day for a group of students on placement where you work. The day is pretty much 'full on' with a packed schedule of different speakers and visits to various departments. One of the students has compromised mobility and struggles to keep up with the group when going on a tour of the hospital; subsequently you find you are slipping behind on schedule. On returning to the training room, the next speaker is waiting to deliver their session and has to speed

up the delivery of information, another student asks them to slow down because they are deaf and need to lip-read.

What this example illustrates is that all students have different needs and such needs should be accounted for and planned - where possible - in advance so as not to compromise the learning process. The implication here is that the group as a whole should aim to be cognisant of each other's learning needs, which in turn suggests that the practice educator must create the conditions for this to happen. This is a pedagogical strategy that is not unknown in several educational contexts, including the National Health Service, for example, by grouping learners in any context into "learning sets" (Lawrence, 2007) which sets out to explicitly discuss ways of acknowledging and then supporting the differing needs of each member of the group, whatever their roles may be. This concerns learner diversity without segregation or discrimination (Liasidou, 2014), indeed, students with a disability are not a homogeneous group. Additionally, it may be that the practice educator has to invest additional time in ensuring the student benefits from the proffered learning. The right approach needs to be negotiated with the student to ensure their learning needs are met in addition to being balanced against the available resources: for example, thinking through the structure of the day, being prepared to go over information again with a student on a one-to-one basis to cover what was not initially picked up or understood. What this scenario also highlights is the importance of acknowledging that students have differing individual needs that need to be planned for more systematically than perhaps is done.

Indeed, Terzi (2005a:215) states "the design of physical infrastructures and social schemes plays a substantial role in the relation between impairment and disability". She also refers to the concept of interfacing, that is, if the environment is conducive for the person with a disability then the effects of disability are mitigated. In a similar vein, Shakespeare (2014:88) pointedly remarks, "different environments mitigate or accentuate disability and disadvantage". Indeed, both Terzi's and Shakespeare's statements are substantiated in my findings as they highlighted examples of interviewees

suggesting that with the right support in place they were *enabled* rather than *disabled*. This resonates in part with the social model of disability in that impairment in this context is less of an issue, and the emphasis is on ensuring the environment is conducive to the needs of the person concerned. Environment in this context is not just physical infrastructures but incorporates professional roles and social practices too.

In Chapter 2 I touched on the concept of the dilemma of difference. Norwich (1994:304) mentions the importance of being cognisant of resources for learning, including an awareness of the “complex interplay of strengths and weaknesses in the interaction of the individual learner and the external environment”. For students with a disability in practice education and key players in practice education, Norwich’s statements are helpful in facilitating the progression of requisite skills, knowledge and attitudes. Furthermore, Norwich (1994) cautions that strengths and weaknesses need to be considered equally alongside explicit learning goals.

Reasonable adjustments is a grey area in that practice educators will sometimes grapple with how far to go. The balance between providing the right amount of and appropriate support needs to be considered alongside the need to ensure that the student is able to demonstrate competence with the requisite skills and knowledge required to pass the placement. Tensions in relation to reasonable adjustment are well documented in the existing literature and resonated within my findings. A significant contribution from my findings is that reasonable adjustments require judicious application but also that there are complexities inherent in their application. For example, implementing reasonable adjustment can solve one aspect of the problem but create another. An example from the findings concerned the use of a Dictaphone to record an interview with a patient but it created an extra workload in having to listen to the entire interview again and necessitated longer working hours. The complexities are also reflected in the non-transferability of reasonable adjustments practised in the university setting versus the reality of what might work in practice in the placement setting. Adjustments can range from the provision of a simple template to aid note-

taking to allowing extra time for the student to complete their patient documentation.

I would suggest we need to exercise caution in thinking that the provision of reasonable adjustments will solve all problems for the student with a disability. If we provide reasonable adjustments does this result in placing the student with a disability on a level playing field - supposedly - with the student without a disability? Leading on from notions of a 'level playing field', relevant here is the concept of individualism as elaborated by Stark (2001:47) who said: "the solution to environmental problems is highly individual for each person and will result from a plan that includes multiple strategies (including architectural modification, assistive technology, programmatic support, and personal support), and considers the perspective of the individual". Although Stark was writing in the context of people with physical disabilities residing in their own homes, her words are nonetheless helpful and translatable to the context of my study as they reinforce the breadth of potential support that can be made available or adapted for students with varying needs in the placement context.

5.2.4 Relationships

The tripartite relationship between the student with a disability, the practice educator and the visiting tutor is key in facilitating the right conditions for a fair and just placement experience. The clinical learning environment lead is peripheral to the tripartite relationship but nonetheless has direct contact where appropriate with the practice educator and visiting tutor.

Communication between the student with a disability and the practice educator coupled with a welcoming environment is paramount. No matter how busy the particular workplace may be, it is of vital importance that the placement has been well planned and thought through by the practice educator, including the needs of the student - particularly if they have disclosed. This should then provide optimal learning conditions for the whole team in addition to a productive working relationship between student and practice educator.

Students are sometimes the recipient of unhelpful comments such as *this is a fast paced environment, how can you cope if you have dyslexia / you cannot hear? Or is this really a suitable place for you to be sent?* Not only do such comments potentially dent a student's confidence upon entering what is, for them, a strange and new environment but also they could even lead to them reviewing their suitability for the course. Indeed, this signals the powerful influence of societal attitudes including the prevailing culture of the work-place and how this can be detrimental for the student with a disability. Nussbaum (2006:73) captures the impact of negative societal influences when she asserts that "people adjust their preferences to what they think they can achieve, and also to what their society tells them a suitable achievement is for someone like them". In some cases, if the adaptive preference is detrimental then potentially this represents a worrying state of affairs and points to the need for action in negating these scenarios. As well, there can be tensions between the therapist versus practice educator role such as adopting more of a therapist rather than an objective practice educator role towards the student, almost treating them as if they were a patient rather than a student. Such a role needs careful monitoring to ensure it is not to the detriment of the student's performance.

A key consideration here is that practice educators need time to acclimatise to having a student with a disability on placement so that the notion shifts from one of feeling the student is a potential burden to one of positively embracing the potential that diversity of staff can bring. This shift from burden to embracing diversity also recognises their dependency on the student with a disability. It is also about embracing students with a disability as part of the workforce and the fact that they can and should be depended upon as part of the team in delivering a high-quality service for the benefit of patients on the receiving end of healthcare. Embracing a diverse workforce can in turn serve to mitigate what I label a state of 'active lethargy'. Active lethargy for me represents a barrier to genuine interdependency between all involved in practice education. I define active lethargy in layperson's terms as paying lip service towards the student with a disability. Active lethargy, I

argue, can exist as a conscious or unconscious process and, if the latter, can possibly be a byproduct of the environment such as pressures of work, the impossibility of changing an aspect of the work environment or the prevalence of negative attitudes towards work colleagues who have a disability.

My findings have been instrumental in identifying a number of significant environmental influences that have impacted on the students' experiences and consequently on their ability to demonstrate effective performance; for example, noise, space, speed of work, and culture of the work-place. In cultivating a paradigmatic shift in relation to notions of disability, it is not just about the student, it should concern all involved in practice education. A more helpful mind-set is the acknowledgement and recognition that we are all differently able or disabled in different situations. In proclaiming this, I can see that it relates to notions of ableism and disabilism, indeed my findings highlight that the binaries between the two would appear not to be so rigid. Key here is the need to ensure that the relationship between abled and non-abled people is conducive and even more so, coupled with an understanding and awareness of the disability in the context of the environment. In embracing diversity, a positive attitude and culture need to emerge and not to view diversity as a threat to the existing workforce. Indeed, Davis (2002:50) asserts that "Disability is not so much the lack of a sense or the presence of a physical or mental impairment as it is the reception and construction of that difference".

A strong message emanating from my findings concerns the importance of not viewing the student's disability as all-encompassing to the extent that the spotlight, so to speak, shines on the student only. Instead, the cultivation of a supportive work environment benefits everyone but is a shared responsibility, drawing on the collective actions of key players in practice education. What is not helpful is an unnaturally forced situation led by political correctness and fear of possible repercussions.

I conclude this section on disability conceptualisation and construction by synthesising the four concepts covered up to this point with reference to the

critical realist approach. Table 8 illustrates the necessarily laminated layer of the critical realist approach described in Chapter 2. The second column depicts the related level, and where appropriate I have assigned more than one level to the identified concept. The third column depicts the mechanism, the issue that is being manifested. The fourth column provides the context of the mechanism described and the final column is the outcome. Application of the critical realist approach and the necessarily laminated layer in relation to the four concepts shows how the impact of disability is construed as complex and multi-faceted.

Table 8: Disability conceptualisation and construction concepts mapped using a critical realist approach

CONCEPT	LEVEL	MECHANISM	CONTEXT	OUTCOME
Stigma & disclosure	<ul style="list-style-type: none"> • Psycho-social • Psychological 	<ul style="list-style-type: none"> • Stigma - how is student perceived by others? 4 characteristics (Ragins, 2008): <ul style="list-style-type: none"> - Controllability - Peril or threat - Disruptiveness - Course • Disclosure disconnects (applicable to invisible disabilities); • Visible disabilities not necessarily easier to manage. 	<ul style="list-style-type: none"> • Potential tension and stress for the student with a disability in making the decision to disclose their disability or not; • Feelings of vulnerability on the part of the student; • Adaptive preference may come into play. 	<ul style="list-style-type: none"> • Not clear-cut, decision to disclose can be a risky one; • If student does not disclose they may struggle on placement.
Work culture & practices	<ul style="list-style-type: none"> • Culture • Psycho-social • Psychological 	How do others perceive the student - medical vs social model of disability or otherwise?	<ul style="list-style-type: none"> • Organisations wield a powerful influence in shaping one's thoughts, behaviour and actions; • Environment is unknown to student initially; • Student under pressure (impression management) in conforming to norms. 	<ul style="list-style-type: none"> • Important not to see disability as a barrier to accessing support.
Inclusivity	Culture	<ul style="list-style-type: none"> • Students have diverse learning needs; • Environment can impact on the person's disability - positive or negative; • Reasonable adjustments require judicious application. 	<ul style="list-style-type: none"> • An inclusive environment is important in creating the right conditions for the student during their practice education experience. 	<ul style="list-style-type: none"> • Some see diversity as a threat; • Are reasonable adjustments in university comparable with those in the work-place?
Relationships	<ul style="list-style-type: none"> • Psychological • Psycho-social 	<ul style="list-style-type: none"> • Intensity of relationship between practice educator and student with a disability. 	<ul style="list-style-type: none"> • Need for clear and open communication. 	<ul style="list-style-type: none"> • Need all key players to work together to facilitate an inclusive learning environment.

Up to this point I have reviewed a number of factors within four key concepts that contribute towards the construction and conceptualisation of disability. I have also applied the critical realist approach in relation to the four concepts. I now want to take this opportunity to explore the place of theoretical frameworks and their utility in aiding an understanding of disability and its impact. In Chapter 2 I provided an in-depth description of the ICF and the capability approach, both of which emphasise the importance of viewing the person with a disability from a holistic perspective. The next section of this chapter explores both theoretical premises in the context of my findings.

5.3 Part III: TOWARDS A THEORETICAL PREMISE: UNDERSTANDING THE LIVED EXPERIENCE OF PRACTICE EDUCATION THROUGH A CONCEPTUAL FRAMEWORK

This section explores the utility of a structured framework in conceptualising disability. I offer a critique of two key frameworks introduced in Chapter 2 - the ICF and the capability approach - and consider whether they have a place in enhancing an understanding of students with a disability in practice education.

In Chapter 2 I suggested that the ICF serves a useful purpose in viewing the differing elements of the ICF and the interplay between them. Figure 7 illustrates the ICF framework again and captures dyslexia as an example health condition (as it was the most prevalent one referred to by the research participants). The non-italicised words are taken from the ICF (WHO, 2001) chapter describing health states according to the relevant classification with descriptions. In addition, I have drawn on examples from my findings to capture how body functions and structures, activity, and participation were impacted because of the disability in relation to use of SystmOne, an electronic form of patient documentation. This scenario captures the challenges a student may commonly experience with patient documentation:

- lacking confidence in note-writing skills whilst talking to patient;
- entering data into IT system which is not user-friendly.

Contextual factors including environmental and personal elements also form an inherent part of the ICF framework. Note within environmental factors how some are facilitators, for example, the helpful attitude of the practice educator, and others are barriers, for example the SystmOne database.

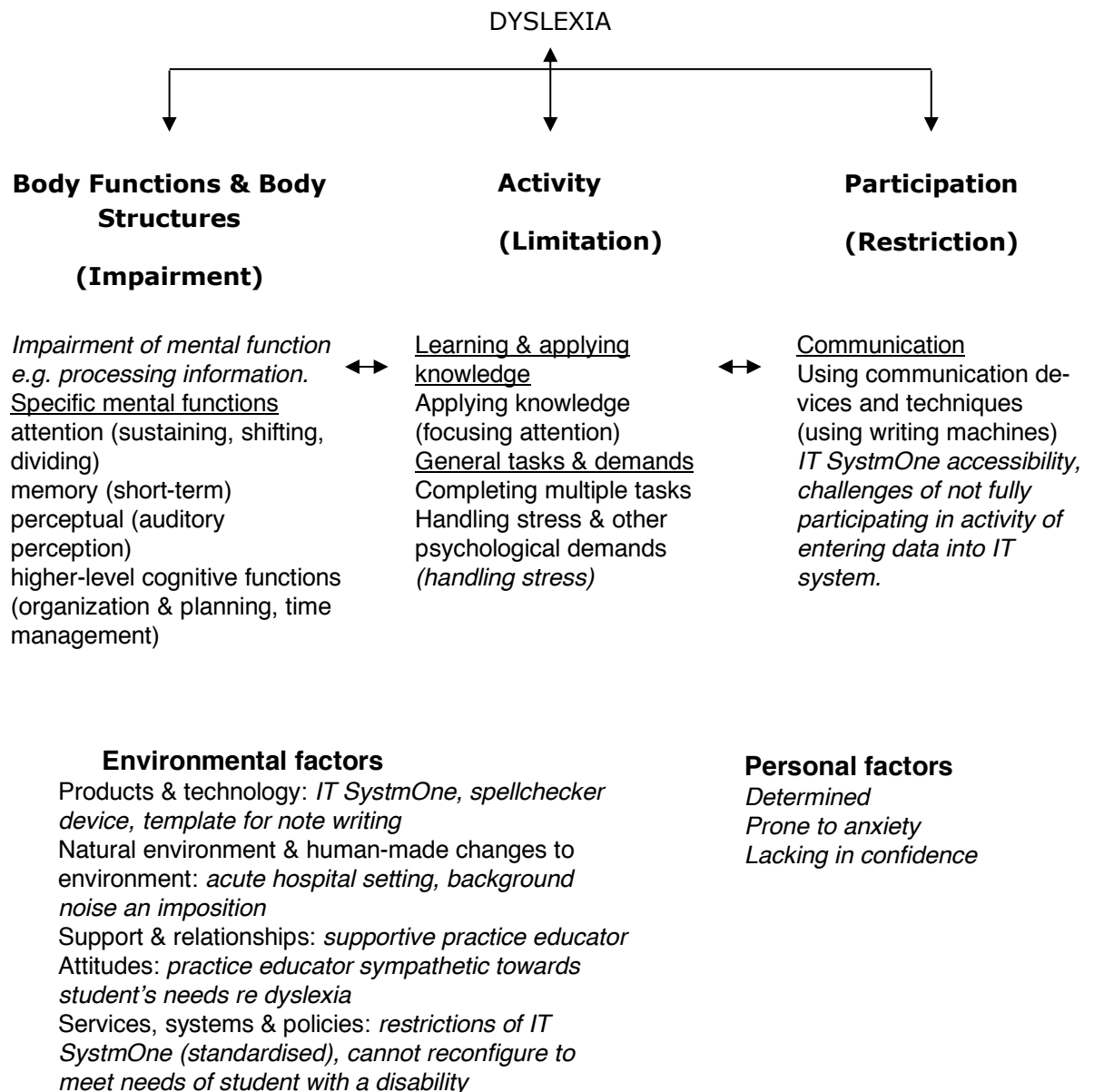


Figure 7: ICF framework (WHO, 2001) in context of student with dyslexia

At this juncture, I recognise the need to consider a complementary framework to the ICF (for reasons explored later in this chapter) and now turn to an exploration of the capability approach. My proposal for the use of the capability approach - in the context of my study - is neatly encapsulated by Walker (2008:151) who says that “because learning is recursive, our capability development shapes our capability, reflexivity and agency in our

future and our future choices and aspirations”. Walker’s words reflect for me the purpose of practice education which affords the opportunity for the repeated rehearsal of knowledge, skills and attitudes in a range of practice environments. Engagement in reflective practice is an inherent part of the student’s journey towards becoming a healthcare professional.

Table 9 depicts twelve capabilities, drawn from a number of authors. The following capabilities are from Walker’s list (2006): practical reason; educational resilience; knowledge and imagination; learning disposition; social relations and networks; respect, dignity and recognition; emotional integrity, emotions; bodily integrity. I have added language from Wolff and de-Shalit’s list (2007) and an additional three items from Mutanga and Walker (2015) - aspiration; culture; identity. In Table 10 I have provided a brief description according to the relevant author (refer to appendix T for a fulsome description of each capability). In the right-hand column, I have provided my interpretation of the identified capabilities in the context of my findings. My reasoning for a general list of interpretations as opposed to relating them individually to each capability is that I view the capabilities I have selected as being inter-dependent, that is, each one has an impact on another. Indeed, Mutanga and Walker (2015:514) concluded that in relation to their list of capabilities some were “architectonic” and some “incommensurable”. An example of interdependency or architectonic capabilities is that I view educational resilience (able to navigate work, study, life) as being interdependent upon learning disposition (having confidence in one’s ability to learn) in that if a student is confident about their learning they are more likely to be able to achieve a good balance between work, study and life. Using this approach enabled me to avoid a formulaic or prescriptive approach that would rigidly demarcate each capability alongside an interpretation.

Table 9: Capabilities in context of student with a disability on placement aligned with my personal interpretation of each. Numbers 1-8: Walker (2006:128-29); number 9: Wolff and de-Shalit (2007:60); numbers 10-12: Mutanga and Walker (2015:511-12).

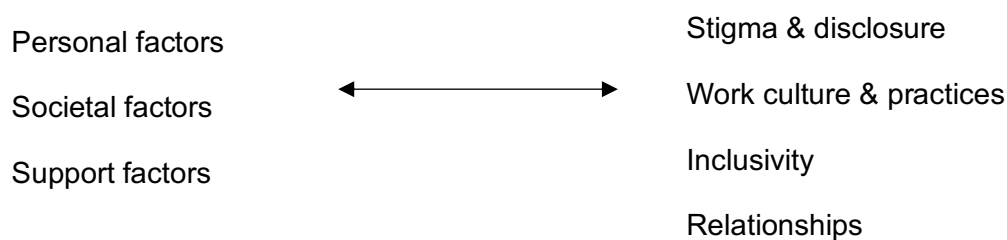
Capabilities	My interpretation
1. Practical reason "Having good judgement".	<ul style="list-style-type: none"> Knowing what strategies work and ability to implement these to manage impact of disability. Confidence to try out strategies in new situations. A sometimes non-traditional approach to studying and learning based on personal experience of disability. Awareness of own personal and professional developmental needs. Practice educator needs to demonstrate knowledge and awareness of how to support the student with a disability and to adopt the right approach, demonstrating empathy and sensitivity. Consider invitational qualities (Billett, 2002) of the work-place. Being on placement can generate feelings of fear - fear of the unknown and fear of failure. Aspirations for getting on with the demands of the healthcare programme, not being unduly affected by adaptive preference formation. Sense of progression and development towards becoming a healthcare professional. Professional socialisation and awareness of the difference between academic and practice environment. Learning to be resilient in the face of stigma due to disability. Awareness of how disability may be perceived by work colleagues and patients in practice. Disability identity: situating oneself in context of disability, student's unique contribution or perspective is an advantage not a limitation. Ability to articulate personal narrative of disability.
2. Educational resilience "Able to navigate study, work and life".	
3. Knowledge and imagination "Being able to use critical thinking and imagination to comprehend the perspectives of multiple others and to form impartial judgements".	
4. Learning disposition "Having confidence in one's ability to learn".	
5. Social relations and social networks "Being able to work with others".	
6. Respect, dignity and recognition "Being able to have respect for oneself and for and from others".	
7. Emotional integrity, emotions "Not being subject to anxiety or fear which diminishes learning".	
8. Bodily integrity "Safety and freedom from all forms of physical and verbal harassment".	
9. Language "Being able to access knowledge in a language that is accessible to students".	
10. Aspiration "Capacities to articulate and pursue aspirations are affected by and affect other capabilities".	
11. Culture "The capability to live without being tripped by culture".	
12. Identity "Being able to choose one's identity".	

Reflecting on this capability framework, I am reminded of Walker's (2008) words when she says not only do higher education institutions need to decide which capabilities are sufficiently meaningful and appropriate to embed within the curriculum but also we need to be mindful as to how such capabilities can be translated into enabling students to achieve them. Having applied the ICF and the capability approach in the context of my findings, I propose that there is a robust case to be made for their use in combination with the key tenets of a critical realist approach. Such an approach affords an exciting opportunity to gain a holistic, multi-faceted perspective and understanding of the lived experience of students with a disability in practice education. As well, such an understanding paves the way for an aspiration of sorts, a paradigmatic shift where we need to cultivate an ethos of shared responsibility in facilitating an optional environment for students with a disability to flourish in practice education. Such shared responsibility must incorporate the key players in practice education - in particular the placement provider and university.

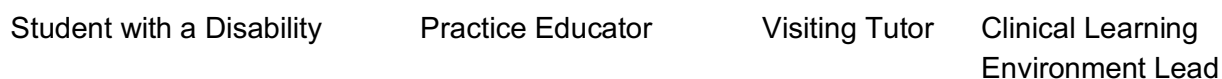
5.4 Part IV: TOWARDS AN ASPIRATION FOR THE ENHANCEMENT OF PRACTICE EDUCATION: AGENTS OF CHANGE IN MAKING SENSE OF DISABILITY CONCEPTUALISATION AND CONSTRUCTION

Following the composite narratives at the start of this chapter, I made an assertion in relation to the need to work towards an overarching aim of ensuring social justice and support for students with a disability in practice education. At this juncture I have presented a number of thoughts and claims concerning conceptualisations of disability and application of a theoretical premise. I have also repeatedly referred to the need to instigate a paradigmatic shift to facilitate an optimal environment for students with a disability in practice education. My advocacy of a paradigmatic shift is based on the need to cultivate an ethos of embracing a diverse workforce in health and social care operationalised through a means of integration. Integration of students with a disability within the workforce is key to facilitating an enabling environment as illustrated in diagrammatic form in Figure 8. A detailed explanation of this illustrative diagram follows.

Integration as a mechanism to create the right environmental conditions on placement



Effective integration in the work-place through working together as agents of change



Theoretical lens as a framework

International Classification of Functioning, Disability and Health
&
Capability Approach

Figure 8: Illustrative diagram showing integration as a mechanism to facilitate optional environmental conditions on placement

Working from the bottom up, the first part of the illustrative diagram depicts the ICF and capability approach used as a theoretical lens, capturing an insider perspective into the lived experience of being a student with a disability on placement. The ICF offers a perspective for appreciating the strengths and challenges that disability brings to the work-place. The capability approach emphasises beings and doings and offers a strategic vision for students to realise their capabilities.

The middle part of the diagram captures the four immediate players in practice education that were part of the study - student with a disability, practice educator, visiting tutor and clinical learning environment lead. The onus and responsibility are on not only all key players but also others within the team that may have contact with the student to ensure the right conditions are provided in respect of a positive work-place culture. This emphasises the need for a dynamic and open relationship between key persons, working together as agents of change to bring about effective integration of students with a disability into the work-place.

The final part of the diagram shows the process of integration in operation. In identifying integration as a key part of my study I have drawn on inspiration from Van de Ven *et al.* (2005) who conducted a study to define the concept of integration from the perspective of people with a disability. They identified five elements of integration: “functioning ordinarily without receiving special attention; mixing with others and not being ignored; taking part in society; trying to realise one’s potential; and directing one’s own life” (Van de Ven *et al.*, 2005:311). The process of integration is influenced by three factors - personal, societal and support, all of which are operationalised through interaction between the person with a disability and society (Van de Ven *et al.*, 2005). The three factors are listed below, drawing on examples from the study by Van de Ven *et al.* (2015) accompanied by my own adaptations to reflect the context of a student with a disability on practice placement.

Personal factors - this includes the student's attributes and how their personality has a bearing on their resilience levels. Part of my findings evidenced the 'can do' attitude of students demonstrating resilience and a determination to just get on with the placement experience.

Societal factors - this includes the need for others working alongside the student to be (ideally) cognisant of their disability and using that knowledge to cultivate a genuine understanding and recognition of the student's needs. Having more awareness of disability and of its impact can help to dispel stigma and work towards a growing acceptance of a diverse workforce. Also relevant here is the need to understand the culture of the work-place and how this in turn can impact upon the student's performance and well-being.

Support factors - this may include practical support (for example, assistive devices) or emotional support. Key here is the right type of support targeted towards and relevant to the students' needs to enable them to flourish in the work-place. As mentioned earlier in this chapter, an important consideration here is whether reasonable adjustments applied in the university setting are translatable and workable in the environment. As well, judicious application of reasonable adjustments is required to ensure the student is not being unfairly advantaged in relation to meeting the requisite placement learning outcomes.

My diagram in Figure 8 shows how the three factors of integration described above have the potential for a two-way interaction with the four concepts identified earlier in this chapter (stigma and disclosure, work culture and practices, inclusivity, and relationships). In Table 9, I demonstrated how these four concepts - applied using a critical realist approach - illustrated disability as complex and multi-faceted. Integration can act as a mechanism to challenge any negative outcomes arising from the four concepts. In other words, the four key players need to work together to foster a positive and inclusive culture to benefit *all* members of the workforce which includes students with a disability on placement. This assertion is corroborated by

Van de Ven *et al.* (2005) whose study showed the value of other people in society as partners in the process of integration for people with a disability.

In drawing this chapter to a close, the following points capture the essence of my overall quest for a paradigmatic shift in supporting students with a disability during their practice education experience:

- institutions have a responsibility to play their part in ensuring that they are genuinely embracing - through their behaviour, words and actions - of students with a disability. This includes the practice educator, visiting tutor and clinical learning environment lead;
- the 'burden' of attending to the needs of such students should not be perceived as such nor fall entirely on their shoulders. Indeed, Walker asserts that "becoming an agent through learning is not straightforward for those who are different from the norm that an education system assumes" (2008:155);
- understanding conceptualisations and constructions of disability can be realised through study of a critical realist approach and critical disability studies;
- the ICF and capability approach are complementary and offer a means of a theoretical lens through which to understand the lived experience of disability.

CHAPTER 6: CONCLUSIONS

“Disability doesn’t make you exceptional, but questioning what you think you know about it does” (Young, 2014).

6.1 Introduction

This doctorate commenced with one aim in mind: what can I learn through research about improving the experience for students with a disability when they are away from university on their practice placement experience? Therefore, it started off as wanting to know more about the challenges they faced and why. I wanted to apply suitable theoretical frameworks to understand the findings of my study, I had to delve deep in considering what this data symbolised as only then could I claim to understand the how and why behind the lived experiences of students with a disability on placement.

Having completed my research, now is an opportune moment to reflect on the extent to which my questions - reproduced below - have been answered in addition to considerations of what I have contributed to the field:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability and / or environment make a difference?
- 3) What existing strategies (if any) are employed to improve the placement experience by both students and others, and how effective are they?

Having completed fifteen interviews and analysis of data, using existing research literature and the key theoretical frameworks of the ICF and the capability approach, I identified two themes with the complexities surrounding the decision to disclose and what influences that decision-making process weaved throughout:

- work context and practices: this theme highlighted that students with a disability are not homogeneous although the commonalities (within this theme) amongst those with a range of disabilities is worth noting, and no one placement provider appears to be better than another. Factors

influencing the student's performance on placement is contextual; for example, the fast-paced nature of the acute environment may suit some students but not others. The environment was considered in relation to speed / pace of work, noise and space. A number of key skills were also identified as being potentially challenging because of the disability, including multi-tasking and information management. This theme also captured the influence of attitudes in the tripartite relationship between student with a disability, practice educator and visiting tutor. The clinical learning environment lead is also important here in that their role cuts across all healthcare professions and they possess extensive experience and knowledge concerning the practice education experience of students with a disability.

- public perception of disabilities and management of identity: this included a number of sub-themes including stigma, visible and non-visible disabilities, disability identity, inclusivity, disability type and awareness-raising, all of which have an influence on how others perceive the student's disability and how in turn the student manages their disability in the face of a sometimes oppressive environment. Pedagogical considerations in respect of strategies that aid students' learning were also identified including the type of support they find helpful.

In Chapter 5, I then applied the findings from the interviews to a theoretical framework, drawing on the ICF, the capability approach and supported by overarching tenets of the critical realist approach within disability studies. In relation to implications for practice, I mapped what I considered as key tenets from the field of critical disability studies to the empirical findings of my research. In addition, whilst acknowledging their limitations, I used the ICF and the capability approach as a lens to understand the experiences of students with a disability during their practice education experience. Utilisation of and reference to critical disability studies in tandem with the ICF and capability approach have the potential to trigger transformative knowledge and social justice in terms of providing a better practice education experience for students with a disability.

In addition, my findings have been instrumental in illuminating the environment as a critical factor in its interaction with students who have a disability and the subsequent impact on their performance during their practice education experience. As well, I have identified the need for a paradigmatic shift in the promotion of an inclusive workforce which will benefit the student with a disability.

My study has shown how such a paradigmatic shift can be operationalised:

- I have utilised both the ICF and the capability approach in aiding an understanding of the lived experience of students with a disability in practice education.
- I have applied the laminated layer framework illustrating how the critical realist approach captures disability as complex and multi-faceted incorporating different levels, mechanisms, contexts and outcomes mapped against the four concepts identified in Chapter 5, Part II - stigma and disclosure; work culture and practices; inclusivity; and relationships.

6.2 Key suggestions for practice education

A document entitled *Inclusive Teaching and Learning in Higher Education as a route to Excellence* (Department for Education, 2017) asks the pertinent question as to whether there is a means of communicating to placement providers expectations around reasonable adjustments and more so, ensuring this actually happens. Key here is the need to emphasise that all stakeholders should participate in activities to make changes leading to an improved practice education experience for students with a disability. This could – and should - feel empowering for everyone as opposed to being a passive recipient of change. My thesis has the potential to address this through the following suggestions:

- 1) Use of the composite narratives as an educational tool to explore key roles that people hold in practice education - student with a disability,

practice educator, visiting tutor and clinical learning environment lead and the inherent complexities, interdependencies and needs of such roles in supporting students with a disability. Working in conjunction with actors, the narratives can be applied in a workshop using the Augustus Boal 'Theatre of the Oppressed'. This utilises a participatory form of theatre encouraging interaction from the audience to explore a range of scenarios related to practice education. The participatory element encourages the audience to replay the scenarios and to influence the outcome for example, how to support a student when disclosing a disability. These composite narratives have pedagogical value to raise awareness of the challenges that students with a disability and key stakeholders face in practice education. As well, the need to cultivate a supportive work environment is paramount in ensuring that learning opportunities meet the diverse needs of students with a disability. In the context of students with a disability, the narratives should generate discussion on the following pedagogical interventions:

- awareness of what constitutes invitational qualities (Billett, 2002) within the work-place, for example, tailored inductions;
- productive use of learning tools including learning contracts and supervision both formal and informal;
- implementation of learning sets within the practice environment. Learning sets have rules which members adhere to and afford the opportunity within a confidential setting to empower members through discussion and problem-solving contextual, real-life scenarios and sensitive issues.

All of the above have potential gains for key persons involved in practice education particularly if helpful suggestions emanating from the group are cascaded more widely as a means of improving the practice education experience. A worked example of a short composite narrative exploring the theme of disclosure is provided in appendix R, such a scenario has the potential to empower the student and to articulate strategies to mitigate challenges and develop resilience. Simultaneously, this scenario encourages the practice educator to think about how they can best support

the student and how they in turn can convey a helpful and supportive approach.

2) In my capacity as Disability Liaison Officer, to encourage the re-establishment of the Students with Additional Learning Needs group however, this could eventually be student-led to foster empowerment and autonomy. Closely related to the notion of learning sets is an opportunity for liaison with the University Student Support Service and the Representation and Opportunities Coordinator. The purpose would be to establish a targeted means of support and information-sharing on practice education experiences for students with a disability through prospective, spective and retrospective reflections together with an identification of effective pedagogical tools to support the placement experience.

3) Construction of a practical Needs Analysis in which the student identifies a specific challenge and lists what these are then identifies the strategies to overcome the challenge. A worked example is furnished below:

Overarching theme: difficulty writing

Clinical need: documenting patient records in accurate, timely way

Challenges

1. noisy environment reduces concentration, increases mistakes
2. handwritten, no spell check
3. anxiety about messing up a legal document
4. difficulties remembering details

Potential solutions / support strategy

1. Noisy environment...
 - 1a. earplugs
 - 1b. move to quieter part of ward
 - 1c. schedule regular time for notes
 - 1d. request that no one asks me questions when writing up
 - 1e. play music in earphones

4) Production of a modular pamphlet intended as a helpful resource, targeted primarily for practice educators to help them gauge the expectations of the student with a disability and how they can help the student on a very practical level. The pamphlet would be constructed using iSpring technology, creating tools for interactive learning. A working party would be convened to complete this work and would include input from students with a disability, practice educators, clinical learning environment leads, visiting tutors and the University's disability team (Student Support Services). It is envisaged that the pamphlet will include the following:

- Chapter 1: Definition of practice education and quotes from students with a disability on what it is like from a student perspective, being on placement – this is likely to include themes of being anxious and overwhelmed, needing time to be orientated to the environment;
- Chapter 2: Information on stigma and disclosure and the impact of these on the student;
- Chapter 3: Key sections to include mental health, sensory disabilities, specific learning difficulties, musculo-skeletal conditions with information on the definition of key diagnoses and how and why it might impact the student's performance on a day-to-day basis in the context of being on placement;
- Chapter 4: examples of reasonable adjustments including practical ideas of how to overcome challenges for example, a structured template to assist with patient documentation;
- Chapter 5: the role of the visiting tutor and University Student Support Services in supporting the student.

5) Employability: for students with a disability, having completed their programme of study, it is not helpful if they experience significant barriers to securing employment in their chosen profession as a result of their disability. Working closely with the Director of Employability and the University's Careers Services affords the opportunity to ensure that final-year students are well informed of any associated caveats that may commonly occur when

applying for jobs, including the complexities inherent within the decision to disclose the disability or not, awareness-raising in relation to resources available for implementation of reasonable adjustments and the transition from student with a disability to newly registered professional with a disability. This information-giving would deliver well within a workshop-type setting, as would inviting past graduates with a disability working in practice to share their experiences of 'life at the coal-face'.

6.3 Limitations

I have reflected on the differing stages of engaging in research and captured some key points I would need to be mindful of when engaging in research-related activities.

Participant recruitment: some limitations were evident, for example, the paucity of practice educators and visiting tutors. On reflection, asking to sit in on staff meetings for both target groups with the aim of talking about my research and using the opportunity for direct recruitment may have yielded more participants and overcome any potential hesitations that individuals may have had in regard to talking about sharing experiences of disability. Additionally, widening the inclusion criteria for students would have enabled me to recruit students with a range of health conditions as the prevailing condition was specific learning difficulties.

Methodological approach: in retrospect, utilising alternative methods to conduct my research may have afforded the opportunity to achieve a more in-depth exploration of the experiences of students with a disability in practice education within a more naturalistic setting. For example, an ethnographic approach would assist in handling some of the more sensitive topics that may arise in relation to practice education and student experiences.

Composite narratives: in their present form, they read as somewhat stilted and lacking a naturalistic tone. Piloting with key partners in practice education would ensure the content and style are appropriate and reflect the challenges that students with a disability, practice educators, visiting tutors

and clinical learning environment leads tend to encounter in practice education.

6.4 Future research

The quest for evidence-based practice is never finite and to that end, my study has opened up new lines of inquiry which in themselves form the basis for further research. In constructing this list, I have grouped suggestions for future research into two main categories - theoretical and pedagogical. Key here is the need to retain a focus on students with a disability in practice education.

Theoretical inquiry:

- Operationalise and evaluate an identified capability set in enhancing 'doings' and 'beings' in the context of practice education. This could be achieved through tracking the same cohort over the duration of their programme.
- To explore how the ICF can be operationalised as a means to understanding the lived experience of students with a disability in practice education.
- To explore how a critical disabilities studies approach can enhance the practice education experience of students with a disability in practice education.

Pedagogical inquiry:

- To critically analyse the opportunities and challenges inherent within learning to ensure that content and delivery of information in addition to the learning environment meet the diverse needs of students with a disability. This should include an examination of pedagogical set-ups such as the invitational qualities of the work-place, inductions (content and delivery), learning sets, learning contracts and tutorials.
- An investigation of how reasonable adjustments can be implemented to meet the diverse needs of students with a disability in addition to

recognising how the learning environment can afford or constrain such opportunities.

6.5 Final reflections

I started this chapter with a thought-provoking statement by Stella Young and I end this chapter on a similar note by Nussbaum (2004:307) who questioned: “why should mere atypicality give one a life of hardship?”. Furthermore, she reminds us that the social, educational and physical environment should be conducive in enabling the person with a disability to function. I like to think that this is true. In the context of practice education, it is time that we stopped treating disability as a potential state of unease and instead embrace students with a disability as part of our future workforce. In doing so, we need to ensure that we are equipped with the right resources in the right place at the right time to support their journey towards becoming a healthcare professional. For this paradigmatic shift to happen we need to heed the words of Watts, Comim and Ridley (2008:2), however, in doing so I caution the need for education to be extended to all key players (and the wider team) within practice education to support the student with a disability:

More and better education may provide the individual with more opportunities to develop the reflection and reflexivity needed to challenge adaptive preferences so that, even if it is not possible for her to change the circumstances constraining her well-being, she can cease her acquiescence in them and learn to recognize the potential for a better life.

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APPENDIX A: LITERATURE SEARCH STRATEGY

Title of research

Healthcare students with a disability in higher education: identifying challenges and coping strategies on practice placement

KEY WORD	
Healthcare Student A1 Healthcare student\$ [s] A2 Allied healthcare student\$ [s] A3 Occupational therap* student\$ [s] A4 Physical therap* student\$ [s] A5 Physiotherap* student\$ [s] A6 Speech and language therap* student\$ [s] A7 Student nurs\$ [s]	
Disability B1 Disab\$ [ed] B2 Additional need\$ [s] B3 Handicap\$ [ed]	
Higher Education C1 Higher Education C2 Universit\$ [y] [ies] C3 College\$ [s]	
Challenges D1 Challeng\$ [e] [es] [ing] D2 Difficul\$ [y] [ies] D3 Problem\$ [s] D4 Demand\$ [s] [ing] D5 Trial\$ [s] D6 Test\$ [ing] [ed]	
Coping E1 Cop\$ [e] [ing] [s] E2 Manag\$ [s] [ing] [ment] E3 Surviv\$ [e] [s] [ing] E4 Withstand\$ [s] [ing] E5 Contend\$ [s] [ing] E6 Handl\$ [e] [es] [ing] E7 Deal\$ [s] [ing]	Strategies F1 Strateg\$ [y] [ies] F2 Method\$ [s] F3 Tactic\$ [s] [al] F4 Plan\$ [s] [ning] F5 Manage\$ [s] [ing] [ment]
Practice Placement G1 Practice placement\$ [s] G2 Fieldwork education G3 Placement education G4 Clinical placement\$ [s] G5 Practice education	

BOOLEAN EXPRESSIONS: 'and' = • 'or' = +

$$[((A \cdot B) \cdot C) \cdot G \cdot D = X$$

$$X \cdot (E+F) = Y$$

$$[((A \cdot B) \cdot C) \cdot G \cdot D] \cdot (E+F) = Y$$

$$\text{Step 1: } (A \cdot B) \cdot C = [1]$$

$$\text{Step 2: } [1] \cdot G = [2]$$

$$\text{Step 3: } [2] \cdot D = [3]$$

$$\text{Step 4: } [3] \cdot (F+E) = [4]$$

APPENDIX B: GATEKEEPER LETTER TO HEAD OF SCHOOL

School of Health Sciences
Faculty of Medicine and Health Sciences
The Queen's Building
University of East Anglia
Norwich
NR4 7TJ
5 February 2015

Dear Head of School

As part of my doctorate in education studies at the University of East Anglia, I am conducting a study entitled: Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach. The purpose of this letter is to seek permission from you to recruit relevant lecturers from the School of Health Sciences who have a role as visiting tutor from the following programmes:

BSc (Hons) Programme in Occupational Therapy
BSc (Hons) Programme in Physiotherapy
BSc (Hons) Programme in Speech and Language Therapy
Pre-registration MSc Programme in Occupational Therapy
Pre-registration MSc Programme in Physiotherapy

My study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development. In addition to eliciting data from students I will also be seeking the perspectives of practice educators and clinical learning environment leads. Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

This study has received approval from the School of Education and Lifelong Learning Ethics Committee and R and D approval from the Norfolk and Norwich University Hospital. If you have any questions please do not hesitate to contact me. Thank you for taking the time to read this letter.

Yours sincerely
Jane M Hibberd
Lecturer in Occupational Therapy j.hibberd@uea.ac.uk

APPENDIX C: GATEKEEPER LETTER TO COURSE DIRECTORS

School of Health Sciences
Faculty of Medicine and Health Sciences
The Queen's Building
University of East Anglia
Norwich
NR4 7TJ
Date to be inserted

Dear (Name of Course Director)

As part of my doctorate in education studies at the University of East Anglia, I am conducting a study entitled: Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach. I am writing to you in your capacity as Course Director for the (select appropriate one from list below)

BSc (Hons) Programme in Occupational Therapy
BSc (Hons) Programme in Physiotherapy
BSc (Hons) Programme in Speech and Language Therapy
Pre-registration MSc Programme in Occupational Therapy
Pre-registration MSc Programme in Physiotherapy

My study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development. In addition to eliciting data from students I will also be seeking the perspectives of practice educators, clinical learning environment leads and visiting tutors. Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

The purpose of this letter is to seek permission to recruit relevant students from your programme to assist me with my study. If you have any questions please do not hesitate to contact me. Thank you for taking the time to read this letter.

Yours sincerely
Jane M Hibberd
Lecturer in Occupational Therapy j.hibberd@uea.ac.uk

APPENDIX D: GATEKEEPER LETTER TO DIRECTOR OF CLINICAL LEARNING ENVIRONMENT LEADS

School of Health Sciences
Faculty of Medicine and Health Sciences
The Queen's Building
University of East Anglia
Norwich
NR4 7TJ
Date to be inserted

Dear (CLEL Lead)

As part of my doctorate in education studies at the University of East Anglia, I am conducting a study entitled: Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach. My study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as a conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development. In addition to eliciting data from students I will also be seeking the perspectives of practice educators and visiting tutors. Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

The purpose of this letter is to seek permission from you to recruit relevant Clinical Learning Environment Leads employed by Health Education East of England and who have links with the School of Health Sciences. If you have any questions please do not hesitate to contact me. Thank you for taking the time to read this letter.

Yours sincerely
Jane M Hibberd
Lecturer in Occupational Therapy
j.hibberd@uea.ac.uk

APPENDIX E: GATEKEEPER LETTER TO THERAPY LEAD

School of Health Sciences
Faculty of Medicine and Health Sciences
The Queen's Building
University of East Anglia
Norwich
NR4 7TJ
Date to be inserted

Dear

As part of my doctorate in education studies at the University of East Anglia, I am conducting a study entitled: Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach. My study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as a conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development. In addition to eliciting data from students I will also be seeking the perspectives of clinical learning environment leads and visiting tutors. Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

The purpose of this letter is to seek permission from you to recruit relevant occupational therapists (target = 8), physiotherapists (target =3) and speech and language therapists (target =1) who have had a student with a disability on placement in the last two years. I will only aim to interview each therapist for 1.5 hours in their own time and may follow up the interview with a one off e-mail to seek verification of the interview notes and any further questions I may have. If you have any questions please do not hesitate to contact me. Thank you for taking the time to read this letter.

Yours sincerely
Jane M Hibberd
Lecturer in Occupational Therapy
j.hibberd@uea.ac.uk

APPENDIX F: PARTICIPANT LETTER TO STUDENT WITH A DISABILITY

School of Health Sciences
Faculty of Medicine and Health Sciences
The Queen's Building
University of East Anglia
Norwich
NR4 7TJ
Date to be inserted

Dear (Name of Student)

As part of my doctorate in education studies at the University of East Anglia, I am conducting a study entitled:

Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach.

I am writing to you because you are currently on my database of students with additional needs and you have had experience of being on practice placement(s). For the purposes of this study, a disabled person, according to the Disability Discrimination Act (DDA) (1995), is defined as someone who: *'...has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'*. Examples of impairment include physical disabilities, sensory impairment, dyslexia, severe disfigurements, autistic spectrum disorders, mental health problems and medical conditions e.g. epilepsy, diabetes, (DDA, 1995). The DDA (2005) added the following conditions which further clarify the definition of a disabled person: cancer, HIV infection and multiple sclerosis.

If you are not a student with a registered disability please disregard this letter and accept my apologies for having sent this in error.

This study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as a conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development.

In addition to eliciting data from students I will also be seeking the perspectives of practice educators, clinical learning environment leads and visiting tutors.

Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

The purpose of this letter is to ask if you would consider being recruited as a research participant. If so, I will send you a participant information sheet which gives more details about this study. I will also arrange a time to conduct a one hour interview regarding your experiences of having been on placement. I need to recruit participants that fulfil the following criteria:

- Must be a current student on one of the following pre-registration programmes:
 - BSc (Hons) Occupational Therapy
 - BSc (Hons) Physiotherapy
 - BSc (Hons) Speech and Language Therapy
 - MSc Occupational Therapy
 - MSc Physiotherapy
- Must have experienced at least one practice placement block
- Must not be currently intercalating

If you would like to participate in this study and if you do meet the criteria as outlined above, then please do contact me for further details – ideally within 4 weeks of receiving this letter. My address and e-mail are located below.

If you have any questions please do not hesitate to contact me. Thank you for taking the time to read this letter.

Yours sincerely

Jane M Hibberd
Lecturer in Occupational Therapy
j.hibberd@uea.ac.uk

APPENDIX G: PARTICIPANT LETTER TO PRACTICE EDUCATOR

School of Health Sciences
Faculty of Medicine and Health Sciences
The Queen's Building
University of East Anglia
Norwich
NR4 7TJ
Date to be inserted

Dear (Name of Practice Educator)

As part of my doctorate in education studies at the University of East Anglia, I am conducting a study entitled:

Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach.

I am writing to you because you may have had experience of supervising a student/s with a disability on placement. If you have not, please disregard this letter.

This study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as a conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development.

In addition to eliciting data from students I will also be seeking the perspectives of clinical learning environment leads and visiting tutors.

Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

For the purposes of this study, a disabled person, according to the Disability Discrimination Act (DDA) (1995), is defined as someone who: *'...has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'*.

Examples of impairment include physical disabilities, sensory impairment, dyslexia, severe disfigurements, autistic spectrum disorders, mental health problems and medical conditions e.g. epilepsy, diabetes, (DDA, 1995). The DDA (2005) added the following conditions which further clarify the definition of a disabled person: cancer, HIV infection and multiple sclerosis.

The purpose of this letter is to ask if you would consider being recruited as a research participant. If so, I will send you a participant information sheet which gives more details about this study. I will also arrange a time to visit you to conduct a one hour interview regarding your experiences of having supervised a student with a disability on placement. I need to recruit in total, around 9-12 practice placement educators that fulfil the following criteria:

- Must be an occupational therapist, physiotherapist or speech and language therapist registered by the Health and Care Professions Council;
- Must be working within a health and social care setting or a non-traditional setting as a therapist at the time of participating in this research;
- Must have completed an approved practice educators course at any University;
- Must have had experience of supervising a student with a disability (from their own discipline), on placement within the last two years from date of initial contact with the researcher;
- The supervised student must be one that is (or has been) registered at the School of Health Sciences at UEA on one of the following programmes:
 - BSc (Hons) Occupational Therapy
 - BSc (Hons) Physiotherapy
 - BSc (Hons) Speech and Language Therapy
 - MSc Occupational Therapy
 - MSc Physiotherapy
- Must be employed by (list here relevant placement provider sites that I will seek permission to recruit from via IRAS).

If you would like to participate in this study and if you do meet the criteria as outlined above, then please do contact me for further details – ideally within 4 weeks of receiving this letter. My address and e-mail are located below.

For the purposes of protecting student confidentiality and to meet the requirements of the ethical review of this study, please do not at any stage of your correspondence with me mention the name of or any identifiable information pertaining to the student/s with a disability that you have supervised.

If you believe that you do not meet any of the criteria (including having supervised a student with a disability) then please feel free to disregard this correspondence and accept my apologies for having contacted you.

Thank you for taking the time to read this letter.

Yours sincerely

Jane M Hibberd
Lecturer in Occupational Therapy
j.hibberd@uea.ac.uk

APPENDIX H: PARTICIPANT LETTER TO VISITING TUTOR

School of Health Sciences
Faculty of Medicine and Health Sciences
The Queen's Building
Norwich
NR4 7TJ
Date to be inserted

Dear (Name of Visiting Tutor)

As part of my doctorate in education studies at the University of East Anglia, I am conducting a study entitled:

Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach.

This study has received approval from the School of Education and Lifelong Learning Ethics Committee and R and D approval from the Norfolk and Norwich University Hospital. I am writing to you because you may have had experience of visiting a student/s with a disability on placement. If you have not, please disregard this letter and accept my apologies for having sent this in error.

This study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as a conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development.

In addition to eliciting data from students I will also be seeking the perspectives of practice educators and clinical learning environment leads.

Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

The purpose of this letter is to ask if you would consider being recruited as a research participant. If so, I will send you a participant information sheet

which gives more details about this study. I will also arrange a time to conduct a one hour one-to-one interview regarding your experiences of having visited a student with a disability on placement. I need to recruit in total, around 9-12 visiting tutors that fulfil the following criteria:

- Must have had experience of visiting a student with a disability (from their own discipline), on placement within the last two years from date of initial contact with the researcher;

If you would like to participate in this study and if you do meet the criteria as outlined above, then please do contact me for further details – ideally within 4 weeks of receiving this letter. My address and e-mail are located below.

For the purposes of protecting student confidentiality and to meet the requirements of the ethical review of this study, please do not at any stage of your correspondence with me mention the name of or any identifiable information pertaining to the student/s with a disability that you have supervised.

If you believe that you do not meet the criteria (including having supervised a student with a disability) then please feel free to disregard this correspondence and accept my apologies for having contacted you.

Thank you for taking the time to read this letter.

Yours sincerely

Jane M Hibberd
Lecturer in Occupational Therapy
j.hibberd@uea.ac.uk

APPENDIX I: PARTICIPANT LETTER TO CLINICAL LEARNING ENVIRONMENT LEAD

School of Health Sciences
Faculty of Medicine and Health Sciences
The Queen's Building
University of East Anglia
Norwich
NR4 7TJ
Date to be inserted

Dear (Name of Clinical Learning Environment Lead)

As part of my doctorate in education studies at the University of East Anglia, I am conducting a study entitled:

Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach.

I am writing to you because you may have had experience of providing support for a practice educator supervising a student/s with a disability on placement within the last two years. If you have not, please disregard this letter.

This study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as a conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development.

In addition to eliciting data from students I will also be seeking the perspectives of practice educators and visiting tutors.

Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

For the purposes of this study, a disabled person, according to the Disability Discrimination Act (DDA) (1995), is defined as someone who: '*...has a*

physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities’.

Examples of impairment include physical disabilities, sensory impairment, dyslexia, severe disfigurements, autistic spectrum disorders, mental health problems and medical conditions e.g. epilepsy, diabetes, (DDA, 1995). The DDA (2005) added the following conditions which further clarify the definition of a disabled person: cancer, HIV infection and multiple sclerosis.

The purpose of this letter is to ask if you would consider being recruited as a research participant. If so, I will send you a participant information sheet which gives more details about this study. I will also arrange a time to conduct a one hour interview regarding your experiences of having visited or supported a practice educator supervising a student with a disability on placement.

If you would like to participate in this study then please do contact me for further details – ideally within 4 weeks of receiving this letter. My address and e-mail are located below.

For the purposes of protecting student confidentiality and to meet the requirements of the ethical review of this study, please do not at any stage of your correspondence with me mention the name of or any identifiable information pertaining to the student/s with a disability that you have supervised.

Thank you for taking the time to read this letter.

Yours sincerely

Jane M Hibberd
Lecturer in Occupational Therapy
j.hibberd@uea.ac.uk

APPENDIX J: PARTICIPANT INFORMATION SHEET FOR STUDENT WITH A DISABILITY

(Adapted from: Information sheets and consent forms, guidance for researchers and reviewers (2007:14-30) National Patient Safety Agency/National Research Ethics Service)

PARTICIPANT INFORMATION SHEET

Study title

Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach.

Invitation paragraph

Thank you for your interest in participating in my study which is being conducted as part of my doctorate in education studies at the University of East Anglia. Before you decide whether you wish to participate you need to understand why the study is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Please do not hesitate to ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as a conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development.

In addition to eliciting data from students I will also be seeking the perspectives of practice educators, practice education facilitators and visiting tutors.

Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

For the purposes of this study, a disabled person, according to the Disability Discrimination Act (DDA) (1995), is defined as someone who: *'...has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'*.

Examples of impairment includes physical disabilities, sensory impairment, dyslexia, severe disfigurements, autistic spectrum disorders, mental health problems and medical conditions e.g. epilepsy, diabetes, (DDA, 1995). The DDA (2005) added the following conditions which further clarify the definition of a disabled person: cancer, HIV infection and multiple sclerosis.

Why have I been invited?

You have been invited as a research participant as you fulfil all the selection criteria as outlined below:

- Must be a current student on one of the following pre-registration programmes:
 - BSc (Hons) Occupational Therapy
 - BSc (Hons) Physiotherapy
 - BSc (Hons) Speech and Language Therapy
 - MSc Occupational Therapy
 - MSc Physiotherapy
- Must have experienced at least one practice placement block
- Must not be currently intercalating

Do I have to take part?

It is up to you to decide. If you do decide to take part you may keep this information sheet for reference. You will also be asked to sign a consent form at interview to show you have agreed to take part. You are free to withdraw from this study at any time, without giving a reason.

What will happen to me if I take part?

I will contact you to arrange a time to conduct a one to one interview at a time and location convenient to you. The room in which the interview is conducted will need to be free from distractions such as noise and other people. The interview group will last approximately 60 minutes. Upon completion of the interview, the contents will be typed up and a copy will be sent to you for verification. If you prefer, I can arrange to meet with you face to face to clarify any anomalies or concerns.

What are the possible disadvantages and risks of taking part?

There are no anticipated disadvantages or risks in relation to taking part in this study.

What are the possible benefits of taking part?

The information gleaned from this study will assist in a better understanding of practice educator's experiences of having a disabled student on placement. Whilst there is no real benefit to taking part in this study, your input is much appreciated.

What if something goes wrong?

The normal complaints mechanisms within the organisation that you work for should be available for you to pursue in the event that you are harmed as a result of participation in this study. If as a result of participating in a one-to-one interview, this triggers emotional responses or otherwise which cause you distress I will halt the interview and ask if you want to continue. I will also advise that you liaise with your personal advisor or see the well being team at the Dean of Students. I will also follow up with you the next day to check on your well being.

Will my taking part in this study be kept confidential?

Yes, all ethical and legal practice guidelines will be followed and all information about you will be handled in confidence. All information, in accordance with the Data Protection Act 1998 will be treated as confidential and interview notes will be destroyed upon completion of the project. All data will be securely stored and confidentiality will be maintained throughout the duration of the project by assigning codes to the interview notes. You will have the right to check the accuracy of data collected from you by reviewing the interview notes and you will have the opportunity to correct any errors.

What will happen if I do not want to carry on with the study?

You are free to withdraw from the study at any time without repercussions from the researcher. Data collected at any stage during the study will be retained for analysis but at all times confidentiality will be maintained.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions: Jane Hibberd (j.hibberd@uea.ac.uk). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure (or Private Institution).

What will happen to the results of the study?

Upon completion of the study, results will be disseminated via several channels including a research seminar with the researcher's university, publication in a peer reviewed journal and a poster presentation at a national conference. You will not be identified in any report/publication.

Who is organising and funding the research?

This research is funded by the School of Health Sciences, University of East Anglia.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people namely the School of Education Research Ethics Committee who protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by the Ethics Committee. This study has also been approved by the Research and Development department at UEA and relevant Trusts where the study is being conducted.

Contact for further information

Thank you for your cooperation and interest in this research. You will be given a copy of this participant information sheet and a signed consent form to retain for your records.

Jane M Hibberd
Lecturer in Occupational Therapy
School of Health Sciences
Faculty of Medicine and Health Sciences
The Queen's Building
School of Allied Health Professions
University of East Anglia
Norwich
NR4 7TJ
j.hibberd@uea.ac.uk

APPENDIX K: PARTICIPANT INFORMATION SHEET FOR PRACTICE EDUCATOR

(Adapted from: Information sheets and consent forms, guidance for researchers and reviewers (2007:14-30) National Patient Safety Agency/National Research Ethics Service)

PARTICIPANT INFORMATION SHEET

Study title

Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach.

Invitation paragraph

Thank you for your interest in participating in my study which is being conducted as part of my doctorate in education studies at the University of East Anglia. Before you decide whether you wish to participate you need to understand why the study is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Please do not hesitate to ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as a conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development.

In addition to eliciting data from students I will also be seeking the perspectives of practice education facilitators and visiting tutors.

Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

For the purposes of this study, a disabled person, according to the Disability Discrimination Act (DDA) (1995), is defined as someone who: *'...has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'*.

Examples of impairment includes physical disabilities, sensory impairment, dyslexia, severe disfigurements, autistic spectrum disorders, mental health problems and medical conditions e.g. epilepsy, diabetes, (DDA, 1995). The DDA (2005) added the following conditions which further clarify the definition of a disabled person: cancer, HIV infection and multiple sclerosis.

Why have I been invited?

You have been invited as a research participant as you fulfil all the selection criteria as outlined below:

- Must be an occupational therapist, physiotherapist or speech and language therapist registered by the Health and Care Professions Council;
- Must be working within a health and social care setting or a non traditional setting as a therapist at the time of participating in this research;
- Must have completed an approved practice educators course at any University;
- Must have had experience of supervising a student with a disability (from their own discipline), on placement within the last two years from date of initial contact with the researcher;
- The supervised student must be one that is (or has been) registered at the School of Health Sciences at UEA on one of the following programmes:
 - BSc (Hons) Occupational Therapy
 - BSc (Hons) Physiotherapy
 - BSc (Hons) Speech and Language Therapy
 - MSc Occupational Therapy
 - MSc Physiotherapy
- Must be employed by list here relevant placement provider sites that I will seek permission to recruit from via IRAS.

Do I have to take part?

It is up to you to decide. If you do decide to take part you may keep this information sheet for reference. You will also be asked to sign a consent form at interview to show you have agreed to take part. You are free to withdraw from this study at any time, without giving a reason.

What will happen to me if I take part?

I will contact you to arrange a time to conduct a one to one interview at a time and location convenient to you. The room in which the interview is conducted will need to be free from distractions such as noise and other people. The interview will last approximately 60 minutes. Upon completion of the interview, the contents will be typed up and a copy will be sent to you for verification. If you prefer, I can arrange to meet with you face to face to clarify any anomalies or concerns.

For the purposes of protecting student confidentiality and to meet the requirements of the ethical review of this study, please do not at any stage of your correspondence with me mention the name of or any identifiable information pertaining to the student/s with a disability whom you have supervised.

What are the possible disadvantages and risks of taking part?

There are no anticipated disadvantages or risks in relation to taking part in this study.

What are the possible benefits of taking part?

The information gleaned from this study will assist in a better understanding of practice educator's experiences of having a disabled student on placement. Whilst there is no real benefit to taking part in this study, your input is much appreciated.

What if something goes wrong?

The normal complaints mechanisms within the organisation that you work for should be available for you to pursue in the event that you are harmed as a result of participation in this study.

Will my taking part in this study be kept confidential?

Yes, all ethical and legal practice guidelines will be followed and all information about you will be handled in confidence. All information, in accordance with the Data Protection Act 1998 will be treated as confidential and the interview notes will be destroyed upon completion of the project. All data will be securely stored and confidentiality will be maintained throughout the duration of the project by assigning codes to the interview notes. You will have the right to check the accuracy of data collected from you by reviewing the interview notes and you will have the opportunity to correct any errors.

What will happen if I do not want to carry on with the study?

You are free to withdraw from the study at any time without repercussions from the researcher. Data collected at any stage during the study will be retained for analysis but at all times confidentiality will be maintained.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions: Jane Hibberd (j.hibberd@uea.ac.uk). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure (or Private Institution).

What will happen to the results of the study?

Upon completion of the study, results will be disseminated via several channels including a research seminar with the researcher's university, publication in a peer reviewed journal and a poster presentation at a national conference. You will not be identified in any report/publication.

Who is organising and funding the research?

This research is funded by the School of Health Sciences, University of East Anglia.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people namely the School of Education Research Ethics Committee who protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by the Ethics Committee. This study has also been approved by the Research and Development department at UEA and relevant Trusts where the study is being conducted.

Contact for further information

Thank you for your cooperation and interest in this research. You will be given a copy of this participant information sheet and a signed consent form to retain for your records.

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APPENDIX L: PARTICIPANT INFORMATION SHEET FOR VISITING TUTOR

(Adapted from: Information sheets and consent forms, guidance for researchers and reviewers (2007:14-30) National Patient Safety Agency/National Research Ethics Service)

PARTICIPANT INFORMATION SHEET

Study title

Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach.

Invitation paragraph

Thank you for your interest in participating in my study which is being conducted as part of my doctorate in education studies at the University of East Anglia. Before you decide whether you wish to participate you need to understand why the study is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Please do not hesitate to ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as a conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development.

In addition to eliciting data from students I will also be seeking the perspectives of practice educators and practice education facilitators.

Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

For the purposes of this study, a disabled person, according to the Disability Discrimination Act (DDA) (1995), is defined as someone who: *'...has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'*.

Examples of impairment includes physical disabilities, sensory impairment, dyslexia, severe disfigurements, autistic spectrum disorders, mental health problems and medical conditions e.g. epilepsy, diabetes, (DDA, 1995). The DDA (2005) added the following conditions which further clarify the definition of a disabled person: cancer, HIV infection and multiple sclerosis.

Why have I been invited?

You have been invited as a research participant as you fulfil all the selection criteria as outlined below:

- Have experience of visiting a student, with a disability on practice placement from one of the following pre-registration programmes:
 - BSc (Hons) Occupational Therapy
 - BSc (Hons) Physiotherapy
 - BSc (Hons) Speech and Language Therapy
 - MSc Occupational Therapy
 - MSc Physiotherapy

Do I have to take part?

It is up to you to decide. If you do decide to take part you may keep this information sheet for reference. You will also be asked to sign a consent form at interview to show you have agreed to take part. You are free to withdraw from this study at any time, without giving a reason.

What will happen to me if I take part?

I will contact you to arrange a time to conduct a one to one interview at a time and location convenient to you. The room in which the interview is conducted will need to be free from distractions such as noise and other people. The interview will last approximately 60 minutes. Upon completion of the interview, the contents will be typed up and a copy will be sent to you for verification. If you prefer, I can arrange to meet with you face to face to clarify any anomalies or concerns.

For the purposes of protecting student confidentiality and to meet the requirements of the ethical review of this study, please do not at any stage of your correspondence with me mention the name of or any identifiable information pertaining to the student/s with a disability whom you have supervised.

What are the possible disadvantages and risks of taking part?

There are no anticipated disadvantages or risks in relation to taking part in this study.

What are the possible benefits of taking part?

The information gleaned from this study will assist in a better understanding of practice educator's experiences of having a disabled student on placement. Whilst there is no real benefit to taking part in this study, your input is much appreciated.

What if something goes wrong?

The normal complaints mechanisms within the organisation that you work for should be available for you to pursue in the event that you are harmed as a result of participation in this study.

Will my taking part in this study be kept confidential?

Yes, all ethical and legal practice guidelines will be followed and all information about you will be handled in confidence. All information, in accordance with the Data Protection Act 1998 will be treated as confidential and interview notes will be destroyed upon completion of the project. All data will be securely stored and confidentiality will be maintained throughout the duration of the project by assigning codes to the interview notes. You will have the right to check the accuracy of data collected from you by reviewing the interview notes and you will have the opportunity to correct any errors.

What will happen if I do not want to carry on with the study?

You are free to withdraw from the study at any time without repercussions from the researcher. Data collected at any stage during the study will be retained for analysis but at all times confidentiality will be maintained.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions: Jane Hibberd (j.hibberd@uea.ac.uk). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure (or Private Institution).

What will happen to the results of the study?

Upon completion of the study, results will be disseminated via several channels including a research seminar with the researcher's university, publication in a peer reviewed journal and a poster presentation at a national conference. You will not be identified in any report/publication.

Who is organising and funding the research?

This research is funded by the School of Health Sciences, University of East Anglia.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people namely the School of Education Research Ethics Committee who protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by the Ethics Committee. This study has also been approved by the Research and Development department at UEA and relevant Trusts where the study is being conducted.

Contact for further information

Thank you for your cooperation and interest in this research. You will be given a copy of this participant information sheet and a signed consent form to retain for your records.

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APPENDIX M: PARTICIPANT INFORMATION SHEET FOR CLINICAL LEARNING ENVIRONMENT LEAD

(Adapted from: Information sheets and consent forms, guidance for researchers and reviewers (2007:14-30) National Patient Safety Agency/National Research Ethics Service)

PARTICIPANT INFORMATION SHEET

Study title

Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach.

Invitation paragraph

Thank you for your interest in participating in my study which is being conducted as part of my doctorate in education studies at the University of East Anglia. Before you decide whether you wish to participate you need to understand why the study is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Please do not hesitate to ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to explore (through one-to-one interviews) the practice placement experiences of occupational therapy, physiotherapy and speech and language therapy students registered with a disability from the School of Health Sciences. The capability approach will be used as a conceptual lens where the experience of students with a disability on placement can be evaluated. The capabilities approach stems from the work of Amartya Sen, an economist, philosopher and Nobel laureate in 1993. In essence, the capability approach is concerned with human development.

In addition to eliciting data from students I will also be seeking the perspectives of practice educators and visiting tutors.

Three broad research questions are posed:

- 1) What are the challenges that students with a disability encounter within the practice placement environment?
- 2) Does the type of disability or environment make a difference?
- 3) What existing strategies (if any) are employed and how effective are they?

For the purposes of this study, a disabled person, according to the Disability Discrimination Act (DDA) (1995), is defined as someone who: *'...has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'*.

Examples of impairment includes physical disabilities, sensory impairment, dyslexia, severe disfigurements, autistic spectrum disorders, mental health problems and medical conditions e.g. epilepsy, diabetes, (DDA, 1995). The DDA (2005) added the following conditions which further clarify the definition of a disabled person: cancer, HIV infection and multiple sclerosis.

Why have I been invited?

You have been invited as a research participant as you fulfil all the selection criteria as outlined below:

- employed by the Health Education East of England;
- have experience in supporting a practice educator who has supervised a student with a disability within the last two years following notification of this study.

Do I have to take part?

It is up to you to decide. If you do decide to take part you may keep this information sheet for reference. You will also be asked to sign a consent form at interview to show you have agreed to take part. You are free to withdraw from this study at any time, without giving a reason.

What will happen to me if I take part?

I will contact you to arrange a time to conduct a one to one interview at a time and location convenient to you. The room in which the interview is conducted will need to be free from distractions such as noise and other people. The interview will last approximately 60 minutes. Upon completion of the interview, the contents will be typed up and a copy will be sent to you for verification. If you prefer, I can arrange to meet with you face to face to clarify any anomalies or concerns.

For the purposes of protecting student confidentiality and to meet the requirements of the ethical review of this study, please do not at any stage of your correspondence with me mention the name of or any identifiable information pertaining to the student/s with a disability whom you have supervised.

What are the possible disadvantages and risks of taking part?

There are no anticipated disadvantages or risks in relation to taking part in this study.

What are the possible benefits of taking part?

The information gleaned from this study will assist in a better understanding of practice educator's experiences of having a disabled student on placement. Whilst there is no real benefit to taking part in this study, your input is much appreciated.

What if something goes wrong?

The normal complaints mechanisms within the organisation that you work for should be available for you to pursue in the event that you are harmed as a result of participation in this study.

Will my taking part in this study be kept confidential?

Yes, all ethical and legal practice guidelines will be followed and all information about you will be handled in confidence. All information, in accordance with the Data Protection Act 1998 will be treated as confidential and interview notes will be destroyed upon completion of the project. All data will be securely stored and confidentiality will be maintained throughout the duration of the project by assigning codes to the interview notes. You will have the right to check the accuracy of data collected from you by reviewing the interview notes and you will have the opportunity to correct any errors.

What will happen if I do not want to carry on with the study?

You are free to withdraw from the study at any time without repercussions from the researcher. Data collected at any stage during the study will be retained for analysis but at all times confidentiality will be maintained.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions: Jane Hibberd (j.hibberd@uea.ac.uk). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure (or Private Institution).

What will happen to the results of the study?

Upon completion of the study, results will be disseminated via several channels including a research seminar with the researcher's university, publication in a peer reviewed journal and a poster presentation at a national conference. You will not be identified in any report/publication.

Who is organising and funding the research?

This research is funded by the School of Health Sciences, University of East Anglia.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people namely the School of Education Research Ethics Committee who protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by the Ethics Committee. This study has also been approved by the Research and Development department at UEA and relevant Trusts where the study is being conducted.

Contact for further information

Thank you for your cooperation and interest in this research. You will be given a copy of this participant information sheet and a signed consent form to retain for your records.

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APPENDIX N: DISABILITY ANALYSIS

Programme Title	Program me Level	Programme Start Date	Number of Starters	No Recorded Disability	Disability Code				
					E	F	G	I	J
Occupational Therapy	Degree	September 2016	38	36	0	0	2	0	0
Occupational Therapy	Degree	September 2015	41	33	0	3	2	2	1
Occupational Therapy	Degree	September 2014	37	34	0	1	1	0	1
Occupational Therapy	Masters	February 2017	29	24	1	1	2	0	1
Occupational Therapy	Masters	February 2016	29	26	1	0	2	0	0
Occupational Therapy	Masters	February 2015	28	22	0	2	4	0	0
Physiotherapy	Degree	September 2016	20	18	1	0	1	0	0
Physiotherapy	Degree	September 2015	27	26	0	1	0	0	0
Physiotherapy	Degree	September 2014	20	19	0	0	0	1	0
Physiotherapy	Masters	February 2017	19	16	0	0	3	0	0
Physiotherapy	Masters	February 2016	22	20	2	0	0	0	0
Physiotherapy	Masters	February 2015	19	14	0	1	4	0	0
Speech & Language	Degree	September 2016	22	21	0	1	0	0	0
Speech & Language	Degree	September 2015	22	22	0	0	0	0	0
Speech & Language	Degree	September 2014	25	25	0	0	0	0	0
Totals			398	356	5	10	21	3	3
Percentage Totals			100.0%	89.4%	1.3 %	2.5 %	5.3 %	0.8 %	0.8 %

Disability Description	SIT's codes
A social/communication impairment such as Asperger's syndrome/other autistic spectrum disorder	B
Blind or a serious visual impairment uncorrected by glasses	C
Deaf or a serious hearing impairment	D
A long-standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease or epilepsy	E
A mental health condition such as depression, schizophrenia or anxiety disorder	F
A specific learning difficulty such as dyslexia, dyspraxia or ADHD	G
A physical impairment or mobility issues such as difficulty using arms or using a wheelchair or crutches	H
A disability, impairment or medical condition not listed above	I
Two or more impairments and/or disabling medical conditions	J
Autistic Spectrum Disorder	T

APPENDIX O: CONSENT FORM

(Adapted from: Information sheets and consent forms, guidance for researchers and reviewers (2007:32) National Patient Safety Agency/National Research Ethics Service)

Participant Identification Number:

CONSENT FORM

Title of Project: Pre-registration healthcare profession students with a disability on practice placement: facilitating empowerment through an application of the capabilities approach.

Name of Researcher: JM Hibberd

Please initial box

I confirm that I have read and understand the participant information sheet dated xx.xx.xx for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

I consent to the interview being typed up for the purposes of data analysis and understand that this information will be treated in strictest confidence and destroyed upon completion of the study.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

☐

I understand that relevant sections of data collected during the study may be looked at by individuals from the School of Health Sciences, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to such data.

☐

I agree to take part in the above study.

☐

Name of Participant
Signature

Date

Researcher
Signature

Date

When completed:

x1 copy to be given to research participant

x1 copy (original) to be retained by researcher

APPENDIX P: INTERVIEW GUIDE

Interview questions STUDENT VERSION

Name:	
Assigned code:	
Date of interview:	
Duration of interview:	
Place of interview:	

- Explain background and rationale of the study;
- Do NOT mention name of student/s, practice educators, clinical learning environment leads, faculty or place names;
- Provide 2nd copy of participant information sheet and ask if any questions;
- Provide 2nd copy of consent form;
- Explain procedure to be followed - that interview will last approximately one hour, non-verbal responses to questions will be noted etc.

PHASE 1

Part A (warm up)

Can you start off by telling me a bit about:

A1: what discipline are you?

A2: how far into the course are you?

A3: what placements have you completed to date?

A4: can you please describe your disability?

Part B (intermediate)

B1: What challenges - if any - did you encounter during your practice placement experience?

Prompt:

- *Attitudes.*
- *Having to work harder to compensate for the disability.*
- *Adapting the way that you work.*
- *How inclusive do you perceive the work environment to be?*

B2: Does the type of disability make a difference to the challenges that you experienced?

Prompt:

- *SpLD, sensory, physical, mental health impairment etc.*

B3: Does the type of placement environment make a difference to the challenges that you experienced?

Prompt:

- *environment, shift working, number of tasks to complete etc.*

B4: What strategies - if any - were employed to accommodate your needs and how effective were they?

Prompt:

- *What factors enabled or hindered the accommodation of your needs?*
- *Disclosure.*
- *Preparing for the placement.*

B5: Have you had a placement where your practice educator has been more of a therapist towards you or have they always been objective?

Part C (winding down)

C1: What advice would you give to a student in a similar situation to yours going out onto their first practice placement?

C2: Is there anything else that you can think of, relevant to what we have been discussing during this interview that you want to add?

- Thank participant for their involvement and explain that copy of interview notes will be sent to them for checking accuracy.
- Explain that once data analysis complete I may ask for further interview to ask more questions based on developing theoretical concepts and ideas.

**Interview questions
PRACTICE EDUCATOR VERSION**

Name:	
Assigned code:	
Date of interview:	
Duration of interview:	
Place of interview:	

- Explain background and rationale of the study;
- Do NOT mention name of student/s, practice educators, clinical learning environment leads, faculty or place names;
- Provide 2nd copy of participant information sheet and ask if any questions;
- Provide 2nd copy of consent form;
- Explain procedure to be followed - that interview will last approximately one hour, non-verbal responses to questions will be noted etc.

PHASE 1

Part A (warm up)

Can you start off by telling me a bit about:

A1: your background as a clinician?

A2: your background as a practice educator?

A3: how many students (with and without a disability) you have had to date?

Part B (intermediate)

Explain that this section is around the role of the clinician as practice educator and their general experience of supervising students who have a disability on placement.

B1: What challenges - if any - did your student encounter during the practice placement experience?

Prompt:

- *Attitudes.*

- *Having to work harder to compensate for the disability.*
- *Adapting the way of working.*
- *How inclusive do you perceive your work environment to be?*

B2: Does the type of disability or placement environment make a difference?

Prompt:

- *SpLD, sensory, physical, mental health impairment etc.*

B3: Does the type of placement environment make a difference?

Prompt:

- *environment, shift working, number of tasks to complete etc.*

B4: What strategies - if any - were employed to accommodate their needs and how effective were they?

Prompt:

- *What factors enable or hinder the accommodation of needs?*
- *Disclosure.*
- *Preparing for the placement.*

B5: Allowing for the reasonable adjustments considerations necessary when having a student with a disability; how do you feel this impacted upon your role as a practice educator?

Prompt:

- *Did you have to change the way that you work?*
- *Are these responsibilities any different towards other students without a disability?*
- *Did you perceive your practice educator role as having a totally objective practice educator role or were there elements of the therapist role coming out?*

Part C (winding down)

C1: What advice would you give to a colleague who is about to have a student with a disability on placement?

C2: Is there anything else that you can think of, relevant to what we have been discussing during this interview, that you want to add?

- Thank participant for their involvement and explain that copy of interview notes will be sent to them for checking accuracy.
- Explain that once data analysis complete I may ask further questions via e-mail based on developing theoretical concepts and ideas.

Interview questions FACULTY VERSION

Name:	
Assigned code:	
Date of interview:	
Duration of interview:	
Place of interview:	

- Explain background and rationale of the study;
- Do NOT mention name of student/s, practice educators, clinical learning environment leads, faculty or place names;
- Provide 2nd copy of participant information sheet and ask if any questions;
- Provide 2nd copy of consent form;
 - Explain procedure to be followed - that interview will last approximately one hour, non-verbal responses to questions will be noted etc.

PHASE 1

Part A (warm up)

Can you start off by telling me a bit about:

A1: your background as a clinician?

A2: how long have you worked in education?

Part B (intermediate)

Explain that this section is around the role of the faculty member as visiting tutor and their general experience of contact (face-to-face or virtual) with students who have a disability on placement.

B1: What challenges - if any - do students tend to encounter within the practice placement experience?

Prompt:
- Attitudes.

- *Having to work harder to compensate for the disability.*
- *Adapting the way of working.*
- *How inclusive do you perceive the work environment to be?*

B2: Does the type of disability make a difference?

Prompt:

- *SpLD, sensory, physical, mental health impairment etc.*

B3: Does the type of placement environment make a difference?

Prompt:

- *environment, shift working, number of tasks to complete etc.*

B4: What strategies - if any - are employed to accommodate students' needs and how effective are they?

Prompt:

- *What factors enable or hinder the accommodation of needs?*
- *Disclosure.*
- *Preparing for the placement.*

B5: Allowing for the reasonable adjustments considerations necessary when having a student with a disability; how do feel this impacts upon the practice educator role?

Prompt:

- *Do they have to change their way of working?*
- *Are these responsibilities any different towards other students without a disability?*
- *Did you perceive the practice educator role as having a totally objective practice educator role or were there elements of the therapist role coming out?*

Part C (winding down)

C1: What advice would you give to a faculty member supporting a student with a disability on placement?

C2: Is there anything else that you can think of, relevant to what we have been discussing during this interview that you want to add?

- Thank participant for their involvement and explain that copy of interview notes will be sent to them for checking accuracy.
- Explain that once data analysis complete I may ask for further interview to ask more questions based on developing theoretical concepts and ideas.

Interview questions
CLINICAL LEARNING ENVIRONMENT LEAD VERSION

Name:	
Assigned code:	
Date of interview:	
Duration of interview:	
Place of interview:	

- Explain background and rationale of the study;
- Do NOT mention name of student/s, practice educators, clinical learning environment leads, faculty or place names;
- Provide 2nd copy of participant information sheet and ask if any questions;
- Provide 2nd copy of consent form;
 - Explain procedure to be followed - that interview will last approximately one hour, non-verbal responses to questions will be noted etc.

PHASE 1

Part A (warm up)

Can you start off by telling me a bit about:

A1: your background as a clinician?

A2: your background as a CLEL?

Part B (intermediate)

Explain that this section is around the role of the CLEL and their general experience of supporting practice educators and mentors with students who have a disability on placement.

B1: What challenges - if any - do students tend to encounter within the practice placement experience?

Prompt:
- Attitudes.

- *Having to work harder to compensate for the disability.*
- *Adapting the way of working.*
- *How inclusive do you perceive the work environment to be?*

B2: Does the type of disability make a difference?

Prompt:

- *SpLD, sensory, physical, mental health impairment etc.*

B3: Does the type of placement environment make a difference?

Prompt:

- *environment, shift working, number of tasks to complete etc.*

B4: What strategies - if any - are employed to accommodate students' needs and how effective are they?

Prompt:

- *What factors enable or hinder the accommodation of needs?*
- *Disclosure.*
- *Preparing for the placement.*

B5: Allowing for the reasonable adjustments considerations necessary when having a student with a disability; how do feel this impacts upon the practice educator role?

Prompt:

- *Do they have to change their way of working?*
- *Are these responsibilities any different towards other students without a disability?*
- *Did you perceive the practice educator role as having a totally objective practice educator role or were there elements of the therapist role coming out?*

Part C (winding down)

C1: What advice would you give to a fellow CLEL colleague supporting a student with a disability on placement?

C2: Is there anything else that you can think of, relevant to what we have been discussing during this interview that you want to add?

- Thank participant for their involvement and explain that copy of interview notes will be sent to them for checking accuracy.
- Explain that once data analysis complete I may ask for further interview to ask more questions based on developing theoretical concepts and ideas.

APPENDIX Q: EXAMPLES OF COMPOSITE NARRATIVES

The student

The placement allocations have been released on Blackboard today. Hmm, not sure how I feel about this particular allocation as I have not worked in an acute hospital before. I am nervous about placements in any case as my performance was shaky on the last one. I feel that people don't understand my particular disability and I am worried about how my prospective practice educator will react if I tell her. The very act of disclosing on my last placement didn't seem to do me any good. I really don't understand why practice educators would not be sympathetic towards a student with a disability, they treat patients day in, day out, patients who have some form of disability or ill health themselves - right? Surely then you would expect them to be sympathetic towards a student with a disability and to cut them some slack? Practice educators see people with a disability on a daily basis so you would think (and I would hope) there is no stigma.

Right, I've completed my letter of introduction and my CV and submitted these to the placement hub at University who will then send it off to my practice educator. The letter was an opportunity to disclose but I couldn't bring myself to do this, I wimped out basically.

Day one of placement, crikey, I am soooo nervous, I couldn't fit in a pre-placement visit so am worried about the commute to the placement setting, will I be able to find a car parking place, not entirely sure of the route either, feeling stressed... feeling very tired too and this is just day one. Regretting the whole thing now, why oh why did I not organise a pre-placement visit? At least I've completed the pre-reading list that my practice educator sent, I just wish I had been more thorough in capturing notes about what I had learnt. Oh well, I have some notes which is better than nothing.

My practice educator seems ok, I still couldn't bring myself to tell her about my dyslexia, I might be ok, I might get away with it. I don't want her to misjudge me or think I am using my disability as an excuse. I am only here

for a few weeks on placement so there probably isn't much point in disclosing.

I find that it's really important for the practice educator not to make assumptions about my disability. Yes, I am disabled, I do identify with that but labels are not the 'be all and end all'. The practice educator needs to ask me about my disability and to see me, acknowledge me as a person first and foremost. Some people can be patronising and I don't like that, it stifles my learning and my whole sense of being, my personal identity if that makes sense?

On a previous placement someone in the team tried to help me spell a word by pronouncing the letters phonetically and that really did not help at all as I didn't recognise the sound of the letters. I just got wound up even though they were trying to help. God, it was embarrassing, I am sure everyone else in the office could hear and I felt stupid, it was like being back in junior school, I am not a child you know. I really don't want to go through that kind of experience again so hence another reason for being hesitant in disclosing my disability.

I do struggle sometimes because of my dyslexia, and when that happens, if I am not getting the right support it can be a lonely place to fight on your own, particularly as I am away from the University, I haven't got my friends and family around me, nor have I got the University staff who I usually go to if things are not going well. We are now a few weeks into the placement and although my practice educator is really nice, I feel worried about bothering her as she is so busy (particularly as they are short staffed this week) and I feel like I am a burden. Am I a burden? I hope not. Sometimes I'm not sure at what point I should say something to my practice educator, I just can't help feeling guilty because, like I said, she seems nice but she is just so busy, I don't feel I want to bother her. I know I am probably being silly.

The multi-disciplinary team meetings are so fast, it's such a quick exchange of information, it is so hard for me to follow, and half the time I don't know which patient they are talking about. It is so confusing. I have been told to speak up in the meetings and to say something about the patients I am

seeing but it creeps me out, the thought of saying something in front of all those qualified healthcare professionals. My brain just won't work properly, I can't seem to get the right words out.

At times I feel that other members of the team just don't 'get me'. I mean, it's just dyslexia that I have, what's the big deal? One person admitted that they thought that having dyslexia meant that I can't read or write. Wrong! How patronising. I was shocked that they hadn't encountered dyslexia before or read up on the condition, seeing as I have to spend quite a bit of time with them as well as my practice educator.

My practice educator suggested I go home the other day, said I was looking tired. I said 'no' and that I was fine. I know I have been working so hard to try and overcome my struggles with dyslexia, I find I have to work twice as hard. In addition, I just want to reinforce that I know my own body, I have coping strategies to counteract the busy periods at work. I also know that if I start going home early, the visiting tutor (due next week) will question this and perhaps ask whether I am coping with this placement or not. The hours count for everything, I can't afford to be down on my hours, I've just got to keep going...

Had the interim assessment today and I was identified as 'at risk of failing' in some areas of my performance. Oh s***, I am so disappointed, I feel like a failure, I really wasn't expecting this at all! My practice educator explained that she has to mark my performance objectively against the placement learning outcomes. I feel that if I had received timely feedback on my performance then I could have rectified those targeted areas in time. My practice educator patiently explained that she had been giving me regular feedback - during both informal and formal supervision. Perhaps I hadn't been recognising this as I have been so wound up and anxious in any case. My practice educator said that my note writing is an issue. I explained that it is hard to concentrate on writing up notes on the ward as it is so noisy, there is a constant humdrum in the background and I need absolute peace and quiet to help me focus. The notes are handwritten too, this means I can't fall back on word processing like I do at University when producing essays and

so on. *I am finding that the coping strategies I use at University can't always be replicated on placement, how frustrating! It's at this point that I blurt out 'I have dyslexia!'. The practice educator looks at me, complete astonishment written all over her face. She asks, 'but why didn't you tell me?' It's at this moment in time that I sense a sudden change in our relationship, a subtle change but one of renewed understanding and acknowledgement - on both sides - of my disability in the context of being on placement. I now understand that the impact of my dyslexia is part of the reason as to why I am at risk of failing, no wonder I am struggling, my practice educator explains that had she known about my dyslexia she would have been able to think more proactively about implementing reasonable adjustments. I ask what kind of adjustments she means? She says well, things like ensuring you have extra time to write up notes and liaising with the matron on the ward to ask if you can use her office to write up the notes so that you are not distracted by the noise. We can also adapt the initial interview template to make it easier for you to record information, a more user friendly layout. Suddenly I heave a sigh of relief. I feel that there is hope after all. We spend the rest of the time coming up with an action plan so that I am clear on how to address the areas of performance that I am struggling with. I feel more relaxed now and have the confidence to continue with this placement experience.*

The practice educator

I have had many students coming out on placement so I have considerable experience of being a practice educator including working alongside students with a disability. First and foremost, let me tell you a bit about my work environment as I want to set the context. I work in a busy, acute hospital setting and as such, we work so fast here. It is so busy with lots of walking to and from the office and the wards.

With any prospective student, in advance of their arrival, I always ensure that I read the student's letter of introduction thoroughly and their CV too as this enables me to construct a plan to help maximise the learning opportunities on placement. On the student's first day of placement, I ensure that I allow

time and opportunity in a quiet private room to afford the student the opportunity to let me know if they have any additional learning needs. I am experienced enough to know that not all students openly disclose their disability via their letter of introduction so it's up to me to probe them and allow that opportunity for disclosure. If a student discloses a disability that I am not familiar with, I ask them if there are any resources I can access to help me understand more about it and the impact it might have on their performance? Without that level of understanding it is going to be hard for me to implement reasonable adjustments. At the end of the day, it's really important for me to know if the student has a disability, if they don't tell me how can I take into account any adjustments they might require? I can't can I, surely it's not my responsibility if I don't know?

I think it can be overwhelming for a student who has a disability and I notice that they seem to tire easily, particularly those who have compromised mobility or a physical type disability. I think there are always going to be challenges for students with a disability in the hospital type setting as well as other health and social care environments. With the hospital setting, it's all about factoring in the noise, the vast space and the speed of work. The acute hospital can be so overwhelming that I end up feeling quite sorry for some students with a disability, it must be so hard for them.

Having said all that, I must admit that with some students, it takes up quite a bit of time - having a student on placement I mean...as with some, I have to sit down with them and help them work out their coping strategies if they don't have any, you would have thought that the University would have done all that. I find that having a student does slow me down in my day to day work because I am having to explain things and, as I said earlier, perhaps having to help them work out coping strategies if they haven't got any. I had a student once and their particular type of disability meant that their limbs had a tendency to contract when tired. When that happened, I had to straighten their limbs out as they couldn't do it themselves. That was really hard and put pressure on me and the wider team as we had to do this for the student. I am under constant pressure to see patients and get them through the system so that they can return home or wherever. I must admit I get a bit

impatient sometimes as you've got to contend with that balancing act between meeting your own work deadlines in addition to having the student but I think that just reflects how busy I am.

I just want to add that I don't believe in labels, I don't think it's helpful for anyone concerned. I have to do my job as a practice educator and I have to assess my student, disability or not, according to the placement learning outcomes. I think sometimes, a little bit of the therapist comes out of me, well, I am a therapist after all but I also need to be objective as I am the gatekeeper to the profession. At the end of the day, I don't think the disability is a problem at all, it's more important to focus on the student, ask them how they like to learn and to concentrate on supporting that process of learning.

The visiting tutor

I have a pretty good understanding of what it's like to work in a hospital, I have been visiting here for a number of years. I recognise the usual patterns in relation to the challenges that students with a disability face, particularly dyslexia as that is so common. Some of the challenges that students might encounter would be things like dealing with the noisy background, finding your way around the hospital and the fast pace of work and rapid exchange of information.

In my experience, you have two types of student, the one who is proactive and says to their practice educator: 'this is how you can help me, these are my coping strategies'. Then, at the other end of the spectrum, you get the student who says: 'I don't know how to manage my disability, please help me.' I think as well, some students can be unrealistic in relation to their coping strategies in that what works in the University setting may not always readily translate to the practice placement setting.

Being a visiting tutor can sometimes be like walking on egg shells because I sometimes find that there is tension in the relationship between a student with a disability and the practice educator if things are not going well. I see my role as trying to support the student with a disability but at the same time,

I am also trying to support the practice educator. I am hearing two sides to the 'story', my job is to unpick the whole situation and try to find some sort of resolution for both parties. I am so aware that the practice educator is under a lot of pressure, they are trying to maintain their case load, they may have staff to manage in addition to having the student on placement. From the student's perspective, their aim is to pass the placement that is their aspiration, naturally. However, alongside that, they may be experiencing home sickness and being devoid of their normal support networks that they have back in the University setting. The student may also be experiencing some anxieties about their ability to perform in the practice placement setting, particularly if the consequences of their disability means that they are struggling.

During the interim visit we have to complete the visiting tutor notes, there is a set of forms for each student which is collated into one pack, so, one pack per student. To an extent I have to rely on the visiting tutor notes to help me understand and appreciate how the student has performed on previous placements. If there is nothing written down about the student's disability, and I don't really know that student and they have not disclosed anything, it makes it harder for me to support the student if they are struggling because of their disability. It may be that my antennae twitches and, based on what I am hearing I may reason that possibly this student has dyslexia for example. I might then ask the student outright if they have particular learning needs or a disability? If not, then I am in a position where I have to rely on the student to tell me if they have a disability and of course, they won't always reveal that information. I find it really embarrassing if I am not aware that the student has a disability. I received a 'phone call from a practice educator once who was telling me about their student as they had some concerns about their performance. This practice educator in effect was giving me a heads up prior to my face-to-face interim visit. I was informed about their disability at that moment in time, but I had no idea until then - how embarrassing!

I find myself sometimes being in the position of trying to encourage the practice educator to demonstrate some empathy for the student, and to support them in trying to ensure that reasonable adjustments are in place.

On one occasion I had to work with the practice educator to work out a range of reasonable adjustments to support the student who had dyslexia as we were racking our brains to come up with ideas as previous adjustments had not been effective. The tricky thing is, with reasonable adjustments, you have to ensure that they are workable in practice and that they will enable the student to meet the placement learning outcomes. I think it is important to support the student with a disability and at the same time we strive to maintain good relationships with our practice placement partners, it's getting that balance act right.

The clinical learning environment lead

My role is an interesting one in that I get to experience placements across a range of professions. I also have the advantage of having worked in my discipline specific profession and having experienced taking a student on placement too. I think one of the key considerations is the importance of practice educators being aware of the resources they can draw upon within their own internal organisation. For example, there may be a key person in the organisation that has a particular remit for supporting staff with disabilities or a particular disability that could also be extended to students. As well, what about the organisations' occupational health department, they should be in a position to offer support and guidance if required. Really, practice educators should be making use of these resources but I just don't think they are always aware.

I also find that there is a significant difference between being at University and being on placement. At University you have things like the Student Support Centre, the student's personal advisor, the placement team and so on, they are all there to support and advise the student. The student doesn't have that same level of support when they are on placement. You need to ensure that a supportive and facilitative learning environment is provided to support the student with a disability. You also need to think about reasonable adjustments, the student might have access to adjustments in the University which works well such as extra time and handouts in advance of teaching sessions and so on which is fine but how readily does this

translate into the practice placement setting? There isn't always the luxury of having lots of time to write up the patient notes or having notes in advance of say, a multi-disciplinary team meeting. There is always so much to achieve in the working day and it is not always so easy to implement reasonable adjustments, they have to be practical and realistic adjustments.

As well, you need to consider who is benefiting from the reasonable adjustment - the student primarily but also other people in the team potentially. I would say that reasonable adjustments is a priority, the practice educator should make time to explore this with the student.

I mentioned earlier about the importance of a good learning environment, after all, that is why the student is on placement, to learn how to be a healthcare professional. The practice educator should ensure that they use a range of learning tools such as finding out how does the student like to learn? If you are not alluding to the student's learning style at times then they are not necessarily going to learn in the most effective manner. You may find that for example, students who have dyslexia, tend to be more of a visual or kinaesthetic learner so trying to afford opportunities to learn via those modes where possible is helpful.

Thinking about the differing types of disability, I don't think there is much parity for students who have a mental health condition. I don't think practice educators know how to support such students, there is a stigma about mental illness. Of course, some students are likely to be reluctant to disclose (for fear of recrimination for example) so that doesn't help the situation either as then sometimes the situation escalates when the student starts struggling on placement and the practice educator doesn't understand why the student is struggling. It might of course be attributed to their mental illness such as poor concentration, anxiety and so on. The culture of the workplace is an important consideration, does this have a bearing on the prevailing attitudes of the workforce in general? Is this positive or negative? The student will pick up on this you know.

I think as well, practice educators can struggle to be objective in their assessment of the student with a disability. There are mixed views regarding

whether the practice educator adopts a therapist role or a purely practice educator role towards the student with a disability. If this isn't carefully balanced and the right role used as appropriate then you could be advantaging the student. Practice educators have an important role as gatekeepers to their profession, they are making a judgement about the student's competence to pass the placement or not. At the end of the day, the practice educator needs to provide an opportune learning environment and to consistently monitor the student's performance against the placement learning outcomes. As well, using the learning contract to identify personal learning objectives to help achieve the learning outcomes is helpful, it's about focusing the student's learning and a means of measuring their performance. Support for the student with a disability is important, you need to 'get it right' in terms of your approach towards them and to ensure that you enable them to realise their potential.

APPENDIX R: EXAMPLE OF A WORKED COMPOSITE NARRATIVE

Scene: two chairs and a table

Theme: Disclosure

Narrator: Joe (student) and Selma (practice educator) are in supervision.

Selma: Joe, we are fast approaching the mid-way stage of your placement with us, tell me please, how do you think things are going?

Joe: Well, I'm a bit worried about doing the initial assessments, it's worrying me yeah, and I think, I should be able to do that by now you know, and to be honest, it's bugging me.

Selma: Okay, let's unpick that a bit more, so...initial assessments, tell me more about why it's worrying you?

Joe: I can't seem to coordinate everything, it's overwhelming like, I'm sat by the patient's bedside, there's all this movement and noise going on around me. I'm trying to listen to the patient and write down what they are saying and then I come away feeling frustrated 'cos I haven't got all the information I should have.

Selma: Tell me what you think would help?

Joe: (mumbling) says something but barely audible.

Awkward silence....

Selma: Remember, I am here to help and support you as best as I can. Perhaps we can think of some strategies to help get around this problem of the initial assessments?

Joe: I can't think of any strategies, I haven't got any. This is the first placement experience where I have had to do the initial assessments on my own. Erm... I've got a disability, that might explain things, I tried to tell you a few weeks ago but the moment wasn't right.

APPENDIX S: DETAILED DESCRIPTION OF KEY THEMES, SUB-THEMES AND CATEGORIES

THEME I: WORK CONTEXT AND PRACTICES The findings presented under this theme concern the placement experiences of the student with a disability with specific reference to the setting and its influence. Students are allocated to a range of settings including the acute hospital or working in the community in people's own homes. Considered is given to the specificities of any environment as an enabler or as a barrier in regard to constraining student learning.		
SUB-THEME/ CATEGORY: TITLE	SUB-THEME: DESCRIPTOR / KEY FINDINGS	SUB-THEME: LOCATION
Environment	The environment covers the sub-themes of speed / pace of work; noise; and space – both within the community and the acute setting.	4.2.1
Speed / pace of work	This part of the findings concentrates on the sense of speed and pace of work and describes the implications for the learning experiences of students with disabilities. The impact of speed / pace of work varies according to the environment and ranges from slow to fast. Some students prefer a slower pace, some a faster pace.	4.2.1.1
Noise	Noise can act as a barrier to the student's performance and concentration levels, particularly when trying to process information.	4.2.1.2
Space	Navigation of vast spaces particularly within an acute hospital environment can pose challenges. This sub-theme covers the categories of space in the community setting contrasted with space in the acute setting.	4.2.1.3 4.2.1.3.1 4.2.1.3.2
Skills	This sub-theme covers a number of key skills identified by research participants that students with a disability may find challenging during their practice education experience. These include multi-tasking and information management, the latter of which covers technology, note-writing, processing and verbal communication.	4.2.2
Multi-tasking	Examples of the challenges of multi-tasking include working in the MSK outpatient setting, having to listen to the patient and take notes at the same time.	4.2.2.1
Information management:	Irrespective of the placement setting, a significant challenge identified by a number of interviewees pertained to information management, specifically patient documentation and the reliance on technology. As a skill, information management is woven throughout the practice placement experience, students are often overwhelmed with the amount of incoming data, both verbal and written, that they need to assimilate and potentially act on. For some students with a disability, information management is a key area presenting challenges for a number of	4.2.2.2 4.2.2.2.1 4.2.2.2.2 4.2.2.2.3 4.2.2.2.4

<ul style="list-style-type: none"> - Technology - Note-writing - Processing - Verbal communication 	<p>reasons. This section covers: information: technology; information: note- writing; information: processing; and information: verbal communication.</p> <p>IT systems can be challenging due to the standard set up. Some settings don't have IT but handwritten notes.</p> <p>Challenges of accurate note-writing within a fast-paced environment.</p> <p>Speed of processing information is phenomenal, easier in slower paced or more controlled settings.</p> <p>Challenges of participation in the ward round or multi-disciplinary team meeting for example, the rapid exchange of information.</p>	
<p>Roles & Relationships</p> <ul style="list-style-type: none"> - Practice educator - Role conflict - Visiting Tutor - Student 	<p>Key here is a consideration of the influence of roles and relationships and how these in turn can impact upon the effective facilitation of support mechanisms and access to resources to support student learning during their practice education experience. Both student and practice educator are key players in respect of the practice education experience. The interplay of dynamics in the student-practice educator relationship is dependent upon a number of factors which will be including attitudes of the practice educator (and role conflict), visiting tutor and student.</p> <p>Practice educator needs to have the right approach towards the student, this is key to facilitating a positive placement experience. This also includes role conflict which concerns the tension between the practice educator as the practice educator as opposed to the practice educator acting as a 'therapist' towards the student with a disability.</p> <p>Visiting tutors need to understand the students' perspective and not to just assume that any challenges are because of the disability. Also important to spend time listening to the student. Visiting tutors also act as the mediator between student and practice educator.</p> <p>Students have different attributes and attitudes which, in some cases can form part of their coping strategies.</p>	<p>4.2.3</p> <p>4.2.3.1</p> <p>4.2.3.1.1</p> <p>4.2.3.2</p> <p>4.2.3.3</p>
DISCLOSURE	<p>Whether a student discloses or not is much written about in the wider literature. A number of factors hinging on the decision to disclose is revealed in the findings and point to important implications for placement providers to be aware of in relation to this phenomenon. The decision to disclose or not to disclose is not as straightforward as it appears.</p>	

THEME II: PUBLIC PERCEPTION AND MANAGEMENT OF IDENTITY As a society, it is interesting to question how far we have progressed in relation to promoting inclusivity to enable better participation of disabled people in everyday walks of life.		
Public Perception <ul style="list-style-type: none"> - Stigma - Disability: visible and non-visible - Disability type 	<p>The prevalence of stigma is variable and manifests itself in a variety of different ways.</p> <p>An outward manifestation of disability can sometimes mean that patients are not happy to be treated by a student with a disability.</p> <p>Sometimes the type of disability can make a difference to the setting worked in on placement and how this in turn influences the students performance.</p>	4.3.1 4.3.1.1 4.3.1.2 4.3.1.3
Management of Identity <ul style="list-style-type: none"> - Disability identity - Inclusivity - Awareness-raising 	<p>Some students identified strongly with their diagnosis, others not so.</p> <p>This concerns the culture of the workplace and the environment in relation to whether students with a disability feel their needs are being met or not.</p> <p>Practice educators need to be cognisant of disability and how this may impact on the student's performance. They also need to be aware of the sources of support to assist the student.</p>	4.3.2 4.3.2.1 4.3.2.2 4.3.2.3
Supporting Student Learning <ul style="list-style-type: none"> - Support: making contact - Support: learning - Support: adjustments 	<p>This sub-theme identifies three key factors collectively construed as instrumental tools in providing the right conditions to support student learning: making contact; learning; and adjustments.</p> <p>The initial contact between practice educator and student is crucial and helps the student to prepare in advance of the placement starting.</p> <p>The practice educator needs awareness of how to support the student's learning on placement and doing so in a way that is supportive.</p> <p>Reasonable adjustments need judicious implementation to ensure they are feasible in practice.</p>	4.3.3 4.3.3.1 4.3.3.2 4.3.3.3

APPENDIX T: CAPABILITY LIST

Taken from Walker (2006:128-129) An ideal-theoretical list for capability

- 1)*Practical reason.* Being able to make well-reasoned, informed, critical, independent, intellectually acute, socially responsible, and reflective choices. Being able to construct a personal life project in an uncertain world. Having good judgement.
- 2)*Educational resilience.* Able to navigate study, work and life. Able to negotiate risk, to persevere academically, to be responsive to educational opportunities and adaptive to constraints. Self-reliant. Having aspirations and hopes for a good future.
- 3)*Knowledge and imagination.* Being able to gain knowledge of a chosen subject – disciplinary and/or professional – its form of academic inquiry and standards. Being able to use critical thinking and imagination to comprehend the perspectives of multiple others and to form impartial judgements. Being able to debate complex issues. Being able to acquire knowledge for pleasure and personal development, for career and economic opportunities, for political, cultural and social action and participation in the world. Awareness of ethical debates and moral issues. Open-mindedness. Knowledge to understand science and technology in public policy.
- 4)*Learning disposition.* Being able to have curiosity and a desire for learning. Having confidence in one's ability to learn. Being an active inquirer.
- 5)*Social relations and social networks.* Being able to participate in a group for learning, working with others to solve problems and tasks. Being able to work with others to form effective or good groups for collaborative and participatory learning. Being able to form networks of friendship and belonging for learning support and leisure. Mutual trust.
- 6)*Respect, dignity and recognition.* Being able to have respect for oneself and for and from others, being treated with dignity, not being diminished or devalued because of one's gender, social class, religion or race, valuing other languages, other religions and spiritual practices and human diversity. Being able to show empathy, compassion, fairness and generosity, listening to and considering other person's points of view in dialogue and debate. Being able to act inclusively and being able to respond to human need. Having competence in inter-cultural communication. Having a voice to participate effectively in learning; a voice to speak out, to debate and persuade; to be able to listen.
- 7)*Emotional integrity, emotions.* Not being subject to anxiety or fear which diminishes learning. Being able to develop emotions for imagination, understanding, empathy, awareness and discernment.

8)*Bodily integrity*. Safety and freedom from all forms of physical and verbal harassment in the higher education environment.

Taken from Wolff and de-Shalit (2007:60)

9)*Language*. The functioning of being able to communicate, including being able to speak the local language, or being verbally independent.

Taken from Mutanga and Walker (2015:511-512)

10)*Aspiration*. The capability to aspire.

11)*Culture*. The capability to live without being tripped by culture.

12)*Identity*. Being able to choose one's identity.