UNIVERSITY OF Southampton

The Higher Education Academy

Appendix 4a Southampton Audiology Qualitative Data (Staff and Students)

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Background to the Audiology Qualitative Data Report

Acknowledgements

This report draws on:

- six individual interviews with third year audiology students regarding their experiences of early clinical placements
- self-report diaries completed by the students
- two interviews with two clinical teachers.

The individual audiology student interviews, preliminary analysis and analysis report were undertaken by Stuart Ekberg. Further analysis and the final report writing was undertaken by Anja Timm. The clinical staff interviews were conducted by Stuart Ekberg and analysed by Anja Timm.

Methodology

All the interviews were conducted with volunteer students who had responded to an open invitation to take part that had been sent out by the programme lead. All volunteers were interviewed where possible. Most interviews took place either at the University of Southampton or at the students' placement site; some of the interviews were conducted over the telephone (due to the considerable distances involved); additional ethics approval was gained for telephone interviews in April and May 2011.

In line with the data collected for nursing and medical students, it would have been preferable to capture audiology students' experiences of their first placement. However, for a number of reasons this was not possible. At the time of interview, all of the students were at the beginning of their second clinical placement; they had completed six months in one location and had just moved to a different one. Also, due to the dispersion of audiology students over a wide geographical area, it was not possible to run a focus group, as originally envisaged. Self-report blogs were completed in March and April 2011 and interviews took place in April and May 2011.

The interviews were semi-structured and followed protocols developed by the project team. They were fully transcribed and entered into NVivo. Analysis included in-depth coding of the interview data using framework analysis and further development of themes using the coded data.

Context

The undergraduate programme in audiology is a relatively new programme. It was implemented in 2008 as part of a national initiative (this means most audiology undergraduate programmes in the UK are quite similar). The duration of undergraduate programme that was researched consisted of four years of undergraduate studies – two years at the university, followed by a placement year (during which students are paid by the Department of Health – with a subsequent year back at university for students to consolidate their scientific and theoretical audiology education.

Clinical placements take place in Year 3. At this point, most audiology students move away from Southampton and take up residence in the town where they are undertaking their first placement. During the placement year students tend to live at home, in rented accommodation, as a lodger or within NHS staff residences. The year is split into two placements, the first taking six months and the second five months. For the duration of their placements students receive an NHS bursary. The 52 week placement year includes 27 days' holidays plus bank holidays. Students work a normal audiology working day (8am to 6pm).

Duration of project: August 2010 to October 2012

Students receive practical audiology skills training during Year 2 of their course. They also have several induction activities organised by the Institute of Sound and Vibration Research, which runs the audiology programme. In addition to lectures that set out the practicalities and requirements, there is a chance for students to meet senior students to find out what it is like to be on placement.

Prior to undertaking clinical placements in Year 3, all audiology students travel to visit an audiology department for a taster day.

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Duration of project: August 2010 to October 2012

Findings from Audiology students

Learning on placement

Learning by observation

All the participants recalled beginning their placements by watching, or shadowing, a trained audiologist. In the early stages of placement, this was something that students spent the bulk of their time doing, with some of them reporting making notes while they were watching. Observing was described by participants as one way in which they could learn something new. Below, Rakesh describes how he began learning about balance testing.

> *I'm with the chief audiologist who is usually my supervisor. And, for example, on the first clinic, first two clinics, I was watching her, taking notes and then interpreting the data.* (Rakesh)

Observing can be a critical phase in the learning process for students. Below, another student describes why she felt she had not yet been able to move beyond observing in paediatric consultations or balance clinics.

> *So balance patients, it's good to observe them, if we do some of the appointments that's good. But I think that the university are aware that it very much depends what centre you go to, because it depends how much balance they do. So here I've observed people doing the balance appointments but I haven't actually inputted at all.... Which is fine, because I wouldn't feel confident to do some of the stuff, it's quite hands on, moving patients around and things. And it's the same with paediatrics, I do mostly observing, purely because I'm just not in the sessions enough to be able to lead an appointment.* (Erin)

Erin's account gives a sense of how students can find observing a means to learn how to conduct particular procedures, such as running a balance clinic consultation. However, she also positively assesses, early in her account, the opportunity to be actively involved in such consultations. What can prevent this is an insufficient number of learning opportunities arising. This indicates that for students, moving from observing to being actively involved is considered to be the ideal learning process.

For some participants, this phase of exclusively observing was quite short: a week or less. Others reported that it took longer before the staff were willing to let them participate in patient care. Below, two students identify the shortcomings of observing rather than participating:

> *I think I was very lucky with my first placement. A few people I know were only allowed to shadow for like the first month, they weren't allowed to do anything, and it just got a bit boring for them I think.* (Amanda)

> *...I think most of us felt that we would kind of just watch for longer, because it's easier, at the end of the day you don't feel so much stress. And because you're with new people all the time, and there's so many staff here, you don't get used to the way that people work until you've been with them before, and the chances are you haven't been with them before so you go, 'I'll just watch kind of all of the appointments,' because that's easier. And so I think we all fell into the trap of not pushing ourselves to start with.* (Sarah)

Although there are some benefits from observing, it seems clear that the audiology participants regarded participation in patient care as the goal for learning on placement. Many students summarised the standard transition that they made in their placements. The following is just one instance.

> *We started off just purely watching and making notes. And then we started helping out with individual parts of the appointment. And then we started doing more of the appointments on our own, if there was anything we came across we'd sort of look frantically at the supervisor who was sat in the corner, and they would usually step in and help us out. And then eventually we were doing it on our own.* (Amy)

Students in audiology conceived of their learning trajectory as starting with observing, progressively moving into participating under observation, and culminating in independent practice. It seems that audiology students are the least likely – of the three disciplines being studied – to spend their time observing, rather than participating, in patient care.

Learning under supervision

The participants all described progressively moving from learning by observing to learning by practising their skills under direct observation by trained audiologists. Often this was their placement supervisor, but most participants also worked with other trained audiologists who were based at their placement site. Some students described negotiating with the audiologist who was supervising them at the time which part, or parts, of the consultation they would attempt to conduct themselves.

> [first day] *Yeah just observing. And then you just start to push your way in and do little bits of the appointment. And then they let you do the whole thing. (…) Yeah, yeah there's not much structure really in terms of, 'Right, they will do this, and then we'll let them do that'.*

Some of the participants who were interviewed described selecting the component, or phases, of the consultation that they were most comfortable with. Not surprisingly, this was usually tasks that they had some direct experience of, from their pre-clinical training, such as programming hearing aids.

Interacting with patients seemed to be the aspect of a standard consultation that participants were the least likely to become involved in, early on in their first placement. When asked what advice she would give to someone beginning an audiology placement for the first time, Jennifer replied:

> *Look at your patients, decide what it is that you want to get out of each patient. Look at them, I mean straight off you'll be doing fits. You've done fits at university. Which bit are you comfortable with having a go at? Now it is quite possible that the bit you're comfortable with is doing the bit on the computer, and you're not so happy about putting things in a patient's actual ears. It's fine doing it on a student that, if you do it too much, they're just going to say, 'Oh that really hurt,' but it's another thing with the patient. So do the bit you're confident with first so that you then don't have to think about that. But every – even from your first day, there must be something in a session that you can do, and that you know you can do it, do that bit.* (Jennifer)

Some participants identified specific benefits of working under direct supervision. Several mentioned the opportunity to learn a range of techniques that could be used to achieve an objective.

> *...being round people that are working, it's really nice that you can talk to them and you can actually discuss things. They've been doing it for a long time so they can come up with all sorts of hints and helpful tips.* (Amy)

Amy was the only participant who described a placement arrangement where she could choose to attend particular audiology consultations that would allow for the most learning opportunities. She found this particularly useful to maximise the likelihood that she would attain all of the competencies detailed in her assessment logbook.

> *...you can bring up everyone's schedules and you just see and you put yourself in with them. If someone wanted me, towards the end of the placement, to do my own patients, they'd just be booked in under my resource, so I could see, 'Oh they want me to do patients'. But other than that it was up to me to sort of think, 'Well I've got to do this kind of patient to have it signed off in my log book, so I'll do this'. It was sort of my own common sense.* (Amy)

Amy described that although there were times when she had to see patients on her own, at other times she was free to identify appropriate learning opportunities. She could do this by scheduling herself in with audiologists who had upcoming consultations that in some way corresponded to a competency that Amy needed to attain as a part of her course assessment.

It is the case that students can have competencies approved by observing a consultation, or even in a skills session back at university following their placement year, if no opportunity arose for them to directly demonstrate competence themselves. Although Amy's arrangement at her placement site indicates that she was able to maximise her chances of attaining all of the competencies that she required for her course assessment, she also indicated that this arrangement allowed for a rich learning experience. She was able to practise the skills for herself. In this sense, Amy moves beyond what is necessarily required for her assessment. Jennifer describes other ways in which working under supervision can help students to move beyond competence, as it is assessed within the audiology degree programme.

> *All the qualified audiologists, they'll all tell you they've been in it for years and years and years, and they still pick up things from other people, they still learn as they go on.... [E]very patient is different and there's going to be somebody that walks through the door, that on paper sounds straightforward, and then you come and do it and it just doesn't work. Now they've had 15-20 years of experience and they know when to throw in the towel and accept the fact that it just doesn't work. They also know 110 little different things that you might try or whatever to get it to work. But you only know those by asking, seeing it done, whatever. If you don't ever ask you won't get those little things*. (Jennifer)

Several students described treating patients by providing a standard fit for their hearing aids as the least optimal way. Jennifer here describes the benefit of working with a range of different audiologists. She reports that you can learn a range of different techniques that you can use in order to accomplish goals like getting the best hearing aid fit for each individual patient. Jennifer also describes audiology as a profession in which practitioners should go on learning from one another throughout their careers. Therefore, in addition to learning from being supervised by different audiologists, it is also possible for students to become socialised into a profession where continuing professional development is taken for granted. However, as we will see below, Amy describes how this is not always the case.

Another benefit of working under supervision that a few participants described was that the supervisor's presence ensured that students' practice was safe for patients. Jennifer describes an extreme example:

> *...if you're about to do it wrong the supervisor will drop in and say, 'Um hmm before you fill that man's ear when he's got a massive great hole through to his brain, would you like to do this?'* (Jennifer)

More generally, participants described working under supervision as the best way to improve their skill at doing something of which they had little to no previous experience.

> Stuart: *What's a good way to learn something new on placement?*
>
> Amanda: *Probably shadowing still.... Or doing the appointment yourself and then someone butting in every ten seconds saying, 'Oh do this, do this. Oh you forgot that'. Or like I think rather than – I think I prefer it that way. Some of them like write notes and then give it to you all at the end, but I'd rather someone butted in saying, 'You haven't done that'.*

Working under close supervision seems a hallmark of apprenticeship-style learning and distinguishes it from the type of learning that students undertake within the university. In contrast to university, where assessment is often the only context through which students receive feedback, feedback on placement is an iterative process, as the quote above indicates. Amanda describes how it allows her to immediately refine her skills. Indeed, in describing her preference for immediate over delayed feedback, Amanda reveals that, for her at least, continuous feedback is the optimal way of learning.

In addition to the strengths of working under direct supervision, some participants described challenges that this can pose. Some students, including Amy, described the range of skills that students can acquire from working with qualified audiologists, yet Amy also describes that this is not always the case:

...in my first placement, if there was an audiologist that had been doing it for, you know, 30 years, they wouldn't really be told any differently, you couldn't really question them too much...[S]ometimes you have to say, 'I'm really sorry, could you just explain this? Why are you doing that? What's this?' And sometimes if they can't answer you, I guess obviously they feel that they should be able to answer, and that's a little bit awkward if they can't… (Amy)

A few participants referred to the most senior generation of audiologists, who began working in the profession at a time when considerably less professional training was provided, as having work practices that meant they could be very difficult to learn from. In Amy's case, she feels that some of these practitioners resist being questioned about their practice because they cannot articulate a basis for their conduct. Other students describe the generational divide as being to do with the scientific basis of the field. That is, as audiology has developed a stronger scientific basis, those practitioners that were not formally trained for the profession have become increasingly marginalised from the standard knowledge base upon which the field rests. This can be a challenge for contemporary students, who have spent two years being trained – as they see it – in both critical inquiry and the scientific basis of audiology practice.

Another challenge of working under the supervision of different audiologists is that different practitioners can have different ways of doing the same thing. Whilst earlier quotes indicate that some participants appreciate this range of approaches, this can also pose challenges for students:

...there are some audiologists that you're with... they think the right way is the way they do it... So you kind of have to have a little bit of a memory that, you know, 'I'm with this person, they like to do it like this'.... I've said... I do it the way my supervisor has taught me because at the end of the day I'm going to have an assessment, and my supervisor is going to be in my assessment, and if I don't do it the way my assessor wants, my assessor will still pass me provided my supervisor sits there and says, 'Well that's the way we've shown her, that's the correct way of doing it'.... Basically I'm doing it the supervisor's way. But I've got a whole load of mental notes that when I'm qualified, and when I'm on my own, I kind of pick up a little bit from what they do and a little bit from this. (Jennifer)

Although there a benefits for students in working with practitioners that have different ways of approaching a given situation, there are also inherent challenges. As Jennifer explains, this can mean that one practitioner can correct a student for conducting themselves in a way that they were instructed to by another. Jennifer discusses two solutions to this practical problem. The first is to try and remember the different ways that she needs to conduct herself around different practitioners. The second is to focus on the way in which her supervisor has taught her, which she justifies on the basis of the way in which she is assessed within her degree programme.

Erin explained that, in her first placement, she found that some audiologists were not keen to supervise students in their sessions because of the additional pressures that this placed on their already tight schedules. At this particular site, she explained that patient consultations are limited to 40 minutes, which she describes as being short.

...people didn't necessarily like having a student with them, because it was almost – it was inevitable that you were going to overrun. Because when you get more competent at things then you start to cut corners, so all the fully trained audiologists, they know how to do things, without compromising patient care, but they can do things a lot quicker. Whereas I'm sat there doing a hearing test exactly how I have to, because otherwise if you don't then they're like, 'Oh you didn't do this properly,' and, 'Well I know, but look what time it is'. So that got quite stressful sometimes. (Erin)

In this fragment, Erin describes the challenge of learning how to do something properly, whilst also trying to keep to schedule. This is difficult for neophytes, who have not yet devised the efficient ways of doing things that experienced practitioners have, without compromising patient care. This problem only seems to arise

because the expectation is that the same amount of work will be accomplished and, in addition to that, a neophyte will be trained.

Another challenge that students can face is determining when they do not feel competent or comfortable participating in patient care, and then being able to communicate that to the audiologist that is supervising them. Amanda describes an instance where she had to do this:

> *Amanda: I've said no to a couple of – like a procedure, you have to take, to make the mould, the ear mould, you have to put like a little foam stopper into a patient's ear and inject some like soft putty stuff. And there's been a couple of times I've said, 'Actually can you do this one? This patient has had surgery,' or, 'They've got a perforation, I'm not really comfortable doing that'. And someone else has done it, they haven't questioned me saying that I don't want to do it.*

Amanda is describing the sort of procedure that Jennifer discussed performing above. In her case, Jennifer felt confident attempting the procedure under supervision, whereas Amanda resolves that it is not appropriate for her to be involved. A challenge for students, then, can be to know their limitations and to communicate those limitations to the audiologists that they are working with. In Amanda's experience, this is something to which staff are receptive.

Another challenge associated with learning under supervision can result from changing working sites midway through the placement year. Students studying at the University of Southampton spend six months at their first placement site, and then another five at a second site. Students generally felt that there were benefits to working across two different sites. They described moving to a second site as allowing them to be exposed to different systems and practices, and it often involved the chance to interact with different types of patients. Erin was the only student to identify a problem with this arrangement.

> *...in [City] I got to the point within a few months were I had all my own patients and I had my own lists. So I think that's a real downfall of the audiology placement, is that you spend six months really being trained up... and then you just get like plucked out of there, thrown somewhere else. And I understand that when I came here, for kind of safety reasons, they can't just let you loose on a patient, and take [Clinic's] word, 'Oh Erin is fine,' or whatever. But I feel like I've been here seven weeks now and I've still not seen any patients on my own... you start to feel like you're being deskilled.* (Erin)

The crux of the problem here seems to be that, unlike other students, who described progressing into independent work very quickly on their second placement, Erin was still doing relatively low-level work seven weeks into her second placement. Throughout her interview she described how, at her second placement site, students are often relied upon to conduct assessments for the nearby Ear, Nose and Throat (ENT) department. She says that this has occupied so much of her time that she is yet to return to doing the sorts of tasks that she was routinely conducting at her first placement site. In the above fragment, she describes that a consequence she feels that there has been an atrophy of the skills that she acquired in her first placement.

A final challenge discussed in the interviews can arise from the process by which students become progressively more independent in their practice, whilst still under the supervision of a qualified audiologist. Jennifer explains:

> *...the way they did it [supervision] was, 'OK, you learn with X, shadow X, she'll' – you know, and X ended up by just sitting in the corner of the room most of the time. And then she said to me, 'Do you know, I can't sit with you anymore, because I think I slept through the last two patients and it's not looking good'. But she was always sort of around somewhere.* (Jennifer)

As time went on and students became more confident, the participants reported that the trained audiologists became progressively less involved in the consultations. This culminated in students being given their own rota of patients although, for some more specialist areas such as paediatrics and balance, this might never happen.

However, once students had their own rotas, they are still supposed to spend time with qualified audiologists, particularly in order to attain new competencies. In the following fragment, Jennifer describes what this was like for her.

> *...other people, now they'll sit with me, and actually quite a few just sit with me. They're supposed to be with me all day and they'll sit with me for about ten minutes and get completely bored and then go and just leave me to it. And others will sit there and say, 'Yeah that's fine,' you know, absolutely no feedback at all, just, 'Yeah that was fine'. (…) There's no learning, you might just as well have been on your own.* (Jennifer)

Jennifer's report of working with these audiologists is made in direct contrast to her description of her official supervisor. Jennifer describes a range of benefits that she has received from working alongside that supervisor, all of which result from engaging with and getting feedback from her. It may be the case, then, that supervisors, due to their association with the university, are more aware of the didactic role that they can play throughout a student's placement, than their colleagues who are less involved in the planning and implementation of student placements.

Learning in independent practice

Once students have displayed prolonged competence as specific tasks to their supervisor's satisfaction, they are given rotas of patients, or patient lists, of their own to work through.

> *...[it] makes you feel really good because you're like, 'Oh good, I can actually – I can do this job'. And you get respect from the patients as well, which is lovely, because they see that you're in there on your own and you've not got somebody sat behind watching you. And that's a really nice feeling, because it's very different, they treat you very differently if you're not being observed, definitely.* (Erin)

On the basis of Erin's report, one of the things that students can learn from being able to work independently with patients is an awareness of their own competency. Realising that they are able to do something independently can foster a sense of confidence in students, which is undoubtedly useful as they move towards working as a qualified professional. It also provides an opportunity for them to work out their preferred method of practicing audiology.

> *...when you are left to just do it by yourself you get into a routine and you get to learn things, you do it your way really rather than being – everyone does it differently, so you learn what works best for you I think.* (Amanda)

Earlier, participants described that benefits and challenges of working with different people can arise from their different approaches to conducting similar or same tasks. Amanda now describes, the opportunity to decide which of these are the best approaches to take in the situations that she personally encounters. Working independently also offers, as Amy describes, opportunities to reflect critically on one's own practice.

> [Asked about potential advantages to sometimes not having someone else in the room] *Yes, yes there are. You don't sort of feel so – like well you don't feel that someone is watching your every move... And sometimes you say something, and you realise you've said it, and you don't need someone else pointing it out to you, you can take that and you think, 'Right, I won't say that next time, I'll say it this way'.* (Amy)

It seems that once students are competent at the technical aspects of their role, they can benefit from being able to work independently. In particular, the opportunity to be able critically to reflect upon, appraise, and amend their own conduct, independent of feedback from a qualified practitioner, is another part of their professional development that the audiology programme facilitates.

The main challenge of working independently that the participants described was deciding when to seek assistance in relation to a patient with whom they were currently consulting. Although participants reported gratitude for having this kind of backup, some described difficulties in accessing it.

Amy: *...it is a bit of a problem here because we get some random patients with all sorts, and there's not always someone about to ask. So you feel a bit silly sometimes knocking on someone's door saying, 'I'm really sorry, can you just come in and help me? I don't know what to do with this patient'.*

Stuart: *How do they usually react to that?*

Amy: *Usually they sort of – usually they're fine, usually they're fine... usually they'll come and help. Obviously they can't stay, but they can come and talk things through and just sort of help me out a little bit.*

From this type of account, it seems that one of the things that students must learn about the practicalities of being on an audiology placement is that it is acceptable to interrupt a consultation-in-progress in order to seek assistance from a qualified audiologist, even if that means disrupting that audiologist's consultation. In the earlier stages of the placement, the awkwardness of this situation can be avoided if a supervising audiologist leaves the room, but only to attend to administrative work. Participants discuss it being much easier to disrupt supervisors doing this type of work than those in consultations. As students get more and more experienced, however, and require less supervision, their supervisors are more likely to schedule patients of their own, and the above challenge that Amy describes becomes more probable.

It is important that students become confident in the practicality of disrupting other's consultations to seek assistance, as the alternative is to compromise patient care.

> *I've got a fitting of a patient tomorrow for a hearing aid I haven't fitted before, and so what I've ended up with is heading on to the – we've got like a common [computer] drive, and there's protocols for fitting different things. And I've got visions of me tomorrow following, just like following a protocol. So if you come across something new, sometimes it's a case of just getting on with it.* (Sarah)

In this fragment, Sarah describes the difficulty of trying to attempt a task of which one has no prior experience. As we heard Amy describe above, there is the option of asking a trained audiologist for assistance, even if that requires disrupting their consultation. Below, she explains another option.

> *...no one vets our patients here, that's sort of left up to us to look at our patients in advance. And they're only put on our schedules three days before the appointment, so it gives us a couple of days just to go through and check that it's a patient that we can actually see, a hearing aid that we can fit. I think I've had a cross aid booked in with me for a fitting and I don't know anything about cross aids, I've never seen one, I've never seen a fitting. And this poor gentleman turned up and I didn't know what to do with him. So again I had to ask someone very kindly to swap with me, and I carried on their appointment and they did mine.* (Amy)

If possible, it seems that there is a tangible benefit for students to plan ahead by reviewing their patients several days before the consultation is due. In the event that they have been allocated a patient with whom they do not feel competent dealing, they can then take steps to address the matter.

In her interview, Jennifer clearly preferred the approach of asking for help.

> *...some of the feedback I've had from my supervisors is one of the things that they have most difficulty with students is knowing their own limitations...l ots of students just, 'OK well I'm having difficulty with that, I'll just do a quick fit'. But actually if you go and ask for a second opinion, the chances are that audiologist will show (…) how you could actually get a proper fit done... whereas if you don't, you just do the quick answer, you've not done the right thing for the patient and you've learnt diddly-squat.* (Jennifer)

In her account, Jennifer describes the sort of situation that Sarah finds herself in as a learning opportunity. Jennifer does not regard the approach that Sarah describes, of following a protocol ('conducting a 'quick fit'', in Jennifer's term), as ideal for either student or patient. She regards getting assistance as the optimal outcome.

On the basis of these interviews, it seems that there can be a real problem for some students when they work independently, of seeking assistance with tasks that they do not feel competent doing on their own. This matter deserves further attention.

Learning by studying

No clear pattern emerged in the interviews as to the formal study opportunities that were available to audiology students when on placement. Some students described having protected half-days that were given over to their independent study, whilst others described that they had to conduct administrative work during this time. Unlike the audiologists that they worked with, they did not have allocated administrative time and were therefore forced to use their study time to fulfil their administrative responsibilities. If they wanted to study, they had to do it in the evenings or at weekends. Only one participant reported attending a professional development course on offer at the hospital where she was based.

Sarah was the only participant to describe at length the opportunities that she had to undertake formal study. Her placement site was relatively large, and supported a sizable number of students. Due to this, they had obviously deemed it worthwhile to offer structured study sessions, and these took the form of fortnightly tutorials. Sarah describes these as good opportunities to gain competence in skills that they might not otherwise get an opportunity to practise, particularly those in which she was required to become competent to pass her formal course assessment. For instance, she had few opportunities to participate in balance clinics at her placement site, so she and the other students were offered vestibular tutorials as an alternative. Sarah describes that these tutorials are:

> *...usually practical based, which is really good, it's the best way you learn always. And it's usually with the member of staff that's kind of the higher up in that area, so it's always by the best person possible to do the tutorial, which is great.*

As beneficial as these tutorials seem to be to Sarah, they are unlikely to be feasible at other placement sites due to their size and the number of students that they supervise at once.

'Not learning' on placement

For the duration of their placement audiology students are employed by the NHS, and might therefore be expected to be used as cheap labour that can be directed to engage in menial tasks. Whilst such situations were described by nursing students, this was not reported to be the case in audiology. Most of the students reported that they had ample opportunities to learn. The instances that were discussed where students engaged in tasks to the detriment of their learning, however, warrant attention. Below, one student describes being given menial tasks and being given what she regards as unreasonable instructions to follow. Importantly, she does not feel that qualified audiologists would be asked to do such things and so she therefore attributes their occurrence to her status as a student.

> *...I think the students were asked to do things that perhaps other members of staff wouldn't be asked to do. (…) Such as if some equipment needed picking up from another hospital, they'd ask us to drive. Because they know that some of us have gone out and bought cars knowing that we need to get around for placement year because we need to travel to different clinics. And so there was one occasion where I drove to [Town 1] in the morning because I was scheduled to be with one of the audiologists there, then I couldn't be with her for a number of reasons, and because her patients didn't turn up, so I drove back to base to [Town 2], I got back, they asked me to drive back again because they needed me to cover a clinic in an hour, and then they wanted me back again at [Town 2] for the afternoon to cover a clinic there. So I just sort of – I felt that they wouldn't have asked another staff member to do that. But because sort of we're, you know, we're students, I think they thought that was a bit more acceptable to ask us to do it.* (Amy)

The participant who most talked about not getting access to learning opportunities was Erin. She was interviewed six weeks into her second placement, and her comments relate to what that second placement has been like.

> Erin*:* *...we've actually had some problems because we've been just used as like ENT slaves really. So we've just been put on because that's something we can do, they don't have to observe us, they don't have to worry about – they can just leave us there.... I'm not sure if there would be as much of that if I was an employed audiologist, but as a student I've maybe been exploited a little bit.*
>
> Stuart*: Was that the same at [Placement 1]?*
>
> Erin*:* *Not as bad. It was more on repairs in [Placement 1]. So I think that they're definitely placement centres, because other people I've spoken to as well have a place where they can sometimes dump their students...I think sometimes there's not a very equal balance between how much training you get and how much they get an extra member of staff that they can use.*

In this fragment, Erin describes how there can be relatively simpler tasks that students can be given. A problem with this scenario can arise if students are being allocated such tasks to the exclusion of other learning opportunities. Erin and other participants described repairs as relatively simple work to which students were prone to be allocated. These participants tended not to describe this as a problem, however, as they discussed making repairs as a central part of being an audiologist. Alternatively, for Erin, being sent to do testing for the ENT department was clearly a different type of task. She felt that she had been sent there because the work was so simple that she did not need to be supervised. Elsewhere, in data not shown here, she discusses the pressures that the department are under at the time she undertook her placement, and attributes her being placed in ENT as possibly due to this. Her work in this department is clearly to the detriment of learning about other parts of the audiological profession and Erin continues to describe how, in the end, she had to confront the matter personally:

> *I talked to the head of department and said (…) 'Right, this is it, I can't do this anymore,' so I went and spoke to him. And it was really – like he's very lovely and really approachable. So you – I kind of feel like I have to fight my own battle a little bit of getting my learning done. There's not necessarily someone responsible, making sure that – I mean I have a supervisor, but she's now ill, and then going away for three weeks, so I'm alone for a month, so I have to make sure myself that I get the learning done that I need to*. (Erin)

Erin's account shows how students can be left to completely manage their training whilst on placement. For Erin, this meant that she had to approach the head of department personally in order to demand the learning opportunities that she needed. For a student less assertive than Erin, this could be a major problem for their placement.

Although accounts like Erin's highlight the risks to student learning whilst they are on placement, Jennifer describes being allocated menial tasks that she felt had helped her to integrate into the department where she was working and to gain access to learning opportunities.

> *At [City] they had jobs that students did, which is fairly mindless sort of jobs like stocking the rooms with the equipment that you need. But it meant that when you got in, if you didn't have your own list to prepare for, you got in and you weren't sort of sitting there thinking, 'I've got half an hour until I see somebody, what do I do?' ...you're not sitting there when you get in in the morning thinking, 'OK, you know, what do I do? When is it time to just go and sit and watch what somebody does?' you've actually got your own job*. (Jennifer)

Although she describes stocking the consulting rooms as a menial task, Jennifer positively appraises it as an opportunity for her to be industrious, at a time of the day when all the other audiologists are preparing themselves for the day ahead. It also means that she frees up some of her colleagues' time, which they might then be dedicated to teaching her later. This trade-off is also reflected below:

> *I'd say that you need to get a good balance between learning and training, but also fitting into a department and being a useful member of staff while you're there. Because it is that you're kind of – you're giving your services, and back they give you kind of training.* (Erin)

Menial tasks, then, pose both a challenge and an opportunity in audiology placements. On the one hand, students can be helpful in ways that can free up time for them to be taught. However, there is also a risk that students can be allocated tasks that contribute to the workload of a department, do not require much supervision, and provide little opportunity for the student to learn.

Working with and learning from patients

Interacting with patients

Most participants reported that interacting with patients was the easiest, or nicest, part of their placements, although some participants acknowledged that this may be something that they personally found easy, whereas others might not. Amy's response illustrates both these themes:

> *…interacting with patients is really easy. But I guess that's probably just a personal thing. Other people might find developing those skills more difficult than others. So I've found that really quite easy, and that's a part of the job that I really like when my patients aren't too complex, as I call them*. (Amy)

Amy also indicated, earlier in her interview, that interacting with patients was a very particularised experienced. That is, there were some patients, particularly those with complex needs, who were more challenging to deal with within consultations. In her above talk, she hints again at this notion, by explaining that easy patients are those that are not 'too complex'.

No participant who was interviewed reported that dealing with patients was difficult for them personally, although some did mention other students whom they felt may have struggled.

Learning from patients

Learning from patient contact figured heavily in participants' accounts of the benefits of clinical experience during their audiology training. Students reported that being on placement, and in particular interacting with patients, allows them to develop a richer 'working understanding' of being an audiologist.

> *...I think it doesn't matter how much knowledge you have, you have to have just seen enough patients to know what to do when they come in with a specific problem. (…) So maybe they'd come in and say like, 'I've got loads of feedback'. And although I knew, I had the theoretical knowledge that if they had an ear full of wax then that's going to give them feedback. But because I hadn't seen enough patients, I didn't necessarily think that straight away.* (Erin)

For Erin, there are concepts that she learnt at university, even quite simple concepts, such as ear wax contributing to hearing aid feedback, that do not assume a practical importance until she has seen an actual case where identifying and addressing this situation can benefit a patient. Learning from patient contact, then, appears to be more salient, at least for some people in some situations, than learning in a formal didactic context.

> *I've enjoyed just learning the new things really and actually putting into practice what you learnt at uni. It's all very well saying, 'OK you're going to do this, this and this to a patient'. And things like counselling, you have lectures on like different counselling techniques and things, but actually putting them into practice and helping someone cope with their hearing loss is very different.* (Amanda)

Here, Amanda describes the benefits of developing a working knowledge of being an audiologist – what she refers to as 'putting into practice'. Patient counselling is an example of working knowledge that is developed

on placement that several participants discussed. For some of them, their theoretical learning on patient counselling was not applicable for practice; patient counselling was a practical skill that they had to completely learn on the job. Others found that they could draw on and adapt the counselling theories that they had learnt, in dealing with patients. Either way, students' working knowledge of the field is developed through patient contact.

Working with patients was also seen to be beneficial because it allows students to gain an understanding of testing hearing, and assisting hearing, on those with actual hearing loss. This contrasts with students' pre-clinical training, where they were trained by practicing on fellow students, who have normal hearing.

> *I think my understanding has definitely developed a lot. Things that should have made sense two years ago suddenly clicked. Like now you've got an actual patient who has got a hearing difficulty. And it's all very well, most of the people on my course were within normal limits of hearing, so actually trying to do stuff on them, you couldn't actually see how it worked properly just testing on each other.* (Amanda)

Alternatively, there are contingencies that simply are not covered in pre-clinical training, such as how to deal with patients who resist wearing hearing aids:

> *I'm also, more than anything, finding out that we get to see the emotional impact on a patient when you find out, oh dear, this patient doesn't actually want hearing aids, what do you do next? We're not taught that in a wet lab session of course, you know, you've just got a dummy in front of you and you talk to it.* (Rakesh)

Rakesh's account of a patient that does not want hearing aids conveys what he perceives to be the practical limits of university-based training. His recollection contrasts simulation with real work contingencies. It is the latter that allows students to realise that they must learn how to respond to patients as individuals. Participants repeatedly explained, often several times within their interviews, the benefits of learning to treat patients as individuals.

> *...it's a case of treating everybody as an individual, and making sure that you've really thought about kind of – you know, there might be some underlying reason why they're adamant they want a certain thing, and if you can address that first then you're less likely to have problems further down the line when you've fitted them with something they think they want and actually it doesn't help them in any way.* (Sarah)

Sarah's account here illustrates the importance of students, and indeed practitioners, taking the time to appreciate patients' perspectives and what it is that they are aiming to accomplish within the consultation. In her account, she conveys that this effort is productive, in the sense that it can circumvent the possibility of certain future problems. Consistent with the notion that students are learning to treat patients as individuals, the following comment show how developing skills to interact with patients occurs across the placement year.

> *I think I've just got to the stage where I know what I'm doing, and now I'm starting to think about, 'How do I do this well?' for each individual.* (Jennifer)

If it is the case that general practical skills need to be customised for use with individual patients, it is not surprising that the participants talked about gaining experience across time. Rakesh describes developing clinical competence that draws upon abstract knowledge and applying it to individual situations. Although Jennifer describes the same, she further mentions that it has taken quite some time to attain this competence. She was interviewed in the ninth month of her placement year and it is only at this point that she feels that she has developed a 'scaffold' of understanding that is capable of supporting customised patient care. This, then, points to a potential benefit from the extended clinical placements that are available to students studying for degrees in audiology.

For the participants in this study, the above themes – developing a working understanding of the profession and being able to treat patients as individuals – are all reasons for including greater levels of clinical experience

in the first two years of their degree programme. Moreover, participants routinely reported that the clinical experience they did have in those first two years was too short and did not allow for interaction with patients.

Challenges in interacting with patients

In the interviews with audiology students, three particular challenges associated with interacting with patients were discussed: developing confidence, addressing their status as students, and being exposed to sexual harassment.

The first of these is the problem of developing confidence, which can be heard in the advice that Rakesh would give to someone starting placement for the first time:

> *I think it's hard to come across as over-confident, and it's easier to come across as shy and confused and not quite sure on how to do something. So I think if I had any tips to give to a person it would probably be that it's better to be bold than to be shy in circumstances with patients.* (Rakesh)

What Rakesh seems to be referring to here is displaying a professional demeanour that allows the consultation to go smoothly, and particularly for the patient to feel comfortable being treated. Several participants mentioned that patients were often unaware when mistakes had been made. This meant that, if identified within the consultation, a mistake could be rectified without any adverse effect on the patient. These students felt that they were safe displaying a professional demeanour, as most mistakes that they could make were of this order.

The account below displays how confidence is something that is developed through patient contact:

> *So you don't get that same clinical experience [at university], that confidence of being with patients, that you do when you start placement... I mean it was really hard, when I first started I didn't know – I think I'm quite a confident person anyway, so maybe I found it easier than other people, but to just have to suddenly talk to patients, like real patients, and you think, 'Oh my goodness, you've actually got a hearing loss, I don't know what to do,' and it's very different.* (Erin)

In spite of identifying herself as a confident person, Erin describes how it took some time for her to feel confident working with patients. This highlights the dilemma that students can face. On the one hand, they do not feel confident early in their professional careers, but on the other it is important to display confidence to patients. Knowing when one can practice a new skill without putting patients at risk seems to be a key mediator in displaying confidence when one might not yet actually have it.

A related theme for the study participants was their status as students consulting with patients. Half of the six students interviewed from audiology reported not introducing themselves as students in consultations with patients.

> *I tend not to introduce myself as a student, and I think most of us take that approach. No doubt they'll see the badge at some point during the appointment... When we send them clinic reports, it's got that we're a student on the bottom of it anyway, so they will know eventually.* (Sarah)

Although Sarah talks about her status as a student as transparent, through her wearing of a badge that says 'student audiologist' and the inclusion of this information at the end of her patient reports, there is clearly some interactional motivation for not revealing her status, particularly at the outset of the consultation. As with the above theme about displaying confidence, the motivation behind not revealing one's status as a student seems to be geared towards maximising the patient's trust in the student. A fragment of Amy's interview shows how this can be the case.

> *...patients have a little bit more faith in you if you haven't got someone sat watching. A lot of people don't even realise we're students, and if we've got someone sat in with us, I think maybe they're a little bit dubious that they're being seen by a student. Even though we are being watched, they'd rather be seen by the person that's watching. And if we're not being sat in with, I don't introduce myself as a student. If they ask I'll say, 'Yes I'm a student and this is' – you know, and tell them what I'm doing.... But I think they have a bit more faith in you if they don't feel like you're sort of a new learner.* (Amy)

From what Amy is saying, it appears that there are instances where trained audiologists and students are involved in consultations where the student's status as a student is not made manifest. As in the above fragment, although it is possible for patients to infer that status from the presence of another person in the room, this is not made explicit. Nevertheless, because it can be inferred, Amy feels that patients sometimes do not have confidence in her ability. Not informing patients of their status as students, then, could be a practical means by which students work to instil confidence in their patients.

Importantly, there are alternatives to the deceptive approach that some students describe. For instance, immediately after Amy's above comments about patients having more confidence if they do not feel as though they're being seen by a neophyte comes the following:

> *[Asked if patients do not want to be seen by students] I had a couple that sort of jokingly said, 'Oh, you know, are there any real audiologists here?' And (…) I've sort of explained that we've been cleared to work with patients, that they are happy with us, you know, 'Would you like to be seen, are you uncomfortable being seen by me, by a student?' And generally, if you're honest with them and say, you know, 'If you're uncomfortable with it we can go and get someone else,' they're fine.* (Amy)

Amy comments show that, although there may be interactional motivations for not disclosing one's status as a student, and while this may benefit the early stages of a consultation, there are alternatives available to students which appear to be successful.

> Stuart*:* *Can you disrupt a consultation and leave the room in order to speak to a colleague if you need to?*
>
> Jennifer*:* *Hmm yeah. I don't think – and I think that's something that takes you a little while to get over, that it's perfectly all right to look at a patient and say, 'You know these results aren't quite what I was expecting, would you mind if I just went and got a second opinion?'*
>
> *Jennifer:* *You can programme up a hearing aid and then look and think, 'Oh no, I've got the right hearing aid on the left ear. Damn'. And then, you know, actually do you really want the patient to go out like that? No. And you get them back and say, 'Actually no, I just want to double check something. Do you mind if I just take a few more measurements?' They don't know, they don't know, they'll just think you're being really conscientious.*

The final challenge associated with interacting with patients that was identified in the data was sexual harassment. Of the four young women that were interviewed, three reported experiencing sexual harassment whilst on placement, and one of these participants also reported being placed in a potentially dangerous situation.

These data would suggest that sexual harassment is a clear problem for many students going on placements in audiology. Amanda's experience of sexual harassment was something that she initially raised in the research diary that she kept as a part of her involvement in the study. In that she wrote:

> *Whilst my mentor went to fetch something from a different room, the patient (85yr old male) began talking about how lovely my mentor was. He then proceeded to ask me how old I thought he was. I stumbled around the question, not knowing how to answer and was unsure why he was asking me this. He made some other remarks I thought a bit forward to which my mentor controlled; however as he was leaving he abruptly slapped my backside and had a rather odd laugh!! I was in a state of shock and came out with, '...umm excuse me' I didn't know how to react, My mentor took control of the situation again warning the p[atien]t he needs to be careful, to little effect.*

When asked about this in her interview, Amanda explained that the patient had diminished mental competence. Several participants described being sexually harassed by patients in this state. Due to patients' mental incapacity, participants normalised their experiences as something to be expected as a part of their job. This can be heard in this participant's response:

> [Asked about how you learn to respond to such situations] *I think they become easier with time. You kind of – you either learn to brush it off and make a joke about it, or if it really is stepping over the line then most of them react quite well to, 'That's not appropriate'.*
>
> [Asked whether there are any procedures that you're supposed to follow in those instances] *I'm not aware of any.... Usually we make a note of it on their records to say that they're either not to be seen by a particular person, or to be seen by two clinicians, and that usually solves the problem, they don't like having an audience.* (Sarah)

Sarah describes sexual harassment as a part of being an audiologist that one gets used to with time. The problem with normalising this type of abuse can be seen in her subsequent comments, where she reports not being aware of the procedures that she should follow when she finds herself in this situation (although she does then explain a procedure that she follows).

Sarah also describes being placed, due to an administrative shortcoming, in a consultation with a patient who was known to be dangerous.

> *I had a patient back in [CITY] that was a mental health patient, and he was a member of a prison I believe, he was very closely guarded, and came in, and it was only until after I'd seen him that I'd managed to get hold of his notes and found out that he wasn't supposed to be seen by a female or a member of staff on their own.* (Sarah)

Sarah subsequently explains that this patient was transferred from the hospital's ENT department, where they use paper rather than electronic notes. Because of this, the patient's notes did not arrive before the patient. It seems that there is a simple administrative problem here that needs redressing in order to maximise safety to both staff and students.

Adjusting to placement sites

All of the participants described the process of settling into a new workplace. The principle topics that were covered include getting acquainted with the physical working space, meeting and developing relationships with staff, and learning how to do their work. The last theme will be discussed further in the section on 'doing'.

Some students described the importance of being able to do something as soon as they arrived on their first day:

I think actually when you get to a department and you don't know anybody and you've just about figured out where the toilets are and where the tea is, and then you sit there thinking, 'What should I be doing?' and they'd go and look at me and think I'm not doing anything. I think that's quite tough. And yet what can you do? You don't know where anything is, you've got no experience. You don't want to suddenly volunteer to take on something and then them say, 'You shouldn't have been doing that'. So actually I think, to settle in, to be given something to do straight away is quite good. (Jennifer)

The first part of the situation that Jennifer describes is the same to any worker who begins in a new workplace. That is, a new member of a workplace must familiarise themselves with the physical layout of the workspace and become acquainted with colleagues. The second part of the situation that Jennifer describes, however, the problem of volunteering, is one that is particularly acute for students, who have little to no practical experience of working in the profession in which they are training. In the light of both unfamiliarity with a workplace and with the profession, Jennifer argues that being *given* something to do is helpful to a student. She goes on to explain, of course, that this should be something that is easily executed by a neophyte. Most participants described being given an induction on their first day, and then being asked to shadow a member of staff.

Below, Amy describes how she felt without any induction to her first placement:

Both of the supervisors, it was myself and another girl who were on placement there, both of our supervisors were away, so was the head of department. Well my supervisor was in another hospital, so wasn't there. And there weren't many staff who were actually working the day that I arrived. So it was a bit sort of like, 'Oh, you know, here's the staff room, just sit in here for a while'. And they found someone to come and show me how to turn on the computer and what my password was. And so it wasn't much of an introduction. I didn't get introduced to people in the department. Whereas when I came here for my second placement (…) my supervisor, walked us all around, gave us phone lists. Just simple things, like if we're unwell, who to phone and who to let know. (Amy)

Amy's experience is unique in the audiology data, but it does illustrate how students can describe obstacles to adjusting to a new workplace. Amy describes staff not being in the workplace and being told to wait and appraises that as not being 'much of an introduction'. She then moves on to describe the experience that she had for her second placement, where her supervisor gave her an orientation on her first day.

The audiology students that were interviewed described different orientation procedures at different placement sites. These ranged from Amy, who received no induction for her first placement, to several students that attended formal half-day orientations. These appear to be offered by larger workplaces that supervise greater numbers of students. Although these formal orientations were evaluated very positively, it was also the case that students who were given less formal orientations also found this to be very helpful for settling in to the workplace.

In addition to getting used to the physical space in which they will be working, students often described the importance of the people that they worked with for adjusting to the workplace. In particular, these students reported that friendly and welcoming staff increased the rate at which they adjusted to their workplace.

[Asked what aspects made it easy to settle in] It was just really friendly. Friendly people. There was an office area, which made it really good, because there was always somewhere you could go, there was always people around that you could chat with. And kind of everyone very um – they accepted that you wouldn't know what to do all of the time, so they were really good to ask questions to. (Erin)

In this fragment, Erin describes how accommodating members of staff address the particular difficulties that students face – that they are both new to a workplace, as well as new to a profession. An acceptance of that allows students to feel comfortable asking for assistance to adjust to both of these new experiences. Students

in audiology overwhelmingly reported that staff were welcoming, although one participant described a mixed experience.

> *Staff tend to take a kind of mixed approach on whether they get to know you or not, because some people have the mind-set, that you're only here for six months, 'Therefore I don't really need to know about you because you're going to be gone soon and replaced by somebody else'.* (Sarah)

Some student reported that they felt as though it took a least a few months to feel completely settled in their first placement. Several students also reported that their second placement took considerably less time to settle into, specifically because they had previous clinical experience to draw upon.

> *The second placement's been a lot easier to settle in just because I know the kind of the layout of how things work, what a fitting is, and what you do in the fitting, and the style of appointments and things*. (Amanda)

Summary of audiology student findings

- Audiology students described the early days of their initial clinical placements as primarily observing a practising audiologist; this was accompanied by taking notes. This continued for a week or so.
- Students then moved on to participating in the appointment. Increasingly, they were being allowed to conduct discrete parts by themselves before handing back to the clinical teacher.
- Some of the interviewees explained how they would select the component, or phases, of the consultation that they were most comfortable with. Often, they had had direct experience of it as part of their pre-clinical training (e.g. programming hearing aids).
- Interacting with patients seemed to be the aspect of a standard consultation that participants were the least likely to become involved in, early on in their first placement.
- Audiology students described progressively moving from learning by observing to learning by practising their skills under direct observation by trained audiologists.
- A key benefit of working under supervision that a few participants described was that the supervisor's presence ensured that students' practice was safe for patients.
- Another important aspect of working under close supervision was also in strong contrast to the type of learning that students undertake within the university. At university assessment is often the only context through which students receive feedback; on placement, however, feedback is an iterative process.
- At times, students encountered audiologists who were not keen to supervise students in their sessions, because it added pressures on their already tight schedules.
- The time pressure on audiology appointments was described as particularly difficult by a number of students. As newcomers they needed time to do things step by step, deliberately and carefully. It contrasts with the efficient ways of doing things that experienced practitioners have, without compromising patient care. This problem only arose when extra time for training was not factored into appointment length. Placement centres varied in their approach to this.
- Learning by observation and then under close supervision threw up inter-generational difficulties also. Students described working with a range of audiologists who exemplified diverse audiology practices. Some of these were considered to be quite different to what students had been taught at university and almost all of the students found this confusing (at least initially).
- As time went on and students become more confident, participants reported that the trained audiologists became progressively less involved in the consultations. This culminated in students being given their own appointments.
- The main challenge of working independently – for the students – was deciding when to seek assistance in relation to a patient with whom they were currently consulting. Although participants reported gratitude for having this kind of backup, some described difficulties in accessing it. From student's reports it appears that placement centres vary significantly in their support for these almost independent trainees.
- In some places students were still supported quite deliberately. For example, supervisors might review (and manage) in advance the students' list and they might make themselves available as back up, doing routine tasks.

- On the basis of these interviews, it seems that there can be a real problem for some students, when they work independently, of seeking assistance with tasks that they do not feel competent doing on their own. One student describes frantically running down the corridor desperately looking for help, but conscious of not wishing to interrupt appointments.
- Some students described having protected half-days that were given over to their independent study, whilst others described that they had to conduct administrative work during this time. If they wished to study, they did this after hours instead.
- Students also described situations where they felt that they were being used to undertake menial tasks, for example being asked to commute in excess of four times within one day or being told to spend days in the ear, nose and throat department (as an 'ENT slave') . They might also be asked to spend long hours in repairs or expected to stock consulting rooms – but students differed in their interpretation as to what this meant.
- In audiology, menial tasks emerged as both a challenge and an opportunity. On the one hand, students can be helpful in ways that can free up time for them to be taught. However, there is also a risk that students can be allocated tasks that contribute to the workload of a department, do not require much supervision, and provide little opportunity for the student to learn.
- Learning from patient contact figured heavily in participants' accounts of the benefits of clinical experience during their audiology training. Students reported that being on placement, and in particular interacting with patients, allows them to develop a richer 'working understanding' of being an audiologist.
- Students also described a range of challenges they experienced in working with patients. For example, they felt that they had to be confident when, especially in the early days, they were not. Some students resorted to non-disclosure of their trainee status in consultations. This was quite prevalent: half of the six students interviewed reported not introducing themselves as students.
- The final challenge associated with interacting with patients that was identified in the data was sexual harassment. Of the four women that were interviewed, three reported experiencing sexual harassment whilst on placement, and one of these participants also reported being placed in a potentially dangerous situation.

Findings from Audiology staff

Factors that influence early clinical placements

The relationship between supervisor and student

Both interviewees stressed that within their audiology placement year, the students status is that of an NHS trainee who is gaining a clinical and professional qualification within the NHS – they may be audiology students whilst they are at the university but, while they are out on placement, they are not considered as such.

This status of an NHS trainee means that, from the outset, students are expected to comply with a number of formalities upfront, including CRB and occupational health checks. They also have to account for themselves as salaried employees, which requires tax forms and pay slips, operating within strict working hours, understanding sick leave notification processes and complying with annual leave booking arrangements and carrying an NHS ID card. It also means that the host site incurs a range of obligations, including on-site inductions and fire training. Here is how one interviewee explains the arrangements:

> *…I keep saying student, it's the wrong term. At the moment these are NHS trainees. They are part of the workforce, they are on a salary, albeit a very lowly one, but they come on a salary. So that year is different, I think, for audiology trainees than any other type of university trained health care professional. I don't think the nurses get paid. And as far as I know none of the other health care workers get paid when they are on placement. So they are not students, they are trainees. And they are, on paper, part of the workforce, but on day one they are not, they don't know what to do.*

At the same time, students are being prepared by the university, which is mindful to consider their personal circumstances. For example, the department puts considerable effort into finding placement sites that are conveniently located so that the student might be able to live with their parents or a relative. Alternatively it also gets involved in arranging NHS or rented accommodation on the students' behalf. These arrangements require staff and students to cooperate in the organisation of the placement year long before it starts. Here is how a staff member from the university side describes the outcome of these preparations:

> *Yeah our students are quite – because we've only got a cohort of a maximum of 30 each year, they're quite friendly and we know them quite well, so they will send an email if there's a problem. But thinking back, we haven't had too many issues when they've started out. Nobody seems to have had like an accommodation crisis or anything, they all seem to have got on fairly well.*

Even before they start their placements, audiology students are fairly closely connected into both the university and into their placements sites – they need to understand and appreciate certain formal requirements and institutional prescriptions and they need to conform to these. Moreover, they need to actively collaborate with both institutions in order to begin their placement year.

In terms of learning on placements, audiology students are expected to progress through to independent practice – certainly within the placement year, but ideally earlier. Here is a quote illustrating 'the deal' from the perspective of the placement site:

> *…in the first six months you'd plough in all the training, you wouldn't gain anything in terms of health service delivery, but in the second six months you would, and you'd get the pay back.*

This means that placement centres have a strong interest in and commitment to students' rapid progression into independent practice.

Placement sites differ in size and specialisation. All placements sites will deal with adult audiology appointments, though paediatric and vestibular appointments are more specialised and not necessarily carried

out in all departments. The actual teaching of audiology students (or trainees) is undertaken by qualified audiologists. Each student has one dedicated supervisor, but they tend to work with a range of individuals.

> *Initially they are going to be supervised one on one. And then throughout the placement they will be left to do more of their own. And then towards the end of the second placement they will have their own lists, so they should be up to speed, ready to go.*

Here is the same process described in more detail from the NHS perspective:

> *…you can have, and again it varies a lot, but you might have, towards the end of the first six months, the bright young thing will have their own list. (…) [With these students, quite quickly] you can then have remote supervision. So you might have the supervisor working at their desk in their office, and they are on call. And what they will do is start the day by reviewing the patients who are coming in with their trainee, and then they will leave their trainee, and at the end of each hour they will check up, you know, 'Are you OK? How has it gone?' And remotely we can see all the activity that's happening on the patient management system.*

Staff interviews also highlighted that there are other benefits to having students on placement. Throughout the placement clinical supervisors set their students assignments (though guidance and suggestions are available on the audiology website supporting the programme). Trainees are given half a day per week for study leave to complete these assignments and conduct research to further their study. Interviewees indicated examples of the kind of things students might be asked to do. These included to 'revamp the patient literature' or to put together a presentation for staff. In addition, the placement centre staff also noted that:

> *our existing workforce does gain skill in different ways of teaching. So we have a pool of workers in the future,[and] we have our own workforce developing through getting involved in training.*

The staff-student relationship was also characterised as a continuing one. When placement had gone well, it was quite likely to lead directly to future employment of that student in the same placement centre.

> *We've had quite a lot of departments employ people that they've had on placement, once they've finished their degree. And we get very good feedback from – they like our students to come to them for placement and be employed afterwards.*

In the interviews there were further comments on the close-knit nature of the audiology community, which suggests that the students and the clinical teachers – in fact the entire team at the placement centre – may, at least to some extent, consider themselves involved and connected longer term; not only for the duration of the placement, but always potentially in terms of becoming lifelong colleagues.

Student variables

As the suggested by quotes provided in the previous section, audiology staff differentiated between different types of students. Firstly, both observed continuities between students' academic and clinical performance.

> *…So what makes a good trainee? I have to say the brighter that they are the better they function and the outcome is better. So the high performers academically turn out to be the high performers clinically.*

Here the university staff member responded to being asked about an example of a student who was not sufficiently prepared for their first placement:

> *I can't think of one off the top of my head. I suppose there are the ones that are going to be academically less ready than others, the ones that just scrape by with 43-45% in Year 1 and 2.*

However, this shared understanding that 'good students' could be spotted in advance was contradicted by the following statement that indicates that some students' initial struggles had little to do with academic performance:

> *I think the problem that students have had in the past tends to be the transition from doing something academically to working with staff and with patients. We've had some really bright students go out and then suddenly realise they don't really know how to talk to people or work within a team, and they find that quite a challenge to put into practice what they've learnt on real people.*

From the interviews the following student characteristics were valued most highly: being academically able, motivated and organised. Here is how one staff member described the benefits:

> *The bright young thing drives and learns rather than has to be taught.*

Whilst some aspects of the job were skills and could be taught, staff interviewees were particularly clear about the need for students to be (or become) patient-centred:

> *And it does seem, the brighter they are, the quicker they learn, and the quicker they learn to extract similarities, they learn to be flexible, they learn that the outcome of the person's appointment is the goal, not a list of activities that you have to tick off. Whereas our average student tends to be someone who needs to have a rote, a pattern to follow, and unfortunately then follows that pattern in a fixed way. And we have to try and expand their abilities so that they can see each individual patient as having an individual need that will fall under this same umbrella, but might be different from the next person. And so you can't just deliver a package that's a standardised package.*

Staff also recognised that some students had to deal with practical issues – such as childcare or family commitments and that these might seriously interfere or hamper their progress on placement. However, staff also appreciated that mature students already brought with them a whole range of skills, including time-management, appropriate attire and communication that were directly transferable into the audiology clinic.

> *…so the more mature person, we don't have to spend time teaching them to turn up at half past eight, that means work starts at half past eight. We don't have to start telling them, 'You're not really dressed appropriately. Would you mind going to Asda and buying a shirt?' They know how to behave in a responsible way as a worker. They turn up on time, they're dressed suitably, they have their hair tied back, you know, they are presentable. They know how to talk to people politely and not look at the floor. They give everybody, staff, colleagues, everyone eye contact. They know how to behave at work. And our more bright young things sometimes have to be taught about how to behave at work...*

The support system

Staff from both the university and the placement centres described their relationship in the terms of a partnership. When the undergraduate degree programme was set up, apparently, much effort had gone into building the relationship between the department and the placement centres. The current relationship was judged to work well at every level – from the more mundane practical aspects to the difficult issues arising from a student in crisis or the need to re-negotiate training arrangements within the changing NHS context. Staff also noted that both the university and the placement centres were part of a close-knit professional community:

> *…audiology is quite a closed profession, almost everybody knows everybody, and a lot of the people who have come here to do our course, they've come to do other courses, so it's all quite a close knit community anyway. [good relationships help] because there is so much experience with the people that we use, and they can spot stuff. And they also know what the university is expecting as well, so they've got a good idea when things aren't going to plan.*

Staff interviews highlighted that the system set in place to support students was built on strong foundations that had been deliberately forged when the programme was created. Moreover, it was based on the existing links within a small community of professionals.

Despite the students being located in a range of locations, the support system for audiology does include face-to-face contact. For example, six weeks into their first placements students come back into the university for a 'pastoral day'.

> *…we do keep in touch with them fairly quickly after they've started to try and pinpoint any problems. But we also talk to the placement supervisor as well by telephone. Whereas the students will come here for the day so we can flag up anything.*

Following on from the pastoral day, there are scheduled phone calls set up in advance between the students and an experienced member of staff at the university. In addition, university staff can also access each student's online logbook. This allows them to monitor progress as well as areas where students might be struggling. Here a university staff member explains:

> *…you kind of take it that no news is good news, that they are just happily ticking along. The centres are so experienced that they only really do get in touch when there is an issue out of the normal criteria for the assessment.*

For the assessment, a university staff member travels to the placement site and undertakes this jointly with the students' local clinical supervisor; it also provides another opportunity for face-to-face feedback.

Staff reported that certain placement sites were considered to be particularly good at dealing with students who were dealing with special circumstances, for example dyslexia. In the interviews, their ability to teach these students well was associated with more advanced teaching skills and commitment. All supervisors have access to training materials on the website that supports the programme and the university organises an annual placement training and feedback day for clinical supervisors.

What the placement adds

Staff from both the university and the placement centre were clear about the advantages of workplace learning. Completing the placement year was associated with increased maturity and confidence. According to the university-based staff member:

> *I think a lot of them come back a lot more confident. They know what they're doing, that they've gained the experience of, not just the practical element, but of how to talk to patients, how the NHS actually works, what they should be doing in the department day to day. So I think a lot of them come back and kind of blossom.*

The placement-based staff member listed a whole range of issues that were not easily captured by the logbook of competencies that students had to complete whilst on placement. For example, on placement, students were learning to deal with equipment – not just how to use it, but what to do when it malfunctioned or was out of order. They also learned to negotiate the spatial aspects of working environment, such as 'how to get an elderly patient with hearing problems from the waiting room to the clinic room'. It was also expected that students would come to appreciate how to work with colleagues and adapt to the pace of the NHS context:

> *So if you were using your chums at university, and they were being the patients and doing a bit of role play, or maybe you were doing the expert patient(…), you're still in a learning and a teaching environment where it's quite protective and it's all very gentle. And there's no pace particularly and you can go at – the pace is about learning and developing. Whereas in the working world there is a pace that you have to keep moving along during the day because there is another person coming in behind and you have to keep it going. And you have*

to learn how to work with your colleagues. So you may be working in a small team scenario, which lots of different allied health care professionals do nowadays. So one person may do the investigation and another colleague might do the treatment. So you could be working in a little mini team, and none of that happens at university. So learning how to take your role. (…) because you're a member of the workforce.

Both staff emphasised that the most important aspect of clinical placements was for the student to encounter and deal with patients.

So I think the working world is definitely the place to learn how to apply, not just the theory, but the practical skills and the management of the patient. And the focus on the patient, not on you the trainee, the focus is on this patient, that's the reason we're all here.

Discussion of early clinical placements in audiology

It should be noted that at the time of data collection audiology students were at a slightly different stage in comparison with the other two cohorts. At Southampton, the project had aimed to capture all the experiences of students from the three professions at the very beginning of their first clinical placement. However, even in the 12 month period we had for data collection, this was logistically not possible (due to clashing commitments and the re-recruitment for the research fellow).

We determined that the second best option would be to capture students' perspectives when they had just started their second placement, i.e. six months into their clinical placement year they all rotate. At this stage, we hoped that students might find it easier to remember what it was like when they first started, as they were comparing starting their second placement to the beginning of their first one.

This difference in the timing may have affected the kinds of issues students raised in interview and it may at least in part account for their (relative) contentment and somewhat 'bigger picture' stance. However, even the survey data – which was collected after students had between nine and eleven months of experience of clinical placements - indicates that audiology students tend to cope (and thrive) on their placements more readily than the other healthcare professions.

There were two aspects of audiology students' practice and experience that emerge as problematic:

Firstly, several students reported not identifying themselves as students once they were running audiology appointments by themselves. It may be that they fear patients' questioning their competence – which is probably understandable – however, none of the students appear to have discussed this aspect with their supervisor who would have been ideally placed to guide them. It is important to note that with the pressure on budgets, appointment lengths are being driven down across the country. This may further exacerbate the situation where students feel they cannot afford the time it takes to inform the patient properly about their student status and seek informed consent.

Secondly, the interviews with female audiology students suggested that a high number of female students were experiencing unwanted physical touch from male patients. Three out of four students interviewed reported such incidents; all these had taken place within the first seven months of students starting clinical placements. In the interviews, students appear to normalise this situation by focusing on the state of the patients, who is described as 'elderly' and / or 'confused'. There appears to be no clear strategy for dealing with such incidents. Interestingly, none of the incidents that students shared in interview were reported in the survey, when students were asked about whether they had witnessed or experienced bullying or harassment (although a few students did choose 'prefer not to answer' in response to the question). Addressing the situation is clearly something that has to be driven and managed by the profession and is beyond the scope of this project. However, the data suggests that it requires urgent action as well as further investigation.

Duration of project: August 2010 to October 2012

Future developments in audiology education

The Department of Health is currently changing undergraduate audiology programmes nationwide as part of the Modernising Scientific Careers initiative. For the programme described above, this means that:

- The overall length of the programme is being reduced from four to three years.
- The first teaching year will be undertaken jointly with vision science and neurophysiology students. The teaching will become less specialised and more generic.
- The shortening of the programme also entails a reduction in placement weeks from 48 weeks to 32 weeks.
- Moreover, students will no longer be paid whilst they are on placement.

For the placement centres, this makes taking on students potentially much less attractive. With shortened placements, the potential of benefitting from an almost fully trained audiologist is significantly reduced.

In addition, placement centres are facing budget cuts, where services need to reduce their expenditure by 30%. The most likely way of reducing costs is by reducing staffing levels and/or cutting appointment length, i.e. seeing the same number of patients in a shorter period of time. How this will effect training is unresolved, though it is unlikely to benefit students when they first start out on placements.

Summary of audiology staff findings

- Audiology staff clarified that the relationship between the placement centre and the student is, to a large extent, determined by the student's status. Whilst on placement, audiology students are salaried employees of the health service; they are officially classified as NHS trainees.
- Becoming a trainee involves significant levels of organisation and compliance for both the student and the placement site.
- University staff continue to be closely involved, for example in finding convenient placement locations and organising accommodation for the students where necessary.
- Students are required to get involved in the placement preparation process and are expected to cooperate and comply.
- Students are anticipated to progress through to independent practice – in any case within the 12 months of their placement year, but ideally earlier (potentially even at around six months).
- Placement sites are highly motivated to facilitate students' progression as this benefits the centre: students who run their own appointment lists will lighten the load of the team.
- Conversely, a student who fails to progress and requires continuing clinical supervision adds pressure to the workload of the team.
- Students initially shadow practicing audiologists and take on discrete parts, more and more until they are ready to assume responsibility for the appointment as a whole.
- Students then begin to run appointments on their own whilst a trained audiologist observes.
- Increasingly, they are left to practise on their own (with colleagues nearby to help and support when necessary).
- Placement teams may gain from the students' presence and participation, for example in terms of their own professional development as teachers, or by setting assignments for their study leave that might benefit the unit as a whole, i.e. updating patient information leaflets, etc.
- Audiology students' placements raise the spectre of future employment – they are not simply there to train and leave. There appears to be a shared awareness that they may soon become colleagues.
- Some staff members suggest that a students' potential ability within clinical practice can be predicted by their academic grades. Others argue that even academically able students may struggle with social and communication skills (dealing with staff and patients).
- Students' being motivated, flexible and patient-centred are highly prized attributes. Staff fully expect that time management, professional attire and communication skills will form part of the teaching.

- The support system for audiology students on placement rests on strong networks within a tight-knit community of clinical audiologists – where everyone knows everyone.
- The programme delivery was designed – from the outset – as a partnership between placement centres and the academic unit.
- Students are supported locally by their clinical supervisor. They return to the university for a pastoral day, set up to troubleshoot difficulties early (six weeks into the first placement). They continue to be supported remotely by telephone calls scheduled with academic staff.
- Audiology staff are confident about the value that is added through clinical placements. Students are considered to have matured and gained confidence as a result.
- Other benefits of audiology placements include students' exposure to technology (working as well as malfunctioning), spatial and organisational aspects of the workplace, and becoming a fully-fledged member of the team; most importantly, they are expected to have gained an in-depth understanding of the patient as an individual.

Duration of project: August 2010 to October 2012

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