Developing Radiotherapy Students’ Emotional Learning through Patient and Carer Engagement: Qualitative Inquiry

Denyse A. Hodgson

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Abstract

The need for patient and carer involvement is driven by health policy and a desire to enhance traditional learning approaches. The purpose of this study was to explore the ways in which radiotherapy students learn from patients' and carers' experience of cancer and to understand how this influences learning. What emerged from the data was that learning focused on emotion and the development of caring skills. A secondary objective was to explore how patient and carer involvement in the curriculum could be enhanced.

A qualitative inquiry approach based on social constructivism was utilised. In-depth interviewing was the method of data collection. 18 participants took part and they were encouraged to interpret their learning as a consequence of interaction with patients and carers. Attride-Stirling's (2001) approach to thematic network analysis was employed as the interpretive framework.

Three global themes were identified: emotional recognition, emotional management and professional presentation linked by the umbrella concept of emotional learning. Patient and carer involvement in the curriculum provided a catalyst for learning and a YOU-US-ME pedagogical model was proposed, based on psychodynamic theory in order to facilitate educational activities. Experiential learning, centred on emotions, promoted higher level thinking in these students about connecting with patients and carers, developing ways of managing emotion and presenting a professional image associated with the care values these students identified.

The study indicates that patient and carer involvement provokes dialogue about the emotional consequences of cancer for patients and carers and students. In response to this two areas for curriculum development are suggested: care for others and care for self. A recommendation is made that activities focus on the exploration of professional values and care and compassionate behaviours, with the development of individualised self-care strategies being an essential element. It is also argued that the principles of patient and carer pedagogy can be applied to other professional areas where the patient/client voice can be heard and learned from.

ACKNOWLEDGEMENTS

Patients and Carers – my thanks to the patients and carers who have been involved in education over the last 5 years and shared their innermost experiences so generously with students. Their personal journeys and interest in education has been inspirational to the teaching team and students alike.

Supervisors – completion of this thesis has been an arduous journey hindered by work and personal commitments; my supervisors' continued encouragement and belief in me has been a source of strength. A special mention to Nick Hodge (Director of Studies), his structured feedback, reassurance and challenges I believe have had such a positive impact on the thesis.

Peers – throughout the research process I have discussed the key findings with peers in both formal and informal ways and valued their encouragement too. This study has been discussed in both academic and professional arenas to gain feedback and further insight. I have worked with a small group of colleagues to implement some curriculum developments and the value they too have placed on involvement activities has been positive.

Family and friends – it feels like this research has been a life-long commitment and in some ways it has. I am certain it will continue beyond thesis submission and publication. At times it has been all-consuming and I have studied alongside my sons, spending hours in the office writing up. My husband has always encouraged me especially throughout this last year and has been a driving force in my completion.

Participants – their honest expression of emotion and learning experiences have provided a rich insight into the impact of patients' and carers' experiences of cancer on their development. As a researcher and teacher it has been a pleasure to share their learning experience. Throughout this thesis pseudonyms replace actual names to ensure anonymity.

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DECLARATION OF AUTHORSHIP

I, Denyse Hodgson, confirm that this thesis and the work presented in it are my own and generated by me as a result of my own original research.

I confirm that:

1. This work was done as part of a Doctorate in Education (EdD)
2. Where I have consulted the published work of others this has been clearly attributed
3. Where I have quoted from others’ work the source is always given
4. I have acknowledged all sources of support

Developing Radiotherapy Students Emotional Learning through Patient and Carer Engagement: Qualitative Inquiry

Thesis Structure

I begin the thesis by contextualising the study by explaining my motivation for conducting this research. My personal biography provides the milieu for my interest in the research topic. I go on to set the policy context and the healthcare landscape, which locates the significance of this work in health education. Each chapter will be outlined in turn proving a brief summary of how the thesis is set out. The literature on the principles of patient and carer involvement is reviewed and will be further explored in relation to pedagogical developments in chapter two. I explain my understanding of reflexive practice which is further augmented in chapter three and eight. My reflexive narrative discusses the challenges in qualitative research and my own learning as a novice researcher. The chapter concludes with a timeline that situates the study within the context of curriculum developments at my institution.

Patient and carer involvement was introduced to the curriculum at my institution; specifically the inclusion of cancer patients and carers in the radiotherapy course from 2008. The influence of this on radiotherapy students is the focus of this study. The rationale for this focus emanates from the gap in the evidence base of the particular *ways* that students learn directly from engaging with patient and carer experiences of illness and treatment. The study presents students' interpretation of their learning as I explore what it is they learn, how this may impact on them as students in radiotherapy practice and how they value patient and carer involvement in education.

Personal biography

As a student therapeutic radiographer working in a busy cancer centre I was always captivated by patients who shared their personal experiences with me. In many ways I regarded this as significant professional learning; not least the fact that I developed a sense of what was important to them and adjusted my practice in response. I learned that cancer is a multi-faceted phenomenon provoking a wide range of emotions, experienced individually by each person faced with the diagnosis. Then as a registered practitioner over a period of fifteen years I continued to be drawn to the human aspects of the role even though the job focused on high technological precision. I also learned from many patients and carers that they valued therapeutic radiographers who were caring and compassionate. I often observed what I regarded as exemplary practice (obvious displays of respect and care for patients), whilst also seeing poor standards of care (lack of concern for carers' feelings). As pivotal incidents, both contributed to my developing practice. I regarded emotional connection as a critical element of my personal philosophy of care.

I continued my professional career as a clinical tutor for a further 10 years, encouraging students to engage in dialogue with patients to enhance their ability to provide patient-centred support. When I made the transition to higher education, I continued my interests in the human experience of cancer through my teaching and through ongoing efforts to involve patients and carers in the curriculum. During the period of this research my own father developed cancer and subsequently died; thus I came to know the patient and carer experience more intimately. Being on 'the other side' and the recipient of both caring and distant professional behaviour reinforced my perception that involving patients and carers in health professional training was essential. My experience influenced the pedagogical approach I developed, that aimed to help students to understand better the impact of their interactions on the patient and carer experience. The experience of being a carer also invigorated my passion for this research and, although external factors were threatening my successful completion of the study, there was a renewed impetus to contribute to the evidence base on service user involvement in the curriculum.

In the wake of the *Mid-Staffordshire Report* (Francis, 2013) which highlighted poor care in the NHS, investigating the potential value of including patients and carers in healthcare curricula in training future professionals became, for me, both compelling and timely. The key focus of the *Francis Report* was to ensure that students and health professionals were equipped with the right skills and values to deliver compassionate care (Department of Health, 2013). In chapter eight I reflect on how the findings of this study resonate with the care and compassion agenda; in particular how patient and carer involvement can contribute to achieving the vision of care and compassion set out by Francis (2013).

Terminology

Oncology refers to the services that care for people with cancer and specifically radiotherapy is treatment using ionising radiation 9approximatel 50% of cancer patient will have radiotherapy). Service user involvement is a term regularly employed in the literature and health policy and is the commonly used idiom to describe various activities by users of a service. This term has evolved within the literature, however the terms patient involvement, participation, collaboration and partnership are commonly utilised (Gott *et al*, 2002; Hodge, 2005; Tritter *et al*, 2003). Involvement is defined as the inclusion of all possible stakeholders of a service such as public, clients, patients and managers with the specific intention of evaluating and improving it (Tritter *et al*, 2003). However, my study focuses specifically on patient and carer involvement as it is their experiences of cancer and its treatment that the student would predominantly be exposed to in a clinical setting. Thus the term ‘patient and carer involvement’ will be used throughout this thesis.

Chapter Summaries

The thesis presents the findings of a study that has sought to capture and understand students’ perspectives on how the involvement of patients and carers in the curriculum may influence learning. I present thematic analysis of how a group of student therapeutic radiographers experience engagement with cancer patients and carers within the curriculum. The purposeful inclusion of involvement activities in the undergraduate therapeutic radiography curriculum focused on the sharing of varied cancer experiences as experienced by patients and carers. This was facilitated through seminars, role-play and workshops with a diverse range of patients and carers (explored further in Chapter Two p.61). Following the inclusion of patient and carer experiences in the radiotherapy course an investigation of the pedagogical and personal worth of such activities was warranted to determine the value of engagement activities. A qualitative inquiry approach was taken that employed in-depth interviews to investigate how participants conceptualised their learning. Participants were encouraged to reflect on curriculum activities and the interactions they had with patients and carers in the clinical setting. The data represents the ways these students felt that interaction had influenced their personal and professional practice. Evidence from this study has had a direct impact on curriculum developments and has contributed to the knowledge of patient and carer involvement pedagogy in health education.

Chapters One to Three provide the context of the inquiry through the identification of professional, theoretical and methodological influences on the research questions and study design. I do not present a discrete literature review chapter; I have included a review of policy and guidance on patient and carer involvement to set the context (Chapter One) and then selected theories related to learning which informed the curriculum activities (Chapter Two). As the findings emerged further theories of learning have been drawn upon to guide the interpretation, notably those around emotional engagement. My perception of curriculum inadequacies and motivation to explore the influence of patient and carer involvement in the curriculum are the driving forces at the study's inception and explored in these early chapters. Chapters Four, Five, Six and Seven present the findings and identify the contribution to knowledge that this thesis makes. A concise description of chapters is provided here to set out the thesis structure to the reader.

Chapter One describes patient and carer involvement as a concept in health care and education. Chapter one draws on the literature and policy relating to patient and carer involvement practices in health and education (Department of Health, 2000, 2001; Freshwater & Stickley, 2004; Tritter, *et al,* 2003; CUILI, 2005; Department of Health, 2013). An overview of policy drivers and current research evidence in this chapter situates the study within contemporary thinking of health care education. Chapter one also contains a reflexive commentary of some key decisions I took during the research process. Further accounts of these can be found in chapter Three and Eight. A timeline for the study is presented on page 38, to illustrate the research process. The timeline also notes the ongoing influence the findings are having on the curriculum at my institution.

Chapter Two begins with a discussion of the theories that underpinned curriculum developments; namely tacit learning (Polanyi, 1966; Eraut 2000), knowledge construction (Pawson *et al*, 2003; Bleakley & Bligh, 2006) and emotional intelligence (Salovey & Mayer, 1990; Goleman, 1995). The theories relevant to construction of knowledge, the meaning of human interaction and emotional intelligence are reviewed here as concepts that informed the study. The second part of Chapter Two is my presentation of the pedagogy of patient and carer involvement as conceptualised within the undergraduate course. This chapter describes the curriculum inclusions designed to address the problems the course team perceived in the undergraduate programme and the resultant influence on students' learning is the focus of this qualitative inquiry.

Chapter Three articulates the methodology of this study. The discussion begins with a justification of the qualitative approach (Creswell, 2013) as the most appropriate to address the research questions and this consequently informed the methods employed. Accordingly, the underpinning social constructivist philosophy reflects the ethos of the study which acknowledges multiple realities and diversity in the perspectives of learners (Creswell, 2013). Key philosophical principles are explored that fit with my ontological and epistemological position. Ethical issues are discussed from both a regulatory perspective and moral obligation and an account of how ethical approval for the study was acquired. This chapter critically explores the 'researcher in the data' debating the issues of researcher assumptions and the potential for bias and power differential, thereby providing the reader with a transparent account of the study. Critical reflection on key methodological decisions is also presented. For example issues such as my background in a scientific research field; the realisation that searching for the 'un-common-sense' themes in the data would lead to important insights. I explore the trepidation I felt about abstraction and using supporting theory and finally my angst about the credibility of this work. I have found that on-going discussion with the supervisory team about such dilemmas has been an enriching experience and vital to reflexive practice.

Chapters Four, Five and Six present the three thematic networks that emerged from the data analysis. These are emotional recognition; emotional management and professional presentation with an overarching theme of emotional learning. Theoretical constructs are drawn upon to explain each thematic network, for example: the use of Pawson *et al's* (2003) concept of knowledge construction as participants make sense of their learning as they recognise the emotion that patients and carers experience. Chapter Five describes how this provokes emotion in them and the need to manage emotion in difficult interactions, a concept that is well recognised in contemporary literature (Hunter & Smith 2007; Huynh *et al*, 2008; Gray, 2008; Smith & Allan, 2010; Rees, 2013,). This study captures the unique identity of therapeutic radiographers characterised in the third thematic network in Chapter Six that identifies how these participants explore their professional identity and how they present a professional persona. I use Goffman's (1959) concept of performance and idealisation as described by Rogers (1980) to explain how participants describe their professional identity which is further explored as an aspect of professional development. The other feature of the third theme is conflict in the role and supported by Bolderston *et al's* (2010) view that the caring and technical expectations of the profession are often difficult to fulfil.

Chapter Seven presents further synthesis of the interpretation where I propose a pedagogical model of learning that acknowledges the value of interaction between student and patient or carer (YOU-US-ME). This psychodynamic model based on human interaction (Theodosius, 2006) supposes that the patient and carer shares their experience (YOU) and the student interacts (US) and learns more which prompts them to look inwards at their behaviours (ME). The ME aspect of this model is further characterised by notions of professional development and identity with the projection of an 'ideal' to others (Goffman 1959; Rogers 1980). Emotional learning is further explained by Dilts & De Lozier's (2000) description of levels of learning drawn from Gregory Bateson's work. Finally, a model of emotional learning with associated curriculum enhancements that seeks to foster compassionate behaviour in student therapeutic radiographers is proposed.

Chapter Eight concludes the thesis with my reflection on the key findings and provides some answers to the research questions. This final chapter identifies my contribution to knowledge and includes recommendations for curriculum development based on my findings. At the time of writing up the thesis the Francis Report (2013) was published which appeared to speak to the findings of this study and so I present a critique of how patient and carer involvement could be central to developing compassionate care. The epilogue focuses on the ethos of patient and carer involvement as an integral component of health care training and an analysis of my own development as a researcher.

Chapter One: Background and Context

Introduction

In this chapter I present the research ‘problem’ notably the perceived deficiencies in the curriculum as perceived to support caring aspects of the radiotherapy course. I go on to explain the decision taken to enhance the curriculum by involving patients and carers. A review of the literature and policy on involvement principles and practices leads to the research questions of the study (page 26). In this chapter I introduce my engagement with reflexive practice by focusing on some key issues: personal motivation and power over participants. In an attempt to defend claims of researcher influence I provide a reflexive narrative that acknowledges my prior assumptions and explains my endeavours for transparency. Further reflexive accounts are included in Chapters Three and Eight. I have also included a timeline which charts the milestones in the research process.

The problem with the curriculum

In 2007, the course team recognised that there were deficiencies in our radiotherapy curriculum that had also been identified across other health care curricula, specifically the ways in which students are supported in their interaction with patients and carers (Freshwater & Stickley, 2004). Edmonds (2001) suggested that this informal and difficult to define learning is not apparent in many curricula, perhaps due to the notable asymmetry of scientific and affective domains. With curricula weighted in favour of the technical over the humanistic elements (Bolderston *et al,* 2010) and including only vague methods to facilitate students’ tacit development of patient care skills, this was an area that needed attention. Recently, health educators have been criticised about programmes that lack explicit references to patient care, dignity, respect and communication as identified by Health Education England (Department of Health, 2013).

At my institution, modules delivered in the classroom or through the e-learning platform tended to focus on technical or formal knowledge and only a small percentage of the curriculum was devoted to this tacit learning about care. Although students were encouraged to learn more of patients' experiences as part of their development it was uncoordinated and mostly occurred in an *ad hoc* manner. My previous experience as a clinical tutor in practice demonstrated that much of my time would be spent with students who were struggling with the emotional aspects of the role and our tutorials focused on helping them develop better coping strategies. There was little reference to the demands of the role in the formal curriculum before they arrived on placement. What I perceived to be the problem with the curriculum in terms of inadequacies provided the motivation to make changes on a pragmatic level.

Programme developments in 2008

The criticisms of healthcare curricula and in particular radiotherapy undergraduate programmes focused on the perceived shift from care values towards prioritising technical content, with learning outcomes focused on professional competency (Bolderston *et al,* 2010). This created a sense that the patient had become almost invisible in the curriculum. A contributing factor was that professional benchmarks for training had focused on technical competence. In recognition of this, recent changes have attempted to address this imbalance by making care values more explicit in course developments (SCoR, 2012; HCPC, 2013). In the past, programmes have utilised observation of clinical staff to develop students' patient care skills and they are assessed with a practice-based assessment. To some extent this was a lottery dependent on whom a student observes coupled with their confidence and aptitude in managing their encounters with patients. The pervasive nature of perpetuating poor care skills through observation is highlighted by Francis (2013) and to a degree suggests poor practice is accepted as normal in a busy hospital environment. However, as a result of this report, healthcare education providers have been charged with addressing 'care' in the curriculum along with NHS Trusts with the aim of influencing the future workforce.

There are assumptions that this problem is evident in other radiotherapy courses and the wider health education provision. However, the issue of improving this aspect of health care training was acknowledged by the course team at my institution when re-validating the radiotherapy programme in 2008. The premise was that by providing students with learning experiences involving patients and carers in a range of modules they could develop strategies to enhance their professional practice and ultimately improve patient care (Freshwater & Stickley, 2004). At that time the course team and patient advisors planned the inclusion of patient and carer activities in the radiotherapy and oncology curriculum (Appendix 1 and 2). Involvement has been positively evaluated by students (Appendix 3). However, an understanding of how the activities influenced students' professional learning was lacking. Whilst module evaluations indicated that the students appreciated these activities, the ways in which it informed their development was to a great extent unknown. There was little evidence in the literature at that time of the influence of patient and carer involvement on student learning, particularly in radiotherapy. The dearth of evidence prompted me to explore in more depth the specific ways that individual students can learn from patients and the potential for developing their practice. Thus a key focus of the study was to explore how and what do students learn from patients and carers and furthermore the ways it would influence their professional development.

The role of literature and policy in conceptualising the research

I came to this research with some theories that I had explored in the taught element of the Education Doctorate, which are explained here. However, as the analysis and interpretation took shape, I needed to find new theories that could help to explain the nature of students' emotional learning. Thus, concepts of compassion and humanisation were drawn on to interpret the data (seen in Chapters Four to Seven). The following discussion provides insight into the early theoretical conceptions. I begin with a discussion of the literature and policy that influenced involvement practices in health and social care services charting curriculum developments in recent years. This leads to a conceptualisation of how patient and carer involvement is valued in health care. The act of sharing patient and carer experiences with students has the potential to influence learning and the professional-patient relationship, but is largely tacit in nature. Concepts of tacit and non-formal learning and knowledge construction are explored further in Chapter 2. My engagement with the literature revealed that more needs to be known about what and how students learn from patients and carers, which give rise to the research questions on page 26.

Patient and carer involvement

There is a consistent message in health and social care policy, professional requirements and educational guidance about the benefits of patient and carer involvement in the taught curriculum. Higher Education Institutions (HEIs) involved in healthcare training are influenced by government policy and more recently have been obligated to make this activity explicit (HCPC, 2013). Education guidelines were developed locally that included best practices (CUILU, 2005) that advocated service user involvement in curriculum design, delivery and assessment. Moreover, professional standards and the regulatory body both recently published expectations of this practice (SCoR, 2012; HCPC, 2013).

The Francis Report (2013) identifies the need for improved patient care and its recommendations suggested that there should be more focus on 'care' values in nursing and medical training. However, this report did not acknowledge any other healthcare professions such as therapeutic radiographers or explicitly recommend patient and carer involvement in education. My assumption is either that the omission of a reference to other healthcare professions is an oversight or their emotional impact on patients and carers is not recognised. Perhaps they are just thought of as skilled technicians rather than carers, however the findings of this study clearly challenges that notion as they too are responsible for providing good care.

The fact that extensive patient involvement provided the main evidence for the report indicates that patient and carer involvement in the curriculum may influence students. As a consequence, a move towards patient and carer involvement as an educational philosophy could have a positive effect on students' practice. The general consensus is that involvement with patients and carers can have a positive effect on both the students and the patients and carers. Warne & McAndrew (2005) indicate that it can develop students' understanding and give a voice to patients so they may influence health care training. What appears to be missing from the evidence base is a body of evidence of *what* it is students learn and *how* that may contribute to professional development. It is this gap in knowledge my study addresses.

A fundamental principle of involvement activity in health and social care is to share a range of patient experiences with professionals and policy makers with the aim of enhancing an organisation's understanding of the services they provide. Tritter & Calnan (2002) suggest that user involvement is essentially a utilitarian activity with the intention of making improvements to services that can benefit all patients. It is argued that organisations may manipulate the nature of involvement activities to suit their own purposes rather than as a genuine attempt to hear the consumer voice (Tritter, 2004). User involvement is viewed as a useful mechanism for decision-making, influencing health policy and evaluation of services. Thus patient and carer involvement in health and social care has developed over a period of time, with health policy advocating listening to patients and acknowledging the importance of their views (Department of Health, 2000; 2001; 2003; 2006; 2012). Historically, there was an escalation of patient and carer involvement initiatives in the NHS with mental health services involving users since 1970s. More recently cancer services have developed structures to support an integrated approach that both recognises and rewards patients and carers who become involved (Department of Health, 2006, 2012). Furthermore, key health and social care policy in the last two decades have included patient and carer involvement to the extent that it is now widely accepted practice in the evaluation and development of services.

Although guidelines exist for involvement practices there are inconsistencies in the methods employed and ultimately there is confusion around what exactly it constitutes and what it should achieve. This uncertainty may present a barrier to effective involvement activities, in addition to other inherent difficulties such as recruitment and scepticism of professionals. In addition, organisations may use patient and carer views for their own benefit rather than for the improvement of service users' experience (Gott *et al*, 2000; Tritter *et al*, 2003; Hubbard *et al*, 2005). In spite of the problems, there has been overwhelming support for such activity (Warne & McAndrew, 2005). As patient and carer involvement has become established practice in the NHS health care education providers have also embraced this practice. Typically, activities have included involvement in course design, delivery such as workshops, stories and talking heads (video of patient experience), and in some cases assessment of students.

Research questions

The research questions in this study (see below) focused specifically on encouraging participants to describe their learning experiences and then, as far as possible, make learning explicit. Notions of knowledge construction were explored and further exploration of participants' judgements of the worth of classroom activities. Finally, students were encouraged to explore their own development in relation to patient and carer interaction. So in conclusion, the purpose of this study was to understand what and how the students experienced and learnt from patient and carers.

The following research questions were developed and approved by Sheffield Hallam Ethics Committee (Appendix 15) as a framework for this study:

1. How do students experience patient and carers' accounts of illness and treatment?

2. In what ways do students identify that patient and carer involvement in the curriculum enables their learning and development?

3. What are these students' perceptions of the value of 'patient and carer experiences' in the curriculum?

4. How might 'patient experiences' impact on students' learning?

The purpose of the research questions was to explore the participants' perspective from both epistemological and ontological positions, identifying the influence of patient and carer involvement on their developing knowledge and beliefs. The aim of the study was to capture reflections on the nature and value of curricula activities and the influence of on-going patient and carer interactions in clinical practice on students' professional development. Key objectives were to specifically identify *what* it is they learn *how* this influences their practice and ultimately how this impacts on them professionally. The intention of the questions was to identify students' interpretation of learning, and as such, the questions were not specific to tacit dimensions. However, prompts developed for the interview were designed to encourage them to explore all facets of learning.

Significance of this study

As indicated in the discussions of policy and academic literature above, little research has been conducted that offers an understanding of the influence of patient and carer involvement on students' learning and so this is an important area for study. Although educationalists posit that patient involvement in the curriculum benefits students (Warne & McAndrew, 2005) it is important that this is supported with evidence. The outcome of this study will not only contribute to the body of evidence on patient and carer involvement in education, but provide insight into how students learn from patients' real life experiences and apply that to their professional practice. This student voice has been missing from the research evidence to date and, especially, with regard to radiotherapy students. My study addresses this gap.

My assumption that patient and carer interaction can lead to students' professional development was founded in the concept of experiential learning (Atkins & Murphy, 1993; Ghaye and Lillyman, 2000). However, the intended outcome of this research is to neither accept nor refute that assumption, rather the focus is to explore how that might be. My view that patient and carer involvement can develop students' ability to demonstrate care and compassion is perhaps more tenuous and could be open to challenge as pre-determined.

Understanding reflexive practice

My engagement with reflexivity was imperative to interrogate my research assumptions and practices in order to provide a transparent account of this study as suggested by Finlay & Gough (2003). They characterise reflexivity as hermeneutic reflection that focuses on examining and understanding phenomena at a deeper level. At the outset of the research process I explored my understanding of reflection as a familiar concept. For me, the key difference between reflection and reflexivity in research was that reflection begins with a concrete experience that prompts a process of learning with the ability to 'enhance professional practice whilst potentially understanding more about 'the self'' (Rees, 2013, p48). The continuum from reflective practices through to reflexivity, as I have experienced, provoked me to explore my awareness of personal assumptions and influences, which Raven (2006) describes as:

> Focusing on unawareness, what we do not know and the consequences of not knowing .... We need help from others to point out our hidden assumptions, limitations and blind spots (p560).

Raven (2006) states that reflexivity is concerned with critical exploration to uncover why and how we have come to know or not know. In order to come to new understandings my engagement with supervisors, peers and experts has given me a greater appreciation of the role that reflexivity plays in qualitative research. External critique has further prompted me to acknowledge and explain my biases, assumptions and misassumptions which are explored here.

A number of definitions of reflexivity exist in the literature with insights into ethical, methodological and social reflexivity (Hellawell, 2006; Finlay & Gough, 2003; Raven, 2006), but it is important to me as a researcher that I present an explicit account of my understanding of the concept and explain its importance in this study. If one accepts the premise that value-neutrality is unachievable in social research then reflexivity is concerned with openly presenting personal and social values that reflect ontological and epistemological positions (Greenbank, 2003). Furthermore, Gerwitz et al (2006, p143) state that ‘social research is inextricably bound up with ethical and political considerations’ and that the researcher’s values will have an effect on interpretation. Therefore, reflexivity may be regarded as an intense and critical activity that requires a deliberate approach to self-scrutiny (Hellawell, 2006) and my own interpretation is presented here:

> *Reflexivity is a personal and methodological approach that requires both self-awareness and honesty about my prior knowledge and assumptions that include my own motivations and political influences. To be reflexive I must continually question myself and the research at all stages of the process and for me this is facilitated by personal scrutiny and critique from others. (Research diary, July 2010)*

Reflexivity as a central tenet of qualitative inquiry

My engagement with reflexive writing begins in this chapter with a discussion about two notable dilemmas I had: my position within the research and the methodological challenges I faced. These key issues are addressed early in the thesis in an attempt as far as possible to demonstrate transparency and critical reflexivity. A further account of researcher reflexivity can be seen in the methodology chapter and the final chapter reflects on how the research process has changed my thinking about knowledge and reflections on my own development.

Etherington's (2009) work on being a reflexive researcher has given me confidence in my research practices and I hope criticisms of researcher influence and power will be ameliorated though making my actions transparent. Etherington (2009) acknowledges that this may be risky. However, in order to demonstrate that I am interested in researching the richness and complexity of being human I am prepared to take that risk. My motivation is to understand how and what students learn from patients and carers rather than to prove that patient and carer involvement in the curriculum is what we must do. As my previous research experience was in the positivist paradigm my first struggle was accepting that qualitative approaches could yield a credible interpretation of the data. Etherington (2009) acknowledges the shift in societal thinking where:

> Even the most objective observers brought themselves and their prior knowledge, personal and cultural histories into the equation (p26).

Etherington (2009) began her reflexive journey equating reflexivity with reflection (as I did) and describes a spectrum from descriptive reflection through deep reflective processes that become explicit as learning occurs. Increasing external critique and the resultant action is how she differentiates reflexivity from reflective processes and whilst she acknowledges multiple reflexivities she describes researcher reflexivity as:

> The capacity of the researcher to acknowledge how their own experiences and contexts inform the process and outcomes of enquiry (p.31).

Rather than trying to justify various approaches to research my intention is to lay bare the qualitative approach I took to exploring the topic in order that the reader can assess the reliability of the claims. Furthermore, the richness and insight that the data represents can be celebrated.

A challenge in reflexive writing is to present an honest and illuminating account, however the negative aspects of reflexivity are often labelled as self-indulgence and narcissism (Finlay & Gough, 2003; Scott & Usher, 1996) and there must be a balance struck between privacy and rigour. However, an authentic account of researcher reflexivity is congruent with the qualitative approach to inquiry and the following discussion is a considered account of my reflexive engagement of the issues pertinent to researcher power, methodology and my own development.

Insider-outsider researcher

I came to this study with an interest in the topic and had embedded patient and carer involvement within the philosophy and principles of the course. As such, I would be viewed as an insider researching my own practice. Hellawell (2006) suggests by undertaking insider-outsider analysis and identifying the researcher's position within the research can provide transparency. At the outset I regarded my insider status as a result of my practice based role in clinical education, being close to students and patients in the NHS. With this came my own insight of the patient experience and an understanding of the terminology that participants would use. However this could also lead me to make assumptions that may influence interpretations. So, throughout data collection I endeavoured to capture the participants' views and whilst a social constructivist perspective was taken, this is my understanding of their experience. I have tried, as far as possible, to present it accurately. To emphasise the participants' voice extensive quotes have been used to illustrate their interpretation of learning from patients and carers (Creswell, 2009).

At the point of data collection I was working full time at the university and operating as researcher with less contact with the student group although I was still involved in some activities (see timeline page 38 and Chapter Two which explains the pedagogy of patient and carer involvement). Although this did not give me outsider status my motivation was to capture the student perspective and ultimately share that with the research community and so every effort was taken to respect the participants' views. Therefore, as an insider my aim was to use my role as researcher to facilitate knowledge construction whilst acknowledging my role in data collection and interpretation.

Researcher influence and power over participants

At the heart of reflexivity is the researcher's understanding of how they may influence the process (Etherington, 2009) and so identifying the problem and area for investigation is the starting point. This in itself suggests researcher influence as I chose to explore a topic that was familiar, something that I had interest in and wanted to understand more deeply. My approach using a qualitative framework was less familiar, although I had conducted focus groups previously and understood how participants could influence each other and that the researcher needed specific facilitation skills. Data collection in this study utilised a method that came naturally to me (conversation about a topic of shared interest) and interpretation was framed within the theories I brought to the study. More importantly, I was open to exploring new concepts and theories that was influenced by the participants' stories. I came to this research with theories of knowledge construction in professional practice, tacit learning and emotional intelligence and, whilst these have had some resonance with the interpretation, it has been the emotional nature of the participants' words that has been the greatest influence on the interpretation. To some extent those early theories were naïve and did not fully explain the data, which has enabled the production of a more complex picture of interaction between students and patients and carers.

The gathering of stories and narratives from participants alongside my own changing story has given the students a voice whilst demonstrating my own transparency and learning (Etherington, 2009). Researching human relationships from a student perspective allowed me to research my own experiences of student learning through listening to their accounts and continually rethinking my own understanding of the pedagogy. This viewpoint of reflexivity demonstrates the social constructionist perspective on knowledge being contextual, complex and of the moment (Kvale, 1995) and Etherington (2009) describes this as:

> ‘the co-creation of multi-faceted stories that honour the messiness and complexity of human life’ (p.28)

Thus, awareness of my own thoughts and feelings informed the dialogue with participants and encouraged collaboration and in the research interviews. Although I am comfortable in making transparent my own involvement and personal connections to the research topic, this could expose me to criticisms of bias or influence and power over participants.

Researcher motivations

At the outset my motivation was made clear as an advocate of patient and carer involvement activity. An uneasy feeling that this might lead to claims of researcher influence has prompted me to explain my ethical motivation. Adler and Hansen (2012) challenge researchers to consider what supports their core motivations in their work and beliefs. They go on to urge researchers to have the courage to act on their findings. Their work was of particular interest to me as they identified compassionate research as that which attempts to help or intervene in order that practice is enriched, which to a large extent was my aim. They also suggest that often researchers are deterred from advocacy with neutrality regarded as the best position and in some cases positively encouraged. This sits uncomfortably with me as I would question the value of research if the outcome is not to change practice or indeed if the research questions do not instil a burning passion within the researcher. Adler and Hansen (2012) go on to speak of life and death consequences of not investigating that key issue and whilst my research cannot be contemplated in such a way it is the courage of my convictions that this study has the potential to improve patient care. A key government publication (Francis, 2013), explored further in the final chapter (pages 196 to 203), has fuelled my belief that the study is not merely of local interest, but has the potential to inform the future of health professional training. This has given me confidence and this comment from my research diary characterises my position:

> *The focus of my research has been shared in many forums within higher education, the radiotherapy profession and in the practice setting. My passion was obvious to others and their positive feedback about the value of this study was reassuring. However publication of the Francis Report (2013) was timely as it reflected my own thoughts about the lack of care evident in some parts of the NHS and validated my research focus. Moreover it was what was missing from the report that could be described as a 'eureka moment', they suggested better training was needed, but made no suggestions about patient and carer involvement. This would*

> *be my contribution to the evidence base and characterise me as a ‘compassionate researcher’. (Research diary, November 2013)*

The fact that a major Department of Health publication echoed my own views about patient care alleviated my concerns about my assumptions and motivations. I feel that ethically the study is justified and, as its focus is to examine healthcare training, then its timeliness is opportune as it has the potential to influence current thinking. Moreover, Adler & Hansen’s (2012) view of compassionate research is a key feature in my acceptance that being passionate about the study is legitimate. The underlying theme of emotional learning was identified through conversation characteristic of the emotional dialogue in research described by Lewis (2008) and I came to accept that this was a major finding of the study and reflective of the participants’ accounts. In many ways this was surprising as I had not anticipated the depth of emotional expression in their stories. In fact, this demonstrated the gap between my assumptions of emotional management as part of everyday practice and those of the participants in this study.

Methodology

Perhaps the greatest reflexive challenge was to identify the epistemological and ontological principles of this study. Whilst the phenomenological premise of understanding the experiences of participants was the starting point, there were aspects of this philosophy that were incongruent with the research operationalization. In particular, this was apparent as I came to the research with prior knowledge and assumptions. Furthermore, my intention was to identify collective views that could inform curriculum developments. The main conflict in phenomenology is the incongruence between those principles rooted in participants’ experience of learning and a social constructionist view of knowledge essentially co-constructed between researcher and participant. I was interested in representing what seemed to be the key elements of the participants’ experience collectively and in taking into account their individual differences. I came to realise that my methodology was in fact a qualitative study using thematic analysis (Attride-Stirling, 2001; Creswell, 2013). My research utilises the interview as an opportunity for participants to reflect on experiences and interpret their resultant learning and my aim was to provide an enhanced explanation of the pedagogy of patient and carer involvement. Chapter three charts the methodological discussion which has been a key personal learning for me and I am now more aware of the importance of the underpinning methodology as a foundation for the methods employed.

Timeline

A timeline is presented below, which illustrates the milestones in this study and charts key decisions and activity as I conducted this research alongside teaching and other work commitments. Table 1, page 38, identifies how the patient and carer involvement activity occurred with respect to the research trajectory. Whilst working life caused a protracted period of study it also enabled me to implement some of the findings of this study in the curriculum and expand patient and carer involvement activities as an example of research informed teaching. Studying the first two years of the Education Doctorate (2006-2008) helped shape the study aims and objectives. In October 2008, I took on a new role as subject lead and this impacted on the time I could devote to the study. Final approval for the study was gained from the university research and ethics panel in February, 2010. Data collection occurred over the summer of the following year (after semester two delivery which included three specific involvement activities) and transcription and analysis followed, which was a lengthy process as extensive data was captured. Thematic analysis using Attride-Stirling’s framework (2001) was time consuming, but as findings emerged I began to extend curriculum activities (the developing pedagogy is discussed in detail in chapter seven). Final write up took 18 months with critique from the supervision team and I commenced writing the thesis.

Table 1:

Date	Milestones
2006	Faculty development of a service user involvement interest group and strategy. I was the link from the subject area of radiotherapy, oncology and end of life care. I began the Doctorate in education programme and studied modules on professionalism 'professional patient' and research methodology 'reflexivity as a method of validation.
2007	Recruited a patient to the re-validation panel for the BSc Radiotherapy & Oncology Programme to enhance the patient focus in the curriculum. EdD Module topics: pilot study using focus group with clinical educators to develop the curriculum and literature review of concepts in patient involvement research (knowledge construction, tacit learning, emotional intelligence). I continued to develop research ideas.
October 2008	New BSc programme commenced with first patient involvement session: communication skills(1) facilitated by patient and researcher (runs each year since 2008). I began a new role as Professional Lead for subject area and this stalled research development. Planned curriculum activities implemented.
March 2009	Patient and carer workshop(2) facilitated by four university lecturers (runs each year since 2009)
April 2009	Role play(3) with patient and researcher focusing on sensitive communication (runs each year since 2009)
Feb 2010	Research proposal developed that focused on exploring students' learning from the patient and carer involvement activities and submitted to university research and ethics committee. This was approved by two rapporteurs and the ethics committee.
Academic year 10/11	Year 2 students who had experienced the 3 curriculum activities in October 2010, March 2011 and April 2011 were invited to take part in the study (n-36).
June 2011	Recruitment email sent to the cohort along with information and consent form.
August 2011	Data collection through in-depth interviews which were audio-recorded.
Dec 2011 – May 2012	Data Analysis and reading (Attride-Stirling, Goffman, Polanyi, Rogers).

May 2012 –2013	Findings chapters developed, reading (Rees, Smith, Mann), critical review by supervisors.
Sept 2013	As a result of the findings two more curriculum activities included in the programme: handling difficult situations(4) and clinical de-brief sessions(5).
March 2013 – 2014	Final thesis write up Reading Francis Report and new literature/policy on curriculum development DoS retired, feedback from new supervisor
Oct 2014	Thesis submission Further curriculum enhancements included in the programme from Oct 2014 as a result of the research: making a pledge to patients and carers(6), concepts of caring and compassion in partnership with patients and carers(7), self-assessment of emotional intelligence(8), the meaning of professionalism(9)
Jan 2015	Thesis writing and examination process

(1-3) Data collection and interpretation based on these activities; (4-9) Activities introduced as a result of the study findings

Study Timeline

Summary

This chapter began with a contextualisation of the study from a pedagogical stance based on the assumption that patient and carer involvement could be a vehicle for professional learning. I had identified the problem with the radiotherapy curriculum, which was an over-emphasis on the technical knowledge related to professional learning. This, coupled with the inherent difficulties of working in a cancer care environment, presents the students with some significant challenges to overcome as they develop towards professional registration. However, there is increasing consensus on the value of patient and carer involvement in the curriculum and professional benchmarks are shifting towards a more patient-centric ethos (HCPC, 2012). As a result of changing values, my course team developed three specific curriculum activities that included patients and carers. This study focuses on identifying the learning that occurs as a consequence of that involvement in the radiotherapy course. I have discussed the literature and policy related to patient and carer involvement with a commentary of how such practice has developed (Gott *et al*, 2000; Tritter *et al*, 2003; Hubbard *et al*, 2005; Warne & McAndrew, 2005; CUILU, 2005; Farrell *et al*, 2006). What is missing from the literature is the radiotherapy student voice and a clear understanding of patient and carer pedagogy and this is my contribution to the evidence base. My interpretation of reflexive practice and some key challenges that I faced have been presented early in the thesis to demonstrate my commitment to self-reflexion and external critique. Chapter Two draws on further literature and describes the patient and carer involvement activities that were implemented prior to the start of data collection

Chapter Two: Pedagogy of patient and carer involvement

Introduction

This chapter is in two sections; the first provides a critical account of the literature that informed the design of three discrete curriculum developments and the second describes the activities that took place in the classroom. The literature identifies the drive for patient and carer involvement and explores how interaction facilitates ‘knowing’ of others’ experiences and the processes involved in learning.

Patient and carer involvement in curriculum delivery

Patient and carer involvement in higher education has become a more pervasive and accepted practice informed by policy and detailed guidelines (CUILU, 2005; Farrell *et al*, 2006). Although there is guidance on involvement, it is predominantly motivated by educators who believe that patient experience enhances learning and has the potential to change practice (Freshwater & Stickley, 2004; Warne & McAndrew, 2005). Involvement initiatives are sometimes criticised as tokenistic gestures by providers of education, but Stark & Stronach (cited in Warne & McAndrew, 2005) suggest that such activities can provide the student with authenticity and clinical relevance that is often absent from the classroom environment. Moreover, opportunities for student engagement with the patient experience away from the clinical setting could aid the development of critical thinking skills and facilitate the expression and regulation of emotion with the potential for students to formulate useful coping strategies for practice (Akerjordet & Severinsson, 2007).

Course development in the early 1990s focused on introducing more theory to the taught curriculum with patients contributing little to students’ education. Effective patient involvement was lacking and students often regarded patients as the recipients of treatment rather than active participants in the process with little or no influence on the syllabus (Freshwater & Stickley, 2004). In particular, mental health and social work education has a strong record of involving users (Bennett & Baikie, 2003; Humphreys, 2005). More recently, practice around patient and carer involvement at my institution has increased and a particular driver for this has been Health Education England which commissions health professional training. This body specifically asks education providers to demonstrate service user involvement in the curriculum and evaluate how this impacts on students' practice. In addition, the Health Care Professions Council (2013) specifically requires registrants to articulate how their continuing professional development impacts on patient care. With an increase in policy initiatives to improve involvement in education there is also a general view that such activity is regarded positively by those who participate such as educators, students and patient and carers.

Cancer patients' and carers' experience of involvement

Macmillan Cancer Support (2009) published their vision on cancer survivorship that focused on strategies for psychological adjustment and the long term side effects of treatment outlining the supportive services available. This document included patient and professional perspectives, but in many ways remained an organisational viewpoint that focused on Macmillan services, psychological assessment, support groups and counselling as methods of coping with survivorship. It is likely that cancer patients also became pro-active in their own survivorship in different ways, but this was not discussed. Macmillan's recently refreshed Cancer Survivor Strategy (Macmillan *et al,* 2013) emphasises self-help strategies. In recognition that personal survivorship is a significant issue for cancer patients the patients and carers involved in our curriculum activities also consented to take part in a qualitative study that I supervised, to understand better their motivations for being involved in developing student learning (Keenan & Hodgson, 2014). The results demonstrate that patients and carers regard the educational activities as a positive strategy for self-management and a significant aspect of their unique survivorship story. It was apparent in Keenan & Hodgson's study that living through cancer shaped the experience very differently for each person and it is this diversity that is thought-provoking and a feature of pedagogical activities. Within this study I wanted to know how the individuality of patient experience affected the students.

Patients' experiences demonstrate an accumulation of knowledge and skills that enable living with cancer and support the notion of the patient as 'expert' with the potential to teach others (Department of Health, 2001). That personal first-person perspective and the study of the human experience is the ethos engendered in many involvement projects (Warne & McAndrew, 2005). Thus, the involvement of patients and carers in education and the potential of classroom activities to influence students' learning became the focus of this investigation.

Learning from the cancer experience

The notion that students can learn from the experience of others is the basis of patient and carer involvement (Warne & McAndrew, 2005). However, Mackenzie & Scully (2007) suggest that people have different epistemic positions and questions how readily one person can access the understandings of another. They state that the more different lives are, the harder it is to empathise. They argue that one way of coming to know the experience of another is by attentively listening and learning from them about how they experience life. Mackenzie & Scully (2007) state that, 'it is implausible to think that an observer can understand the experience' (p347). Perhaps this supports the notion that sharing experiences aids students' comprehension of patient and carer perspectives; what it cannot enable is how it may feel to have cancer. Mackenzie & Scully (2007) argue that in some way listening facilitates knowing. Thus, the value of the interactions may be seen as a mechanism for students to recognise what they do not know about the experience of cancer, but can find out more by asking patients and carers.

The significance of the cancer experience for families is recognised in the literature (Hodges *et al,* 2005; Teixeira & Pereira, 2012) demonstrating that carers experience cancer from yet another unique perspective and one that may not always be fully understood or attended to by health professionals. Carer perspectives have the ability to illustrate the ‘ripple effect’ that cancer has on the family and provide a further psychosocial dimension to the experience. Teixeira & Pereira (2012) suggest the impact of caring on the psychological well-being of the carer is a significant psychological burden and the severity is dependent on the availability of wider social support. This substantial impact of cancer on the carer is further demonstrated in the findings of this study as an important source of learning for students. A number of students recognised the impact of the cancer experience on the mother of a young boy who had undergone amputation.

In recognition that emotion impacts on communication one must consciously select certain communication skills to manage the situation (Fallowfield, 2009). There is a wealth of literature published on communication skills training in the oncology setting that utilise patients and carers as a mechanism for improving those skills (Fallowfield & Jenkins, 2006; Fallowfield, 2009). Research on communication skills training demonstrates the effectiveness of education on professionals, but there are diverse explanations of what those skills constitute. Key skills such as respect, dignity, establishing rapport, listening and responding can be seen in the NICE Guidance on Supporting Adults with Cancer (Department of Health, 2004), which provides clear direction on face-to-face communication. The characteristics of effective communication can be seen as a way of interacting that focuses on developing a relationship in Butler *et al’s* review (2005). They reviewed 47 studies on communication and assimilate a range of attributes that include: attitude, reflection, flexibility, emotional expression and the ability to elicit concerns in a comforting environment.

Tacit learning

The previous discussion suggests that the act of interacting with patients is subjective and reliant on implicit learning rather than a formal process that is often characteristic of technical knowledge acquisition. Student interaction with patients and carers whilst part of the professional curriculum is not detailed in the same way as the formal technical knowledge associated with therapeutic radiography. This has made learning outcomes problematic to classify because subjective and implicit skills are more difficult to describe. Professional learning outcomes such as ‘understanding the patient and carer experience’ have been used (Appendix 6), but how that relates to learning is dependent on their engagement with patient and carer experiences. It is this tacit nature of learning that is relevant to the objectives of this study. The notion of tacit learning may not sit comfortably with curriculum planners and professional bodies, but there should be space in the curriculum for undirected, independent tacit learning in order that students can develop notions of care (Freshwater & Stickley, 2004). Tacit learning perhaps evokes a sense of haphazardness or disorganisation that is discordant with professional standards and the term tacit requires further explanation of its role in student learning. Polanyi (1959) claims that tacit learning is charged with personal feelings and this pre-logical state of knowing is what makes it tacit. He identifies such learning as a process of discovery:

> To hold such knowledge is an act deeply committed to the conviction that there is something to be discovered. It is personal in the sense of involving the personality of him who holds it and also in the sense of being (Polanyi 1959, p25).

Thus, the act of exploration and discovery becomes a key feature of tacit learning and facilitation of learning experiences with patients and carers encourages the student to identify personal responsibility. Perhaps then such learning can be transferred to other similar situations in practice and learning continues. More recently, Imel (2003) suggests that rather than tacit learning being an unknown in professional practice, the problem lies in the difficulties in identifying or labelling it. This particular argument further explains the dilemmas for curriculum planners who struggle with the inclusion of terms such as tacit and discovery in learning outcomes that need to be explicit.

The argument of whether making learning explicit negates its claim to tacit-ness has been presented by Eraut (2000) and in the context of this study has caused some minor consternation. However, the purpose of this research is to demonstrate the tacit learning students derive from patients and carers and to make it explicit. The debate then about whether this learning loses its claim to tacit-ness becomes less relevant as the process of understanding human experiences and ways of connecting with patients will never be fully conceptualised (Thorne *et al,* 2005). It is proposed that the process of tacit learning can lead to claims of 'know how' in professional practice (Eraut, 2000) and the idea of acquiring tacit knowledge within a discipline will be further explored.

Imel (2003) describes tacit knowledge as personal, experiential, contextualised, role specific, sub-conscious and conscious and central to an individual's ability to perform their role. This presents a particular dilemma as professional courses require assessment of professional knowledge and the challenge is then 'how to assess know-how?' Eraut (2000) asks what tacit knowledge is; 'Is it an attribute of the knower where some can communicate and some cannot; or is it an attribute of the knowledge itself?' (p118). Professional knowledge may be difficult to define due to its complexity and the influence of various factors, or some individuals may have difficulty in describing it. Both aspects of tacit-ness present different issues for assessment, but Reinders' (2010) view is that observation of practice is a way of assessing know-how. This dilemma provides an opportunity to make a distinction between tacit and formal professional knowledge. Formal knowledge is largely conceptualised through research and evidence that is based on theory related to the profession. Through assessment a student demonstrates their knowledge of, for example, the theory of the production of x-rays. Some students may perform better in the assessment dependant on their understanding of the concept and the ability to articulate the answer. One could say the same about tacit knowledge – the student may understand the related concepts and articulate it well. Tacit knowledge is conceptualised as intuitive and based on personal learning gained from experiences and feedback facilitated through reflective practices. However, tacit knowledge does not rely solely on the synthesis of experiences that contribute to ‘know-how’, but is the result of the symbiotic relationship with formal knowledge. Thus, tacit knowledge is seen as a complexity of subjective viewpoints based on the relationship of experience and a selection of theories and situations. So, the task of assessing students on patient interaction is more problematic than assessing their knowledge of x-ray production, as the attributes of the ‘knower’ and ‘knowledge’ are more intensely particular to the individual. Tacit knowledge whilst dependent on the knower and the focus of knowledge, arguably presents a greater potential for diversity of understanding as opposed to some formal knowledge. Polanyi’s claim that knowledge is ‘solitary’ demonstrates the personal meaning of learning and provides some further clarity to the concept of knower versus knowledge. Then the ability to articulate tacit knowledge is based on the sense one makes of learning; so how someone thinks or learns about a phenomenon is dependent on them as an individual and the situation they are faced with. Eraut (2000) suggests that people’s capability to articulate tacit knowledge is linked to their prior experience of talking about what they know and that talking more explicitly can facilitate further knowing. Some participants in this study seemed more used to talking about experiences than others.

Eraut (2000) proposes that learning from experience inevitably impacts on behaviour and thus knowledge does not remain implicit, rather it becomes explicit and then vice versa. This suggests that in a particular field, such as healthcare, tacit and explicit knowledge co-exist with one dependent on the other whilst having distinct and separate features (Higgs & Titchen, 1995). Eraut (2000) goes on to say that explicit knowledge is required to improve professional performance, which in turn becomes implicit as one synthesises formal knowledge in relation to a new situation. Similarly implicit knowledge becomes more explicit through reflection and articulation of learning. Evans *et* *al*, (2010) term this re-contextualisation, putting knowledge to work in new situations. So, in the context of the participants' accounts in this study tacit knowledge becomes explicit through their ability to tell what they have come to know. The relationship between both forms of knowledge may be evident through conversation or writing that endeavours to make learning explicit. This connection is described by Higgs & Titchen (1995, p521) as a 'dynamic phenomenon undergoing constant changes and testing' and that knowledge, whilst unique to an individual adjusts over time. Therefore, regardless of how knowledge is standardised in a professional arena, individual characteristics and experience will contextualise learning. Tacit knowledge development requires the ability to synthesise learning experiences and has the potential to promote the acquisition of skills over a period of time. In the context of this study the development of skills in caring for patients and carers assumes that engagement with a number of experiences can assist the individual in moving from a tendency to be rigid in their practice to become more accomplished and intuitive (Eraut, 2000). However, tacit learning is not totally dependent on one's own experiences and thinking but is inevitably shaped by social values and culture (Kvale, 1995) that can be facilitated within a group activity and in some ways will serve to challenge prior assumptions of practice. The proposition is that curriculum activities may provide the basis for ongoing tacit learning that occurs in the clinical setting.

The role of tacit knowledge in skills development

The previous discussion argues that tacit knowledge is essential to professional education and this is explored further by Edmond (2001) who says there is evidence of a paradigm shift in knowledge construction in professional identities. Edmond (2001) focuses on current health education systems and the ways in which clinical education should be developed, and provides some insights on how formal and informal processes should be more effectively integrated in the curriculum. Her view is that a theory based syllabus that lacks experiential elements of learning, is flawed. She states that an over-emphasis on formal learning fails to develop more holistic pedagogical approaches.

The discussion has so far focused on the literature that defines both tacit and formal knowledge domains and the way in which they both contribute to an individual's development of know-how or skill. The skills that reflect individual professions have been to a large degree written in professional standards, but still the term 'skill' has been a vague and evolving concept. Skill is defined as the capacity to practice in a field that requires special knowledge and ability. A recent publication, *Delivering High Quality, Effective and Compassionate Care* (Department of Health, 2013) contends that the right people with the right knowledge, capability and values are central in achieving this. This document emphasises the role of Health Education England in ensuring 'excellence in training that affords better experience and outcomes for patients, students and trainees' (Department of Health, 2013 p5) and supports the 'NHS values and behaviours to provide person-centred care'. Thus for the health professions the notion of skill may be regarded as a broad concept that includes technical competence, interpersonal characteristics, ethical and moral attributes (HCPC, 2013).

This shift towards a more value-focused ethos is reported by Payne (2010) who charts the changing face of skills in relation to a profession and recognises a shift towards 'soft' relational skills in many professions. From this, a much broader definition of skill has emerged. For Payne (2010), 'skill', includes the requirement of knowledge and personal qualities needed for practice with an emphasis on the attributes of coping, inter-personalisation and values. The informal and difficult to measure skills characterised by 'a range of tacit behaviours, personality traits and attitudes' (Payne 2010, p361) has crept into many role descriptions. Eraut (2000) and Reinders (2010) suggest that through the observation of practice tacit knowledge is seen, indicating that it becomes explicit and thus identifiable. This proposition leads to the assumption that tacit-ness in practice could in some way be a skill to be measured and ultimately an assessment of quality of patient care (Reinders, 2010). So, as observable tacit behaviours have become an expected part of professional practice the curriculum must address this through overt learning, teaching and assessment strategies. This study examines the influence of learning and teaching strategies that promote tacit knowing, but the challenges in assessing the use of soft skills will present further research opportunities. This discussion of tacit learning has so far considered the propositions of theorists and educators on the characteristics of tacit knowledge development and the professional standards of compassion, dignity and respect that reflect patient-centred practice. To further examine the concept of professional development models of knowledge construction are now discussed.

Knowledge construction within professional groups

To better understand the multi-dimensional nature of knowledge Hegarty (2000) suggests that for a professional group discipline knowledge is enhanced by tacit knowledge. He says that tacit knowledge begins with some act of socialisation followed by externalisation or articulation through propositional language informed by more formal sources of knowledge. Hegarty says that as concepts proliferate a body of theoretical knowledge is formulated and as further internalisation occur individuals incorporate this into their tacit behaviour. Hegarty's framework provides insight into how knowledge may be constructed within professional groups. His model of 'insight' relies on tacit and formal domains and proposes that theory, other knowledge, experience and skills are essential, but that a particular learning situation triggers intuitive professional practice. Intuitive behaviour leads to more explicitly known and reflected upon behaviours that are informed by both tacit and formal learning. This notion provides a basic tenet for the aims of this study as patient and carer experience in the classroom is seen as a mechanism to promote learning and along with more formal methods of learning can contribute to professional education. The idea that a number of modes of learning contribute to an individual's knowledge and know-how is further explored through a typology presented by Pawson *et al* (2003). Their partnership with the Social Care Institute of Excellence produced a framework employed in assessing practitioner standards (Pawson *et al,* 2003). The typology proposes five sources of knowledge (see Table 2, p.51) and although it relates to qualified practitioners it could be similarly applied to student learning. The sources of knowledge identified for social work focus on how an individual may construct their understanding from a range of domains and parallels are drawn with radiotherapy and oncology.

Table 2:

	Source 1	Source 2	Source 3	Source 4	Source 5
Types of knowledge	**Organisation knowledge** gained from management and governance of services	**Practitioner knowledge** gained from the conduct of practice (clinical experience)	**Policy and community knowledge** gained from the wider policy environment	**Research knowledge** gathered systematically with pre-determined design	**User and carer knowledge** gained from experience of service user and reflection
Application to Radio-therapy and Oncology	*Knowledge gained from NHS Trusts, cancer networks and radiotherapy departments*	*Knowledge gained from clinical placements, practitioners, systems of work, peers*	*Knowledge gained from Department of Health cancer policy, national group*	*Knowledge gained from academic studies which includes research*	*Knowledge gained from patients and carers*

Sources of knowledge adapted from Pawson *et al's* Typology in Social Work (2003)

This framework proposes that all sources are essential to practitioner development and addresses formal and non-formal types of knowledge. Although Pawson *et al* (2003) clearly state that this is not a hierarchy of knowledge, at undergraduate level the emphasis is on source 2 and 4 (clinical learning and fundamental theory). In radiotherapy and oncology education the curricula focus on these two domains and one could argue that this is based on the essential requirements in any professional group. Implicit in the radiotherapy curriculum are the other sources of knowledge, which gain increasing importance as the student progresses and becomes a qualified practitioner. The challenge is then of giving importance to source 5, user and carer, at undergraduate level and to persuade others that this should have focus in the curriculum.

The notion that we must review the health professional curriculum is supported by Bleakley & Bligh (2006) who suggest that we reconsider the dated perceptions on how knowledge is constructed and reject traditional notions. They propose that the patient be placed at the centre of knowledge construction, which requires the student to understand the patient's condition in collaboration with the patient. This recognition that knowledge emanates from the patient and is central to providing effective care is perhaps overstated as equally the student must engage in learning theoretical concepts and practical skills. Where Bleakley & Bligh's (2006) work is particularly relevant is their suggestion that communication between professional and patient through facilitated activity contributes to professional knowledge. Their model further explains the types of communication that occur between facilitator-student; student-patient; and facilitator-patient, which in different ways contribute to learning. This model could illustrate how patient involvement activity is explained within a collaborative framework with mechanisms that open lines of communication between student, patient and facilitator enabling all to contribute to knowledge construction. I now turn to the theories relating to emotional intelligence as characteristic of tacit learning. Before the data were collected my assumption was a distinction exists between tacit and formal learning. Tacit learning can be made explicit through reflection and can both inform and be informed by formal and professional knowledge. The aim of this study was to identify the tacit knowledge being learned and make it explicit through the research process.

Emotional intelligence

The concept of emotional intelligence as an aspect of social interaction has gained interest as it recognises that logical thinking in isolation cannot facilitate effective relationships. This suggests that formal and tacit learning are essential in developing those skills necessary for meaningful interaction. A seminal paper on emotional intelligence published by Salovey and Mayer (1990 p185) describes this concept as:

> a set of skills that contribute to the accurate appraisal and expression of emotion in oneself and in others, the effective regulation of emotion in self and others, and the use of emotion to motivate, plan and achieve in one's life.

Emotional intelligence is regarded by Goleman (1995) as complementary to other forms of intelligence and seen as a subset of social intelligence. Goleman believes that in health care practice it identifies the skills relevant to emotional situations and therefore presents a useful concept to investigate. My assumption was that the tacit skills required by the students in patient interactions included the relational skills described in the literature on emotional intelligence.

Appraising and expressing emotion accurately is part of emotional intelligence, dependent on the ability to verbalise emotional feelings and equally important in identifying emotion in others. Salovey and Mayer (1990) describe a range of tools that measure emotional intelligence, but what is more enlightening in this work is their focus on the skill of empathy. They suggest that emotional appraisal and expression are closely related to empathy and in fact they believe it to be central to the emotionally intelligent individual. Mackenzie & Scully (2007) identify the difficulties in developing empathy and requires one to carefully attend to how another experiences their life. However, it is feasible that one can empathise with emotional feelings and to some degree come to understand better another's experience. The theory on emotional intelligence suggests that regulation of emotion in oneself and in others can be used in the management of emotional situations. Although some social scientists may disagree with the concept of emotional intelligence it is useful in understanding the relationship between patients and carers and students. The students who recognise emotion and then respond appropriately whilst maintaining their own emotional well-being may be more effective in developing relationships. A final aspect of Salovey & Mayer's work that explains this particular point is the relationship between adjustment and emotional intelligence. The person who is emotionally intelligent possesses good mental health, self-awareness, excellent communication skills and the ability to adapt to different situations and maintain mutually positive relationships with others. They suggest that in contrast, individuals who are deficient in emotional intelligence may have problems with adjustment in emotional situations, which could perhaps lead to dissatisfaction and burnout (Dunn *et al*, 2008). Perhaps to focus on deficiency is unhelpful, rather the development of emotional intelligence should be the concern within the curriculum for students preparing for professional practice.

The Mayer-Salovey Four Branch Model of EI (Mayer & Salovey cited in Salovey & Sluyter, 1997), tend to use the term emotional management ability rather than potential, which to some degree suggests a level to be achieved and not a continuous process. This notion of potential for development is better presented by Goleman (1995) who examines the concept in a more holistic way and uses life scenarios and situations to emphasise the potential of individuals to learn and become skilled in emotional management. He discusses the importance of developing relationships and stresses that self-awareness is a key attribute. His view is that the more aware we are of our own feelings the better we are attuned to others. Emotional intelligence literature draws on the work of Rogers (1980) who describes the attributes required for effective interaction identifying the core conditions. In a heath care setting the focus on technical skills often takes precedence over personal attribute but Goleman (1995) states that it is not acceptable when feelings are neglected and proposes that compassion should be a part of good health care with the premise that the emotionally intelligent health practitioner can more effectively provide holistic patient care.

The idea that emotional intelligence in health practitioners is essential is supported by Freshwater & Stickley (2004) who studied the concept in health professional education. They argue that both formal and non-formal knowledge should be taught simultaneously in order to develop practitioners capable of caring for patients. To underline this view they state that:

> It is the emotionally intelligent practitioner that hears the sigh, makes eye contact, communicates understanding and demonstrates human care (Freshwater & Stickley, 2004, p93).

Their notion that opportunities for effective communication skills development and insight into the human experience could improve relationships with patients is the basis for advocating facilitated interaction between students and patients and carers. Other researchers in the health professions have further examined this concept. A qualitative study on emotional intelligence within the nursing profession postulates that emotional competence improves both outcomes for patients and practitioners (Kooker *et al*, 2007). They propose that new recruits should be screened for emotional intelligence and that the concept should be more openly discussed within the curriculum. Bar-On (2006) developed the Emotional Quotient Inventory (EQ-i), a measure of emotional-social intelligence, but my reservations about testing emotional intelligence are based on Goleman’s notion of potential. I believe self-awareness strategies to support development are more appealing (this particular issue is further explored in Chapter Seven). Ways in which emotional intelligence may improve patient care is considered in the literature, but traditionally this has been a difficult area to evaluate and should be perhaps an area for future research (Akerjordet & Severinsson, 2007). However, the application of emotional intelligence in health care is of particular interest and the work of Freshwater & Stickley (2004) amongst others explains the link between emotional intelligence and clinical practice specifically in terms of patient care (Kooker *et al*, 2007; Mikolajczak *et al,* 2007; Montes-Berges & Augusto, 2007).

Skills for caring

Throughout this chapter there is reference to ‘care’ and the relationship with knowledge construction and professional development. Furthermore, compassion is regarded as an attribute of the caring practitioner. Emotional intelligence is particularly relevant to compassion in that the ability to empathise with another’s experience is a key feature. However, equally important is a student’s potential to cope in emotional situations. Montes-Berges & Augusto (2007) hypothesise that emotional intelligence correlates positively with the ability to mediate stressful situations. They propose that high emotional intelligence indicates the ability to clarify emotions, employ more adaptive coping styles and help individuals to repair emotionally. Again, they propose that attention to these skills should be part of the curriculum. In a similar way, Mikolajczak *et al* (2007) studied nurses’ ability to employ emotions appropriately, identifying the complex processes that are utilised in reducing stress and burnout in individuals. The need to manage stress and identify the potential for burnout is emphasised in Potter *et al’s* (2010) study on compassion fatigue which concludes that training in effective coping has a protective effect against stress.

The proposition that the patient and carer is a mechanism for tacit learning as part of professional development is presented by Freshwater & Stickley (2004). They suggest that the sharing of authentic human experience in a positive, respectful way enables individuals to understand others’ perspective and learn from the phenomena, which contributes to their practice. Lave & Wenger (1990) term this ‘situated learning’ which is embedded in contextual activity based on social interaction and collaboration. They state that situated learning as peripheral participation is often unintentional, although their conceptualisation of a community of practice suggests that this can also be purposeful. In much the same way, this study was conceived to explore students’ professional development as a consequence of planned activities involving patients and carers.

This discussion provides an insight into the theories I drew from as I began the research process and emphasises: construction of knowledge from both tacit and formal sources, the importance of the patient and carer as a source of knowledge and the premise that emotional learning can occur as a result of interactions. The patient and carer experience is regarded as a significant source of knowledge and this is combined with other more formal sources to develop professional knowledge. Then, the student as communicator and reflector is able to synthesise learning as an element of their professional practice. However, the complexities associated with professional development are recognised and that the improvement of those softer care skills may indeed be ‘hard’.

In summary, the development of tacit knowledge is dependent on the skills of communication, respect, awareness, empathy and reflection which are characteristic of emotional intelligence (Salovey & Mayer, 1990; Goleman, 1995). I suggest that tacit learning is synonymous with learning how to care. To date there has been an extensive body of literature on service user involvement in both education and oncology services. Concepts related to emotional intelligence and compassion have been ‘in vogue’ and researched widely. However it is apparent that there are few published studies that particularly examine the pedagogy of the patient and carer experience on learning ‘how’ to care and professional development. The background policy and literature drawn on in this chapter has shaped the research questions and provided a generalised conceptual framework for this study. However, it was acknowledged that this was merely a set of contextual guiding principles that were refined as the findings emerged.

Pedagogy of patient and carer involvement

I now describe the patient and carer involvement activities in the curriculum that were the focus of this inquiry. The notion that the cancer patient is on a journey of discovery, relating to their illness, and so too is the student, presents an opportunity for shared learning. The concept of the pathway or journey is popular in oncology as it provides an explicit series of events that professionals can become familiar with and then engage in improving experiences. The idea that students can derive valuable learning through their interaction with patients and carers is further articulated in the following discussion.

It has been claimed that through collaboration with patients the student is able to glean individualised patient-generated knowledge of cancer as opposed to general principles (Bleakley and Bligh, 2006). There is also an argument that this has the potential for generalisation to patient care approaches. The assumption then is that the contextual information generated between student and patient has the ability to influence students' practice and tacit knowledge development (Eraut, 2000). Patient and carer involvement activities in the classroom can provide a platform for interaction that informs further interaction in the clinical setting. The notion is that learning is transferred to new situations (Evans *et al*, 2010) and forms the theoretical basis for the involvement of patient and carers in the curriculum. There are many references in the literature that relate to the perceived gap that exists between formal knowledge and clinical practice, which leads me to reflect on Rolfe's view (cited in Warne and McAndrew, 2005). Rolfe argues, that as a nurse, most of what he had learned as a student that was important came from the patient and this was a perspective that I identify with. The proposition that informed our curriculum developments is that by placing the patient at the centre of learning this will lead to opportunities for bridging the gap to some extent between theory and practice.

Some key websites have been utilised with our students to facilitate better understanding of the impact that cancer and its treatment has on individuals.

One such site www.healthtalkonline.org is a useful educational tool, but a preference for face-to-face activities was expressed by the students in module evaluations. The interactional nature of listening, questioning and clarifying can provide a type of connection between student and patient or carer that has the potential to facilitate deeper and more meaningful dialogue. It is perhaps this notion of sharing learning (the patient learns something too) that makes the face-to-face sessions so popular with students and the patients and carers (Keenan & Hodgson, 2014).

It is proposed that the experience of interaction and the subsequent reflection has an influence upon developing practice. To maximise potential learning from the face-to-face activities students were encouraged to critically reflect on their own communication style and how effective it was. An introduction to effective communication principles workshop with a patient and lecturer was their first opportunity to use those skills whilst they listened and responded to a patient talking about her experience. At the outset of this study it was difficult to predict how and what students would learn from patient and carer involvement but I recognised the potential for them to be able to see things differently. And further, appreciate the psychosocial consequences of cancer and perhaps reflect on their interpersonal skills and thereby develop their practice.

The patient and carer experience of cancer 'shared'

Educational activities that involve cancer patients and carers predominantly focus on the sharing of their unique experiences with students (Bennett & Baikie, 2003; Humphreys, 2005; Warne & McAndrew, 2005). Experience is the subjective consciousness of lived events especially those that make a powerful impression on the individual and the resultant thoughts and emotions are what create that experience (Theodosius, 2006). Arguably the cancer experience leaves an indelible mark on the person who lives through it and their 'survival story' can have positive and negative connotations shared through conversation with others (such as students). In this study, the experiences shared by patients and carers provoked dialogue in the classroom that focused on how the student can learn from this and develop their practice. Further, experiences with patients and carers in the clinical setting prompted reflective engagement with learning that may inform students' ongoing thinking about practice. This was evident in some students' clinical portfolios which require reflection on professional learning.

Programme developments 2008-2009

In collaboration with a patient from the local cancer forum three specific activities were designed to be included in the oncology modules along with some e-learning resources. A summary can be seen in Table 3, below, with an explanation of the pedagogy and student evaluations.

Table 3:

1. Communication skills seminar	• Icebreaker followed by group work communication skills exercises , focused on listening skills (role play) • Patient shares experience of breast cancer treatment (chemotherapy, surgery & radiotherapy)
2. Service user workshop	• Small group work with a 4-6 service users, sharing experiences and focusing on the impact of cancer on 'self' and relationships • Associated reflective activities
3. Role play	• Professional / patient dialogue with a focus on providing treatment information • Exploring difficult communications

Patient and carer involvement activities

Communication skills seminar

The first activity that the students engaged in was a basic communication skills workshop. This was delivered before their first placement and for many their first experience with a cancer patient. An icebreaker activity was designed to get students talking to each other and consisted of a list of ‘types’ which they had to match up with fellow students e.g. ‘mother’, ‘vegetarian’, ‘driver’, ‘speaks a foreign language’ etc. This prompted discussion about how we make judgements based on stereotypes and engages the student in the rest of the session. Students were placed in groups of three and asked to take on the role of speaker, listener and observer and given a topic to talk about. The interaction between speaker and listener was observed and feedback on specific skills that encourage or discourage listening were discussed in the larger group. Patient A, co-facilitated this exercise and gave her feedback about helpful and unhelpful skills from her own experience. The second part of this session focused on the patient sharing her experience of cancer. The researcher acted as facilitator by prompting the patient to ‘tell her story’ and encourage questions from the group. A prior planning session with the patient mapped out the activity and explored the potential for patient distress. The facilitator therefore has an important role in supporting the patient to share their story and an opportunity for de-brief following the activity is crucial (Warne & McAndrew 2005). Awareness that this too may provoke distress in students is acknowledged and before the patient shared their experiences this was communicated to the group and an opportunity to follow-up afterwards was offered. Inevitably, some students would have personal experience of cancer and the activity may induce distress. Therefore my role as facilitator was to also observe the activity and pick up any cues from the students that would need following up.

My observation of this activity demonstrated that some students were really engaged in the patient’s story, the room was very quiet and all student eyes were on the patient. They asked many questions about different aspects of her experience. One male student remembered she had commented about a male radiographer being in the room and asked if it was a problem. Then at the end of the session students stayed back to talk further to the patient. The evaluation indicated that students found this a useful activity. As a new teaching activity evaluation is essential in gaining feedback on its relevance so a brief questionnaire was given to students at the end of the session. 46 students attended the seminars, 43 questionnaires were returned (93% response rate). See results in Appendix 3. The key feature of the evaluation was that students thought that the patient sharing her experience was rated as ‘very effective’ by 98%. This was supported by the comments, some are included here:

> Meeting a patient and hearing about experiences helped a lot. Very moving and in my view the most effective way of gaining an insight into how the patient feels (Anonymous)

> I now feel more confident about having a conversation with a patient (Anonymous)

This suggested a sense that students were learning something valuable and gave me confidence that the other activities would be well received by students.

Service user workshop

This session was conceived as an opportunity for students to engage with diverse experiences of cancer and to understand more about the impact of cancer on the individual, their relationships and ways of coping. Through various clinical networks we invited patients and carers to become involved and the first delivery of the workshop included a range of patients and carers. The people who took part: a middle-aged man who had undergone treatment for testicular cancer; a young man who had an amputation for bone cancer and his mother; a woman with breast cancer and an afro-Caribbean man who had prostate cancer. Each person brought a different dimension to the cancer experience and this was explored with students in small groups. Each patient or carer paired with facilitator to provide support and encourage questioning. Subsequent delivery of this workshop has involved different patients and carers with a changing composition of group members. It has been interesting to see how the patient and carer group have supported each other and influenced how the session is delivered. As an associated activity students were encouraged to reflect on the workshop using a reflective template based on Gibbs (1988) and some comments from the evaluation are included:

> I understand how different patients react and how it really affects their home life. This will help me approach patients more open minded, understanding that a small problem for one patient may be a massive problem for another (Anonymous)
>
> I feel I may be able to relate to patients on a more personal level which will give me confidence in my clinical ability (Anonymous)

It was evident from the evaluations and comments to the patients and carers at the end of session that the students enjoyed these workshops and they were rated highly in the overall course evaluations.

Role-play

The final session participants engaged with was a role play that included a patient with cancer and tutor recreating the professional/patient discussion about radiotherapy and side effects. Prior to this session the patient had a brief to approach the role play with anger, distress and social problems or any other issue that she regarded as challenging. In order that the role play would feel authentic I would approach the interaction with basic information that included her name and the treatment plan. The role play begins with a brief to students that the aim is to provide the patient with information and answer questions similar to what happens in practice on the patient’s first day of treatment. Students are asked to make notes about what they see during the

10 minute role play and this provokes lengthy discussion about how the interaction went, ways of improving it and the students' own experience in practice. Further discussions focus around issues such as: 'whose agenda was it?' and the use of touch and silence in interactions. The patient feedback on their experience in the role play further enhances that discussion. The session ends with a role play of the same situation where we purposefully include the strategies identified by the students themselves. It is not intended to be perfect but at least an improvement on the first, which then prompts further discussion. Of the three patient and carer involvement activities this was the one we were less confident about, as it required the tutor to display certain overt behaviours in the first role play such as not listening, blocking conversation. Following group discussion the tutor was then required to employ more empathic behaviours. Again, evaluations indicated that they appreciated how communication can affect the patient experience:

> I had never really thought so much about the patient relationship and how to act towards them as individuals (Anonymous)

Summary

Each of the patient and carer involvement activities outlined in this chapter were developed with patient and carer input and evaluated as part of module delivery. There was a sense that important learning had occurred and that interaction between student and patient was the mechanism for that learning. How and in what ways learning was taking place was not fully understood. This study aimed to make explicit some of the tacit learning both to inform the students themselves through the reflective process and explore the pedagogy in more detail to inform further activities. This chapter has therefore explained the patient and care involvement activities as informed by the evidence base at that time and driven by health and social care and educational policy, the background to which was presented in chapter one. The three curriculum activities described were antecedent to, and the basis for, the ensuing qualitative inquiry. The next chapter now presents the methodology based on Creswell's (2013) qualitative approach.

Chapter Three: Methodology

Introduction

The first part of this chapter presents the methodology that provided a guiding framework for this study and identifies the methods used. I include reflexive accounts throughout the chapter to provide insights into the methodological challenges I faced. The second part of the chapter demonstrates the ethical issues and explains the operationalisation of the research method.

Reflexivity in qualitative research

In Chapter One I identified the personal motivation that inspired my research. I also discussed the decisions I made in the design of the study and how my relationship with the participants influenced the dialogue. In this chapter I add to this through reflexive commentaries to illuminate important assumptions, decisions and issues encountered as a researcher. A number of critical issues are explored such as the decisions I took regarding the underpinning philosophy, ethics, the methods employed and the interpretation process. To enhance the credibility and trustworthiness of the study engagement with critical self-reflection was an uneasy process that prompted me to challenge previous assumptions. Over time I became more adept at this. Reflexive thinking about methodological decisions has also stimulated me to problematize every aspect of the research process. Pillow (2006) advocates an introspective approach based on self-awareness, self-monitoring, self-disclosure and honesty. She suggests that whilst this may be uncomfortable it is a necessary exploit in order to provide a transparent account of decisions made. However, my critical engagement with others was paramount to my decision-making which aided me to ‘move beyond previous understandings’ (Finlay & Gough, 2003, p.108) and comprehend more clearly my position in this study.

Qualitative Inquiry

A qualitative approach to inquiry was chosen as the most appropriate for exploring a topic that was focused on interpretation of experience and individual learning in-depth. Creswell (2013) defines qualitative research as progressive and situated within a framework of researcher assumptions:

> The process of qualitative research begins with assumptions and the use of interpretive frameworks that inform the study. Qualitative researchers use an emerging qualitative approach to inquiry through the collection of data, sensitive to the people under study. Data analysis is inductive and deductive to establish themes and presentation includes the voices of participants, the reflexivity of researcher, complex description and interpretation of the problem and its contribution to literature or a call for change (Creswell, 2013, p44).

Furthermore, Silverman (2000) suggests that the aim of the qualitative researcher is to empower individuals to share their story and convey the context of their views. The researcher's role is to explore a situation or problem, uncover the meaning of the participants' experiences, through the analytical process generate understandings of the complexity of the issue under investigation, and then present a coherent research account of the issue. The problem with the curriculum was explored in chapter one and the strategy for patient and carer involvement pedagogy explained in Chapter Two. In this chapter, I explain how the underpinning methodology demonstrates congruence with the research questions, the methods of data collection and modes of analysis.

Theories, paradigms, perspectives and philosophical assumptions characterise the nature of research and the underpinning methodology (Crotty, 1998; Creswell, 2013). The following discussion sets out the philosophical assumptions and interpretive framework of this study.

Philosophical Assumptions

My philosophical assumptions are based on my experience, reading, advice from others and considerations of how these may inform the theories that influenced the research process. The starting point in selecting an appropriate methodology was to examine the research process and identify potential philosophical affinities. Creswell (2013) discusses the four philosophical assumptions of qualitative research: ontology, epistemology, axiology and methodology. I will explain how those philosophical assumptions have influenced my approach to the research process.

West (2013, p.66) suggests a key approach to selecting methodology is a 'careful consideration of epistemology and ontology'. In this qualitative study, the ontological assumption is that reality is regarded as 'multiple' and characterised by numerous views, which led to the presentation of different perspectives as the themes developed (Denzin & Lincoln, 2013). My intention was to explore individual perspectives along with the collective views of participants to better understand the complexities of their learning and make that explicit in the interpretation. From an epistemological viewpoint, the qualitative study relies on the researcher to get close to the subjective evidence from individuals and so uncover what is known about the phenomenon (Creswell, 2013). In this study my experience as clinician, tutor and researcher allowed me to 'get close' to participants' learning experiences and so collaborate with them to better understand the context of their views. This view of epistemology as subjective construction of meaning acknowledges that different people see the same phenomenon in different ways (Crotty, 1998) and so adds to the richness of the data. The research process has been inductive and has been shaped by my experience of interviewing the participants. In my endeavour to stay close to participants' views the interview questions were developed in light of emerging issues as new areas of interest arose. This is demonstrated in the interview map as prompts were developed in response to emerging issues. Appendix 10 illustrates how primary research questions began to yield further areas of interest which were added to the schedule as secondary questions and tertiary prompts. Creswell (2013) says that the nature of qualitative inquiry can lead us to new research questions that take a different path from those that were predetermined and this will lead to a more detailed knowledge of the subject.

Creswell (2013) and Denzin & Lincoln (2011) describe axiology as the role of values in research and as researcher I have tried as far as possible to openly acknowledge the values and potential biases of which I am aware and that may be present in this study. My own professional background, my interest in patient and carer involvement and insider status, has influenced interpretation. Publication of the Francis Report and my views about health education has added a dimension that ultimately shaped the narrative (which can be seen in the final chapter, page 196). Although I regarded myself as an insider I failed to recognise the extent of the emotional impact of interactions between students, patients and carers. Before I had gathered the data I had not realised the nature and extent of the emotional learning that was happening for the students within the patient and carer exchanges. I was open to what the students saw as the essential elements of their experience and endeavoured to represent their interpretation of that learning. Although the stories presented in this thesis are my interpretation I hope they are at least close to the students' understanding of their experience. I make use of extensive quotes from the data to make my interpretation as explicit as possible for the reader to evaluate the reliability of this study. Ellingson (cited in Denzin & Lincoln, 2013) argues that participants are the main focus of qualitative inquiry; however she states that the researcher's positionality is crucial to the formation of the findings. In chapter one I acknowledged my position within the research as directed by Creswell to 'carefully lay out biases' (p.22) and throughout this chapter I discuss the dilemmas of this in qualitative research. As the nature of qualitative research is to bring new understanding to a topic, thematic analysis may make use of anticipated themes, but should also remain open to the emergent themes that can bring unexpected understandings of experience (see chapters four, five and six – thematic networks).

Congruent with the philosophical assumptions, an approach to thematic analysis requires the ability to present multiple perspectives, complexity of concepts and an approach that permits a coherent articulation of the findings. To provide an established structure to aid in this challenging task I selected Attride-Stirling’s (2001) thematic network analysis (TNA) framework and is discussed in more detail on page 82.

Interpretative Framework

My philosophical assumptions have been articulated above, now my interpretative framework is articulated, as Creswell states:

> Like the loom on which fabric is woven, general assumptions and interpretive frameworks hold qualitative research together (Creswell, 2013, p.42).

Creswell (2013) states that philosophical assumptions are key premises that relate to interpretive frameworks ‘that frame the theoretical lens of the study’ (p.22). Social constructivism is the interpretative framework that best describes this study. Rather than assuming that one reality exists and is waiting to be discovered the social constructivist view assumes that reality is socially constructed and the outcome of social processes (Green & Thorogood, 2014). The philosophical principles underlying social constructivism are based on the view that there are varied and multiple realities which lead the researcher to look for the complexity of views (Crotty, 1998). Crotty, defines constructivism as:

> All knowledge and therefore all meaningful reality as such is contingent upon human practices being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context. Therefore meaning is not discovered but constructed (Crotty, 1998, p42).

In my study I acknowledge that the participant accounts are co-constructed within the interview and their views may be influenced by peers and prior experience. The social constructivist perspective embraces the processes of interaction where co-construction of the dialogue between researcher and researched becomes part of the research narrative (Kvale, 1996). Kvale states that interaction is the vehicle for data capture. In the interview, individual values should be honoured and through the inductive process of conversation ideas emerge within the interview. This concern with valuing participants' perspectives has influenced the aims and research questions and from an ontological and epistemological stance they were framed as '*how* and in *what* ways do you experience patient and carer interactions?' And so, it was the participants' experience and meaning for them that was the focus of researcher-participant interaction. Issues of axiology are inherent in the research process as I asked participants what value they placed on the patient and carer as a mechanism for learning. As I engaged in data analysis I reflected on how the values I brought to the research had both commonality and diversity with the participants' values and interpretation of the learning experience. Congruence between their views and mine came from how they placed value on the activities, as I did. However, differences in the types of learning they experienced differed in emphasis to my own understanding. Denzin & Lincoln (2011) acknowledge that qualitative research is value-laden and the social constructivist framework acknowledges that both the values of the researcher and participants' values create the narrative. As the research progressed I realised that I was utilising a flexible and dynamic approach that became more evident as the data collection proceeded. I consciously asked fewer questions about their ‘learning’ as my prior interest in knowledge construction (Pawson *et al*, 2003) was overshadowed by the participants’ accounts of emotion. Instead I became more focused on their experiences of interacting with patients and carers and more adept at picking up cues around emotion and the professional discourse, following these up within the interview.

In summary, this qualitative inquiry uses a social constructivist framework as a means to explore the ways in which participants learn from patients and carers. The methodology draws on the social constructivist perspective of multiple shared realities and co-construction of knowing as employed in the method of interviewing. At the outset of this study my interest was in understanding the ways that students learned from patients and carers through interaction. I perhaps anticipated that this would emerge as notions of knowledge construction or that the tacit learning that occurs would be more explicitly articulated through the interviews. I had also explored the literature on emotional intelligence as a potential theoretical framework. However, what emerged strongly in the data was the emotional impact of the cancer experience on patients and carers (recollected by participants) and the emotional work that they themselves engaged in. This emergence of unexpected themes is typical of qualitative studies and enabled me to unearth new insights and perspectives of the issues under investigation. The social constructivist perspective offered me a methodology that allowed me to follow those cues that related to emotional expression in the participants. Figure 1, on page 72 provides an illustrative representation of the underpinning research methodology and the methods utilised in conducting this study. Below, I provide a further rationale for the methodological decisions made.

Figure 1:

Methodological Framework

Underpinning philosophy: reflexive commentary

This has been my greatest challenge and the one aspect of the study that has been most problematic and I have felt least confident about. Chapter one explains how this has developed as a result of external critique and at the beginning of this chapter I explain an approach to qualitative inquiry that best describes the research process employed *in this study. As I grappled with methodological decisions I became increasingly reflexive and have gained immense learning that I can utilise as a research supervisor. My appreciation is that reflexivity is central to qualitative research. Etherington (2009) describes this as the ability to be aware of our responses to the world, other people and events. Furthermore, she states that knowledge can then be used to inform actions, communications and understandings.*

Key methodological principles explored

To further investigate methodological choice with respect to the research process there are three issues that will be further discussed: Knowledge, perception, and credibility of narratives.

Knowledge as a result of interaction

As an intimate and personal action, the relationship between knower and knowledge in relation to tacit learning is recognised although challenging to articulate as Eraut (2000) states. Booth (2008) identifies the relationship between the knower and the known as situated within the learning experience and so the acquisition of knowledge arises from that inter-relationship, similarly characterised by Kvale (1996).

Whilst individual learning may be investigated, the relational view of knowledge suggests issues of commonality. Booth (2008) argues that there is a limitation of the different qualitative ways that learning is experienced and thus studies tend to present qualitative categories of description. In this study, collective views are presented and utilised to inform the development of aspects of the curriculum to address important knowledge related to practice. However, understanding the differences between participants' experience will also help us recognise complexities of learning, the range of issues for students, and inform how to better support individual development. In this study it is recognised that learning is multi-faceted and experienced differently. Booth (2008) explains variation as not merely differences between individual learning, but suggests that learning is concerned with discerning new features of an experience, seeing new ways and thus deriving new meaning. Moreover, she states that the ability to identify new features requires one to question previously held assumptions. Variation theory discussed by Marton & Booth (1997) characterises learning as seeing a situation in a new way and adapting future personal practice in response to this and is the guiding principle of this study.

Social constructionism views 'reality, knowledge, thought and texts as community-generated and community-maintained via linguistic entities that define the communities that generate them' (Bruffee, 1986, p774). This definition attempts to capture the work of many proponents of social construction theory who regard knowledge as a socially constructed activity rather than an internal act. Bruffee (1986) discusses how different professional groups focus on developing a critical consciousness through the language they use to talk about knowledge. Kvale (1995) states that people do not merely experience a situation and describe it, they talk about it and derive meanings from it based on private recollections and socially constructed views. They present their interpretation and then through conversation they may articulate meaning and identify new insights. As such, conversation may take place between students and the patient and carers in a classroom setting, also with their peers and clinical staff which may contribute to their knowledge and understanding. Further cognition of the patient and carer experience may be facilitated through reflection on different situations in their practice (Rees, 2013) and further conversation. Thus it is postulated that reflection through conversation can be viewed as a significant mechanism for co-construction of knowledge (Kvale, 1996).

Perception

The notion that perception is central to learning is based on the premise that each experience is unique and suggests that each participant may have a different view of interactions with patients. In this study, the assumption is that participants' experience of interacting with patients and carers engenders in them a personal perspective that they attempt to attach meaning to. However, their interpretation is based on other factors such as prior knowledge, experience of illness and personal recollections that reinforces the notion of a unique perspective (Converse, 2010). Thus, the analysis of individual experience can offer insight into the variety of perspectives and enrich our understanding of the complexities associated with learning. Equally, as each participant is training for the same professional role, the potential to identify a collective perspective is likely and indeed became a desirable outcome for the study. Investigation requires interpretation of the group perspective in addition to the individual and the ability to translate the various viewpoints into common themes that will inform pedagogical developments. Commonality suggests that the uniqueness of experience may be diminished (Pang, 2003), but could identify broad curriculum issues. The range of insights of individual learning could lead to the enhancement of specific teaching strategies that can support each student in their personal development. The issue of perception, individual or socially constructed, may also raise questions about the trustworthiness of participants' accounts and this is further debated.

Credibility of narratives

In qualitative research participants are actively encouraged to tell their story, and the focus is to elicit this personal view (Silverman, 2000). However, story-telling may be viewed as unreliable and dependent on many external factors on the day of data collection (Levering, 2006). Levering (2006) discusses credibility as an epistemological issue by asking, 'How authoritative are people's accounts of their own perceptions?' (p.451). He suggests that the subjectivity of experience is a starting point and, in response to the argument that perception is unreliable, he advocates that we the reader must decide if an account is convincing or not. I believe that attempting to make such decisions about the credibility of what participants say is futile as ultimately the narrative returns to the personal meaning participants attach to their experience of learning (Levering, 2006). This study accepts that assumption, but accepts that questions may remain regarding the ‘believability’ of the narratives. The challenge for the interviewer/researcher is to use the tactics and interviewing skills that allow exploration of the significance of the account for the individual, for instance “can you give me an example of how that influenced you?” A further challenge to the credibility of participants’ narratives is the notion that they may subscribe to a popular discourse about the value of patient and carer involvement in a pre-reflective way as part of socialised practice. This particular issue can be seen in two ways: first, it may be argued that one of the aims of health professional training is to instil a sense of the patient and carer experience and respond compassionately (HCPC, 2012). Thus, by subscribing to the discourse the participants could be regarded as fulfilling that aim. On the other hand the narrative is less about personal experience of a phenomenon and more about collective views and perhaps the participant recalls stories that fit the discourse. In this case, two options to enhance credibility are available. The first is to endeavour to guide the conversation back to the participant’s experience and the second strategy is to acknowledge the discursive nature of experience and attempt to represent the variety of perspectives in the analysis (Jones, 2000).

Another dilemma that also relates to the popular discourse argument is that participants may tell me what they think as a researcher I want to hear and crucially I may hear what I want. I find reassurance in Levering’s view (2006) that the narrative describes ‘their story which is directly linked to their learning’ (p460). Levering discusses how in narratives the participant may talk about other people’s views and experiences, but ultimately the narrative returns to their own experience of a situation. To some extent the question of credibility is an accepted consequence for the qualitative researcher and often debated when justifying the research approach (Levering, 2006). My response to this debate is that I am curious and interested in coming to know perspectives that are different from my own. My aim is to represent participants' learning in as transparent a way as possible.

For the reasons outlined, the interview presents an opportunity to explore in depth a topic and has the added advantage of including further questions, exploring interesting ideas and clarifying the meaning of responses which is impossible in a survey (Silverman, 2000). In-depth interviewing was therefore the chosen method for this study.

Interview Strategy

Although interviews are commonly utilised in qualitative research to investigate the varieties of experience, reliance on this as a sole technique has been criticised as it is suggested it will provide versions of an experience depending on the audience (Jones *et al*, 2000). To justify my use of the interview I deliberate on some critical and pragmatic issues: interview as conversation and the interpersonal skills of the researcher in eliciting students' perspectives on their experience of learning. Finally, notions of power in research are acknowledged as a consideration in the interview strategy.

Interview as conversation

Justification for a conversational approach to interviewing is advocated by Kvale (1996) who discusses a number of features that characterise this approach. First, he proposes that conversation is a mechanism to access knowledge and through narratives of personal experience participants construct their own perspective on their experience. However, he reinforces the contextual nature of knowledge, as conversation belongs in the moment and is dependent on the situation. So, the context of an individual's perspective is dependent on their experiences and thus becomes the focus of their account (Kvale, 1996). The interview, then, represents this relational nature of knowledge and inter-relationship between researcher and participant. Thus, the interview as conversation is a socially constructed, contextual and linguistic construction of perspective.

Research undertaken for a professional doctorate that utilises interviews in this manner must answer the question of how the knowledge produced is useful to practice (Pang, 2003) and this question is revisited in the final chapters of the thesis. There is some tension here between eliciting the participants' viewpoint using a conversational style that encourages researcher-researched interaction, and the potential for researcher influence or bias. However, an interviewing style that is less interactional could not elicit the type of rich data sought, as my very early interviews demonstrated, so a choice was made of an interviewing style that leads to claims of knowledge that are essentially co-constructed. To counteract potential claims of bias and undue researcher influence it is important to explain the interview skills employed.

Researcher interviewing skills

The conversational approach to interviewing may appear largely *laissez-faire* and to a degree the intention is that the participant should feel comfortable in the research interview and not subject to interrogation. However, a more considered strategy is developed based on the work of Kvale (1996) and Rogers (1980). A self-appraisal (Appendix 8) was undertaken that addressed the skills I thought essential and which help me develop a strategy for interviewing. This embraced a non-judgemental approach that emphasises that there is no correct response to the questions posed and reflects Rogers' core conditions of genuineness, positive regard and empathy (Rogers 1980). To truly hear participants requires attentive, empathic listening and the ability to probe, reflect, paraphrase and clarify the meaning they attach to learning with the intention of exposing rich data that explores the impact of learning on their development. In this approach, it is important to encourage participants to describe their experience and via prompts such as, “can you give an example?” explore the issues related to their learning. Hamill & Sinclair (2010) suggest a strategy that includes being a ‘curious’ researcher, similar to

Etherington's (2004) view that 'during the conversation we should ask curious questions related to their stories' (p.38). It is vital to acknowledge that participants may change their views and that the act of reflection may prompt them to understand their learning differently. Another factor to recognise is that emotion and distress could arise as a result of working in oncology, thus as interviewer I had to be sensitive to the potential for participants to revisit emotional experiences and become distressed.

In addition to the interpersonal skills utilised in interviewing, organisational skills are equally necessary for successful completion of interviews (Appendix 9). Apart from the operational issues of venue choice, recording and consent decisions are made about the interview based on the research questions (Silverman, 2000). In recognition that they can change in the first few interviews an interview map was developed (Appendix 10) including further themes and areas of interest. This consists of primary questions that focus on description of the experience and secondary questions that require interviewees to explore their learning and I shared these with participants at the beginning of the interview. Tertiary prompts were developed and added to the map as related concepts and new ideas emerged from the interviews. These were not shared with participants overtly, but were utilised when necessary as I paid critical attention to what was said (Kvale, 1996). For example:

> **Researcher:** you mentioned earlier something about 'showing you care'. How would you describe care? What do you mean by that?

As developing discourses emerged it was possible to explore participant understanding by asking for their opinion, for example:

> **Researcher:** You talked a little bit there about the conflict of the technical aspects of the role and that patient centred-ness side. Do you think there is a conflict?

Karen: I don't know about the profession, but as a student when you're trying to learn there is. Because you do need to focus on the techniques and I find that difficult sometimes, when you know there's somebody [patient] there but you need to be looking at what people [clinical staff] are doing.

Interview method: reflexive commentary

I was to a large extent comfortable with the interview method, but perhaps naïve in my assumption that I could ask the participants about their learning and their responses would answer the research questions. My aspiration to be an impartial researcher was founded in my prior experience of the positivist paradigm and I now consider this to be wholly inappropriate. The first few interviews provided lots of data, which on reading presented a number of opportunities for further exploration that I had not exploited. External critique confirmed the uneasy feeling I had that my interviewing technique required refining and prompted me to revisit the method. The disappointment I felt prompted two major actions that drew on concepts of knowledge construction and interview as conversation (Kvale, 1996). The idea that researcher and participant co-construct knowledge in a social context gave me permission to interview more freely and where an interesting topic emerged to follow that up with the interviewee using prompts, and questions to allow deeper exploration. With greater fluidity of the interview schedule I became more conscious of a change in the style of dialogue; a more conversational approach actually yielded more disclosure about the difficult emotional situations that participants had experienced. In addition it allowed clarification of their accounts and

> *sharing of further experiences in practice, which added to the authenticity of data. I was also conscious of disclosing my own experiences and attempted to do this in a way to encourage their openness whilst limiting my position of power. (Research Diary, September 2011)*

The data analysis strategy was another dynamic development that was a process of trial and error, as I now discuss.

Data analysis strategy

Qualitative data analysis is described as the process of examining collected information and transforming it into a coherent account of what was found (Green *et al,* 2006). This process is a pervasive and iterative activity, commencing at the proposal stage and continuing throughout the research process culminating in the final report or thesis (Silverman, 2000). Analytical decisions at the outset are based on the participants' experience of learning and it is acknowledged that theoretical pre-suppositions may inform interpretation. It is therefore crucial that this is augmented by endeavours to look for the non-common-sense themes in the data (Walker & Myrick, 2006) in an attempt to avoid presenting a pre-determined interpretation.

Thematic analysis is used extensively in qualitative research utilising a variety of techniques with quality being a determinant of credible findings. The aim is to choose a method that facilitates answers to the research questions whilst demonstrating compatibility with philosophical assumptions and overall design (Fade & Swift, 2010). Green *et al* (2006) present a model of qualitative data analysis that focuses on the processes of data immersion, coding, categorising and identification of themes. Whilst the instructional nature of this framework was appealing there was a sense that the individual meanings in the data may be lost. Therefore, a framework that was true to the epistemological and ontological values of qualitative inquiry that would not distort or minimise the essence of individual meaning was chosen and is discussed in what follows.

Thematic Network Analysis by Attride-Stirling (2001) advocates that in order for qualitative research to yield meaningful insights the data should be analysed in a methodical way. She presents a tool for thematic network analysis (TNA) based on argumentation theory by Toulmin (1958 cited in Attride-Stirling, 2001). Argumentation theory supports the analyst to explore a line of discussion by identifying connections between explicit statements and implicit meanings. The assumption is that data consists of evidence or examples that support a claim and there may also be data that warrants or backs the argument. Examining the data for contradictions, supporting evidence or alternative views is fundamental to her analytical approach. An example is included here from thematic network two.

My approach to TNA

Participants reported that responding to emotion was a difficult task, creating personal and professional dilemmas in everyday practice (claim). Acceptance and validation of patients' emotions was generally viewed by participants as appropriate practice, as advocated in health communication texts (Burnard, 2005) (warrant - supported by literature). However there was discordance in how one should regulate emotion (doubt - a qualifier from data). Angela, along with others believed that some sort of expression of emotion is important as a professional (backing from the data – validation of patients' emotions), but this raises the question of what level is right. Hunter & Smith (2007) define emotional labour in situations that require emotional regulation (warrant). This may not be the view of others and an example in physiotherapy advocates clearly defined professional boundaries (rebuttal). The data suggests that in order to manage emotions some students regarded it necessary to experience distress (alternate claim - so not just accept the emotions of patients, but also feel them). At the same time, there is data that suggest elements of doubt in the claims (qualifiers) and other statements in the data which may falsify the claim and point towards alternative claims.

The value of this approach is that arguments can be de-constructed and presented coherently and as Attride-Stirling suggests (2001) argumentation theory merely provides the background logic for thematic networks. It is utilised in qualitative research as a method of identifying conceptual complexity, variation and dichotomy in the data. Attride-Stirling (2001) has adapted this theoretical position, which has parallels with grounded theory for use in thematic networks. Thus, thematic analysis is a way of uncovering the salient themes in a text at different levels and the thematic network, depicted as a spider-like web, provides a structure by which the theme can be fully articulated (Attride-Stirling, 2001). This approach is commensurable with the desire to elicit a variety of perspectives from participants and corresponds with the philosophical framework employed in this study. Rather than attempt to reconcile conflicting perspectives this approach to analysis arguably results in a deeper understanding of learning. Attride-Stirling (2001) describes thematic networks as a system which extracts lowest order premises (basic themes) where similar issues are grouped together to summarise more abstract principles (organisational themes) that reveal what is happening in the text. Organisational themes are then similarly grouped together as global themes that represent the ‘principal metaphors’ in the text (p388). Thus the global theme is the core of the thematic network and depending on the set of texts analysed there may be one or more global networks.

I feel affinity with the tool that Attride-Stirling presents where the thematic organisation of the data allows a non-hierarchal overview and demonstrates inter-relationships within and across networks. Interpretation of the interviews as a whole is facilitated through description and articulation of the networks emphasising their interconnectivity. An attraction of this approach is the diagrammatic illustration of the web-like networks based on the relationship between themes. As a researcher the added value of this approach is the overall accessibility of the thematic analysis and the ability to move easily between raw data, coding and thematic networks and thus keep a view of the data as a whole. Thus, I have employed Attride-Stirling’s framework to give structure and coherence to my interpretation. I was cognisant of the similarities and variance within participants’ account and sought to represent complexity in the ways that students learn. The coding and thematic identification can be seen in Appendix 11 and the final interpretation is seen in the diagrammatic networks represented in chapters four, five and six.

> *Interpretation: reflexive commentary*
>
> *Interpretation of the data, whilst at times exhilarating, was a lengthy and problematic process which highlighted four important eureka moments: the first was in the coding and basic thematic analysis, the second was in identifying a tool for developing thematic networks, the third was in my understanding of abstraction and lastly in the development of the revised theoretical framework. This has perhaps been my most fulfilling engagement in reflexivity as the thesis finally took shape. Each of these eureka moments is explained further.*
>
> *Early attempts at coding and categorising the accounts led to themes that were obvious and identifiable as pre-determined by the interview schedule. External critique (supervisory team) challenged my attention to a common sense approach to analysis and I was prompted to look for the un-common sense themes proposed by Glaser (cited in Walker & Myrick, 2006). Thus the transcripts were revisited and my 'new' un-common sense approach allowed me to really see the accounts in a much more literal sense unfettered by my prior views, which subsequently yielded very different themes. New themes emerged that related to emotion that I had perhaps previously taken for granted 'eureka!' I had worked for many years in that clinical environment, but for the participants these were new experiences that as a researcher I must not forget. Thus, I began to see how emergent themes identified differences in participants' experience of learning and my early attempts at thematic analysis could be seen as one-dimensional. Coding and basic theme identification was laborious, but at the same time invigorating as I saw the potential concepts emerging as rich and complex constructs. The next 'sticking point' was where to go with my interpretation and both external critique and personal self-reflexion contributed to my strategy. The challenge was to make sense of the*

basic themes and in searching for a tool to aid this process the work of Attride-Stirling (2001) was discovered. The use of a thematic network approach allowed me to organise the themes into groups and identify global themes and although this felt like a major step the niggling feeling of 'what now?' persisted. Then a pivotal moment in my understanding of qualitative research analysis occurred as I embraced the concept of abstraction. I had assumed that I must adhere closely to the participants' words and offer little in the way of interpretation but once this hiatus was overcome and I started discussing ideas with the supervisory team I could see how this brought meaning and coherence to the analytical process. Again my positivist sub-conscious voice questioned whether my interpretation would stand up to external scrutiny and I was reassured when I went back to the raw data and extracts really did support the emerging story (Marshall & Rossman, 2011). This gave both reassurance of my skills and affirmation that the interpretation process was credible.

Marshall & Rossman (2011) state that the qualitative researcher must then compare the viability of emerging themes and explanations and in order to do this one must revisit my early conceptualisations. Once I dared to make this 'leap' I began to critically review my original conceptual framework, which led me to some related constructs and theories that explained the findings more effectively. Particular attention focused on emotional learning (Dilts & DeLozier, 2000) emotional management (Mann, 2005; Hunter & Smith, 2007; Huyne, 2008); connection (Rogers, 1980; Thorne, 2005) and professional identity (Bolderston, 2010; Goffman, 1959). A sense of learning about care and compassion was emerging and so current health and education policy was drawn upon to support this interpretation. Engagement with these theoretical constructs gave me confidence in my explanations and through peer discussion I was gaining a sense of the importance of the findings for the professional community. Perhaps this was not a 'eureka moment', rather a slowly burning flame of

> *increasing intensity that fuelled my sense of myself as a 'passionate researcher'. (Research Diary, April 2012)*

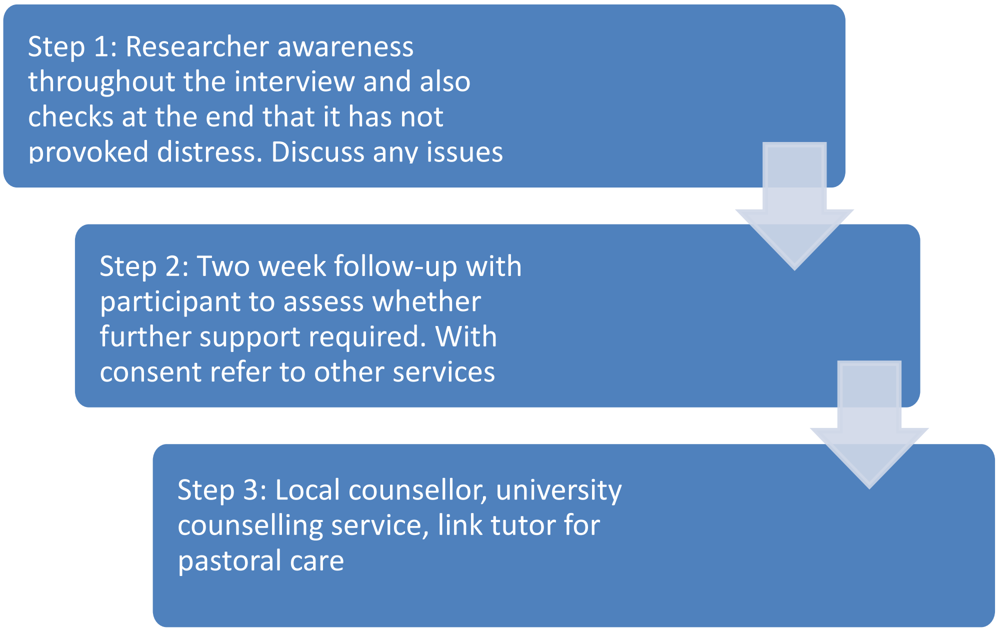
Ethics

My responsibility as a researcher was to consider the ethical implications of the project based on the fundamental principles of research as set out in the Sheffield Hallam University regulations. This study was conducted and supervised by appropriately qualified supervisors in the university. The principles of beneficence, non-malfeasance, informed consent, confidentiality and anonymity were all considered within the research design.

Beneficence is the principle of goodness in acts that can benefit the participants or a wider population (Creswell, 2013). In the context of this study the research has the potential to support the health education community in three distinct ways. First, the interview, through reflective processes, can aid students in developing their reflective practice and 'helps them to recognise the significance of personal learning that could emerge from such activity' (Rees, 2007, p.107). Engaging in the study could improve students' understanding of the patient perspective and thus their ability to assimilate practical and theoretical knowledge. Second, it has the potential to add to a body of research evidence that argues that patient and carer experiences enhance professional education and the findings can be shared with the research community that informs curriculum developments. Lastly, as a researcher and tutor I am committed to a research informed curriculum as a result of the findings.

Non-malfeasance was a major consideration as my intention was not to cause additional burden to participants' studies or provoke emotional harm (Creswell, 2013). It was recognised that reflecting on patient and carer experiences could be emotive so I needed to ensure a safe environment where participants could talk about their experiences. Sensitivity and care must be taken when conducting interviews that may provoke distress and appropriate psychological support mechanisms if required. This was carefully planned for the purposes of this study where a confidential support process is set out in figure 2, below:

Figure 2:



Steps to ensure participant well-being

I followed the process detailed in Step 1 for all participants and for one there was a requirement to move to Step 2 as I was concerned about her welfare. No participants required formal psychological support as a result of participating in this study.

Informed and valid consent is a requirement for all research undertaken to protect the autonomy of participants (Green & Thorogood, 2014). An information sheet was developed that explained the aims of the project and what was required of participants (Appendix 12). This clearly stated that participation was voluntary and that they could withdraw at any time during the study. The information sheet and consent form were emailed to all potential participants and those that volunteered were asked to bring the consent form to the interview. Before interview, I asked each participant if they had any questions and gained informed consent in person.

Participants were assured that anything said within the interview was confidential and no raw data would be shared with a third party except for the supervisory team. It was explained that all data would be anonymised and that upon publication, no participant would be identifiable. All data has been stored securely on password protected computers (audio and transcriptions) and will be kept for a maximum of five years. All names used in the writing up of this research have been changed and only gender may be identifiable.

Ethical approval

The above issues are my responsibility as a researcher and SHU Ethical approval was sought and the revised project proposal was approved in April 2010 (Appendix 15).

Researcher integrity

As researcher I took a reflexive approach throughout the process to maintain professional standards and treat each participant with dignity and respect. I kept a research journal throughout the process that documented decisions, procedures and findings (all are stored on a password protected computer). To further enhance the integrity of the research process steps were taken to balance the differential power between myself and the participants. This is discussed further.

Partisanship and power relations in research

The concepts of partisanship and power relationships in research have ethical implications that can affect the credibility of the study. The role of partisanship in research is used when the researcher has an emphatic or biased view of the topic under enquiry and may be integral to their approach. Denscombe (1995), states that partisanship may be openly expressed by a researcher who then utilises their position to challenge participants' perceptions. A covert partisan approach may lead to claims of researcher bias and results that support a particular stance, which represents an influence of power over participants. Although I do not regard myself as strongly partisan I do have an established opinion about patient involvement which is articulated in chapter one, so the challenge is to use gentle prompts to explore views rather than change perceptions. Denscombe (1995) advocates honesty and transparency by the researcher rather than attempts at impartiality; the researcher should make clear their stance and acknowledge this effect on the data. He says that all research is premised on researcher's beliefs and theories about the phenomenon under investigation, but the problem is often that not all researchers acknowledge this. From the outset I have explicitly shared my position and my reflexive approach is detailed in chapter seven.

In addition, it is important to consider my view of the researcher-participant relationship in terms of hierarchies of power. As the relationship of tutor-student may be considered an inherent power differential then an attempt to promote a more egalitarian relationship is considered. An exploration of power in qualitative health research is discussed by Karnieli-Miller *et al* (2009) who suggest that the researcher undertakes a critical review of hierarchal relationships and commits to redistributing the power between interviewer and interviewee. The relationship may be influenced by the researcher's personality, world view, background and professional discipline and consequently may be seen as expert. This infers a power asymmetry and to equalise requires the researcher to regard the participant as the expert in their experience. I communicated this stance to my participants at the beginning of the interviews.

> *Power over participants: reflexive commentary*
>
> *An ethical dilemma I had to face was the issue of the potential power differential between researcher and participant. Green & Thorogood (2014) suggest that the researcher gives over the interview to the participants by exploring what they think is important and respecting their autonomy. Although I followed up on some aspects of the participants' views I also allowed them to decline to comment which was crucial in developing a rapport built on respect. Whilst informed consent is gained the participant must not feel pressured in taking part and this was communicated. Green & Thorogood (2014) also suggest that the participant is not powerless and they decide what to say. Other ways I attempted to offset the power imbalance was to choose a comfortable, familiar environment and adopting a democratic conversational approach. (Research Diary, December 2011)*

Researcher or tutor

The duality of the educator researching practice caused some tension with the eventual stance being one of acceptance that I sat between researcher and tutor. The question of whether that was due to personal choice or inability to separate the roles requires consideration. As a reflexive tool, insider-outsider analysis was a useful model to explore my position. I was an insider as practitioner and educator and so this afforded me 'common ground' and as a researcher I thought that this would perhaps facilitate disclosure from the participants (Hellawell, 2006). However, I was aware that as an insider I may take things for granted and not explore some cues, so my status as a 'non-student' allowed me to act as an interested researcher. On reflection, I felt more like an insider due to my professional background and my language reinforced this with comments in the interviews such as, "yes I have experienced that too". Another criticism of the insider position is the potential to slip into the teaching role as students would associate this with me. It was difficult at times not to suggest different ways of dealing with emotional situations they recounted and I took a questioning approach in these situations, for example:

> **Caroline:** Yes and you definitely have to tailor it to every person, quite a lot of people are happy to hop in and get home but others take quite a lot of coaxing.
>
> **Me:** How do you know which type of patient they are?
>
> **Caroline:** You can usually get quite a good judge of people especially from the first day chats. I always have an idea after you've talked to them, you know if they're going to be nervous or if they're quite jokey.
>
> **Me:** Would you change how you were with them?
>
> **Caroline:** Sometimes yes I change the way I talk to people, there are some people you will remain in a professional way but others who prefer you to have a bit of a laugh and a joke rather than just clinical all the time.
>
> **Me:** Maybe if somebody was upset what would you do in that situation?
>
> **Caroline:** I think a lot of the time I would take them out of the main waiting room because it's the people you don't think are ever going to be upset but all of a sudden they do get quite upset so it's nice to get them out of the way and give them a few minutes.

This approach allowed me to explore some of the emerging discourses. Equally, I purposefully did not challenge some participants about how they had dealt with certain situations even though I wanted to, so I asked, “how might you have done that differently?” In one instance I moved to the next question on the interview schedule rather than becoming more involved in a tutor/student discussion:

> **Carl:** you're trying to be as holistic and friendly as you can but in the back of your mind you're thinking, we've got 40 more patients today.
>
> **Me:** So that's a constant thing that's going on for you and quite difficult to break that?
>
> **Carl:** …. sometimes I feel that I've been a bit harsh because I am just pushing them along, "that's really nice but come on can you get changed, this way" sort of thing.
>
> **Me:** There's a bit of internal conflict there isn't there?
>
> **Carl:** Yes because you do want to be nice to them, you can understand what they're going through, you want to make them feel that we care about them…. but you've also got other patients you've got to care about as well and at the end of the day the most important thing is to have their treatment.
>
> **Me** (I move to a different question as I sense I want to engage in instruction): In the session we did when there was quite a few people in, you would have heard different perspectives, what have you learnt from that?

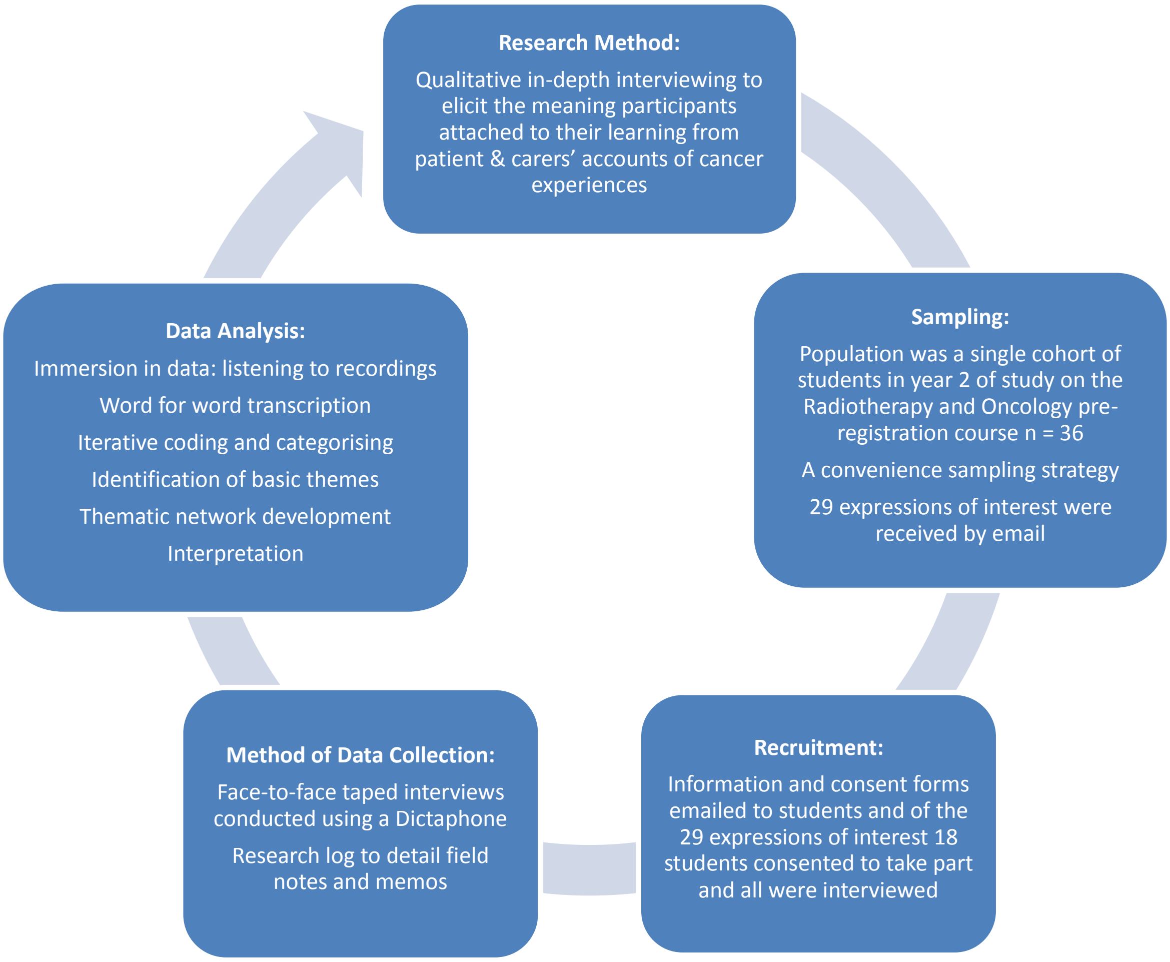
This perceived imbalance of expertise can lead to a power differential in the research relationship and I had to deliberately disengage with instruction. It was important that each student felt valued for their involvement in the research and that I was as non-judgemental as I could be.

In summary, the ethical implications of this study have been two-fold. First, the governance requirements of the university have been adhered to and recognised standards followed for successful approval. Equally, important has been the desire to respect the participants’ role as key stakeholders and ameliorate the potential for power asymmetry. Students volunteered to take part and were not coerced; hence the assumption is that participants were willing. Those who did not volunteer were perhaps less willing or had other priorities. Data collection occurred over the summer months when students were on placement and this may have impacted on recruitment. Students were provided with the study information and consent forms. At the beginning of each interview I emphasised that I was interested in their views and that there were no right or wrong answers to the questions. The consent form clearly stated that they could withdraw at any time and this would not affect their studies. Another assumption may be that the students wanted to impress me as a tutor on their course of study, however their rich and detailed descriptions of emotional interactions in the classroom and encounters in the clinical setting were very personal experiences of their learning (Levering, 2006). And whilst there were times that I purposely avoided instruction, there were no recollections about patients and carers that I was unduly concerned about. Bell & Nutt in (Mauthner, 2002) discuss the ethical issues of practitioners researching their practice. They warn against the divided loyalties of registered practitioner (duty of care to patient), lecturer (desire to provide effective education) and researcher wishing to contribute to the evidence on patient and carer involvement. Whilst I cannot separate the three, I was able to focus on the research aspect of the role and acknowledge the potential influence of being a lecturer and practitioner, which were explored on page 90. The ethics proposal and approval can be seen in Appendix 15.

Research Operationalisation

This section details the operationalization of the research process. It is organised under distinct headings that chart the methods and procedures followed in completing the study (Figure 3, below).

Figure 3:



Research Process

Method

This study has taken an in-depth qualitative approach in the investigation of how and what students learned from the learning activities detailed in chapter two and how they felt that this would impact on their development as professionals. The interview method utilised a conversational style to encourage participants to access the meanings that they attached to their learning and articulate the influence of patient and carers on their development. Audio-taped interviews were undertaken and a research log maintained as they progressed.

Sampling

Students who had completed the patient and carer activities in year one and two were invited to take part. A convenience sampling strategy was employed where all students were invited to take part in the hope that from a cohort of 36 a reasonable sample size would be achieved. The intention was to aim for 15-20 participants in line with the numbers recruited on similar studies to investigate student learning (Trigwell, 2006), whilst not excluding willing volunteers. 29 students expressed interest through email, but as this was followed-up and, due to placement and timetable constraints, interviews were completed with 18 participants within the timescales I set for data collection.

Recruitment

Following the classroom activities in year two of the programme I contacted students by email explaining the purpose of the research and inviting them to take part in the study. Information and consent forms were emailed (Appendix 12) and potential participants were asked to reply by email. I followed up all positive responses via telephone or further emails to confirm their willingness to take part and agreed a convenient interview date. It is acknowledged that the students who were more interested in the patient and carer workshops and those who preferred that aspect of their training would be more likely to volunteer. However, I attempted to encourage all students in the cohort to consider taking part by saying that I was particularly interested in different perspectives and experiences of learning. The data suggests that a heterogeneous sample was achieved.

Data collection

A plan for the interviews was developed with a schedule, which can be seen in Appendix 9, that ensured arrangements with participants were documented along with consent forms. Quiet rooms were booked and recording equipment checked. Interview questions were printed for transparency and consistency and adequate time allocated for each interview. Field notes were recorded at the end of each interview. My skills as an interviewer improved over time and I felt more confident to gently probe, challenge and explore issues.

The decision to embark on interviewing as a research method inevitably incurred ethical responsibilities, so it was crucial to reassure participants of their right to anonymity and clarify the intended outcomes of the study. Another important consideration was to do no harm to participants and make clear supportive mechanisms should the need arise (Rubin & Rubin, 1995). The formal consent process prior to interview promised that all data would be confidential and it was made clear to the participants that the findings would inform future curriculum developments and be published.

On a practical level, careful planning ensured a fairly unproblematic interviewing experience and I enjoyed this aspect of the study. Although there were emotional experiences recounted by participants this did not appear to adversely affect them apart from one individual. Sasha became upset at the end of the interview after the tape was switched off, so I took time to sit with her and listen. She told me that the interview had made her think of her own family’s experience of cancer and it was something she had not really spoken to anyone about, even her family members. We sat for a while as she talked further and then her mood lifted and she said it had helped to ‘get things off her chest’ and that she had appreciated the chance to talk. I offered Sasha the opportunity for further support but she declined saying it was not necessary. Two weeks later I did speak to her again to ask how she was and she again confirmed that she was fine and required nothing further. This instance highlighted to me the range of skills required by the researcher and that a support mechanism must be in place. After each interview the audio files were saved to a password protected computer ready for transcription.

Data analysis

As sole interviewer, immersion in the data began at the data collection stage and thus I began thinking about what the data was suggesting and recording field notes (Richards, 2005). Subsequently, listening to the audio files and really hearing for the first time what some participants had said facilitated a deeper engagement with the data. There has been some disagreement about whether the researcher should transcribe the interviews or not (Green *et al,* 2007; Attride-Stirling, 2001). On a practical level and due to time constraints I decided to employ a transcriber and then re-immerse myself in the written data, occasionally listening to the tapes to clarify meaning. Immersion allowed me to begin to really ‘hear’ what was said and identify possibilities for analysis which were recorded in the field notes (Green *et al,* 2006).

Coding the transcripts line by line was a laborious process which facilitated a deeper understanding of what was actually said, that the act of reading and re-reading transcripts had not unearthed. The ability for coding to convert my perception of what was said to the actual meaning of what was articulated was a validation of the importance of the coding process. There were a number of examples where on listening to the tapes I thought I understood what the participant was saying and then the coding process demonstrated a different viewpoint. Becky spoke about how shy she was and embarrassed talking to patients and she did appear a little embarrassed in the interview. I felt I was beginning to adopt a tutor stance and my field notes identify this (Appendix). However, on coding the transcript she had described how was able to talk to patients about embarrassing topics:

> Yes, we have to talk to them about quite in depth things, their bowels and things. If you don't make them feel comfortable they're not going to want to share that with you. If they don't tell us we can't help them, especially for people who've got diarrhoea. If we've got that rapport with them they feel they can tell us anything and we can help them. (Becky)

So, line by line coding was undertaken highlighting key words that represented meaning and condensing the data whilst not losing the essence of what was said. A codebook was developed that made distinctions of what the codes represented (Appendix 11). An independent researcher also coded 3 interviews for comparison with the codes I had assigned and demonstrated concurrence. Although it may be postulated that this is unnecessary as the thesis presents my interpretation I found their agreement reassuring which gave me confidence in the analysis. Basic themes/categories were labelled by grouping coded segments together that had similar meaning. This was iterative in nature with a constant revisiting of transcripts to check if new themes could be applied. After the first 5 interviews fewer new categories emerged and by interview 13 all categories were established with further minimal changes in labels completed as the thematic networks were developed. Assigning basic themes was trickier than anticipated with my ‘common sense’ approach challenged after the first 6 interviews. My initial assigning of themes such as: learning from patients, reflecting on practice and communication skills was arguably naïve. An uncomfortable albeit necessary return to the ‘drawing board’ in my thinking ultimately produced themes that were less common sense or personally motivated and truer to the participants’ accounts. This was validated on returning to the raw data and retracting quotes that demonstrated themes that better captured what was really happening for the participants.

Up until this point, Green *et al* (2007) had provided a useful analytical framework to work with, but at the point of identifying the main themes in the data their next step felt unsatisfactory and the Attride-Stirling (2001) framework seemed more suited. This allowed me to go back to the basic themes and check the data again for the issues discussed. This process facilitated the identification of the 'basic themes' which were the fundamental blocks of each thematic network. This approach to thematic networks was not straightforward and thinking about how the basic themes were grouped was informed through further reading around some of the concepts identified. This cross-checking of theoretical concepts provided further validation of the thematic networks as they enhanced my interpretation. Thus, basic themes were grouped around an organisational theme and then two or more organisational themes were grouped around a global theme. Characteristic of this process was my interaction with the data at a basic thematic level and then the construction of more complex arrangement of themes to capture the essence of meaning. The final thematic networks are seen in chapter five where the relationship of basic themes with organisational and global themes is represented.

The analysis produced three networks and thus three global themes: emotional recognition; emotional management and professional presentation. The themes symbolized the meaning participants attributed to their learning from patients and carers as my interpretation. Further interpretation of the data led to a theory of how students engaged in emotional learning (Chapter Six). Furthermore, distinctions between individual participants in how they managed emotion were also identified.

Summary

In summary, the operationalization of the research adhered to the ethical principles outlined in relation to this study and was congruent with a social constructivist ideology. Attride-Stirling's TNA (2001) was utilised as a framework for analysis to organise basic, organisational and global themes. At the start of the enquiry I was open to all aspects of student learning. What emerged through my analysis of the data that the most significant element for the students was emotional learning.

The following three chapters present the findings in detail as three thematic networks and chapter seven further discusses the findings and explains how patient and carer involvement as a pedagogical activity contributes to learning.

Chapter Four: Emotional Recognition

Introduction

This chapter and the two that follow, present my interpretation of the data as three thematic networks that are linked by the concept of interaction, both facilitated and clinical encounters, as a mechanism for emotional learning. Chapter seven explores emotional learning further by drawing on psycho-dynamic theory and proposes how patient and carer involvement can be explicitly included in the curriculum to promote emotional management and compassionate care.

The patient and carer involvement activities provided a forum for interaction and an opportunity to explore the psycho-dynamics of the relationship between patients and carers and the participants. A simple pedagogical model of interaction emerged from my interpretation of the data and is presented thus: YOU-US-ME as a psycho-dynamic approach to learning. Allan (2011) describes psycho-dynamic group work as a method which facilitates learning and used by Theodosius (2006) to explore emotional situations and feelings of students. The model is based on the assumption that learning commences with the experience of patients and carers, which from the perspective of the student (ME) is YOU. The interaction demonstrates an iterative process of listening and questioning that focuses on inter-relationships (US) that has the potential to promote further understanding of the patient and carer experience. Reflection on those interactions may lead in various ways to participants examining their own development (ME) and making value judgements about the importance of recognising and managing emotion as an aspect of professional development. Interaction was a key feature of the classroom activities and encouraged as preparation for subsequent interactions in clinical placements. The notion of YOU-US-ME is explored in each of the thematic networks and its significance in promoting learning is further discussed in chapter seven.

Thematic Analysis

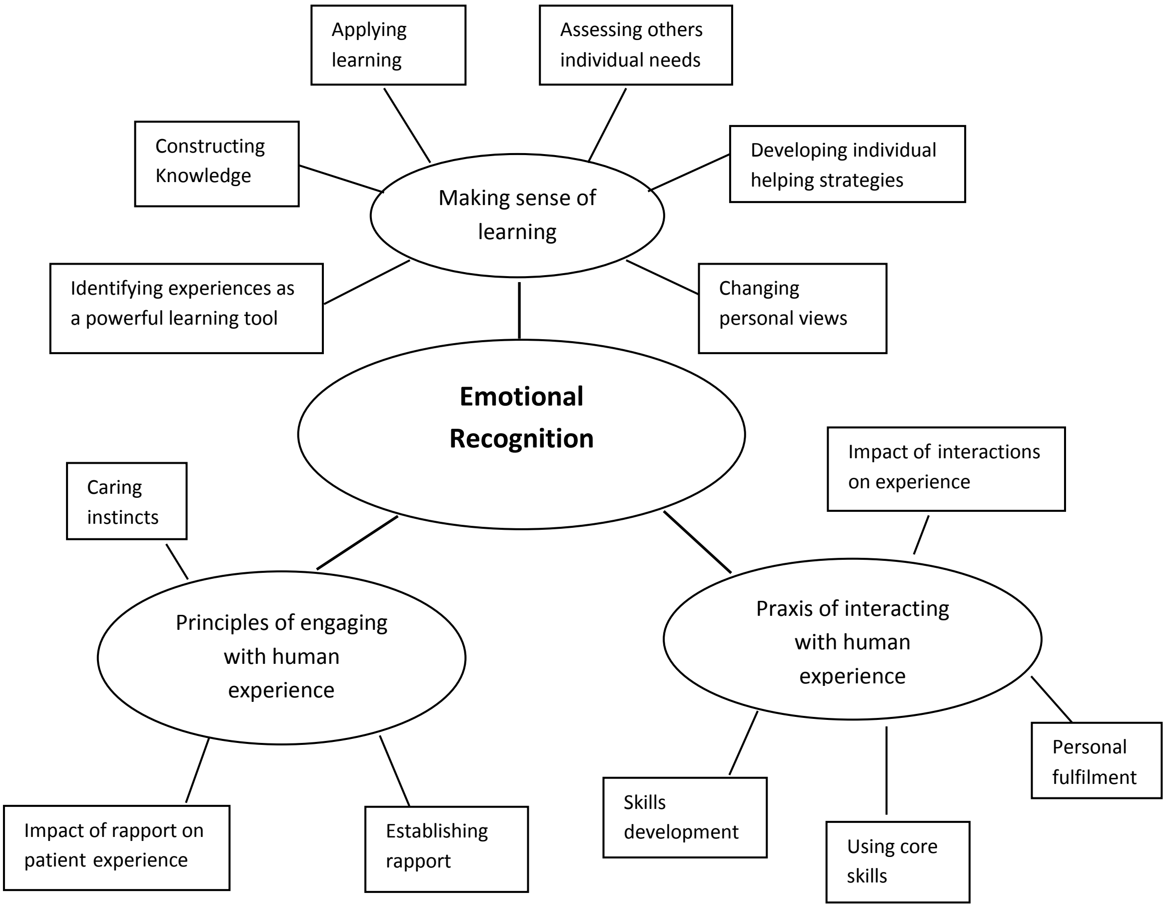
Eighteen students from the under-graduate radiotherapy and oncology programme took part in this study, comprising eight males and ten females with an age range of 20 to 44 years. A brief description of each participant taken from field notes can be found in the participant profiles seen in Appendix 13. The three main themes identified from the data were emotional recognition; emotional management and professional presentation seen as separate but related thematic networks (Attride-Stirling, 2001). Each of the thematic networks comprises a global theme, two or three organisational themes and basic themes identified through the coding stage of analysis. Thematic networks are explored and conceptualised in turn, drawing on constructs and theories from literature and direct quotes from participants' accounts to provide my interpretation of the data. Contradictions within the themes are explored for further significance, highlighting variety in students' learning and the challenges of emotional work. The first thematic network represents the meanings participants attached to interactions with patients and carers and thus depicts the fundamental learning that occurred. The second thematic network discusses the emotional nature of interactions and how participants themselves worked with emotion. The final thematic network explores the premise that effective emotional management can, in particular ways; contribute to their development as professionals. As emotion emerged as the most significant aspect of the learning experience each theme represents a particular aspect of emotion learning.

In essence, the remainder of this chapter provides a representation of the participants' conceptualisations of how they learn from patients and carers. Through the interviews I explored participants' educational experiences with patients and carers, as described in Chapter Two, augmented by subsequent interactions in everyday practice. This led to their conceptualisation of the principles and praxis of interactions in a way that reflected Todres *et al's* (2009) humanisation of care.

Emotional Recognition: Thematic Network One

This global theme incorporates three organisational themes and 13 basic themes from the 36 identified in the data. The three organisational themes relate to the conceptualisation that interactions with patients and carers aid recognition and appreciation of them as emotional beings and how the different ways of engaging can impact on their experience. The organisational themes reveal inter-related actions that participants are engaged in. The first is that of conscious reflection helping participants make sense of their learning. This is followed by participants' reflections on the everyday praxis of interacting with the human experience of being a patient/carer and their suffering, which led to the construction of a discourse on principles of engaging with human experience effectively. Figure 4, on the next page, provides a diagrammatic representation.

Figure 4:



Emotional Recognition: Thematic Network One

Making sense of learning

Most participants reported that their interaction with patients and carers was a powerful educational tool enabling them to explore their experiences and facilitate insight into ways of enhancing practice. Students placed emphasis on the human contact with patients and carers as a mechanism for gaining a deeper understanding of the cancer experience:

> It's not just something you're reading, it's not a slide show; I think that's a really powerful tool for learning. It helped me to focus; this is a person that's had this condition that I'm learning about and I can see how that affected him (Sam)

Through the interview process the participants attempted to make sense of that learning with the focus of many of their accounts being about constructing knowledge from a range of sources including patients and carers. Pawson *et al* (2003) identify five types of knowledge that contribute to professional learning with the service user or patient as one of them. The other four sources include research, organisation, peer, and policy knowledge. It can be seen that the typology includes both formal and informal sources and one could argue that the patient and carer falls into the informal or tacit domain and made formal within the context of the curriculum. Arguably, patient and carer involvement is seen as an opportunity for tacit learning. This recognition of the role of 'tacit knowing' was popularised by Polanyi (1959) and more recently explored in professional learning by Eraut (2000) where he emphasises the value of tacit learning through conscious and subconscious processing of experiences. Participants discussed how the learning gained from the interactions worked synergistically with other more formal ways of learning such as lectures, textbooks and everyday practice to produce a more holistic understanding of patients' and carers' experiences and the role that may have in constructing professional knowledge.

> So you learnt about breast cancer and then somebody who'd had breast cancer came in and said "this is my experience of it" (Carl)
>
> Patient experience is not knowledge on its own, its combined with theory and practice which gives a rounded picture. Learning comes from different areas they all play a part (Brigitte)
>
> I have remembered some things better, because the patients told me. When I sat the exam I could hear patient A telling me what they experienced (Vishnu)

The notion that students could use the knowledge gained in this context and apply that to the clinical setting is explored by Evans *et al* (2010) in their study on integrating subject and work based aspects of the curriculum more effectively. They suggest that students re-contextualise their knowledge gained in the university to new situations and experiences in practice. Furthermore, as Brigitte suggested that learning is derived from many sources, she recognises both professional knowledge and the patient experience knowledge. As such, Pawson et al (2003) framework for knowledge construction is relevant. One student explained knowledge construction and re-contextualisation in simple terms:

> Seeing an example at university, helped by role play, observed in clinical, seeing it in action, done yourself; that all helps (Becky)

Evans *et al's* (2010) suggest the transference of knowledge from one setting to another is one method of closing the theory practice gap. They state that knowledge generated and practised in one context can be put to work in new situations and requires re-contextualisation. Content and pedagogic re-contextualisation focuses on the design of the programme and teaching and learning strategies; in this study, the focus on patient and carer involvement activities in the curriculum. As a result, the students engage in workplace re-contextualisation and personal learning that Evans et al (2010) term 'learner re-contextualisation'.

The personal significance of learning was highlighted by a number of participants as the act of coming to understand the whole person and feel something of their experience. Rogers (1980, p6) describes this ability to feel another's emotion as a consequence of attending to their expression of emotion as, 'the visceral reactions and feelings as well as thoughts and words'. Students explained how they attempted to understand the patients' and carers' feelings in a more explicit way:

> I wanted to know what's going through a patient's head. Lecturers say what patients might think, but it's their interpretation. You can ask the doctors, but all they tell you is the facts, they can't tell you how it feels (Beth)
>
> Having contact with ex patients in the classroom gives you extended time with people who have gone through treatment. I think it humanises patients in general (John)

These extracts indicate that participants wanted to better understand and feel empathy with patients and carers emotions, which seemed a key feature of the learning that occurred as a result of the activities. In addition to developing their knowledge and understanding of the complexity of the patient experience the participants reported that this had led them to reflect on ways that they could improve the care of patients in everyday practice (Jasper, 2003). Some participants discussed applying that learning in pragmatic ways:

> I brought a lot back into clinical … like when I'm bringing a patient in from the waiting room now I'll look and see if they're with somebody or ask if they want someone to sit in with them while we chat. We saw a patient and his Mum so I'm more aware of the support around patients (Angela)
>
> Something I can put into practice is directing them to help (Brigitte)
>
> Places like the support centre, I really push it now with patients and family (Jilly)

This also prompted the students to reflect on how they had actively changed their practice and come to question how they interacted with patients and carers:

> I think sometimes we just don't listen. I try now to listen more… (Angela)
>
> It's completely changed the way I think about people in that respect. I will sit back now and let them tell me what the issues are… (Steve)

An ontological shift was apparent as Steve went on to discuss how this had improved his understanding of the different perspectives of patients and carers as each experience was unique. He discussed how this realisation could help inform his practice and Beth believed care should be adapted for each patient:

> The more exposure to different patients you have, you get an idea of how to deal with patients that are really upset; you have to gauge it individually (Steve)
>
> You've got to tailor everything to each patient, it's something you're constantly learning (Beth)

The act of making sense of their own learning prompted students to talk about how the activities and interactions with patients and carers in the classroom had changed their outlook, sometimes in fundamental ways. The impact those interactions had on some appeared to be profound:

> Of all the taught sessions we had that was probably the one that really hit home, to be truthful. It’s a very people orientated area to work in, it was useful to listen to her experiences, what she’d gone through (David)
>
> Those classes had a big impact; everybody spoke about it afterwards (Brigitte)
>
> You can't put a value on that, for me, I will remember all those patients (Malcolm)

For David, it had also provoked a feeling of admiration for how patients coped and I sensed a deep appreciation of the experiences:

> Certainly since starting clinical education it’s been really humbling to see how stoically people deal with the situations they’re in and certainly that sort of day and the discussion afterwards was useful (David)

David’s comment implies that the activity had given him insight into the personal experience of cancer, which he was then able to transfer to the clinical setting and observe how individuals were coping. His reflection on personal learning centred on a heightened sense of the human being rather than the ‘patient’:

> What I learnt was a very personal experience…. I think if you’ve not been touched by cancer you don’t really appreciate the human costs to people and their families and carers (David)

John and David spoke of humanisation, which Todres *et al* (2009) define as placing human beings at the centre of care, evident in the curriculum activities that identified the patient and carers as experts. The focus of learning was demonstrated in the interview with language that reflects the person rather than patient.

Furthermore, some participants acknowledged that there are different viewpoints and hearing those perspectives directly from patients and carers prompted a more reflexive way of thinking:

> You make assumptions based on your own beliefs. Hearing someone’s experience makes it more realistic and you see things in a different light. A reminder …. not making judgements and keeping open-minded (Brigitte)

Thus, the act of making sense of their learning was characterised by participants as recognition of the individuality of the emotional experience of patients and carers and for some the ability to feel that experience too. Participants indicated that patient interaction contributed to their learning and that this new understanding could help their practice. Learning from those interactions also had the potential to transform personal preconceived views and further reflection on their everyday practice facilitated deeper understanding of the patient and carer experience and thoughts of how this can be improved.

Praxis of interacting with human experience

Participants reported that the activities in the classroom prompted a discussion of applying their learning in practical ways. Exploration of how they could impact on a patient's experience prompted them to construct a meaning of everyday praxis of interacting with the human experience. Practice is defined as performance that is routine or habitual, however the term praxis is used here as a more considered act of using particular learning in professional practice. Moreover, it also requires the practitioner to make ethical judgements and act appropriately in subsequent situations (Carr & Kemmis 1986). As a result of conversation with the patients and carers, students identified communication strategies that would enhance care. They also reflected on various scenarios where they had attempted to implement their newfound understanding. This prompted them to talk of how patients' needs might differ and how strategies for helping them needed to be individualised. The ability to identify what those needs may be is supported by Rogerian theory (1967) which emphasises the value of recognising an individual's needs and that the student's capability to respond to his/her agenda could contribute to effective interpersonal relationships.

> Every patient is different and has a different attitude and they communicate in different ways. It helps to take that into consideration when you're talking to them (Jess)
>
> Understanding what's most important to patients, making sure they have all they need. For instance breast cancer patients: we just see them for 3 weeks, but it may have been a year long journey for them so it gives us more appreciation of that overall pathway (Karen)

Karen's view that she would be involved with a patient for a limited time period required her to establish something of their 'whole experience' and provide optimum care at that point in time. She said the classroom interaction gave her more confidence in asking patients about their needs in practice.

During the classroom activities, the patients and carers discussed a range of experiences, but many students recalled the negative situations that they had talked about and how those instances could be learned from and perhaps rectified for other patients. Listening to the experiences of individuals is regarded as a useful trigger for reflection and Jasper (2003) recognises that students have a tendency to focus on negative situations as key learning experiences:

> When the patient explained her experience … you see then how things don’t go perfectly (Becky)
>
> Even when it's not great it's still something to learn from (Sam)

Conversely, participants reported that when they perceived that ‘things had gone well’ in practice it reinforced learning and gave them a sense of personal satisfaction and fulfilment. One student in particular highlighted this as an aspect of the role they enjoyed and demonstrated the micro-practices of non-verbal communication:

> For me it is the social interaction with the patients that I get more pleasure and fulfilment from …. It’s made much more of a mark on me than any of the academic or technical stuff. Even simple things, just a smile or a nod ….. I’ve purposely gone out and tried to do that and it’s really good when I get positive feedback (David)
>
> I'm very pro-active talking to patients and something I really do enjoy, getting to know them a bit better and spend a lot of time doing. It’s important when you're a student because it's good for the person to know there is someone there (Ben)

Ben and David implied that as students they perhaps had more time to converse with patients and carers and that this was something they enjoyed developing. Additionally there was a sense that their own feelings about interactions contributed to their approach to conversations. Rogers (1980) discussed his own learning about communication and described this feeling of warm, pleasurable satisfaction from certain interactions whilst equally he reports feelings of displeasure and discontentment when sensing the interaction is unhelpful. He proposes that the analysis of both types of interactions can lead to new understanding of what may or may not be effective.

In this study, participants reflected extensively on the perceived importance of communication skills and how these could be developed whilst on placement:

> Communication is the most important part, without it you're just doing things to patients. It’s part of making them feel comfortable in that situation and it’s part of expanding your own knowledge. Without the communication they don’t know what’s going to happen, won’t want to come for treatment. It kind of holds everything together, communication between the professions too, you need that to keep the patient experience well oiled (Jess)

Jess indicated that through communication, knowledge would be expanded which suggests that interaction directly impacts on learning. There was also a sense that their role required them to be effective communicators:

> We have to communicate with patients as part of our job otherwise we wouldn't know about problems they were having (Katie)

Their accounts focused on the core skills they had utilised in their interactions with patients. The ability to listen (Adler & Rodman, 2006) was the most reported skill that students identified for effective interaction to take place and may have been a result of specific teaching in the module in addition to the patients’ accounts of their experiences of observing clinical staff not listening. Equally how you talk to patients is important:

> As long as I actually mean it and listen to what they're saying, that's what's important. It comes from your tone of voice, I've learnt how you actually speak to people makes difference (Angela)

> Prior to starting the course I would talk a lot, but perhaps talk over people, since being on this course I've realised it's not about me talking … it's about listening to them (Steve)

Rogers (1980) describes listening as the ability to really hear someone and therefore to be in touch with another person. Although students talked about specific communication skills it was this indefinable and tacit knowing of being with a patient that many participants spoke about. Thorne *et al* (2005) identifies how patients desire 'human connection' and place importance on being known by the health professional. The idea of learning to 'be with' a patient prompted one student to simply articulate:

> I've learned to listen more…. learn to be with a patient (Vishnu)

The notion of relational ontology is described by Rogers (1967) as human connection. The act of simply 'being with another' and by dealing with tensions in the human relationship can lead to personal development. Thus, it appeared that the activities in some way facilitated an implicit learning that Vishnu could not fully articulate. Central to Polanyi's (1966) work is the notion that this inability to articulate what we know characterises the implicit, intuitive nature of learning that can never truly be made explicit and reflects his assertion that we know more than we can tell. Recounting examples from the clinical setting can provide some evidence of 'know-how' and one participant said that what you might say to a patient who is feeling anxious could directly impact on their emotional state:

> Over time you build up experience of patients and their issues. It means you are not blind when you arrive on placement. An example of this was two weeks ago… a lady was terrified. You could think “oh it’s just a simple short treatment and dismiss her fears” (John)
>
> What did you do? (Me)
>
> I understood she was frightened and so I talked slower, changed my tone, tried to be reassuring and included her husband when giving information (John)

The emotion of the situation was recognised and the student somehow knew that an appropriate response was required. Furthermore, Brigitte was concerned how she may be perceived by patients and carers:

> I think we can be frightened to talk about cancer. We worry that it's such a delicate matter, you just wouldn't want to upset or offend somebody … you have to be careful, but then you could probably come across a bit cold then as well (Brigitte)

The activities had in some sense prompted students to adopt a changing position, which can be characterised as gaining a deeper understanding of the patient’s emotional experience rather than being focused on disease management. This new knowledge can be seen as an ontological shift in the students understanding of their relationship with patients.

In their accounts, a number of students used the term empathy, a core skill that Rogerian theory emphasises as the ability to understand another’s internal frame of reference and to communicate this back to them (Haugh & Merry, 2000). Van der Cingel (2014) states that empathy is a condition of compassion and a requirement of ‘good care’ and ‘is of major significance for health care professions’ (p1254). Her seven dimensions of compassion relate to Rogerian theory and focus on attentiveness, acknowledgement of suffering, trust, ‘being with’ and knowing what is important to the patient. Some participants’ conceptualisation of empathy was vague whilst several expressed the view that they had this skill and others discussed how it was difficult to demonstrate:

> [Empathy] I don't think it's something you wake up and say oh yes I can do that because I think you have to have experience to get that far. I don't think I'm excellent at it; you're not going to be perfect because every experience is different (Beth)
>
> In that situation it's difficult to empathise because I don't have children and I can't even imagine what it would be like (Ben)

Explanations about empathy perhaps reflect Polanyi’s concept of tacit knowledge and the inability of students to put into words what this meant. However, one participant was explicit in her view that to be empathic it required the ability to demonstrate a genuine interest in patients as human beings:

> .. making sure that you’re doing it genuinely. Genuineness is part of showing that you’re interested. I think you can fake it, but I think it’s really obvious if you do, people can see (Angela)

Genuineness is regarded by Rogers (1980) as one of the core conditions of interaction and this is described within a health care setting by Allan & Barber (2005) as authenticity. Angela captures the sense of authenticity in her view that fakery is observable.

Some participants talked about specific communication skills in terms of whether they can be learned or intrinsic in an individual. Much work has been conducted in the field of communication in cancer and the general view is that communication skills can be learned (Fallowfield, 2009), but it is also recognised that individuals have personal skills that can influence their potential for development. Students indicated that skills could be learned and also that some were inherent in an individual:

> Communication is such a massive thing, but it's something that's really hard to learn. I found it really difficult to know what to say. You have to learn… even 30 years down the line you're not going to be perfect because every experience is different (Beth)
>
> Certain communication skills can be learnt but sometimes I think it's innate (David)

Although participants talked about the intrinsic factors that contributed to effective interaction they equally stated that time constraints in the clinical setting had a negative impact on patient experience and referred to this perceived paradox in everyday practice due to the busy technical environment (Bolderston *et al* 2010). For some students the realisation that they were not able to meet patient and carers' emotional needs was difficult:

> It's perhaps the time constraints; if you don't dig and look then you can move onto the next person easily (Jilly)
>
> A constant flow of patients … you're trying to be friendly… but in the back of your mind you're thinking "we've got 40 more patients today" (Carl)
>
> Staff shortages mean they are working constantly and there isn't the same opportunity for the interaction which is really sad (Ben)

The classroom activities perhaps gave students a view of patient expectations which may not be achievable in a busy work environment, a dissonance that will be explored further in thematic network three. However, a number of students reported that they had more time than clinical staff with patients, which they viewed as having a positive impact on interaction.

> As students we do have more time to listen (Malcolm)
>
> I like doing 'first day chats' as it gives you more time to go through things, if patients are clear about what's happening they're a bit

> happier to go ahead with things. You can sort the little things that might be really worrying them (Caroline)

The praxis of interacting with human experience was conceptualised in participants' accounts of their learning from positive and negative situations they faced and utilising that understanding to develop know-how in responding to different situations. Although they did not explicitly verbalise Rogerian theory (1967) and it is not explicitly taught in the curriculum, many of the constructs they described related to his core conditions for effective interaction. This deeper understanding of human experience had impacted on their thinking about daily interactions and led to further analysis of what was important to the patient and carer.

Principles of engaging with human experience

The opportunity for participants to reflect on their everyday interactions with patients and carers promoted an exploration of the values they believed integral to effective engagement or involvement. This prompted participants to theorise on some fundamental principles of care. The concept of caring was discussed by some participants, although students tended to use the constructs of rapport, connection and attachment to describe their relationship with patients in everyday practice. The concept of human connection was explored by Bolderston *et al* (2010) with therapeutic radiographers and they regarded it as an important feature of their professional practice. The function of the 'first day chat' with patients was the most reported mechanism utilised to establish rapport (Martin & Hodgson, 2006, p.158). The first day chat is where the professional spends time to explain the treatment and side effects to the patient and answer questions or explore potential issues for the individual. One participant's reflection on the purpose of the first day chat was to provide information, but also as the beginnings of an ongoing relationship:

> So, on that first day chat do you give a lot of information, is that the purpose? (Me)

> Yes, you tell them what to expect today, then you tell them about side effects and then you go through appointment times, things like that. I've found if I start off with ‘how are you today?’ you get all their worries ‘out of the road’ (Carl)
>
> Do you think that has an impact on your interactions with them throughout the treatment? (Me)
>
> If you do somebody's first day chat you’re their "go to" person, they'll always remember you, they mostly remember your name. They have an attachment to you (Carl)

The ‘go to’ person suggests human connection, which Thorne *et al*, (2005) term ‘being known’. They state that when the patient perceives the health professional as knowing him/her then the patient feels cared for, ‘knowing the case, the patient and the person’ (p.895). Being the ‘go to’ person was reported as a positive consequence of the first day chat, conversely it could also be viewed as an unwanted responsibility. However, the first day chat was regarded by the majority of participants as a positive mutual experience, similarly reported by Bolderston *et al* (2010). Participants went on to use different terms to describe the continuing relationship throughout treatment reflecting the notion of connection or bond (Allan & Barber, 2005). It was reported in similar ways by many of the participants:

> If you're the person who speaks to them on that first day, gives information it seems to form a bond. They seem to identify with you as a person they can talk to and they'll say something to me that they won't say to other members of staff (Sam)
>
> If I talk to a patient on the first day you've got more of a connection with them and it's nice to see them through their treatment (Beth)
>
> Building rapport is really important, it’s not something I thought of much to start with ... (Karen)
>
> Having this connection with patients and having a positive influence on their experience (Jess)

Many participants talked about ‘the little things’ that they perceives as making a difference to patients; details about their family or what music they liked to listen to in order to maintain the relationship throughout a course of treatment:

> I usually try and remember little details of what people have told me … and I’ll follow that up the next day (Angela)

The perceived impact of rapport was explored by a number of participants through their reflections on experiences in the clinical setting. They reported how certain things that patients did made them believe rapport had been established:

> There was a patient … who I’d spoken to quite a bit over a couple of weeks and she brought in a bag of sweets for me that she knew I liked.. it felt like I had made a difference even as a student (Karen)
>
> I got to know her and she came to me and told me things and I think that was a good rapport and probably did help her (Jilly)
>
> I'm chatty and friendly and it's nice to see that you can make a difference to patients; they’ve commented that it made it so much easier coming for treatment (Steve)

The concept of caring, was articulated in different ways by participants through secondary prompts (See Interview Map Appendix 10). “Can you describe your learning?” Notions of care emerged as interviews progressed and I added prompts such as “What does caring mean?” and “How do you describe care?” When they were asked what caring meant they did not offer a definition but talked of ‘relationship building’ and ‘rapport’. This appears to echo Polanyi’s (1966) concept of tacit knowing and perhaps they found caring difficult to define, however they readily suggested ways in which you could demonstrate that you cared. Thus the notion of ‘care’ was articulated from a range of perspectives:

> To understand what they've been through from start to finish, how it's affected them ….. if you can show them that you're interested (Angela)
>
> Caring about how they are coping. Check if they don't look well, whether they need any more help and you can do that. Being more involved in helping that patient through their treatment (Sasha)
>
> It is hard to describe, it's about your body language (Jess)
>
> I wanted to make a difference in people's care. In my family no one has had cancer, but my sister was ill so I understand the impact on a family. I want to help in that sense (Brigitte)

Participants' discussions about caring describe embodied knowing, which is instrumental in acts of caring (Thorne *et al*, 2005). Understanding patients' and carers' experience and communicating that to them (Angela) and through body language (Jess) is instrumental in helping them (Sasha & Brigitte). In addition to describing ways that students could embody care, one participant discussed the act of caring as being a key attribute of the role and that through observation you could see that other people cared:

> It's fundamental; you can't class yourself as a good radiographer if you don't care ….. you look at the way people act and their genuine concern and you know they care (David)

In the interviews, the students constructed a discourse around the principles of engaging with human experience that focused on recognising emotion and the ability to establish a connection or rapport with patients and carers. Many referred to the first day chat as the starting point for effective interaction and the ability to build a relationship that was mutually beneficial. The 'connection' discourse reflects principles based on Rogerian core skills and was regarded as the fundamental basis of interaction. Participants defined human connection and a conceptualisation of 'caring' emerged from the definitions. A sense that connection and care were linked emerged; almost a realisation for participants that connection and knowing how to be with a patient would lead to caring. The idea that caring was an important aspect of their role prompted participants to give examples of how they demonstrated care. For many participants this was articulated as doing ‘little things’ that they believed made a difference to the patient experience.

Global theme of emotional recognition

The data reveals that participants learned about the emotional aspects of the cancer experience through their interactions with patients and carers. Their attempt to make sense of their learning was a result of reflecting on the classroom activities with patients and carers and their subsequent clinical experience with other patients and carers. The learning was articulated by the participants as emotional feelings as they came to understand more of the whole person. For some, recognising for the first time how cancer can affect all aspects of experience and in particular their understanding of the emotional cost to individuals is central. Feelings-based knowledge gained was re-contextualised and reflected on in practice which, in turn added to their learning experience (Evans *et al*, 2010). Whilst the classroom activities alone cannot be solely responsible for their learning (as learning continues in practice) it was clear that they provided an opportunity for engagement that facilitated a deeper understanding of the emotional nature of cancer. Two significant aspects of their learning were first, using particular communication skills and developing a bond with patients and carers that appeared to change both their understanding of emotion, and secondly, their practice with patients and carers. Central to this thematic network is the sense that recognition of emotion requires action; to respond using genuine communication skills and the ability to form a connection with patients and carers that can facilitate a caring and authentic relationship (Allan & Barber, 2005). A changing epistemological position was seen in some participants with a shift away from formal disease-related knowledge towards affective feeling based knowledge and recognition that patient and carer experience could be a powerful learning opportunity. The knowledge generated from the patients and carers appeared to facilitate an enhancement of the caring aspect of their work that in turn would to improve the patient experience.

The findings presented in this chapter suggest that the experiences of patients and carers are viewed by participants as being of particular importance to their learning. Their descriptions included features similarly presented by Pawson *et al* (2003) in their typology of knowledge construction. This construct presented the patient as one of five sources of knowledge that contribute to professional development with the patient as the fifth source perhaps suggesting a position lower in a hierarchy of knowledge. Bligh & Bleakley's (2006) suggest that the curriculum should place the patient at the focus of knowledge generation, a view which indicates that the primary locus for knowledge production comes from the student working collaboratively with the patient. Perhaps taking this one step further, the data suggests that the patient provides important and unique knowledge for practice articulated by Rolfe (cited in McAndrew & Warne, 2005):

> When I reflect on my own experiences as a student nurse, it is clear that I learnt almost nothing from anyone other than patients. Or put another way I learned very little as a student, but most of it was from patients not tutors or staff. When I voiced my concerns they said not to worry that would come once qualified. And so it did; once again it was mostly from patients (page xii).

Elements of learning for the students appeared to be that they could see what it was that patients wanted from interactions and this caused them to question previously held beliefs and values. As Rees (2013) found in her research, a changing ontological position could be seen in students through their reflections on emotional work, but she argues that they will not all shift in the same direction. Some participants in Rees' study justified professional detachment, whereas others valued a more embodied sense of care. My data supports Rees' assertion that reflective practices can transform an individual's ontological position. The student's ability to put to one side previously held beliefs indicated they had valued the patient's perspective creating the potential for personal transformation (Rogers, 1980).

The interview gave participants the opportunity to reflect on the classroom activities and this appeared to prompt further reflections on everyday interactions. Jilly, Ben and Sasha talked about particularly emotional encounters in practice. Thus participants explored and considered the praxis of human interaction. Participants' accounts featured the use of 'effective' communication skills and important attributes to develop (Haugh & Merry, 2000). There was disagreement amongst participants in whether skills were inherent or could be learned and different accounts illustrated this. However, the work of Fallowfield (2009) shows that individuals do have the potential to improve and students' reflections on practice indicated that they were becoming more confident in their interactions with patients. There was a conceptualisation of what it meant to 'be with' a patient and what that felt like for the participants, which prompted them to explore and develop a discourse focusing on the principles of engaging with the human experience. This discourse centred on the human relationship and the view that the one should establish some sort of connection or rapport (Allan & Barber, 2005) was held by all participants as they predominantly began this process with patients on the first day of treatment. Connection was regarded as mutually beneficial and the majority of participants gave accounts of how this developed into a relationship over the course of treatment (which may last up to 35 visits). Thus, this global theme represents the potential for developing an enhanced view of patients as emotional beings through interactions and of how this learning can be translated to practice. The psycho-dynamic nature of the classroom activities facilitates understanding of patient and carer experience (YOU) and through interaction this was developed further (US); the outcome being that the participants' learned about themselves and practice (ME).

Chapter Five: Emotional Management

Introduction

The global theme of emotional management incorporates two organising themes and 11 basic themes which arose from the data. The theme of emotional management represents the broader concept of dealing with emotional interactions, as expressed by participants. This thematic network encompasses theories drawn from emotional labour conceived by Hochschild (1983) and later developed by others to include emotional management and emotional expression as part of health care work (Fabricius, 1991; Theodosisus, 2006; Smith & Lorentson 2005; Smith & Allan, 2010; Allan, 2011). Hochschild's (1983) theory of emotional labour focuses on how the individual, in their work, is required to actively manage their own emotions when they do not feel what is expected in a certain situation. The expectation is that the individual reflects organisational values and adheres to 'feeling rules' (how one thinks one ought to feel in a particular situation). Although those rules may vary in different professional contexts the aim is that the client or patient is satisfied. Hochschild identified two strategies to manage feelings: surface acting and deep acting. Deep acting requires the modification of inner feelings to express organisationally desired emotion, whereas surface acting is concerned with change in emotional expression without a change of inner emotional state. Surface acting is characterised by suppression of emotion in an attempt to respond appropriately to emotional situations and is likely to lead to emotional dissonance (Theodosius, 2006).

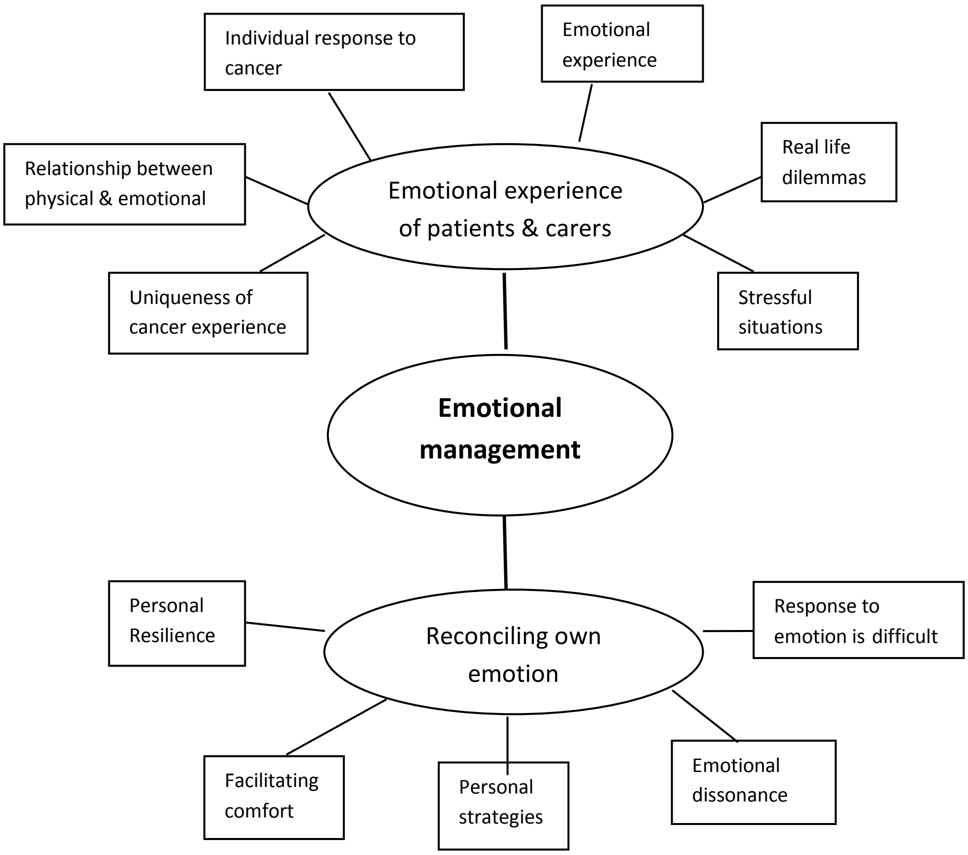
Psycho-dynamic theory explains the difference between conscious suppression of emotion that the worker engages in to deliver socially accepted care, and repressed emotion which is largely an unconscious defence mechanism against feelings of anxiety, utilising strategies such as detachment and task orientation (Fabricius, 1991). Karim & Weisz (2011) studied how affectivity has an impact on the acting, stating that individuals with high negativity have a tendency to use surface acting and those with high positivity use deep acting to re-interpret situations in positive ways. Smith & Lorentzon (2005) explored the notion of 'acting' and propose that deep and surface acting can create tensions in relationships and suggest that authenticity is the goal in relationships that are often complex, with no definitive rules. Awareness of those tensions and the ability to genuinely interact will facilitate a comfortable relationship.

Hochschild's concept of emotional work supposes that emotion is consciously managed within a social context. However, Theodosius (2006) challenges this view as emotion is both conscious and unconscious and, whilst cognitive management is possible, it is also 'open to irrational action that overrides attempts to manage it' (p899). She further claims that management of emotion can itself create other unconscious emotions. Theodosius' view is that emotional management is more complex than observable acts and internal feelings may not be evident. She advocates a more holistic perspective of emotion suggests exploring, 'emotional processes and their management as if emotion itself were interactive, relational, conscious and unconscious' (Theodosius, 2006, p900). Thus, the thematic network of emotional management attempts to describe the emotional work that participants engaged in with patients and carers, but also acknowledges the raw emotions they witnessed, experienced, responded to and attempted to make sense of.

In the research, participants' accounts suggested that emotional management arose from two related constructs: first, the experience of the patients and carers' emotion; and second, the attempt to reconcile their own emotions. This in many ways characterises the accepted notion of emotional labour which is predominantly concerned with managing emotions in difficult situations that often arise in health care settings (Mann 2005; Hunter & Smith 2007; Huyne et al 2008). In Thematic Network One the emotional experience of patients and carers was conceptualised as recognition and the attempts of participants to make sense of their learning. Through that conscious act of reflection they were able to recognise themselves as emotional beings. As a result they identified some tensions in how they may reconcile those feelings and regulate their own emotions represented in this thematic network.

In thematic network one, the model YOU-US-ME illustrates how the patient and carer (YOU) talks about their experience; the students interact, question and listen (US) and begin to learn about interaction. When applied to this thematic network the model essentially focuses on the emotional learning as the participant interacts with the patient and carers' emotional experience (US) and thus they come to feel the emotion. Internalisation of that experience enables them to learn something about themselves (ME) and thus is seen as a psycho-dynamic model of learning and knowing. In terms of emotional learning the next step is to effectively manage the emotion and develop professional behaviours, which is conceptualised further in thematic network three. The following discussion explores participants' expression of emotional experience and modes of personal reconciliation which characterises the global theme of emotional management. Figure 5, represents the thematic network.

Figure 5:



Emotional Management: Thematic Network Two

Emotional experience

Participants talked about the patients and carers who were involved in the classroom activities. They recognised the emotional experience of each patient and carer who shared unique and individual dimensions of their personal journey. The majority of students talked about the emotion of the interactions and further explored other emotional situations faced in clinical practice. Alternative learning resources made available to students included websites that provided video and audio accounts of the cancer experience (www.healthtalkonline.org.uk and www.patientvoices.org.uk). Also a number of articles written by patients and carers exist in the literature and quite uniquely Michael Petrone's depiction of his emotional journey through art (www.cancercare.org.uk). Although students had access to this material the data shows that they preferred the interactive nature of the workshops with patients and carers. This reinforces the value of the psycho-dynamic YOU-US-ME model of emotional learning as learning is achieved through person to person connection.

Through the patient and carer experiences the participants identified a link between the physical effects of the disease trajectory and the associated psychological impact on the individual. As a consequence of the activities, a wide variety of emotional responses in patients were explicitly recognised by participants such as shock, anger, depression and acceptance (Kubler-Ross 1970):

> At the very beginning of that process they're devastated (Steve)
>
> It doesn't seem to have affected her in a bad way, she seems positive about it ….. I think she's become a stronger person for that, she said that herself (Sam)

Many stated that a key aspect of their learning was an enhanced awareness of the difference in patient and carers' emotional response to a cancer diagnosis. Having the ability to ask the patients and carers questions about their experiences facilitated understanding of different ways of coping with cancer. One participant's account was echoed by others:

> The thing that stands out the most was the mother and son; two different perspectives about what was going on (Karen)

Participants reported that the activities had facilitated further insight into the real life dilemmas for patients and carers previously unknown to them:

> You recognise that these people have gone through something that could be very traumatic. Some had really sad life changing experiences, it pulled some of their families together and it separated others (Brigitte)

The data indicates that the ability to engage in conversation had opened students' minds to the personal experiences of cancer. As one participant commented, the classroom activities with patients were conducted in a safe environment that facilitated useful discussion related to dealing with emotional issues. Interestingly students commented that this would be more difficult in clinical practice, they would not have time or feel uncomfortable talking about such issues. In trying to understand this viewpoint, Goffman's work (1959) on social groups may provide an explanation. He discusses how in the presence of others' interactions may be awkward or tentative and that the characteristics of a conversation may be negatively assessed by others. Perhaps it is a fear of being judged by clinical staff undesirably that students perceived this depth of interaction would not be welcomed in clinical practice:

> The patients and carers knew why they were there. We are not at work so wouldn't be judged, we can ask any questions it was easy, not worried about offending them (Brigitte)

Participants said that this learning activity allowed them to be less cautious in their questioning and as a result learn more about individuals' experiences.

> There was interaction, as it was set up for learning, different from clinical (Ben)

However, the activities prompted nearly all participants to reflect on emotional and stressful situations in clinical practice, consciously raising their awareness of their own emotional struggle and triggering varying degrees of unease:

> He was a young man, I'd never seen that treatment technique and was just focused on that. We were all set and went to leave the room. I turned round and there was just this figure sat on the bed, I could cry now thinking about it, and he just looked so ill and so vulnerable. I thought "oh my God, what are we doing?" I was upset at myself for thinking about the technical and I did lose sight that there was a patient there … the enormity of what we were about to do to him hit me (Jilly)
>
> A patient was in clinic and I saw him being told it had spread and it was hard to be sitting in that room, being told there was nothing to be done… Seeing the family was hard to watch but you know that's what people are going through. I left the room at one point… it was hard really (Sasha)
>
> The cancer she thought had gone had come back and she was just a shell of a woman … horrible. I just didn't know what I could say … it was a horrible day and it still affects me now (Steve)

Theodosius (2006) argues that how feeling is managed can create further emotion and Jilly, Sasha and Steve described how the emotion of a situation stimulated emotion in themselves that they found difficult to bear. According to Theodosius (2006):

> Our emotions and feelings do not just arise in isolation within ourselves they are directly elicited in response to the relationship we have with others. Between people emotion states collide, impacting, bouncing and feeding off one another, creating a further emotional state borne out of that interaction (Theodosius, 2006 p900)

The patient and carer volunteers who took part in the classroom activities had lived their experiences and were in remission. Although they could facilitate insight into the emotional experience of cancer it also prompted participants to reflect on related experience in practice. What became evident to me from the data was the emotional language participants used to express their own feelings in response to the emotional situations. Feelings of wanting to cry, being upset and pain were recollected:

> I nearly cried.. It upset me for about two days afterwards. I couldn't stop thinking about it (Jilly) (practice)
>
> I thought about patient B a lot… a young man with a false leg. I found it really painful (Vishnu) (curriculum activity)

Emotional dissonance is discussed by Hunter & Smith (2007) who state that many students are ill-prepared for emotional work and finding a way of managing it is essential in order to avoid the emotional cost to the worker. Although some participants clearly found the experiences difficult, others saw it as 'part of the territory', something that had to be accepted:

> I can talk about things and not get emotional about it, as if it's... it's life really isn't it? (Sasha)
>
> That day and the discussion afterwards was useful because it was very emotional and quite nice because I think the group gelled a bit more, we were able to talk about more emotional things (David)

Being part of a group discussion that reflected on the activities may help mediate the difficult feelings experienced, which could be further enhanced by psycho-dynamic group work and supervision (Allan, 2011). However, I would argue that the patient and carer activities bring an additional dimension to the psycho-dynamics of the student-patient relationship. All participants engaged in conversation with the patients and carers, which seemed to facilitate a shared insight of the individual patient and carer experiences. They further reflected on those experiences in their peer group. Allan (2011) shows that working with emotions in a safe environment may serve to ‘unlock the repression or suppression they might be using to cope with painful feelings evoked’ (p.522).

As a result of these reflections, the students reported a heightened awareness of the emotional experience of patients but, perhaps even more so, they displayed a sense of their own various feelings in response to what they had witnessed. Students’ accounts of their own feelings prompted them to reflect further on the uncomfortable nature of emotional situations (Jasper, 2003).

> High emotion can be discomforting… you know…. when someone is angry or tearful (John)
>
> It was uncomfortable, not in a, "I don't want this to be happening" kind of way, but highly emotional (Sam)
>
> I didn't feel uncomfortable like I had to leave but I didn't really know what to do for the best. It takes you off your guard (Caroline)

Recognising and verbalising emotion led students to contemplate on how they could reconcile those feelings.

Reconciling emotion

Feeling both one’s own and others’ emotion was seen as disquieting but, at the same time, as an enabling experience, with reconciliation of those feelings viewed as one aspect of personal development. Fabricius (1991) in her study with nurses used the psycho-dynamic approach with the aim of improving their communications with patients. Her aim was to ‘help them become more aware, both of their feelings, fears and impulses and of the defences they use in order not to be aware’ (p.137). The general consensus of the participants was that the process of acknowledging those emotions and uncomfortable feelings had led to new learning and a greater degree of ease in emotional situations, as is consonant with findings by Atkins & Murphy (1993). The idea that emotional experience can lead to new understanding is further discussed in Chapter seven.

Many participants expressed the view that acknowledging discomfort in patients requires an appropriate response, as is suggested by Hochschild (1983), demonstrating a desire to make the patient feel comfortable:

> Because it's about the patient feeling comfortable, if the patient doesn't feel they can talk to you then the whole experience is just going to be horrible for them (Jess)

Although what the response should be was equally perplexing to some and difficult situations drawn from practice emphasised this challenge:

> It was very strange, difficult knowing what to do, it was even more complicated because the parents were divorced so they weren't comforting each other and they wanted comfort (Ben)

When I asked one participant “what would you say in that situation?” the response was tentative and underpinned by a desire to do ‘no harm’:

> I don't know what I'd say really, you don't want to say too much, but you don't want to say nothing. I feel a bit apprehensive about what

> to say…. obviously you don't want to make people feel worse (Sasha)

Although uncertainty was evident for some participants about knowing ‘the right thing to say’ others appeared confident in knowing how to comfort a patient. This tacit knowing to some extent became explicit through one participant’s account:

> You get an idea if you’ve done it right. It’s an internal thing that you regulate yourself… a patient was crying and I took her hand and let her talk and she said “thank you so much for that” (Steve)

Although the majority of participants agreed that the act of comforting a distressed patient was necessary, how it should be done was debated. The personal approach of participants in life to uncomfortable situations seemed to determine their preferred approach, whilst they also recognised that there was a professional boundary. Allan & Barber (2005) acknowledge the difficulties of managing emotion within a professional-client relationship and suggest that although emotional distance can be learned they question what the limits of detachment may be. Perhaps too much distance gives the impression of not caring? They suggest that the imperative is to create authentic relationships that feel comfortable for professional and patient. The data describes the difficulty in ‘knowing’ the extent of emotional engagement required to fulfil the professional role:

> Comforting, is hard to describe, it's about your body language and empathising with them, trying to bring them back from being that emotional. If it was family you'd be really touchy feely, you'd give them a hug, that's not appropriate with patients so it's about being caring (Jess)

> It’s not always appropriate I’m aware of that and if people I know are upset I just hug them. If I see somebody upset I think ‘no’ it’s not appropriate (Jilly)

Rees (2013, p.50) states that through reflection one comes to know what is right in certain situations, ‘it was the right thing to do, to put my arms around him and comfort him’. To comfort in this way may not be the view of others and as an example, in professional physiotherapy guidance they advocate maintaining clearly defined professional boundaries. Comforting in such a way would be regarded negatively (www.csp.org.uk). Participants reported that responding to emotion was a difficult task, creating personal and professional dilemmas in everyday practice. Acceptance and validation of patients’ emotions was generally viewed as appropriate practice and advocated in health care communication texts (Burnard, 2005). However, the data suggests that managing one’s own emotions is also required and there was discordance in how students should regulate their own emotions and achieve some sort of personal balance. A number of students reported feeling emotional in the classroom activities with one saying:

> I found it quite upsetting and shed a few tears because I found it quite emotional... but I think if it doesn’t affect you you’re not really the right person for the job, because you don’t care enough (Angela)

Angela, along with others believed that some expression of emotion is important as a professional, but this raises the question of what level is ‘right’. Hunter & Smith (2007) describe situations that require emotional regulation by either suppressing or expressing feelings and Rees’ work (2013) identified differing perspectives of this in nurses. In this study, some students demonstrated aspects of suppression to fulfil their role and repression as an unconscious act to avoid painful feelings as a way of coping, similarly identified in Fabricius’ study (1991):

> I wanted to cry but then the other part of me was doing a job to help her and you need to be strong and I was like “it’s fine, it’s fine” (Steve)
>
> I don't think I'm a very emotional person, I try and distance myself from it because I've gone through people with cancer in my family so I've already done the emotional side of it (Carl)

For some, there was a preference for distancing strategies as the cost of becoming too emotionally engaged could be great (Allan & Barber, 2005). Similarly, Mann (2005) reports that professional detachment is a recognised mechanism in health care settings. In contrast, in order to manage emotions in the clinical environment some students regarded it necessary to experience the distress, whilst conveying a professional outward appearance (Hunter & Smith 2007). The motivation for taking this approach was two-fold: to facilitate comfort both in the patient and themselves:

> I knew why I was there and what was going to happen before the people came in, I didn't feel uncomfortable, just very conscious of not distracting from the information that's being given. Really… it was gut-wrenching (Ben)
>
> Now I feel more comfortable in situations where patients get emotional, but when I started I wouldn't have known what to do or how to act, it helps them to be able to say these things and get it off their chest (Jess)

However, many students talked about the need to get the balance correct in terms of demonstrating (or not) signs of emotion. A number of participants talked about how this could be achieved through a balance between engagement and distance (Allan & Barber, 2005):

> I worry that I seem a bit cold, but at the same time patients probably don’t want us to be visibly upset. It’s a bit unprofessional, it’s best to hold off until you’re by yourself but at the same time you

> do want to show the patient that you understand, you don't want them to feel that they have no right to be upset so it's finding a balance (Karen)
>
> I would try not to show that I was upset because it's the patient's grief time, it's not about me. If you went to pieces as well you're not being any support to them; I wouldn't be hard and uncaring, but I wouldn't want to cry or anything in front of anybody, it's difficult. It's quite a fine balance (Jilly)

In order to facilitate personal reconciliation of emotions a conscious appraisal and regulation of feelings is required, as described by Mayer & Sluyter (1997). Personal management of emotions requires a degree of personal resilience (Dunn, 2008). Students referred to this as 'being strong':

> You have to stay strong; you have to show that you're not going to get upset when somebody else is. It's not going to help them they're going to think that they're not getting any support (Sasha)

The recognition of patient discomfort provoked unease in the students, but also instilled a desire to provide comfort and care. Their view was that in order to effectively support the patient in emotional distress they must demonstrate resilience by managing their own feelings. Participants' accounts of how this could be achieved were variable and a tension existed around the perceived benefits of regulating emotion through either expression or suppression and how this was perceived in a professional context. It could be argued that the emotionally intelligent practitioner expertly employs both strategies depending on the context (Goleman, 1995). Karim & Weisz (2011) suggest that high emotional intelligence facilitates effective emotional work and positivity promotes helping. However, dissonance can occur due to the conflict between feelings and what should be felt and participants' awareness of this dilemma was evident in some accounts. For example, Sasha's insistence about being strong was not congruent with her distress at the end of the interview and her disclosure that she was described as 'soft' by her family. Theodosius (2006, p894) illuminates this point well, stating that emotional management can be learned, but ‘emotion has both dependence upon and independence from cognition, there is a difficulty in identifying the full nature of emotion and its social significance’.

Global theme: emotional management

Although this theme is titled emotional management, a phrase which evokes a sense of control, the data shows that the activities and subsequent reflection permitted participants’ to express their own emotional feelings. Thus, emotional management not only represents the participants’ cognition of managing patients’ and carers’ feelings to portray a professionally acceptable image of care, but acknowledges the irrational and unconscious feelings they experienced. Emotion management is influenced by the kinds of emotion experienced and the feeling rules that define emotional expression (expectations). However, Theodosius (2006) argues that we need to understand the interactive nature of emotion and the unconscious processes at work. Emotional management evokes a sense of cognition, but equally the participants displayed emotional expression that was less conscious and more reactive to the emotional interactions they witnessed. I would argue that the curriculum activities prompted participants to become more conscious of their emotions. Theodosius (2006) suggests that understanding the nature of emotion actually creates further knowing that may be tacit, rather than explicit, in nature:

> ‘Being sensitive to these processes can develop our understanding beyond cognition and situate emotional management within a truly relational context’ (p.894).

Thus, this thematic network represents the psycho-dynamic processes which precede emotional management, including conscious and unconscious responses.

The data drawn on in this discussion suggest that classroom activities provided an interactive ‘safe environment’ that allowed students to recognise the different emotions that patients and carers experience and to some extent understand what patient and carer needs might be. Experiencing emotion in this context prompted students to reflect on situations in the clinical setting and this unearthed some intensely emotional accounts that centred on their own feelings in response to stressful situations.

The term ‘comfort’ was used in different contexts throughout the students accounts of stressful situations and in particularly when they were describing their response to emotional encounters. ‘Discomfort’ was used by one participant to describe the condition of being uncomfortable (in body or mind) as they perceived the patient to feel in a particular situation. However, the adjective ‘uncomfortable’ was used more readily to describe not only their perception of how the patient might feel, but more commonly in reference to themselves to describe an uneasy feeling. Atkins and Murphy (1993) focused their model of reflective practice on the awareness of an uncomfortable feeling which can lead to analysis and action. This supposed that actions identified can be applied to new situations and perhaps this also suggests that in time one becomes more comfortable. In my study there was a general view this was a desirable alternative state for patients to be in, or a preference for themselves as students. As participants described how they would respond to difficult situations they expressed a desire to comfort or soothe the patient. As students talked about emotion in this way it seemed that the idea of achieving comfort for the patient is somehow linked to concepts of care (Bolderston *et al,* 2010). Finally, in identifying basic themes in this thematic network I used ‘discomfit’ as a verb to describe the ability of stressful situations to cause or provoke uneasiness.

My study illuminates how students’ emotional management is characterised by three distinct levels of action. The first level is the effort required to interact with and attempt to understand patient and carers emotions by listening and attending to their stories. At times, this provoked uncomfortable feelings. The second level requires participants to acknowledge their own emotions and begin to develop strategies for coping. Finally, the students were preparing to engage in emotional work in order to develop an accepted professional persona (Hochschild, 1983) that can demonstrate and appropriate level of caring. However, a stepwise progression through these emotional states cannot be assumed and the data illuminates some of the tensions at each of these levels. The notion of levels of learning (Dilts & DeLozier 2000) will be explored further in chapter seven. Emotional dissonance ultimately impacts on the students' ability to successfully manage their emotions and still a further conflict lies in whether this should involve distancing or compassionate strategies or more realistically a balance of both as suggested by Allan & Barber (2005).

The emotional impact of practice on the student therapeutic radiographer has been demonstrated through the thematic analysis of participants' accounts and indicates a need to address this particular issue in the curriculum. The YOU-US-ME pedagogical model represents the psychodynamic inter-relational nature of emotion and provides a framework for exploring emotional work as part of professional practice and is discussed further in Chapter Six.

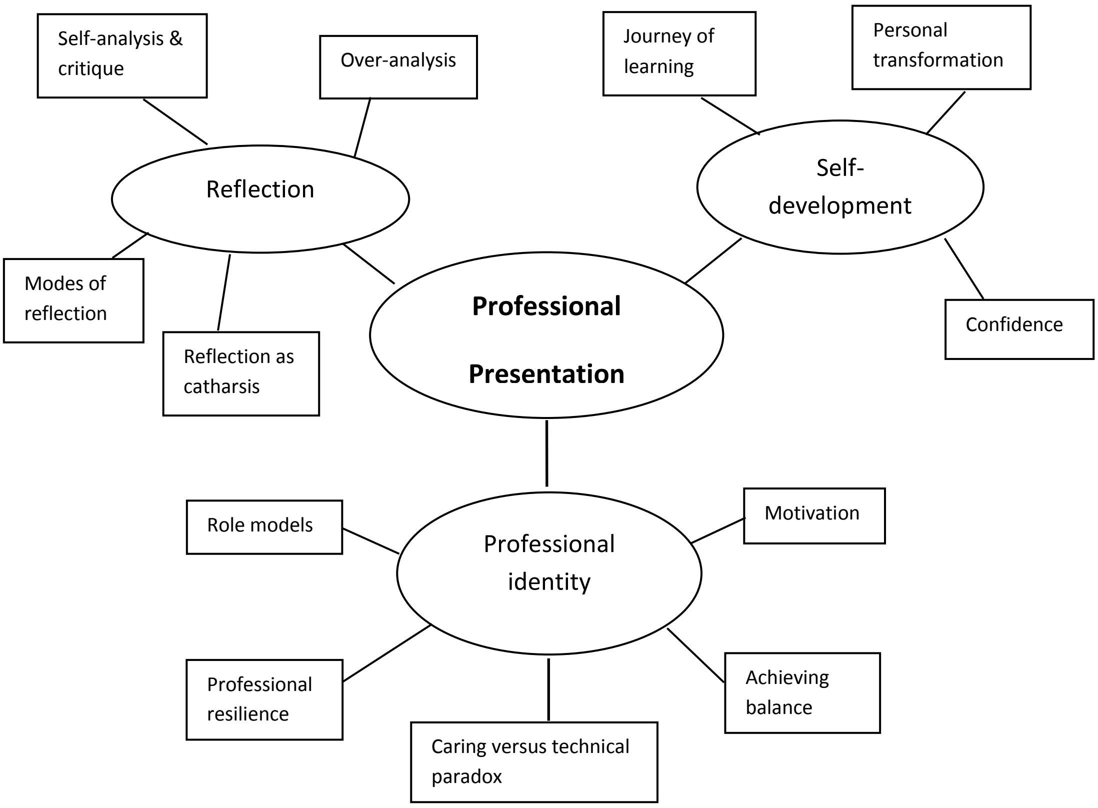
Chapter Six: Professional Presentation

Introduction

This global theme incorporates three organisational themes and 12 basic themes from the 36 identified in the data. The organisational themes present three distinct, but intertwined constructs that demonstrate the participants' views of themselves as professionals. The data suggests that an important aspect of professional presentation is the management of emotion. I draw on Goffman's (1959) *Presentation of Self in Everyday Life* to conceptualise this theme. Goffman suggests that a face, front or performance in everyday life is a conscious or unconscious expression of identity and in this context could be related to the professional presentation of the therapeutic radiographer. Participants expressed what they believed to be the ideal performance of a professional and as researcher I worried that the students were perhaps consciously presenting that 'ideal' to me as I was their tutor and had introduced the patient and carer involvement activities. I explore this further towards the end of this chapter.

The global theme professional presentation, although central to this thematic network, was also a feature of the previous two networks. In network 1 this was evident through the focus on how students engaged with patients and carers and transference of learning to the clinical setting by examples of their improved practice. In network two, it was characterised through talk of emotional dissonance and 'getting the balance right' in managing emotional situations. Here, professional presentation as a global theme is characterised by the participants' ability to engage in critical reflection that could influence their professional development. Figure 6, on the next page, is a representation of the thematic network.

Figure 6:



Professional Presentation: Thematic Network Three

Reflection

Many students talked about how their reflection on the classroom activities could contribute to their development. They gave accounts of their personal modes of reflection and how this was an accepted part of their professional practice and as such, a ‘performative’ undertaking:

> I have what I call a memory folder, if I do something or if something's happened and I'd like a memory of it … If it has been something memorable… I'll do a reflection in my portfolio (Beth)
>
> At a base level we reflected on what went well and thought how we could mimic that (Brigitte)

> The first thing I did when we got back from the workshop was to write a reflection about it... One thing I really wanted to improve on was my patient communication (Karen)
>
> …maybe in the future I could do this… or say different things (Jess)

The value of reflection was evident across all thematic networks as the interviewing process prompted students to think back on the classroom activities and clinical situations. It was evident in the data that the interview facilitated further analysis of learning and a deeper sense of knowing themselves (Rees, 2013). Conducting the interviews from a constructivist perspective (Kvale, 1996) allowed participants and myself to co-construct new understanding and it was perhaps through conversation that students were able articulate their thoughts about learning from patients and carers further.

The reflective process gave participants an opportunity to explore their own feelings and it was evident in their accounts that there was a cathartic nature to their reflections as seen in Rees' study (2013). Some students explained that it 'felt good' to express their feelings:

> It was good to get it out …. I put down exactly how I felt and it meant so much to me at that point (Steve)
>
> The patients talking about it is an outlet and reflecting that's an outlet for me (Jess)

For one student, reflection had been a 'reality check':

> Afterwards I reflected on that session it was the first time the gravity of the course and the path I was starting on really hit home (David)

Some students scrutinised themselves and their practice:

> It made me examine myself clinically and the way I talk to people (Karen)
>
> It was a reminder, things you know, but forget (Brigitte)

However, David commented on his tendency to over analyse situations and saw how this could then impact on his self-assurance:

> Sometimes I over reflect, over analyse situations instead of just thinking that's what I did and that's how I reacted…I've had one or two moments that's affected my confidence (David)

Jasper (2003) criticises a focus on negative emotions in reflective practice and suggests that positive experiences can facilitate learning. In my study, participants were able to look at both positive experiences and learn from both:

> So just shaping your practice around the good and bad experiences people had (Ben)

This theme focused on reflection and as part of pre-registration training students are encouraged to reflect on their learning in a continuous way in a professional portfolio. Students talked about reflecting on difficult situations and used the interview as a means of further self-analysis and areas they wanted to develop.

Self-development

Participants assessed their own learning and development by commenting on their confidence in everyday interactions. The ability to talk to patients in the classroom and understand some of their issues gave students assurance that they could indeed address this in practice. The belief that this was a safe place that enabled risk-taking in a supportive environment facilitated their development:

> Being able to talk to real patients away from practice has been good and helped me build my confidence (Karen)
>
> Just test the water. It's made me more confident about asking 'what's going off?' (Angela)

Confidence in how they presented themselves appeared to be a critical element in participants' accounts; not only in their knowledge, but also their interaction skills. Another aspect of their development over time, as they reported it, was the ability to cope with emotion (related to thematic network 2). They identified how the action of reflection allowed them to consciously manage those feelings.

> I dealt with it and you have to go through these things, situations that are uncomfortable (David)
>
> I am much better at this now. I'm able to chat with patients and ….yes I can cope with it. You have to manage it professionally (Vishnu)

Students perceived that a number of factors contributed to their professional development. The data show that they perceived the management of emotions as a professional skill that they should master, with self-development in managing emotions dependant on reflection, formal knowledge and role models in practice. Participants spoke at length about the value of role models in practice:

> One time we had a really young patient…. he only had a month to live. I watched some of the staff with him…… I didn't know what to do, but they handled it really well and got him involved talking to me and another student. Humour was used and it was important in that situation. That helped me handle it (Vishnu)

> Part of this course is seeing staff work and learning from them. On my first day I wouldn't have known what to do and they say, "this is what you need to do, just watch and then you can have a go”, that's not something you learn in academic (Caroline)

Their experience of role models was both positive and negative and some participants were discerning in their choice of role models, expressing opinions about the approach to patients by clinical staff:

> Some staff are a bit harsh with patients (Carl)
>
> Seeing how other people treat patients in good and bad ways it makes you either think "I'm not going to speak to a patient like that" or "I'm going to do exactly what they do" (Steve)

I did not explore their perception of ‘harsh’ in this context, but a number of participants commented on how clinical staff interacted with patients. In health profession training, students utilise role models typically to focus on clinical competency, but Felstead (2013) argues that equally their purpose is to role model professional behaviours as. This suggests that emotional responses are learnt in the classroom and may be refined in practice.

All participants referred to their learning from interacting with patients and carers, both in specific and general ways and used the term ‘professional’ frequently when they described the types of behaviours they display. Their accounts of how they developed over time as a professional represented a journey on which they had embarked at the beginning of the course and were still travelling:

> In the first year I made conversation with patients, if they asked me a question I wouldn't be sure of the answer. In my student feedback, staff said I needed to improve my communication with patients … it's definitely improved. Next year I will have more opportunity to build confidence (Katie)

> Comparing how I am now to then and some of the things that have happened that’s brought me here; the workshop with patients and carers has been one of them (Karen)

Participants also referred to how their perceptions had changed as a result of their reflections on the patient and carer experiences that demonstrated personal growth:

> Things change, I have a different outlook, and this is good for me (Brigitte)
>
> Before, anything bad … I wouldn't let things affect me. But this was a kind of whoa…. actually some things should affect you (Steve)
>
> It helps you to grow as a person and I know it's helped me outside of the course when I meet new people (Jess)

Professional identity

The participants were encouraged to explore the role of patient interaction in the profession of therapeutic radiography. The commonest theme to emerge was related to their motivation to join the profession and secondly the paradox of the caring versus technical aspects of the role. Many participants described their motivation for joining the course was due to both the caring and technical elements of the role as reported by Bolderston *et al (*2010):

> I wanted to work in a caring profession, but I wanted to do something specialised and they both go hand in hand (Angela)
>
> I chose this job for the interaction. Personal reasons for choosing this career, two things work for me, contact and the technical side of things (Brigitte)
>
> I was going to do diagnostic at first, radiotherapy ended up being what was available to me, but it's worked out well for me when I saw there was much more patient contact. To have this connection

> with patients and having a positive influence on their experience (Jess)
>
> You have to be a certain kind of person to want to work in the health profession I got into the role because it's heavily science based … but it's also the patient care aspect which I love (Steve)

The potential dissonance that exists within the profession has seen radiographers debate the importance of the caring aspects of the role as technological advances in the field threaten the balance between the ‘technical and the humanist’ aspects (Bolderston *et al* 2010, p.200). It was evident from their accounts they saw a potential conflict between the scientific and caring aspects of the role:

> I was upset at myself for being focussed on the technical and I did lose sight that there was a patient there (Jilly)

Other paradoxical constructs discussed by participants related to dissonance around displaying emotion. Thematic network two was concerned with managing emotions and touched upon this conflict; here it is contextualised explicitly as a professional consequence that participants attempted to reconcile within themselves. For some students there was a more complex emotional picture, for example those who had joined the profession for personal reasons could be vulnerable in emotional situations. As one student said:

> Everyone starts the course for a reason, you've usually been touched by cancer and it's not always a good outlook (Beth)

However, the majority of accounts focused on the professional conflicts in managing emotion and to some extent participants were perhaps not just reflecting on their personal experience, but the professional dialogue that they had experienced in the workplace. In some cases it appeared that their experiences of clinical placement did not necessarily reflect their hopes:

> I don't feel we quite support people as much as we could… I don't see the supportive side as much as I thought I would, it's definitely the physical care we deal with more. I'd rather be involved in supportive care (Steve)
>
> That doesn't match what we are taught at university. It's not just about the technical stuff there is the holistic care of the patient….sometimes the two don't marry up (Brigitte)

For some I felt that this would continue to be source of conflict in their professional careers. As seen in thematic network two, the concept of managing the idea of being strong and not showing emotion was linked to notions of professionalism:

> It's …. Unprofessional for us to be upset (Karen)
>
> You have to manage it professionally (Vishnu)

The majority of students expressed some form of opinion on this, discussing the difficulties in displaying emotion and the professional behaviours that they may adopt in response to professional and personal conflicts. There was a view by some participants that showing emotion was in conflict with being professional. Various strategies are adopted that participants use in coping with emotion, one is avoidance:

> Certain patients that come in, I've tried to avoid (David)

Avoidance has been described as a negative coping mechanism that may eventually lead to burnout (Fallowfield, 2009) and that the acknowledgment of emotion could lead to more positive ways of coping. Most of the participants, asserted that as a professional emotion is something that should be controlled, but appropriate displays are at times desirable. Reconciling this dilemma or achieving balance was how some participants talked about their professional role and viewed it as part of their development. Rees' study (2013) identified two approaches by nurses to emotional situations. Those who believed professional distancing was the 'right' approach in emotional situations and others that developed an enhanced sense of being with a patient. Participants in this study considered how best to respond:

> I don't want to be a robot, it's always going to affect me, but if you become emotionally attached, then you're not going to get do your job properly (Beth)
>
> It's really about balancing distancing and compassionate behaviours (Brigitte)

Clearly there is tension and ultimately the individual chooses how to present themselves as a professional. Arguably, this develops over time, but the interactions with patients and carers can provide an important base from which to build on. Further comments from participants about their response to managing emotional situations relate to professional resilience: they talked about experiences that could be quite overwhelming and identified a need to be strong. Dunn *et al* (2008, p.47) looked at promoting resilience in medical students by identifying 'replenishing factors to the coping reservoir'. They propose a model that identifies negative inputs to the reservoir (stress, internal conflict, time and energy demands) and positive input as psychosocial support, social activities, mentorship and intellectual stimulation. An aspect of their work explores approaches to resilience and identifies factors that are dependent on the individual's strengths, coping style, personal traits and temperament. Resilience, therefore, is seen as an important attribute of a professional.

Global theme: professional presentation

This global theme relates to the participants' endeavours to present themselves as a professional to patients and carers with a distinct identity that encompasses a humanistic element. Reflective practice as a mechanism supports participants to analyse their interactions with patients and carers that can facilitate a better understanding of their personal ideology of the professional role. Self-development is influenced by external and internal factors: the synergy of learning from patients and other professionals is internalised to create a personal meaning (Felstead, 2013). The participants in this study conceptualise their own development as professionals, specifically their ability and confidence to cope with emotion over a period of time, which suggests their learning from patients and carers in the classroom is part of a much broader process of learning.

Through the interview process a shared understanding between researcher and participant emerged as the uniqueness of the therapeutic radiographer role was articulated. This uniqueness was reported by Bolderston *et al* (2010) and is borne out in this research: participants' perception that both technical and caring elements are required to effectively care for patients. This idealization of the role in itself creates a paradox as it may not be representative of practice and may cause disillusionment. This particular issue that technical competence may be favoured over care values is documented in the literature (Allan & Barber, 2005; Smith & Allan, 2010). The data show that patient and carer involvement in the curriculum illuminates this conflict and as a result of the findings should be explicitly addressed in the curriculum as an important aspect of 'professionalism'.

The notion of the 'ideal professional presentation' can be further explored through the work of Goffman (1959) and Rogers (1980). Although presented from different perspectives they are drawn on to illustrate this interpretation. Goffman suggests that an individual fulfilling a role will learn the part required for social acceptance and as such they will put on a 'performance'. Furthermore, he says an individual will adapt that performance in different aspects of their life to be accepted. As a professional practising in health care, there are certain standards and behaviours that are viewed as fundamental notably respect, dignity, caring, compassion and thus an accepted way for professionals to act (HCPC, 2012; Francis, 2013). So, the performance may be seen as an essential aspect of professional development. Goffman's conceptualisation of performance is further elucidated by his use of terms such as putting on a 'face' or 'front' and with this comes the implication of fakery. Today, these terms tend to be used in a negative context associated with an intention to deceive. He defends the use of such terms as he explains that it is the performer's belief in the part that should be questioned and whether the face is sincere or not. The patient and carer exposed to that performance will inevitably judge the authenticity of the interaction and as one participant said "the patient will know if you are genuine or not" (Angela). This notion of genuineness is discussed by Rogers (1980) as his conceptualisation of the 'ideal' focuses more on the belief in the role rather than the performance. In his work, *A Way of Being* (1980) he identifies that being with a person and feeling something of their feelings helps us to establish rapport and is the foundation for meaningful interaction. Rogers believes that these necessary skills require life-long commitment to learning and there are times when we will feel incongruent, but that in itself demonstrates realness.

As students on a course of professional study, there is an assumption that they must practise their craft and Goffman (1959) explains that the person practising the role will strive to become the role they play and thus the professional. In terms of participants' idealisation of the role of the therapeutic radiographer both Goffman's and Rogers' conceptualisations provide some explanation. As researcher, I accepted the participants' accounts of their role and so the fact they are practising to be a professional to some degree reflects Goffman's conceptualisation of performance. However, as participants talked frequently of how they perceived patients feelings and indeed their own feelings as a result of interactions it is perhaps Rogers' concept of being with the patient they were consciously striving for. Thus, students' professional presentation relates to this notion of developing purposeful care and compassion synonymous with the profession. Perhaps they were reflecting on what the ideal should be as through the interviews participants appeared to be projecting an image of the ‘ideal professional identity’. This could arguably be a habitual pre-reflective act *or* a more conscious attempt to be regarded positively by the researcher. However, what is evident in the data is participants’ desire to interact with patients and carers in an authentic way and present themselves as caring professionals.

To further explore this line of argument issues of power must be considered. As a researcher of/and in practice, I am aware of the inherent power relationship that existed between me and the participants in addition to my role as facilitator of the patient and carer workshops with students, which perhaps placed me in an epistemological position as ‘expert’. This thematic network focuses on the construct of the professional presentation and to some degree students’ idealisation of their professional role. However, I question whether they are also motivated to portray the ideal role as they wanted it to be seen by me to see (someone they perceived in a position of power). They were perhaps presenting a ‘face’ they aspire to and wanted me to regard them as good professionals. Perhaps then, Goffman’s construct is valid and the interviews have provided the students with an opportunity to give a performance of the ideal professional. Conversely, the classroom provides a safe space where students can explore the different ways of performing their professional role. The classroom activities could be developed to provide a forum for discussion on the ways they may achieve positive ways of engaging with patients and carers.

Thus, thematic network three has provided an interpretation of the participants’ conceptualisation of how their learning has influenced their professional development largely borne from an exploration of the tensions they experienced in practice. There is recognition that emotional work is one aspect of their professional role and an important feature of their developing practice. Internal conflicts around their practice and the ability to be reflexive has contributed to their sense of professional and emotional development. For many participants this prompted them to examine not only the professional role but the values and behaviours they believed were synonymous with it. A developing discourse emerged of the ‘ideal’ role in radiotherapy practice and paradoxes formed part of the discourse. To return to the YOU-US-ME psycho-dynamic model, this thematic network focuses on ME as participants explored how emotion should be expressed in their professional role and further how they projected an image back to the patient or carer. This brings learning back to YOU and emphasises continuing interaction and learning.

Chapter Seven: Emotional Learning and Professional Development

Introduction

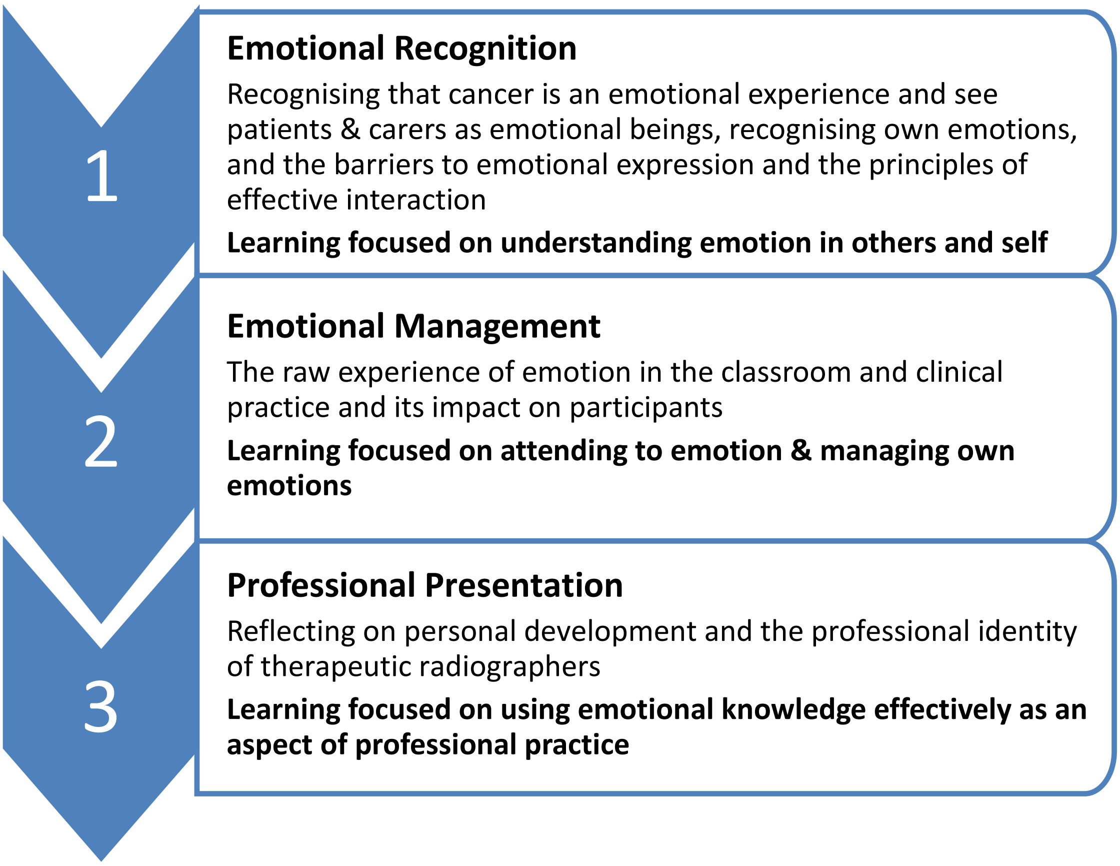
Three global themes emerged from the data as the central metaphors that represented the participants' accounts emotional recognition, emotional management and professional presentation. Organised as thematic networks interpretation has sought to explain the global themes' key characteristics and the features that support interpretation. Emotional recognition described the ways in which the classroom activities provide an opportunity for deeper conversation that highlights and makes clearer the emotions experienced by patients and carers. As participants made sense of their own learning this featured ways in which they could improve the experience of patients and carers in the clinical setting. Emotion, as experienced by participants, was characterised by the recognition of the emotional costs of cancer for patients and themselves. Reconciliation of those 'uncomfortable' feelings was seen as part of health professionals' work. The global theme professional presentation explored the reflective processes necessary to facilitate development and typically the ways in which participants became emotionally more adept in role performance. This chapter discusses emotional learning by drawing on theory about emotional learning from Fabricius (1991); Dilts & DeLozier (2000); Allan & Barber (2005); Theodosius (2006); and Allan (2011). In addition, the premise that emotional learning can facilitate humanisation and compassionate care is explored (Todres *et al*, 2009; van der Cingel 2014). The variations in participants' accounts are included in order to illustrate the differences in managing emotion in the workplace. The concept of emotional intelligence as a consequence of learning is explored as a premise for developing the skills required to deliver compassionate care, and to further explore the notion of emotion management. The chapter concludes with an argument as to how this thesis might contribute to curriculum developments. My contribution to curriculum knowledge is a psycho-dynamic pedagogical framework for patient and carer involvement that promotes emotional learning. To date, there has been little evidence for how radiotherapy students experience patient and carer involvement in the curriculum and this study informs HEIs and professionals of the value of involvement. In chapter eight I propose how the findings of this study can contribute to the current debate on teaching compassion (Francis, 2013; Richardson *et al*, 2015)

Emotional learning as a consequence of patient and carer experiences

What is evident throughout the three thematic networks is the role of the patient and carer in emotional learning of radiotherapy students. Figure 7, on the following page, depicts the emotional learning in each thematic network that occurs as a consequence of participants' interactions with the experiences of patients and carers and how it may influence their development as aspiring therapeutic radiographers.

The overarching theme of emotional learning positions the thematic networks as distinct yet related aspects of learning. Theme one represents the recognition that new learning arises from understanding the experiences of patients and carers, and that we all experience emotion in varying ways. As a consequence of witnessing patients and carers emotions, participants explore their own feelings and ways of managing emotion. Some dissonance exists between 'feelings rules' (Hochschild's view of management as a organisational goal) and the relational, unconscious and interactive nature of emotion described by Theodosius (2006). The tension of knowing the right way to express emotion was evident in the data and theme three explored this in terms of the participants' practice and the projection of a professional persona. Thus, the relationship of participants with patients and carers is fundamental to their emotional learning. Whilst they recognise painful emotions in others it provokes further emotions within them, and they express a desire to act on those emotions to provide good care (Allan & Barber, 2005; Theodosius, 2006; Karim & Weisz, 2011).

Figure 7:



Emotional Recognition

Recognising that cancer is an emotional experience and see patients & carers as emotional beings, recognising own emotions, and the barriers to emotional expression and the principles of effective interaction

Learning focused on understanding emotion in others and self

Emotional Management

The raw experience of emotion in the classroom and clinical practice and its impact on participants

Learning focused on attending to emotion & managing own emotions

Professional Presentation

Reflecting on personal development and the professional identity of therapeutic radiographers

Learning focused on using emotional knowledge effectively as an aspect of professional practice

Emotional learning represented in each of the three thematic networks

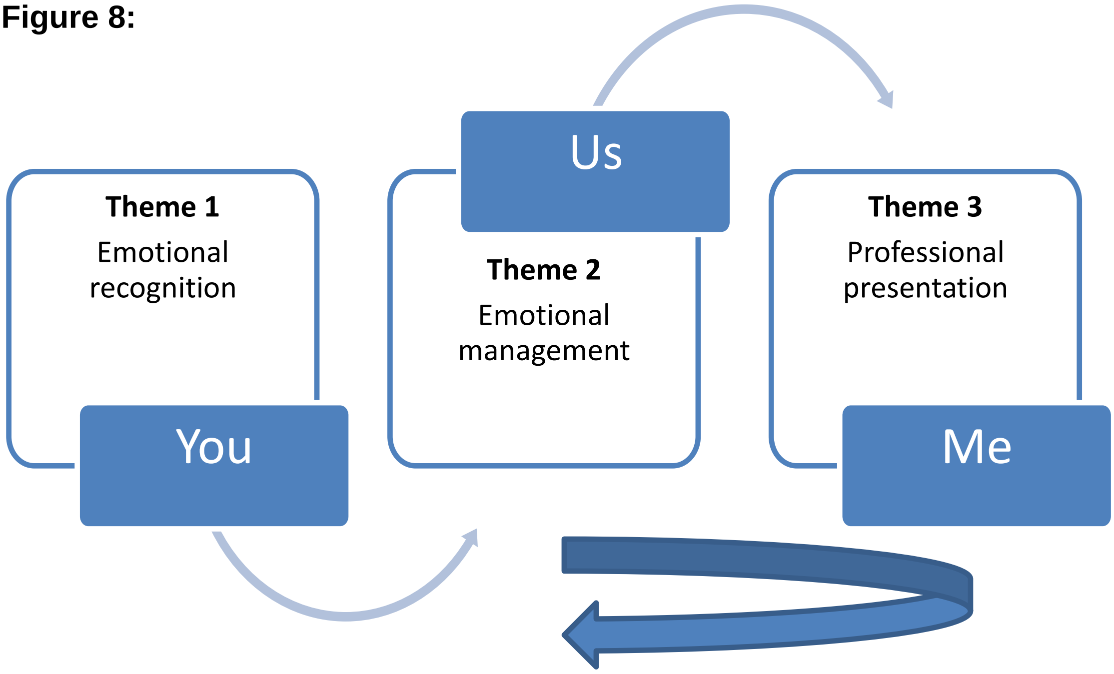
The findings indicate that the learning process begins with interaction between student and patients and carers represented by the YOU-US-ME psychodynamic model discussed in the three previous chapters and Dilts & DeLozier's (2000) framework of experiential learning, which are now further discussed.

YOU-US-ME: a psycho-dynamic model of interactional learning

Allan (2011) has used psycho-dynamic small group work to explore emotional issues from practice; similarly the curriculum activities prior to this investigation were designed to promote discussion and reflection on the patient and carer experience. In the activities, students asked questions and explored in more depth issues that were important to the patients and carers.

And so, the relational nature of the curriculum activities allows a two-way, ‘back and forth’ opportunity to explore experience. Hence, I chose to term this YOU-ME-US, and from this developed a simple psycho-dynamic model as follows. YOU tell me about your experience, you and me talk (US) I then think about ME and my practice. This model represents the interactive nature of learning in relation to the three global themes; the emphasis placed on YOU, US or ME varies in each theme. Learning as a collaborative process can contribute in different ways to students’ development by focusing on the patient and carer experience (YOU); the interaction (US) and the students’ internalisation of experiences (ME). Ultimately thinking about ME and what I do will then shape how further interaction follows with YOU the patient or carer. As a pedagogical model, YOU-US-ME represents a cyclical process of continual learning. Figure 8, on the next page, illustrates how the YOU-US-ME model of interaction relates to the themes of emotional recognition, emotional management and professional development, and further discussion identifies its significance as a tool for self-development. The emphasis of this model is that students listen to experiences, they discuss and learn from those experiences and as a consequence learn something about themselves as developing professionals and endeavour to project an ideal image to patients and carers. In essence, the premise of the learning activity is that the patients and carers are ‘knowledge brokers’ and a conversational approach expands the learner’s knowledge, which they apply to new situations (Evans, *et al,* 2010).

Figure 8:



The relationship of the three themes to participants' learning through interaction (YOU-US-ME)

The first box in the YOU-US-ME model represents the patients and carers sharing experiences with the participants (YOU). This prompts active listening to those experiences. Then the emphasis changes to interaction (US) and, through questioning and responding, the learner understands more about the emotional experience and the impact of cancer. As a pedagogical approach this promotes learning and exploration of what patients and carers would want in practice. Notably, thematic network two recognises the challenges of engagement in emotional talk (US) and features of emotional dissonance in response to difficult situations both in the classroom activities and then in the clinical setting. Through reflection on distressing situations the intensity of what is felt shifts emphasis to personal emotions (ME) and professional responsibility. This internalisation of emotion presents the opportunity to 'feel' the patients' and carers' experiences and thus to some extent demonstrate some empathy. However, the management of emotions and internal conflict was also viewed by participants as essential professional activity, "I think you're pushed out of your comfort zone and you realise you've got to step up" (Jess).

A further characteristic of thematic network 3 is the participants' reflections on their practice (ME) and their thinking about how they present a professional image to others. As learning is synthesised they may strive to portray an outward professional image, as a construction of the 'ideal' therapeutic radiographer expressed in different ways by participants.

Dilts & DeLozier: a model of experiential learning

My study provides compelling grounds for proposing that emotional interaction with patients and carers can facilitate deeper learning through experiential pedagogy. Participants' accounts indicated that engagement in emotional dialogue in the educational setting provides a catalyst to shape their subsequent thinking. Furthermore, my use of the in-depth interview with participants facilitates a clearer articulation of their own emotions with talk of feelings, responses to emotional situations and the values they hold as individuals. The Dilts & DeLozier (2000) framework identifies 'levels' of cognition taken from the work of Gregory Bateson (1972) and his concern with the process of thinking. The framework identifies experience as the fundamental basis of learning and a trigger for cognitive processes that may promote higher level understanding. The framework proposes that learning at a lower level changes thinking about learning at a higher level (see Table 4, on the following page). However, Dilts & DeLozier recognise that equally it may not change thinking and it is this distinction that perhaps characterises the differences in participants' accounts of emotional experiences. An example of this was when Jilly talked of how an emotional situation affected her thinking and she began to question the fundamental goals of the profession "I thought, oh my God, what are we doing?" In contrast, Carl preferred, "not to go there emotionally". Carl's response suggests that he felt more comfortable not challenging his own beliefs and values and did not attempt to question his position. In both these cases their views are influenced by 'gut feelings', which is described by Dilts & DeLozier (2000) as neurological pathways that are closely linked with visceral responses (feelings). They define emotion as a ‘physiological departure from homeostasis subjectively experienced in strong feeling’ (Dilts & DeLozier 2000 p.355), which suggests that emotional interaction provides a platform for lower level experiential learning. This recognises that emotional learning is grounded in the feelings experienced by the individual and further learning occurs through cognitive processes. The following discussion utilises the Dilts & DeLozier framework to identify the levels beginning with the lowest level of experience, then how this may influence behaviours, capability, beliefs and values and finally reaching a higher level of knowing the self.

Table 4:

LEVEL		LEARNING
High	Spiritual	A sense of purpose and belonging to something ‘deeper’ – ‘connectedness’
↑	Identity	Role conflict: caring versus technical – subscribing to ‘caring profession’
↑	Beliefs and values	Challenge previously held beliefs, develop notions of care and compassion values
↑	Capabilities	Developing strategies to deal with emotion in self and others in practice
↑	Behaviours	Automatic response to those emotions vary between individuals
Low	Environment	Experience of patient and carers’ emotions

Levels of Learning adapted from Dilts & DeLozier (2000)

Lower level learning

The first level of learning is the environment and is represented by the experience of emotion through interaction. Participants reflected on emotional situations and their responses to them as spontaneous behaviours or neurophysiological automatic responses (Dilts & DeLozier, 2000) with experiences of raw emotion exemplified in a number of the interviews. The idea that experience provokes automatic emotional responses is discussed by Theodosius (2006, p.899) as ‘unconscious emotional expression’. The interview then prompted further reflection and participants described how they developed mental strategies to guide their professional behaviours in practice. Learning at the next level focused on their capabilities of interacting with emotion through the selection and adaptation of behaviours to deal with a wider set of situations. This illustrates the development of cognitive capability; a function of higher level thought processes (Dilts & DeLozier, 2000).

Learning that changes values and beliefs

Dilts & DeLozier (2000) identify the next level of learning as ‘evaluative’ where cognitive processes focus on making judgements that may ultimately influence personal values and beliefs. Rees (2013) also describes this potential to change thinking as previously held beliefs are questioned. At this intermediate level of learning individuals engage in evaluation of self and others that could influence their thinking about emotional interactions. Evaluative statements were evident in participants’ accounts as their learning was articulated through the construction of a discourse on effective interaction and exploration of the professional values of caring. Angela’s use of the term ‘genuineness’ and Karen’s use of ‘rapport’ demonstrated the ways participants perceive what care should be. Yet there was often something more that was difficult to explain, “I’ve learned to listen more…. learned to be with a patient” (Vishnu). I was most struck by the internal conflict apparent in the participants’ stories and how emotional dissonance and the ability to reconcile uncomfortable feelings were viewed as important to their development.

Professional identity

At this level, further evaluation of their role was evident as they identified values synonymous with their view of the profession. The implications of this for the curriculum are to develop ways of explicitly discussing professional values and expectations of them in practice. Participants explored their identity and the attributes they believed characterise the profession. Dilts & DeLozier (2000 p.868) describe identity as ‘a collective concept with the organisation of values, capabilities and behaviours into a single system’. This suggests that in order to develop as a professional, engagement in cognitive processes that move through the levels from low to high is necessary. Indicative of this journey of learning is the ability to be reflexive, recognise personal growth and confidently challenge assumptions in self and others. As explained in Chapter Six, the professional identity that participants described featured issues of conflict perhaps reflective of this notion of higher level thinking. Two particular challenges emerged: the conflict between the caring and technical aspects of the role and perhaps, more crucially, that their expectations of the caring role did not match reality in the clinical setting. Bolderston (2010) has reported similar tensions in the profession. Evans et al (2010, p247) identify that the workplace environment fundamentally affects how ‘knowledge is put to work’ and so the learning that occurred in the classroom will require workplace re-contextualisation by the learner that will vary depending on placements. As a result new knowledge and understanding is generated, but as Evans *et al* (2010) state the challenge is to develop a shared sense of professional identity. Exploration of conflicts should be part of professional development and included in the curriculum.

Higher level learning

Bateson’s theory suggests that a sense of ‘spirituality’ occurs at the highest level of learning and Dilts & DeLozier (2000, p.866) define spiritual learning as ‘a sense of being part of something deeper; the pattern which connects all things together’. Perhaps in terms of professional identity this is concerned with belonging to a collective with a sense of purpose. It is arguably the cognitive processes that facilitate a connection between all stages of professional learning which demonstrate the potential for individual development. However, one cannot assume all students would achieve this highest level of understanding and there are some distinctions that require clarification. Firstly, it could be argued that higher level learning promotes a shared sense of meaning of the professional role and, whilst conflict will always exist, it may be assumed that higher level thinking may help mediate tensions. The second effect is through the professional discourse and aspirations to project the ideal professional face to patients and carers and colleagues. Both can positively promote the care values associated with professional practice (HCPC, 2013). A further consequence of this level of thinking is how it engenders a questioning approach to practice and instils self-confidence in the individual to challenge behaviours and beliefs that are not congruent with those identified professional values. By developing these characteristics one may argue that there is the potential to aid further development of individuals and promote learning to the highest level. However, it must be recognised that the application of learning in practice may be challenging due to personal, peer and organisational constraints. Furthermore, the suggestion that cognitive processes at the highest level require sequential learning is rather simplistic, but the premise is based on models of reflective practice (Jasper, 2003). The question of whether an individual has the potential to reach this highest level depends on their ability to question their practice and critique the professional discourse. As a consequence this has the potential to facilitate a deeper sense of professional practice. I would argue that the patient and carer involvement in the curriculum contributes to this level of thinking in individuals.

My research indicates that participants value the ability to engage effectively on an emotional level with patients and carers whilst recognising the need for personal development. Characteristic of the highest level of learning is the ability to question those fundamental values and develop a sense of what good practice entails. These values were variously defended by participants and as David said “why be a radiographer, if you don’t care?” This may appear a fairly innocuous challenge, but behind such a question is the more profound search for the meaning of care. Further synthesis of Bateson's concept of spiritual learning is represented in this study as a level of learning that is intuitive and insightful with the potential to have a deep influence on practice. Polanyi (1959) describes this as tacit knowing, a difficult to articulate state of learning, which some participants discussed to a greater degree than others. The findings demonstrate that interaction with emotional situations is the basis of this type of learning as this provokes automatic responses in individuals. However, it is the thought processes that occur after the event that is where learning begins and individuals develop personal strategies and values that shape their professional practice. Furthermore, learning at a higher level is the result of an individual's capacity to question and challenge themselves and others and thus impact on new learning situations and experiences. Dilts & DeLozier's framework (2000) has been a useful construct to interpret the learning from emotional experiences, but how emotional learning has the potential to influence compassion is explored further.

Emotional Learning and Compassion

Within the following discussion I present an argument that the ability to experience and express emotion facilitates empathic interactions with patients and carers, which in turn promotes humanisation and compassionate care.

Emotional expression

Emotion was expressed in various ways by the participants and a number of quotes in thematic network two demonstrate painful feelings. Theodosius's stance (2006) is to explore emotion in its literal and visceral sense as although it may be cognitively managed it is also associated by unmanaged irrational action. Participants spoke of visible emotion, "I shed a tear" (Angela), but for some there was evidence that this had been to some extent hidden, "I wouldn't want to cry or anything in front of anybody, it's difficult" (Jilly). Theodosius (2006) states that those hidden emotions whether conscious or unconscious should be explored. Fabricius (1991) reported in her study that group work gave nurses an opportunity of explore feelings about work that they were previously unaware of, or perhaps thought unacceptable. In this study, there was a sense that students used peer discussion and the interview to identify and express their emotions. Theodosius (2006) states that in order to identify emotions,

> The individual would need to disclose them, but such disclosure relies on the individual being consciously aware of their actual feelings and their emotional management, which would not always be the case (p901).

That some students shared deep emotions and some focused on how they managed emotion so as not to show it to patients and carers; and this perhaps reflects Theodosius' view. One must question whether complete disclosure of emotion is possible or desirable, and if not, how might the student use that emotion in their practice? Allan (2011) states that students need to be able to make sense of their feelings and group discussion and reflective practices can be a facilitator. Reflection on action allows one to learn from experience and Karen indicated that she had engaged in this throughout the programme in her professional portfolio. Additionally, the dialogue with patients and carers permits a heightened sense of what that patient or carer needs (Allan & Barber, 2005). Participants' felt emotion and subsequent reflection suggests both embodiment (intuitively knowing) and cognition (learning from experiences) and their endeavours to apply this knowledge to new situations.

Dimensions of humanisation in participants' accounts

The data has shown a heightened sense in participants of the personal experience of cancer and learning was evident in the focus on ways of demonstrating human care. As John said in his view of the curriculum activities, it 'humanises care' and then how he adapted his behaviour when he recognised distress in the patient. Humanisation of care is explored by Todres *et al* (2009) who state that humanisation is to be:

> Concerned with upholding a view or value of what it means to be human, and furthermore to find ways to act on this concern (p69)

To further explore the concept of humanisation, Todres *at al* (2009), whilst they acknowledge the important technical aspects of healthcare, suggest that this may lead to the de-humanisation of care. Their value framework identifies eight dimensions of humanisation and opposites that represent dehumanisation. Table 5, below, summarises the framework.

Table 5:

Forms of Humanisation	Forms of De-humanisation
Insider-ness of being human our sense of feeling, mood and emotion is the lens by which our worlds are coloured. Sharing emotions.	Objectification
Agency, freedom to act – dignity sense of personhood	Passivity
The uniqueness of the individual in this moment	Homogenisation
Togetherness as part of a community creates a sense of empathy	Isolation
Sense making - finding significance in our interactions and motivation to bring things together	Loss of meaning
To be human is to be on a personal journey connected to a sense of continuity	Loss of personal journey
Sense of place belonging to a community	Dislocation
Embodiment	Reductionist body

Conceptual Framework of the Dimensions of Humanisation (Todres *et al* (2009, p.70)

This framework although designed to identify issues that could be qualitatively researched, also provides an evaluative framework from which humanising and dehumanising elements of care can be judged. In relation to this study, it facilitates further discussion of how interaction with patients and carers can promote humanity.

Dimensions of humanisation were evident in the data and the following discussion identifies the ways in which participants reflected the different aspects of humanity as a consequence of engaging with patient and carer experiences. Participants voiced their sense of feeling and emotion as human beings, which in turn facilitated their 'response to human need' (Todres, *et al,* p70). Karen demonstrated this sense of humanity, "understanding what's most important to patients, making sure they have what they need". And further, to act on that sense of insider-ness "I understood she was frightened… I tried to be reassuring and included her husband" (John). Todres e*t al* (2009) suggest that agency (the ability to act) is closely linked with dignity and a sense that John valued human emotion was evident as he responded to the patient.

Many participants reported that the activities gave them a sense of the 'individual', the unique experiences of cancer and ways to 'tailor care' (Thematic network one). Angela described her attention to individuals as "remembering little details of what people have told me and following that up the next day". Equally, to be human is to be part of a community and whilst there are commonalities, such as emotional feelings, we make sense of this it in unique ways. Todres *et al* (2009) further discuss this sense of community and suggest that togetherness facilitates empathy and appreciation of others' struggles. Beth spoke of developing empathy through different experiences with patients and the curriculum activities promoted this sense of community between students and the patients and carers. "To understand what they have been through from start to finish, how it's affected them" (Angela). Perhaps, feeling those emotions contributed to a sense of community and heightened empathy (Rogers, 1980). The activities also facilitated a sense of the patient and carer journey and for the participants making sense of experiences helped them connect with patients and carers, “I got to know her and she came to me and told me things and I think that was good rapport and it probably did help her” (Jilly). Todres *et al* (2009, p.73) define a sense of place as ‘a kind of belonging that provides a degree of security’ and many participants spoke of connection, rapport and relationship building that would provide comfort, continuity and reassurance. The final dimension of humanisation is human embodiment, an intuitive knowing of the fragility of being human expressed by Sasha, “Seeing the family was hard to watch, but you know that’s what people are going through”.

This discussion has sought to demonstrate how the participants identified ways in which they connected with the carers and patients in the classroom; implicit in their accounts were humanising behaviours. Furthermore, participants spoke of how they endeavoured to bring humanity to ongoing relationships in the clinical setting. Fabricius (1991) states that activities that promote awareness of feelings can create an understanding of the humanisation of care. Several references to establishing rapport as an aspect of professional practice were made by the participants suggesting they valued the relationship with patient and carers. Thorne, *et al* (2005, p890) identify that ‘human connection is considered a universal ingredient of effective cancer care’

Care and compassion

A number of participants explored the meaning of ‘care’ or more specifically how they showed they cared. Care included: understanding others’ experiences, interest, genuine concern about how they were coping and ‘making a difference’. Care in relation to the health setting encompasses feelings of concern for another, but also involves ‘looking after’ another suggesting a task orientated activity. The debate about the tension between technical and humanistic care has been articulated in radiotherapy (Bolderston *et al*, 2010) and nursing (Fabricius, 1991; Freshwater & Stickley, 2004; Theodosius, 2006; Schantz, 2007; Smith & Allan, 2010). Richardson *et al* (2015) state that care is predominantly associated with patient interactions:

human presence, respect, connectedness and knowledge/skills. The suggestion that knowledge and skills may lean towards technical competence is evident in many undergraduate programmes and indeed assessment of technical competency takes precedence over interpersonal skills. Care organisations exist in many guises and whilst ‘care’ is a universal concept with identifiable interpersonal qualities (Kawamura, 2013) there are those that are concerned with merely delivering a ‘care service’. Thus, the notion of compassion is now further explored.

Van der Cingel (2014), states that compassion is a requirement of good care, with the terms care and compassion often used interchangeably, along with empathy, sympathy and kindness. However, there are clear distinctions which Schantz (2007) explores. She describes care as an overarching concept that is a state of mind, whereas compassion is based on emotions and feelings similarly described by van der Cingel (2014). Schantz (2007) further identifies that compassion is based on the motivation to act borne from the inner feelings of the practitioner. Both van der Cingel and Schantz argue that empathy is a condition for compassionate behaviour rather than an interchangeable term. Schantz (2007) identifies three facets of compassion: identifying with the suffering of another, feeling emotion and a desire to relieve suffering and it is that concern with pain that defines the concept. She questions whether compassion is an inherent quality or not, but suggests it can be learned through experience, good role models and will manifest itself through small gestures. One may argue that it is an individual’s choice whether to be compassionate in certain situations, however, Msiska *et al* (2014) in their study with nurses working with HIV patients, suggests that compassion is a moral obligation in health care.

In essence, compassion is a consequence of being human and provides a tangible link with the concept of humanity (Schantz, 2007). Schantz’s seven dimensions of compassion that mirror Todres *et al*’s (2009) dimensions of humanisation, provide a practical framework that can be included in curricula (see table 6 on the next page).

Table 6:

Seven Dimensions of Compassion
1. Attentiveness towards another human being facilitates interaction 2. Active listening to their story using silence and prompts 3. Acknowledge suffering use paraphrasing to make it visible, recognise emotions 4. Involvement in their situation, sharing their emotion, establishing trust 5. Helping as a practical component of compassion ‘doing something’ 6. Being with, and knowing what is important to the patient 7. Understanding of their experience, checking you understand, using that understanding in a professional role

Seven Dimensions of Compassion (Adapted from van der Cingel 2014, p.1255)

Furthermore, there are questions about whether compassion can blur professional boundaries and how much engagement/detachment is appropriate (Allan & Barber, 2005). Compassion by its definition requires engagement in emotion and as a consequence fatigue may occur (Potter *et al,* 2010). The discussion on page 171, explores in more detail how three of the participants coped with the emotional demands of interactions and how this may translate into compassionate behaviours. How this can be supported in the curriculum is discussed on page 179. Richardson *et al* (2015) has also called for curricula to address compassion, care and empathy if we are to meet the needs of patients and professionals in health care.

Differences in managing emotion and displaying compassion

Although every participant expressed the view that they should acknowledge patients' and carers' emotions there were clear distinctions between individuals on how they do this and also how they cope with emotional interactions in their work. In particular, variety existed across the whole sample in how comfortable they were with emotion and how they subsequently developed relationships with patients. There were also some differences in how they reported their on-going learning and professional development. In order to illuminate these points, I include three extracts from the interviews with Karen, Carl and David (Appendix 14) and explore how emotional learning and ways of coping vary. Differences between individuals will be explored with respect to personal values, their coping styles, the unique nature of their learning and potential for emotional growth and compassion. This aspect of the findings is particularly important when developing the curriculum to support individual professional development.

Each of the three participants talked about their learning from patients and carers, reflecting on the classroom activities and clinical experiences. A key aspect of Karen's learning was to understand what was important to patients and to begin to apply this in the clinical setting. For Karen, it was the 'little things' that made a difference to patients and she increasingly used this know-how in her interactions with patients. In contrast, Carl said that he sometimes forgot there was a patient on the bed as he was so focused on learning the technical aspects of the role. He talked of time pressures in a busy environment, but also how he enjoyed chatting with patients as he collected them from the waiting area and how he became their 'go to' person. I sensed there was limited time to listen to patients and his strategy was borne from a desire to 'get on' with the job. Alternatively, I noticed David's sensitivity and the language he used to describe his experiences with patients. It was evident that he valued the emotional connection he felt with patients as he talked about being touched by their experiences. Although Karen and Carl also spoke of how they developed relationships with patients David's accounts of specific situations in practice demonstrated a heightened sense of empathy.

With respect to professional development, both Karen and David had actively reflected on situations, but Carl was unsure of whether he did this. Reflecting on experiences is reported in the literature as a key aspect of emotional learning (Fabricius, 1991; Allan & Barber, 2005; Msiska *et al*, 2014; Richardson *et al*, 2015). However, all three recounted emotional situations in clinical practice that they had learned from. Karen was committed to learning from experiences and although she had felt rather unconfident with interactions early on in the course she felt she was improving. She commented that the classroom activities had helped her, but she said there were times in clinical practice where your confidence would be 'knocked'. As a researcher, this created for me the sense of a learning journey that Karen was travelling, which began with the classroom activities and characterised by her reflective practice that focused on continuous improvement of communication skills. David had a tendency to over-analyse situations and at times this affected his confidence, whereas Carl seemed self-assured. This appeared to show the different approaches of each student in their engagement with reflective practice.

All three students spoke about managing their emotions, but in different ways. When asked about the emotional aspects of the activities Karen did not think that displays of emotion were professional, but that one needed to achieve a balance so as not to appear 'cold'. On the other hand, David spoke readily about emotion and recounted how he responded to different situations. He talked about developing a professional relationship, but also about being engaging with patients and carers. Whereas, Carl described himself as a 'logical rather than emotional thinker'; using distancing strategies as a way of coping. Rees (2013) describes the act of developing personal boundaries as a way of coping with the emotional work involved in health care. Alternatively, she also describes attachment behaviours and engaging humanely, that for some will feel more appropriate. There was a sense that David took that stance as he said, “I am interested in how people feel and how they are emotionally and maybe that’s one of my strengths”. Definitions of compassion identify engagement as a feature of compassionate behaviour (Schantz, 2007; van der Cingel, 2014; Msiska *et al*, 2014).

These three interviews were chosen as they represented the variance in students' emotional learning and whilst they all recognised the emotional impact of cancer and demonstrated potential for developing compassionate behaviours there are some distinct differences. Karen represents a number of students in this study who seem to some extent unconfident in their ability to engage on an emotional level, but have clear potential to develop those skills. Through active learning they will strive to improve interactions and develop a style that employs both distancing and compassionate behaviours to achieve balance (Allan & Barber, 2005). Carl and some other students preferred to utilise distancing strategies in emotional situations as they recognised the potential for burn-out and the impact this could have on them. However, it could be argued that this may prevent the development of compassionate behaviours. As reported by Fallowfield (2009) distancing can contribute to burn-out as individuals fail to engage with emotion on a daily basis. She suggests that by acknowledging and working through emotions this can afford the health care practitioner fulfilment in their role. David's narrative was similar to Jilly, Angela and Steve's in that they appeared to recognise emotional situations and regulate their own feelings. This may in part, be due to their maturity and life experiences and as such perhaps were more likely to foster a human attachment in interactions with patients and demonstrate compassionate behaviours. David recognised the need for establishing professional boundaries and although he appeared to have the ability to cope with emotion there could be a danger of compassion fatigue identified by Potter et al (2010). These different approaches to emotional interaction highlight the potential for burn-out in students that become overly attached or detached and perhaps those that develop a balanced approach better demonstrate emotional regulation.

The purpose of presenting the three accounts is not to judge one as superior to another, rather to illustrate the varying ways that students cope with emotional interaction. This study suggests that a balance of these behaviours is a desirable way forward and that students will to some degree decide this for themselves. The value of interacting with patients and carers in an educational setting is that previously held beliefs on how to deal with emotional situations in practice can be challenged as many participants reported a significant shift in their thinking and this could then create a basis for further development (Dilts & DeLozier, 2000). It appeared that learning about emotion through interaction prompted students to identify their own style and what felt most comfortable for them as individuals could be developed over time. The evidence leads me to propose that through other educational activities this perhaps could be explored further to support students in finding a balance of behaviours and select helpful coping strategies as their progress through the course.

Emotional intelligence

The following discussion identifies how emotional intelligence, developed through emotional learning, may facilitate students to be compassionate and relevant to my findings. The ability to display compassion is dependent on an individual’s propensity to effectively manage emotion (Potter *et al*, 2010). Features of the Salovey & Mayer (1997) Four Branch Model of Emotional Intelligence (see Table 7, on the next page) were implicit in participants’ accounts, typically as they spoke of developing and testing out strategies for interacting with emotional situations and how they cope with their own emotions. Branch one of the model views recognition of emotion as the first step in developing emotional intelligence and this sense of emotional understanding was evident in the data as participants’ recognised emotion (thematic network one). The attempt to understand emotions and reconcile their feelings reflected branch two and three of the model and emotional management (thematic network two). Participants spoke of regulating emotions (Branch four) and recognised that emotional management benefitted not only patients and carers, but also contributed to their development and the potential to avoid burnout (Dunn *et al*, 2008).

Table 7:

Adaptation of Salovey & Mayer Four Branch Model of Emotional Intelligence
1. Perception, appraisal and expression of emotion
The ability to *recognise emotions* through listening to patient and carers experiences and identifying their emotions
2. Emotional facilitation of thinking
Emotional states encourage specific problem-solving approaches through interacting with patients and carers and experiencing emotion in everyday practice
3. Understanding and analysing emotion, employing emotional knowledge
Learning to interpret meaning in emotions and complex feelings - *emotional work;* experiencing and managing emotion
4. Reflective regulation
Ability to stay open to feelings and reflectively engage or detach depending on situation, regulate own emotions and recognise *own development;* achieve balance.

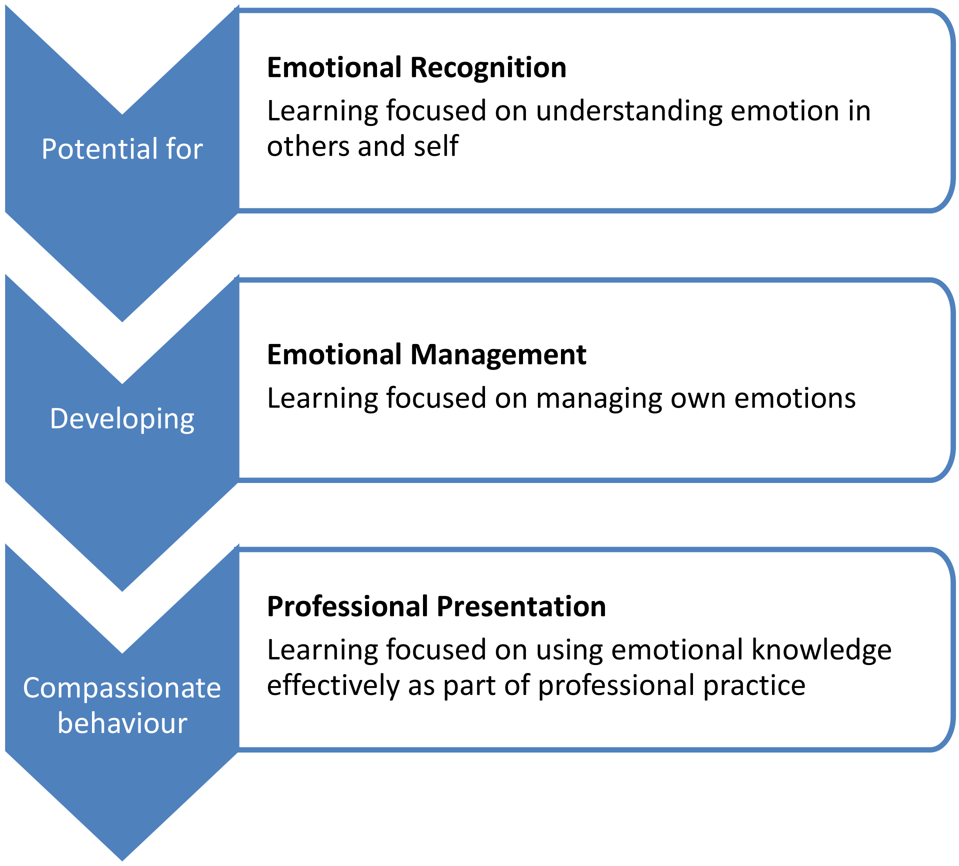
Mayer-Salovey's Four Branch Model of Emotional Intelligence (Mayer & Sluyter 1997): adapted to show features of participants' experiences of interacting with patients

Participants in this study demonstrated a sense of professional responsibility and the desire to display appropriate behaviours as they responded to emotion such as "speaking more slowly" (John) and "listening ... let them tell me what the problem is" (Steve). It was this sense that participants strove to 'do the right thing' in certain situations that I recognised as compassion. Their desire to project a professional image and find 'balance in displaying distancing and compassionate behaviours' (Brigitte) prompts further exploration of the link between emotional intelligence and compassion.

The theory of emotional intelligence (Goleman, 1995; Salovey & Mayer, 1997; Kooker *et al,* 2007; Montes-Berges, et al 2007) along with concepts of knowledge construction (Pawson *et al*, 2003) and tacit learning (Polanyi, 1959; Eraut, 2000) provide the conceptual framework that links emotional learning with the potential to be compassionate. The findings of this study suggest that emotional intelligence could be aided by the purposeful inclusion of patients and carers in curriculum delivery and in turn this tacit learning can enhance understanding of 'care'. The idea that emotional intelligence is a necessary feature of a caring professional is supported by Freshwater and Stickley (2004) who are advocates of the inclusion of this type of tacit knowledge in the curriculum to aid the development of emotionally intelligent practitioners. It appeared that the biggest impact of the classroom activities was on helping students to develop a sense of what was important to patients and how they could make a positive impact on the cancer experience. It is proposed by Goleman (1995) that emotional intelligence and compassion are positive attributes of an individual who provides care. With renewed interest in the health services to 'get back to basics' and provide high standards of care, as indicated by Francis (2013), there is an opportunity to apply Goleman's theories to the curriculum.

The majority of participants discussed their potential to develop their caring skills, respond appropriately in emotional situations, connect with patients and have a positive influence on experience. The potential for developing compassionate behaviours is individually-dependent and each student will uniquely synthesise their learning and apply this in practice. The data suggests that this is realised through their desire to utilise learning to improve the patient and carer experience. To effectively attend to patients' emotional needs students must in turn manage their own feelings. Gelhaus (2012) discusses compassion as an attribute of health care professionals and suggests it is equally important as technical competence. She describes compassion as an emotional attitude that is characterised by the ability to feel others' feelings and provide an emotional response to their experience. A distinction she makes is that in an emotional situation the compassionate practitioner will inevitably take ownership for action (Schantz, 2007). It is perhaps this sense of responsibility that was evident in participants' accounts, and so compassionate practice may also be viewed as a burden. Gelhaus (2012) acknowledges this caveat, stating that a compassionate person may be at risk of burn out and she proposes finding balance. In current healthcare arenas the tension between organisational responsibilities such as targets and the need to demonstrate care should be addressed in the curriculum in order that students achieve balance. As emotional intelligence particularly focuses on the ability to regulate emotions it could be argued that the emotionally intelligent practitioner is able to achieve balance whilst acting in a compassionate manner.

Figure 9:



Potential for developing compassionate behaviours

How the findings can be translated into curriculum activities

As a researcher and tutor I believe that the involvement activities in the curriculum have added a humanistic dimension to the modules and this is supported by the data. Furthermore, the study has provided insight into the ways this occurs and how that may impact on professional development. An objective of this study was to better understand the learning students derived and to identify how the curriculum could be enhanced further to support their development. Earlier assumptions were that this would focus on the development of patient care skills, and the data suggests they developed and enhanced awareness of emotional management and compassionate behaviours. Potter *et al* (2010) assert that in order to be compassionate towards others then one must take care of oneself to avoid burnout and fatigue. The findings indicate that concepts of professional values with their associated tensions and self-care strategies warrant equal attention in the curriculum. The following discussion explains the curriculum enhancements identified as a direct result of this study and an argument is made for how this can reform the curriculum for radiotherapy students. I have categorised the new developments into two separate areas, ‘caring for others’ and ‘self-care’ which I will discuss further and have summarised in table 8, page 182.

Caring for others

The findings demonstrate that the classroom activities prompt students to reflect on how patients and carers experience cancer and the plan is to incorporate a seminar or workshop into each module of study in the programme. To further encourage development a reflexive activity will be introduced to facilitate deeper learning (Dilts & DeLozier, 2000) based on a framework proposed by Burkitt (2012). Burkitt regards emotion as a central principle of reflexivity and an inter-relational process that uses dialogue to make feelings explicit. His simple framework begins with unconscious self-feeling followed by subjective and objective reflection to promote reflexive awareness and subsequent motivated action. This approach can support caring strategies whilst identifying for individuals aspects that they find particularly challenging.

Basic communication skills workshops are currently delivered in the first year of the programme, but the plan will be to introduce feedback from patients and carers directly to students. The format of this activity would be to simulate the ‘first day chat’ with patients and carers who would highlight good communication skills and aspects of the communication that they found unhelpful, uncompassionate or poor. Students will be encouraged to use learned strategies in the clinical setting and gain further feedback from staff and patients about their caring skills. Although compassionate care is expected in the current healthcare system (Department of Health, 2013) students often have limited conceptualisation of what this entails. So, the plan is to deliver a workshop that explores therapeutic relationships in healthcare and compassionate care including ways that these may be enhanced.

This study has demonstrated how emotional situations are often challenging to the students and a further development will incorporate ‘managing difficult scenarios’ in the programme. One way to evaluate learning is for students to identify how they might make a difference to patient and carer experience and in a workshop that encourages students to ‘make a pledge’ is inspired by Turnbull et al (2013). Furthermore, students will be asked to evaluate the impact of their pledge in clinical practice as a long term commitment to patient care.

Self-care

It was apparent that students enter the profession with varying views of what the role entails. Vague notions of it being a role that has technical and caring elements was coloured by the experiences of some participants. Jilly’s reflection highlights the impact this can have on the individual:

> I turned round and there was just this figure sat on the bed, I could cry now thinking about it, and he just looked so ill …. It was “oh my God, what are we doing?” … the shock of seeing him sitting there looking all vulnerable and the enormity of what we were about to do….

First, this has implications in the recruitment of students and the emotional nature of the work must be transparent to potential recruits (Msiska *et al*, 2014). It also demonstrates the importance of supporting students to develop self-care strategies that would enable them to become resilient whilst empowering them to be compassionate to others. Another curriculum activity will be to deliver a session on emotional intelligence to third year students that include activities with patients and carers and a self-assessment questionnaire, but this perhaps needs to be introduced earlier in the programme. Exposing students to the requirements of self-care may not only improve their resilience, but as a consequence improve retention to the course. In recognition that difficult situations will arise in students' practice indicates that a 'clinical de-brief' based on psycho-dynamic group discussion can facilitate awareness of emotional dissonance and coping mechanisms (Allan & Barber, 2005; Theodosius, 2006; Smith & Allan 2010; Allan, 2011). Further, development of a tool kit that includes scenarios and strategies to support students to become resilient may be helpful.

In the past, students who have struggled with emotional situations sought advice and support from clinical tutors or local staff, but what this consisted of has been largely variable. This has also highlighted a need for staff training so that they in turn may better support students to effectively work with emotion in their professional practice. Whilst a range of strategies for coping with emotion can be shared with students we plan to identify individual needs and develop a structure for supporting emotional learning. Furthermore, a number of developments are planned that include self-appraisal and exploration of professional and care values to help students create a sense of professional identity. It is hoped that these additional activities can provide a basis for continuing development throughout the programme and better prepare students for the challenges they face in the oncology setting (Potter *et al* 2010). Although I have summarised the developments planned at this point in time it is an evolving process and continuing evaluation will inevitably shape what works best. What is clear is that patient and carer involvement in the curriculum can impact on how students perceive care and with augmented activity supports their associated professional development.

Table 8:

Care for others	**Curriculum Activities**
Increased awareness of patient & carer experience	• Incorporating patient and carer experience in each module to enhance content. • Reflexive activity that focuses on emotional awareness (Burkitt, 2012) to promote higher level thinking (Dilts & DeLozier, 2000)
Improved communication skills	• Communication skills workshops with patients and carers. • Role play with patient and carer feedback on skills
Compassionate behaviours	• Exploration of therapeutic relationships (Rigg, 2012) and compassion (Schantz 2007; Bolderston, *et al* 2010; Francis 2013; van der Cingel, 2014)
Managing difficult situations	• Group work – working with emotional scenarios and responding to difficult questions (listening, picking up cues, responding: Rogers 1980)
Making a difference	• 'Making a pledge' to improve patient and carer experience (Turnbull *et al*, 2013). • Evaluating the impact of the pledge in practice and own development.
Self-care	**Curriculum Activities**
Self-awareness and emotional intelligence	• Self-appraisal of previous experience at the beginning of the course. • Self-assessment of emotional intelligence (Neale *et al*, 2009) and identify development needs.
Reflecting on situations in practice	• Clinical de-brief after placement – psycho-dynamic group work (Allan, 2011) to reflect on different experiences and responses to emotional interactions

Achieving balance	• Explore distancing and compassionate behaviours (Allan & Barber, 2005; Rees, 2013) • Discuss burn-out (Potter *et al*, 2010)
Resilience and coping strategies	• Identify personal coping strategies - explore self-help techniques (Dunn *et al*, 2008). • Group support as part of clinical de-brief • Tutor support (tutor resilience training)
Professionalism – values and conflicts	• Workshop on professionalism in therapeutic radiography. • Explore values and conflicts and identify strategies for management in professional practice module.

Curriculum developments

Summary

This chapter has discussed how patient and carer involvement in curriculum activities that focus on sharing emotional experiences can promote emotional awareness in students. Reflecting on those experiences encouraged emotional expression in the participants and consequently they articulated the tacit learning about care, which had occurred. Further cognition as described by Dilts & DeLozier (2000) promotes learning about emotional expression and management. In addition, learning from patients and carers could enhance embodied understanding of the humanisation of care (Todres *et al*, 2009). Furthermore, participants were able to articulate what it means to show compassion to patients and carers and the skills that necessitate achieving a balance between distancing and engagement in their professional role (Allan & Barber, 2005). Differences in the coping strategies of students characterise how compassion is demonstrated and suggests that all students have the potential to become compassionate through facilitated engagement with human experiences.

A key contribution of this study to knowledge is the development of an explicit pedagogy of patient and carer involvement that facilitates emotional involvement and management. Whilst this study was undertaken with radiotherapy students the findings are applicable to all health care professionals. Learning directly from patients and carers about the experience of cancer can enhance the technical knowledge that is profession specific and inform notions of care. The premise of patient and carer involvement pedagogy focuses on relational knowledge construction with reflective processes central to the application of using knowledge in new situations (Evans *et al*, 2010). Learning begins with interaction characterised by the psycho-dynamic activity between students and patients and carers (YOU-US-ME). Experiential learning, as described by Dilts and DeLozier (2000), stimulates cognitive processes that inform capability in working with emotion and for some further understanding of the values and behaviours synonymous with their professional identity. However, more difficult to articulate is the tacit learning that varies between individuals that was evident in their attempts to describe their own emotions and compassionate behaviours. It is perhaps how this aspect of learning can be translated into the curriculum that requires more thought (Richardson *et al*, 2015).

The table on page 182 charts the improvements to the curriculum to address three specific strands of professional development. The first aspect is the care of others, with activities that promote emotional awareness and improved communications in difficult emotional situations (Fabricius, 1991). Further activities that explore compassionate care are included to develop students' understanding of helping strategies. Secondly, working with emotion requires students to explore self-care and develop strategies that alleviate personal stress to avoid burn out (Dunne *et al*, 2008; Potter *et al,* 2010). Lastly, the findings show that patient and carer involvement promotes professional awareness of care values and the role of compassion as an important aspect of their professional image. As a result of the findings in this study, specific learning outcomes that relate to patient and carer experience, compassion, self-management and professionalism have been incorporated into the radiotherapy curriculum. The generic wording of these learning outcomes can be applied to all health care curricula.

A limitation of this study is that the whole cohort did not take part and therefore the assumption may be made that not all students would develop emotional knowledge to the extent the data suggests. However, as the current driver for compassionate care is clear in health and education policy (Department of Health, 2013), I would argue that the development of a patient and carer pedagogy can be applied to any health and social care courses and is of interest to the wider community. Furthermore, as a direct consequence of the findings, the course team have included these specific activities in the curriculum with positive feedback from students. In fact, students have given feedback that they would prefer some of the more challenging activities to be delivered earlier in the course to help prepare them better for practice. A structured approach to pedagogy that includes course design, teaching activity and facilitating students to re-contextualise knowledge is proposed by Evans *et al* (2010). There is evidence to suggest that the pedagogical approach I propose can have the desired impact of enhancing students' ability to engage in emotional work as part of their professional practice. My study highlights the need for further research which explores the influence of students' learning on their practice and for research into how emotional learning influences continuing practices (Schantz, 2007).

Chapter Eight: Conclusions

Introduction

This thesis explores the influence of patient and carer experience on student learning. The research is rooted in my interest in the patient and carer perspective as discrete involvements in the curriculum, and as informed by professional standards (HCPC, 2013) and policy that advocated such activity in HEIs (CUILU, 2005; Farrell *et al,* 2006). The findings demonstrate the different learning that occurs, but specifically how patient and carer involvement influences emotional learning and the potential to promote compassionate care. This chapter summarises the findings of the study and includes a personal reflection of the research process. A number of publications emerged after completion of data analysis appeared to speak directly to my data (Francis, 2013; Department of Health, 2013; Francis, 2015). I have included a critique of how the Francis (2013) speaks to the findings and reinforces the assertion that patient and carer involvement in the curriculum can promote compassionate care. The epilogue proposes how this study has contributed to pedagogical understanding of the value of patient and carer involvement.

Reflections on the research focus

At the outset, this doctoral research was concerned with examining the particular ways in which radiotherapy and oncology students could learn from patients and carers as a result of facilitated classroom interaction augmented by on-going clinical experience. As my own experience of patient-practitioner engagement suggested that learning could take place, involvement activities were developed to facilitate insight into cancer patients' and carers' experiences. These activities were included in modules that had only focused on formal knowledge (lectures, texts and research) to promote understanding of the human experience of cancer. The aim of this study was therefore to illuminate the *ways* that students processed this learning with respect to their professional development and thus contribute to the developing evidence base on the value of patient and carer involvement in education (Warne & McAndrew, 2005). Furthermore, the evidence could inform my own and other HEIs as to how and why patient and carer involvement should be part of the curriculum.

Concepts of knowledge construction (Pawson *et al,* 2003; Bleakley & Bligh, 2006) and emotional intelligence (Goleman, 1995; Salovey & Sluyter, 1997) were guiding frameworks in the conceptualisation of the research. These were selected to understand learning in its widest sense, but as participants' accounts highlighted emotional feelings as a central aspect of the learning experience, interpretation focused on their emotional learning. Although notions of knowledge construction and reflection, as mechanisms for learning, featured in their accounts, these were often articulated in deeply emotional language. Listening back to the recordings and seeing expressions of their own emotions in the transcripts surprised me. Comments such as, 'it was a painful experience', 'gut-wrenching', 'I nearly cried .. it upset me for two days afterwards', 'it made me realise the gravity of what I was embarking on' were emotional words and difficult to hear. I worried about how they coped with such interactions. On the other hand, why should this surprise me? Students beginning their professional journey are likely to be touched by those experiences and I began to question my own taken for granted perceptions around emotion being 'part of the territory'. I came to realise the significance of supporting students in their development.

Participants offered their perception of learning in a variety of ways. Typically they articulated that they came to recognise the emotional consequences of cancer in others (patients and carers) and indeed their own uncomfortable feelings, resulting in a desire to manage distress. Talk surfaced around difficult situations they had experienced in practice and a need demonstrate that they cared. Some articulated this in a way that was about their personal motivation to care, while others spoke about how caring was a professional responsibility. Furthermore, in some instances participants attempted to evaluate the emotional nature of their professional role and how they should portray themselves in the clinical setting. Thus, emotional learning as a consequence of patient and carer involvement became the overarching theme in the findings. After analysis, this led me to propose that patient and carer involvement can provide a basis for emotional learning that may then foster compassionate behaviour in students. Perhaps more crucially, patient and carer involvement can prompt students to explore their own ways of coping with emotion in professional work.

Summary of chapters

Chapter One

Chapter one set out the context for the study, which culminated in the formulation of research questions. It was imperative to explore whether patient and carer involvement could address the problem in the curriculum and promote care values. I acknowledged at the outset that a major stimulus for the study is a personal belief that the patient should be placed at the centre of learning. My assumption that interaction with the patient and carer experience can offer an added dimension to professional knowledge development underpinned the focus of my research interests. A reflexive account of the challenges of being a novice researcher was included with a timeline that charted the extended period of study. The chapter emphasised my assumptions prior to the investigation and how new insights emerged from the data as 'emotional learning'.

Chapter Two

Chapter two discussed the underpinning literature that informed the curriculum activities involving patients and carers in healthcare education. Each of the patient and carer involvement activities were developed with patient and carer input and evaluated as part of a module. The student evaluations identified learning, which indicated that interaction between the students and patients and carers provides an opportunity for learning, but *how* *and in what ways* that learning was experienced was not fully understood by the course team and was absent in the literature. My aim was to understand the extent and nature of the learning that was taking place as a result of facilitated patient-carer-student interactions.

Chapter Three

Chapter three positioned the research within a theoretical framework and provided a rationale for choosing qualitative inquiry as a suitable approach. The rationale is based on epistemological and ontological principles associated with social constructivism (Cresswell, 2013) and a number of issues that relate to methodological decisions were discussed. More importantly, I discussed my own influence on the research and potential for bias was also explored. I remained alert to my own opinions that could infer a higher state of knowing and endeavoured to value participants' views (Hamill & Sinclair, 2010). Attride-Stirling's (2001) thematic network analysis framework was selected as a framework that enabled interpretation and presentation of the data as complex metaphors characteristic of participants' interpretation of learning. The operationalisation of the study was fairly unproblematic with interviews recorded and transcribed verbatim. However, early in the interviewing process is the point where my own learning began. There were important insights for me as a researcher, particularly in developing an interviewing style that was more conversational and then utilising subsequent interviews with other participants to explore emerging issues. More crucially I started to challenge my own views of the value of patient and carer involvement. Were the involvement activities too difficult or challenging? As interviews were increasingly focused on emotion I revisited the audiotapes and the emergence of emotional learning as a key theme became apparent. As I repeatedly listened to the interviews were the feelings of participants were more evident. I could hear this clearly in participants' voices as they reflected on emotional situations. I was struck by the tone, the hesitation, the dip in volume and the language they used that was laden with emotion. It was this iterative activity that gave tangibility to the emerging interpretation of emotional learning that I had previously taken for granted. My view that emotional awareness was just one aspect of knowledge construction in professional practice (Eraut, 2000; Pawson *et al,* 2003) was superseded by a realisation that emotional learning was the central feature of the data. The awareness of how my prior assumptions could influence interpretation marked my growing reflexive cognisance.

Chapter Four

Emotional recognition was characterised by participants' reflections on the emotions expressed by patients and carers and how that appreciation could inform their developing practice. There appeared to be a heightened awareness of the uniqueness of the cancer experience and how they must then tailor care to meet different needs. Central to this thematic network was the sense that, for these students, recognition of emotion requires action; to respond to emotion by using genuine communication skills. Furthermore, a key characteristic of this theme is the importance participants attached to forming a connection with patients and carers, thereby facilitating a caring and authentic relationship (Allan & Barber, 2005).

Chapter Five

Emotional management represented the participants' cognition of managing feelings, but also acknowledged that irrational and unconscious feelings are experienced (Theodosius, 2006). Emotional management evokes a sense of cognition, but equally the participants displayed emotional expression that was less conscious and more reactive to the emotional interactions they witnessed. And so, the theme of emotional management was characterised by three distinct levels of action. At the first level was the effort required to interact with and attempt to understand patient and carers emotions, which provoked uncomfortable feelings. The second level required participants to acknowledge their own emotions and begin to develop strategies for becoming adept at managing their feelings. Finally, the students were preparing to engage in emotional work. However, a stepwise progression through these emotional states cannot be assumed and the data show that emotional dissonance ultimately impacts on the students' ability to successfully manage their emotions and still a further conflict lies in whether this should involve distancing or compassionate strategies or more realistically a balance of both (Allan & Barber, 2005).

Chapter Six

This global theme related to the participants' endeavours to present themselves as a professional to patients and carers with a distinct identity that encompasses a humanistic element (Frank *et al*, 1994). The participants in this study conceptualised their development as professionals, specifically their ability and confidence to cope with emotion over a period of time, which suggests their learning from patients and carers in the classroom is part of a much broader process of learning.

The findings from my research build on the views of Bolderston *et al* (2010) regarding the uniqueness of the therapeutic radiographer role, in that participants' indicate both technical and caring elements are required to effectively care for patients. The idealization of the role (as a caring profession) in itself creates a paradox as it may not be representative of what students witness in practice and may cause disillusionment. The data show that participants identify a mismatch between what they are taught in university (caring strategies) and what they may see in practice (displays of uncaring behaviours) and must be explored further.

Chapter Seven

Three global themes emerged as the central concepts that represent participants' accounts of their experience. As three distinct aspects of emotional learning they are characterised by the participants' recognition of the patients and carers' emotional experience of cancer and their own emotional reactions to this. As aspiring therapeutic radiographers they recognise that reconciliation of those feelings is an important aspect of professional practice. As a researcher I perceive their accounts to be explicit descriptions of what the concept ‘therapeutic’ mean to these students and indeed their protected title of ‘therapeutic radiographer’ (HCPC, 2013). Their view of the caring aspect of their role uncovers both conflict (tensions between the technical and caring aspects of the role) and empowerment (confidence to manage emotional encounters). As such, emotional learning was regarded as a characteristic of professional development.

Furthermore, participants were able to articulate what it means to them to show compassion to patients and carers and the skills that necessitate achieving a balance between distancing and engagement in their professional role (Allan & Barber, 2005). Although the findings illuminated differences in the coping strategies of students and differences in how compassion is demonstrated I suggest that all students have the potential to become compassionate through facilitated engagement with human experiences. Chapter seven also contains my development of an evidence-based, theoretically grounded and structured approach to patient and carer pedagogy. I make the case that such an approach can facilitate professional development through specific learning activities in ways which are relevant to all health professionals. Furthermore, this pedagogical approach may be used in other educational settings for example trainee teachers listening to children with special needs and their parents/carers.

Summary of thematic analysis

My interpretation identified three themes as distinct aspects of emotional learning which offer new insights into the pedagogy of patient and carer involvement and emotional learning. This is a further contribution to knowledge of this study. Emotional recognition represents the way in which the classroom activities provide an opportunity for students to recognise and appreciate the emotional nature and impacts of illness on patients, carers and themselves. Emotional management is characterised by emotional expression, emotional dissonance and reconciliation linked to a wish to facilitate comfort for patients and carers. Professional presentation identifies the reflexive processes necessary to facilitate development and typically the ways in, which participants become emotionally more adept in their professional role. The professional identity they associated with (caring) presented a range of tensions that may be ameliorated through the development of emotional knowledge and achieving balance in professional practice. And so, the three thematic networks are linked by the construct of emotional learning.

Emotional learning, as an umbrella concept that connects the three thematic networks, originates in the felt but un-reflected raw emotions shared by patients and carers and experienced by participants too. Cognitive processes that involve reflexivity, further experience and the ability to challenge personal behaviours appear to facilitate a deeper understanding of emotion. Dilts & DeLozier's (2000) framework offers justification for the proposition that patient and carer involvement facilitates learning that promotes behaviour change and improved capability in dealing with emotion. Dilts & DeLozier (2000) identify thinking at the highest level as spiritual and they describe it as 'a sense of being part of something' (p867) suggesting a collective professional purpose. Whilst this sense of spiritual learning supports the notion of role identity and shared professional values, I would argue that spiritual learning is equally a deeply personal cognition that characterises the uniqueness of learning experiences. Reflexive thinking has the potential to foster both personal and professional transformation (Dilts & DeLozier, 2000); it may also improve their potential for managing their own emotions and developing compassionate behaviours (Goleman, 1995; Salovey & Sluyter, 1997; van der Cingel, 2014).

Returning to the research questions

In light of the findings of this study I now consider to what extent the data has informed the concerns in radiotherapy practice that gave rise to the research questions. Some conclusions are drawn that contribute to the evidence base on patient and carer involvement in curriculum delivery.

How do students experience patients' and carers' accounts of illness and treatment?

The participants' experiences of patients' and carers' accounts demonstrate considerable emotional associations. All participants recalled individual patients' and carers' emotional experiences: what was said, by whom and what happened as a result of interaction. Rich and detailed descriptions provide insight into the participants' emotional experiences heightened by the opportunity for in-depth interaction with patients and carers in the classroom. Participants report that interactions of this nature are less typical in the busy clinical setting, but the fact that students recalled difficult situations in practice demonstrating their exposure to emotional situations. Therefore, it is argued that this research data supports the proposition that experiences with patients and carers have the potential to enrich students' understanding of the complex feelings that accompany a diagnosis of cancer. In addition, patient and carer involvement provides the basis for further learning. This coheres with Dilts & DeLozier (2000) who state that learning, which begins at this experiential level, is likely to promote deeper thinking. Pedagogical activities that utilise experiences to facilitate learning and development are explored in curriculum developments (page 180).

In what ways do students identify that patient and carer involvement in the curriculum enables their learning and development?

Participants' reflections on their learning and development are evident in various ways and at different levels. Typically, they identify practical methods that demonstrate their learning including the development of personal skills. Rather than unconsciously reacting to patients' and carers' emotion they are concerned with identifying and reflecting on the emotions at play. In addition, participants reflected on the most appropriate ways to respond as a direct consequence of hearing what patients and carers want from professional interaction. This suggests that their personal reflection is concerned with developing capability or skill in practice (Dilts & Delozier, 2000). The participants spoke of effective communication skills, but more notable is their articulation of concepts such as rapport and connection. This arguably demonstrates their developing understanding of what ‘being with’ a patient or carer means, establishing rapport and making a connection (Rogers, 1980). As a consequence of understanding the impact on students further curriculum developments centred on communication skills, self-assessment and managing difficult situations were proposed.

What are these students’ perceptions of the value of patient and carer experiences in the curriculum?

How participants value the activities is articulated in different ways. Value as a personally motivated stance (Neale *et al,* 2009) is described in a personal sense, “You can't put a value on that, for me, I will remember all those patients” (Malcolm). Value then as a socially constructed view, is influenced by others’ views, peer discussion and professionally accepted norms. A socially constructed shared value about the sessions is evident in the data, “Those classes had a big impact; everybody spoke about it afterwards” (Brigitte) and “We gelled more as a group” (David). This socially constructed view infers that the value lies in the opportunity to discuss desirable standards and principles for practice. Moreover, as a consequence of patient and carer interactions this presents an opportunity to hear their perspective and understand alternative perspectives:

> You make assumptions based on your own beliefs. Hearing someone’s experience makes it more realistic and you see things in a different light (Brigitte)

Thus, the pedagogy of patient and carer involvement creates a learning experience for students in that they may come to understand individual needs, change thinking, improve practice and develop a sense of the professional identity as represented by Dilts and DeLozier’s (2000) higher level learning.

How might patient experiences impact on students' learning?

The findings suggest that experiences will impact on different students in different ways. Patient experience may help students evaluate formal knowledge against the real actual experiences of individuals. However, it appears that for these students emotional learning is the most significant impact on students' personal and professional development. Emotional learning is not only concerned with engagement that requires an informed appraisal of emotion in others, but also concerned with self-management and is the basis for developing emotional intelligence (Salovey & Sluyter, 1997). Potter *et al* (2010) argue that it is an important aspect of professional practice to develop self-care strategies and avoid burn-out. Dunn *et al* (2008) explored strategies to support resilience in medical students and the potential to include this type of activity in our curriculum may enhance the ability of students to manage emotion. It is also postulated that for some students, deeper emotional learning may aid their expression of compassionate behaviours whilst acknowledging the importance of self-care.

Further Study

My personal interest in the stories of individual participants, their different perspectives and the various ways of coping with emotion presents another avenue for further study. The accounts of Karen, Carl and David were used as a demonstration of different approaches of engagement with patients and carers and the potential for certain strategies to lead to professional burnout. It would be interesting to revisit these individuals as they continue in their professional career and identify how their strategies to manage emotion have influenced their ability to remain in practice. I would be interested to explore if their perceptions of emotional management and compassionate care have changed and whether new experiences have reinforced or challenged previously held values and beliefs. Detailed evaluation of the patient and carer theme within the curriculum will be undertaken this academic year and feedback from students will be obtained. Their views and those of the patients and carers will inform further curriculum enhancements and, from this, particular ways in which we can support students struggling to cope with emotion could be explored. The focus should be on how patient experience can be best represented to have the most effect and how established practitioners can be supported in managing emotions. I have also been asked to advise how this pedagogy may be used with student teachers. I am currently leading a project in partnership with Macmillan to evaluate approaches to resilience with cancer workers based on managing emotions. Additionally, this study identified professional conflicts particularly in relation to caring and I have an interest in investigating this further. Thus, there are a number of potential avenues for research and as the drive for compassionate care continues this could contribute to a growing evidence base. There is further potential in applying the patient and carer pedagogy across all healthcare disciplines, disease pathways and with larger samples. This approach may lead to new insights on care and compassion in current healthcare. The following discussion investigates the influence of the Francis Report (2013) and suggests how patient and carer involvement in the curriculum may promote compassion in health care.

The Francis Report (2013)

My research was carried out before the publication of the final report into the Mid-Staffordshire NHS Foundation Trust in March 2013. However, Francis' views on patient care strongly resonate with the findings of this study. The report became available at the time that I was writing up my work and it was apparent that the pedagogy of patient and carer involvement had the potential to address the question of how we can instil compassion in health care professionals. The following critique of the report and subsequent response publications suggest some deficiencies in the recommendations of the Francis Report. I argue how my findings can inform the development of future practice. The case for patient and carer involvement as a way of developing compassion in students will be explored as a response to how we can improve education.

The report was a public inquiry into the failings of one particular NHS Trust and was highly critical of a system that failed to protect patients and ignored warning signs. The report highlighted a systems-focused culture that failed to identify or act on issues for concern and the pervasive toleration of poor standards of care. Furthermore, there was an inability of the Trust to be self-critical or to tackle those challenges in a transparent way. The organisation was found to be lacking in responsibility and communication at all levels; particularly the inability to listen to patients and frontline staff. Francis was critical in his appraisal of the shortcomings and extensive in his recommendations that were intended as 'lessons to be learned' (2013, p.17). Perhaps the detailed criticism was a result of little evidence of progress since his first inquiry and his belief that the patient voice had been lost (Francis 2013). Although 290 recommendations were presented these fell largely into two key areas: the need for improved regulation; and greater focus on patients. The challenge for all organisations is now to foster a patient-centred culture and develop widely acceptable standards that can be rigorously monitored. In essence, what is needed is a cultural change that embraces transparency and supports continuous performance management, accountability, and the value of good leadership and training and an increased emphasis on caring. All agencies involved in training and the delivery of care were tasked with considering the findings and recommendations and deciding how to address them. Before Francis, at my own institution we were already developing our training to have a greater patient focus. As a result of the findings from my own study we had begun to expand patient and carer involvement. As previously discussed in chapter seven, the evidence argued that patient and carer involvement in the curriculum contributed to the development of care values and practices and was addressing the compassion agenda.

Responses to Francis

Professional bodies responded publicly to the report and the Nursing Midwifery Council NMC (2013) published a detailed plan of action which focused on regulation and registration of staff and revalidation of student education. The NMC response reflected the system-based recommendations of Francis, Garner (2014) however criticises a ‘systems’ focus as she argues that the personal relations between health practitioner and patient should have a greater emphasis. Garner’s critique questions whether actions at an organisational level can have the desired impact at the point of patient contact. Although the NMC have raised the profile of their code of conduct and revalidated pre-registration programmes to include care and compassion, the ways that this could be delivered within the curriculum are not specified. However, the NMC have focused on pre-registration education as a mechanism to create and sustain a change in the culture of care. In response to this, pre-requisite training and values based recruitment processes have been introduced to ensure the right people with the right values and skills embark on health professional training (Health Education England, 2014). Skills in emotional recognition and management are critical to achieving this and participants in my study described caring values and how interaction with patients and carers enhanced their understanding of how to care. Perhaps HEE should recognise that emotional learning is an essential skill in all health training.

Similarly, the Health Care Professions Council has introduced education and training standards relating to service user involvement in education programmes for allied health professionals and social workers (HCPC, 2013). Whilst the Francis Report focuses on nurses and doctors it is equally recognised by other health professions that care is everyone’s responsibility and other responses have been published. For example, the Society & College of Radiographers (SCoR), whilst recognising the profession were not mentioned in the report, acknowledges that their work may well have brought them into contact with patients experiencing poor care. Another aspect of the HCPC recommendations was recognition of the crucial role that quality placements for students impacts on the culture of care. In addition, trainees that raised issues of poor patient care and experienced bullying, but there was a failure to follow this up (Francis, 2015). This is reminiscent of the participants’ accounts of witnessing both caring instincts in practitioners and also cultures of poor care and their own discernment of what would constitute the core principles of engaging with human experience.

Post Francis

Following the Francis Report the Keogh Review (2013) of 14 NHS Trusts provided further detail about ‘the problem’ and served to add weight to the recommendations already in the public domain. The Cavendish Review (2013) specifically focused on support workers in recognition that they comprise a sizeable proportion of the care workforce. This was a comprehensive review of the role and resulted in key recommendations that related to recruitment and fundamental care education of support workers aligned to the nursing profession as part of a recognised career framework. Crucially, this review identified that ‘time to care’ was essential in delivering excellent services and concluded that support staff with the right skills and training ought to be valued by the organisation in which they are employed. Similarly students in my study spoke of ‘having more time than qualified staff to listen to patients’ and this facilitated rapport. This indicates that patient and carer pedagogy should be incorporated into support worker training too.

One year on, some changes were evident as NHS Trusts and other care organisations had reflected on the key messages in the Francis Report and many had assigned leads to take forward the recommendations (Tingle, 2014). The Care Quality Commission inspections had begun and issues such as recording staffing levels on wards and processes for raising concerns had been improved. However, tensions still existed between quality of care and financial constraints, with a top-down management still being an issue. There was little reported on the culture of care in organisations and to some extent this is difficult to measure and would arguably take longer than one year to see any real impact.

One of the criticisms of the Francis report was that regulatory bodies operated independently with poor communication between agencies. The NMC response to the Francis Report focused on the organisational recommendations identifying staffing levels as a key action. They produced a detailed report outlining professional care standards and recruitment guidance to ensure the right people are employed. They along with other professional bodies have also produced guidance on whistleblowing. Effective handling of complaints and whistleblowing were key features of the Francis Report and the Keogh review. Two years after the Francis Report the *Freedom to Speak Up* report was published (Francis, 2015). This report recognised that staff can make a difference to patient care by speaking up, although it was acknowledged that handling concerns may not be easy as it is often difficult to distinguish genuine concerns from those of a spurious nature. However, it is crucial that health professionals are able to speak up in order that patients are protected from poor care. The report focuses on the discrimination received by staff who whistle blow and aims to set out the framework that all organisations should follow. Whistle blowing inevitably brings with it a host of emotional challenges that require emotional management skills; patient and care involvement pedagogy could provide a powerful learning opportunity. One aspect of this would be to develop a compassionate view of the patient/carer experience and identify appropriate ways of responding to concerns. Perhaps what is more challenging is how to develop the skills needed for advocacy and challenging poor practice or colleagues. Whilst there is a system in place to manage concerns which requires improvement, the report recognises that there is also:

> a lack of the skills needed to resolve difficult and sensitive situations that can arise when staff performance is questioned (Francis, 2015, p.20).

The worrying aspect of this report are the experiences of students and trainees who feared speaking up, who felt bullied and believed that raising concerns would have a negative impact on clinical assessments. There was no evidence that this had been the experience of participants in my study, however they did speak of poor practice and my view is that they need to be supported with developing the confidence and skills to raise concerns. In response to the revelations of discrimination, Francis (2015) sets out 20 principles to guide the development of a consistent system to raise concerns.

I am particularly interested in principle 18, which focuses on students and trainees who are viewed as vulnerable groups, and the report details how they should be supported, which has significant implications for training. Students and trainees are regarded as agents of good practice and it was identified that speaking up had consequences for those in training who rely on clinical assessment to progress. It is a challenge that students require support with. If they are expected to raise concerns, ‘how’ to do this should be included in the curriculum and student well-being must be paramount in the wake of raising a concern about patient care. Aspects of the curriculum developments I outline on page 202, that relate to professionalism and clinical de-brief are intended to develop those skills in students that will help them to raise concerns. In addition, it is recommended that regulation of placements as part of course approval should occur and so student experience and processes for raising concerns can be examined and acted upon. This in itself will be challenging for the student and education provider and is further evidence that the development of interpersonal skills is paramount.

A mandate to Health Education England by the Department of Health (2013) mirrored the recommendations of Francis with a proposed reform of education and training to develop competent and flexible practitioners with the right values and skills. This mandate clearly articulated that the patient voice must be evident in training and one method of achieving this is through patient and carer involvement in the curriculum. My findings evidence the value students place on ‘hearing’ the patient and carer voice and using that knowledge to improve their practice.

Implications for education

Garner (2014) criticises the organisational focus of the Francis report and subsequent responses as she explores the notion of psychosocial relationships and says it is the ‘human understanding of what is helpful and what is not’ (p5) that is missing. She suggests that we need an environment and culture where staff can raise concerns about themselves, others and the organisation. Staff should be able to recognise their own limitations and ask for support. Specifically, she discusses generic skills training about psychosocial aspects of care and relationships stating that this should be introduced early in training. She argues that education must acknowledge common humanity and understandings of what it is like to be cared for to avoid patronising attitudes and dehumanising care. The emphasis needs to be on the fundamental skills for respectful communication, listening and empathy, and her suggestion is that the management of difficult or sensitive situations should also be part of training. One may argue that the emotional skills students develop through patient and carer involvement training could help them in their relations with colleagues. In a caring environment, it is important that those interpersonal skills extend to team dynamics and care for staff is facilitated through mentorship, supervision and support. The notion of collective care and respect between patients and health care workers and between workers themselves is at the heart of a caring culture and is the basis for effecting change within the organisation. This has direct relevance to my findings in that Thematic network three, explores the view that the participants see this as their professional role and belonging to a caring profession. Whilst care is fundamental to codes of professional behaviour and regulatory changes can offer a robust system of monitoring we must consider how education and training can be enhanced to achieve this sense of ‘care’.

Nolan (2014) was present at the Francis Inquiry and recalled listening to witnesses as emotionally draining and says the recommendations did not address how services should be delivered on a daily basis. Nolan argues that there is still a gap between education and practice and he calls for this to be reduced and compassionate care to come to the fore. His talk of role models and mentorship suggest that good quality training is dependent on the educator’s skills. He suggests that quality training and supervision are vital to improving patient care and central to this is basic humanity that does not lose sight of patients:

> ‘Sharing patient and carer experiences can serve as a reminder that the NHS is a human organisation, run by humans, for humans’ (Nolan 2014, p842).

Sharing personal experiences in a busy organisation can be challenging, but the facilitation of interaction in a classroom setting can help students develop the skills for compassionate communication and by fostering a culture of listening and learning this has the potential to effect and sustain change. An interesting feature of my study is how, through the one-to-one interview process, participants were able to reflect on their experiences of care and articulate their own emotional development. This suggests that there is value to individual student support and this to some extent is facilitated through the personal tutor system, where the personal tutor is part based in practice and contributes to the taught curriculum too. As a result of sharing my findings with the course team we have included a care and compassion theme within the programme. This includes the activities outlined on page 182 and a raised awareness of emotional challenges in the personal tutors who are now better equipped to provide personalised support to students.

Key messages

Francis’s messages have been clear with the public and professional and regulatory organisations in agreement. The headline is that health care professionals need to demonstrate better compassion and humanity by placing the patient at the centre of care. Whilst regulation can enforce change and punish poor practice, education and training has the potential to modify the way people think about care and behave. Thus, consideration must be given to how we foreground the human within the curriculum. How do we develop the appropriate skills in students that reflect care values and instil confidence to challenge poor care? Specific curriculum activities, that were the basis of my inquiry, allow patients and carers to present themselves to students as human beings and experts in their own experiences and facilitate students' learning. In this safe educational environment, humanisation is fostered and power lies with the patient and carer as educators of human experience. Interaction with patients and carers based on listening, responding and questioning can encourage students to develop insight into their experiences and the skills to demonstrate compassion.

Dissemination of findings

Interpretation has led to a pedagogical model that supports emotional development in professional practice. However, a key outcome must be the dissemination of findings to interested parties as it is hoped these curriculum strategies can be implemented elsewhere. At a local level the findings have been shared with the subject team through our research forum and course planning groups. Further dissemination at a faculty level and with the local NHS Trust is planned soon through two conference presentations (Coventry Inter-professional Learning Unit and Achieving Excellence in Radiography Research). Nationally, I presented early interpretations at a multi-disciplinary conference and received much interest from other higher education institutions. I plan to disseminate the final project through other similar professional conferences and to education commissioners as evidence of a curriculum that supports students to develop care values. I also have a plan for publication (first paper accepted in the *Journal of Medical Imaging and Radiation Science*, Innovation in Education Edition). Two further papers will be submitted to other journals. I hope to contribute to the HEA Learning by Experience Network (LEN) a community of practice in patient and carer involvement. I also plan to supervise a PhD student and take forward some of my research ideas. In addition, I plan to support initial teacher education with developing empathy between students and parents of children with special educational needs and disabilities.

Epilogue: the value of patient and carer experience

My aim throughout this project has been to understand how and in what ways students can learn from the patient and carer experience as they develop as professionals. This research has culminated in some conclusions about how a professional group recognises and identifies with the emotional experience of others. I describe this as emotional learning and propose this as an important process for developing compassionate care (Department of Health, 2013). This Department of Health mandate to Health Education England focuses on developing training that ensures the workforce have the right skills and values to deliver patient-centred care. At the outset my attention was on the curriculum activities conceived as a deliberate attempt to share the personal experiences of cancer through interaction between student and patient and carer. As I consequence I anticipated this would help students positively influence the cancer experience for patients and carers. I have come to understand that it is the significance of *how* interaction is valued by students that is central to their interpretation of experience. As ‘one-off’ pedagogical activities the value lay in the catalytic impact of hearing first-person accounts of cancer, its treatment and emotional consequences, perhaps for the first time. The safe environment of a classroom setting with patients and carers readily sharing experiences provides students with a basis for further reflective learning. It is their reflections on interaction that ultimately influences them as aspiring professionals and their practice. The interview itself created an environment for reflection and as such a valuable learning environment. This has been included in the curriculum as ‘clinical de-brief’ and ‘managing difficult situations’.

My research demonstrates that such activities prompt the student to ‘step outside’ their previous sphere of understanding and to focus on others’ experience (patients and carers). Whilst the activities cannot be solely responsible for emotional learning they can promote a deeper understanding of practice and as part of a programme of study is a valuable component.

I see the value in terms of students’ learning from three perspectives: personal learning, professional learning and the impact on practice. Students’ interpretation of patient and carer experiences identifies that the value lay in stimulating questions about their own perceptions of cancer. Moreover, individuals may challenge their previous thinking and identify new ways of seeing the cancer experience and responding to emotion. I would argue that learning in this way has the potential to embody professional values of care and contribute to notions of an ideal professional image. My argument is that experiential learning ultimately impacts on further experiences and practices promoting more informed acts of caring. Where students develop a more critical questioning approach this may lead to denigration of others' practice and contribute to the growth in condemnation of 'poor practices' (Francis 2013). Whilst I believe the ability of the novice to challenge others may be difficult, to promote a patient-centred service, poor standards should be openly and professionally discussed. Equally, I must be cognisant that planned curriculum developments may produce more empowered students who then require the interpersonal skills to deal with these challenges in the clinical environment (Clywd & Hart, 2013). Of course students will deal variously with such professional demands and the curriculum is not solely responsible for professional development. Academic and clinical staff must be trained in supporting students' confidence in the workplace. And so, my results indicate that patient and carer involvement could be an important mechanism for re-dressing the balance of technical and humanistic elements in healthcare training (Bolderston *et al,* 2010).

Additionally, my study lends weight to the view that exploration and utilisation of distancing and compassionate strategies should be a key feature of professional learning. The potential for burnout is recognised for this professional group (Dunn *et al,* 2008; Potter *et al,* 2010) and so a need for better understanding of emotional intelligence and resilience is indicated (Goleman, 1995; Mikolajczak *et al,* 2007). An important source of validation of the role of patient and carer involvement has been student evaluation of curriculum activities and feedback that suggests they were an important aspect of the course. This feedback from students supports the value that patients and carers bring to education.

My own learning along the trajectory of study has been most enlightening; in particular the enrichment of my understanding of the complexities of student engagement in emotional dialogue. The challenge to my prior assumption that 'attachment is good' and the fact that I did not fully recognise the potential cost to the novice student when faced with emotional situations has been valuable learning. As a researcher, I thought I was an 'insider', but in actual fact I realised that more than 30 years away from being a student the best I could do was be a 'curious' researcher and that in relation to the experience of being a student I was in fact an obvious outsider.

Whist recognising the value of patient and carer involvement on student and researcher development, one must also consider how the patients and carers who took part in the activities viewed the experience. A recent small study demonstrated that patients and carers gained a sense of purpose and achievement from being involved in students' training (Keenan & Hodgson, 2014). This is reassuring as I would not want to cause distress or angst to the very people who had been through so much and gave of themselves unreservedly in the classroom. More importantly I want to acknowledge that without their commitment, enthusiasm and involvement in education this research would have been inconceivable. Over the last six years, curriculum activities have evolved along with other developments with patients and carers. Throughout this time I have shared the students' awe and humility on hearing individual experiences. I too have felt the visceral response to their emotional pain and will continue to regard my involvement with patients and carers as a privilege. Those involvement activities provided students with valuable insight and gave me too a greater understanding of the patient and carer experience. My research has illuminated the complexities of emotional work that I could not have previously comprehended. Moreover, the students' interpretations of learning have contributed to a research experience that has undoubtedly changed my perception of knowledge. How I regard emotional work and the way I view other people has changed. My beliefs and assumptions about talking to patients and carers have been challenged and more crucially I am able to better articulate my own understanding of how patients' and carers' experience impact on radiotherapy students.

As a final reflection on the research process my closing remarks reflect the implicit nature of my personal development in an attempt to make my new understanding explicit:

> *I came to this research with a view that patient and carer involvement in education was a good thing. It was a view borne from personal and professional experience; a feeling or sense that it would aid students' learning and development. I could not fully articulate my reasoning (it was implicit) and I hoped that the research would do this for me. Through listening to participants' interpretation of their learning I understood better the tacit-ness of emotional learning and the value of patient and carer involvement. As the participants attempted to make their learning explicit I reflected on Polanyi's words, 'we know more than we can tell'. I too felt that as I attempted to articulate my understanding of their interpretation I came to know things that were previously unknown to me regarding emotional learning. Through this thesis I have redefined what I did know and been able to better tell what I have come to know. And whilst I have endeavoured to make explicit my tacit knowing, as the final chapter is completed, I sense now that I know even more than I have been able to put into words.*
>
> *(Research Diary, September 2014)*

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