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AN INTERPRETIVE PHENOMENOLOGICAL STUDY TO UNDERSTAND THE PERCEIVED VALUE AND IMPACT OF FEEDBACK ON THE LEARNING EXPERIENCE OF PRE-REGISTRATION HEALTHCARE STUDENTS.

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A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for the degree of Doctor of Education

The University of Huddersfield

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Copyright statement

Abstract

This thesis examines how feedback is used by pre-registration healthcare students to support their learning. It investigates feedback experiences in authentic academic and practice-based environments, using the student's experience as the main vehicle by which to develop an understanding about the value and impact of feedback. This interpretative phenomenological study utilises a small sample of pre-registration healthcare students and staff from a single UK university and explores their lived experiences of feedback through a lifeworld lens. Situated learning and the theory of communities of practice is used to understand the data. The study identifies the significance of the healthcare discipline to shape the learning from feedback experiences of the students in relation to their developing identity as practitioners. The situation in which learning takes place for pre-registration healthcare students is complex. Students learn across multiple sites and have a dual role of learner and clinician. This complexity of the learning experience alongside the students' uncertainties in relation to their developing identity affects how they engage with feedback. The students' perception of "self" also influences how feedback is understood and internalised. The study argues that relationships and learning-focussed communities of practice are core to the way that feedback is experienced by these students. The dual role that these students occupy, and lack of direction from their educators in making clear how feedback should be used, appears to create a lack of clarity regarding the purpose of feedback. The authenticity of the learning experience was also found to be significant in supporting the students' learning. The relationship between the learner "self", the purpose of feedback, the authenticity of the learning experience, and the membership of multiple communities of practice are intertwined and appear to be significant to the impact and value of learning from feedback for the pre-registration healthcare students.

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Dedications and Acknowledgements

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Glossary of Terms and Abbreviations

CoP	Community of Practice
FE	Further Education
HCPC	Health and Care Professions Council
HE	Higher Education
HEFCE	Higher Education Funding Council for England
HEI	Higher Education Institution
MSR	Model for Structured Reflection
NHS	National Health Service
NMC	Nursing and Midwifery Council
NSS	National Student Survey
QAA	The Quality Assurance Agency for Higher Education
TA	Template Analysis
TEF	Teaching Excellence Framework
TQEF	Teaching Quality Enhancement Funding

Patients

Throughout this thesis the term "patients" is used to represent all consumers of healthcare services including patients, service users and clients.

Learners and students

Throughout this thesis "students" and "learners" are used interchangeably.

Educators

Throughout this thesis the term "university-based educator" is used to represent academic staff who work within an HEI to support student learning. The term "practice-based educator" is used to represent clinical staff who work within a healthcare setting to support student learning – this includes mentors, practice educators and clinical educators.

Chapter 1: Introduction

1.1 Background to the Study and Interest in the Topic

This study explores how pre-registration healthcare students use feedback within both university and practice-based education to support their ongoing learning. My interest in understanding the effect of feedback on learning has been long standing. During my early academic career, and primarily in order to improve my own pedagogical practices as a novice academic, I undertook a small scale research project that investigated the usefulness of a self-assessment dialogue tool. This tool included the use of feedback and this study gave insight into how university-based educators and students develop their teaching and assessment, and learning practices respectively. This work highlighted to me that feedback was a complex practice, prone to misinterpretation and one that did not necessarily result in the outcomes that were intended by the educator.

The higher education institution (HEI) where I work was successful in receiving Teaching Quality Enhancement Funding (TQEF) in 2006 to support a project around formative assessment. The aim of this project was to develop more co-ordinated, effective approaches to formative assessment across the University, and to put formative assessment at the centre of quality enhancement in the curriculum such that student retention, progression and achievement would improve. Therefore, as part of its continuing commitment to improving the educational experience of its students, coupled with the Higher Education Academy's "Change Academy" process, the HEI has invested significant resource into clearly articulating the expectations of staff around the management and implementation of assessment and feedback processes. The HEI's current Assessment and Feedback Strategy (University of Huddersfield, 2016a) sets out core expectations and values and has a goal of informing and improving the work of both students and educators. Within the Strategy it is clear that students are expected to engage with feedback in the learning environment and use their feedback to plan ongoing learning.

As a professional doctorate, this study is drawn from my interest and informs my professional practice and responsibilities. Staff workload is an ongoing challenge within higher education (HE). As someone with managerial and developmental responsibility for academic staff, and as someone who is accountable for the student experience and the quality assurance of courses within a healthcare area, it is essential that I fully understand

the impact of teaching, learning and assessment processes in order to best support both students and staff in their progressive development.

1.2 The Political Context

The time spent marking is a considerable part of an academic's workload in a time of increasing pressures. Staff workload is constantly under scrutiny, with the 2016 Workload Survey by the University and College Union (University and College Union, 2016) providing cautionary evidence that the academic workload for staff in HE is unreasonable and excessive. The data suggest that excessive working hours are embedded within the HE culture, and that HE staff are investing more time than ever before in pastoral support for students and research and scholarly work. Significantly to this focus of my research, this current data states that more than one third of academics in HE spend significantly more time marking in comparison to the time spent on that activity three years ago, and that in excess of half of working time is spent on teaching-related activities including marking.

The healthcare education sector in England is currently in the midst of unprecedented change. From September 2017 the long-standing practice of commissioning healthcare education places will cease (Department of Health Workforce Development Team, 2016) and an "open market" will exist within the sector with students in England paying tuition fees. It is currently uncertain what definitive impact this competitive climate will have on the sector in terms of student numbers and healthcare workforce supply but it is anticipated, based on evidence from previous HE funding changes in non-healthcare sectors (Kandiko & Mawer, 2013), that the expectations of students will be much higher than ever before given that they will be funding their own education. Evidence from this non-healthcare Quality Assurance Agency for Higher Education (QAA) funded project makes clear that students expect to get their "money's worth" from their course when self-funding, some of which includes having a greater insight into how their course fees are being spent by the HEI, quality assuring the credibility of educators in their field of expertise, and having direct links within the course to career planning and employability.

The issue of feedback is prominent within higher education, with the National Student Survey (NSS) purposely asking students about their assessment and feedback experience. The NSS was explored by Williams and Kane (2009) who identified that the "feedback" component of the "Assessment and Feedback" section was that which scored the lowest satisfaction rate. The NSS continues to be actively used within the media to create "league tables" of desirable higher education institutions and by potential students to help them

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select their preferred HEI, making the NSS a powerful tool. With the exception of operating department practice students (who reported a 81% satisfaction level), all 2012 graduate cohorts from the pre-registration healthcare courses at the HEI where I work indicated that they were between 90% and 100% satisfied with their course overall. However, when asked about assessment and feedback in particular, the cohorts reported that they were all less satisfied (with a range of 70-90% satisfaction reported) with the way in which feedback during the course had helped them clarify things they did not understand. This institutional data is in keeping with that published nationally with the Higher Education Funding Council for England (2014) reporting that the assessment and feedback section of the NSS remains the lowest despite it being the section that has seen the most growth between 2005 and 2013. 2016 NSS data suggests a 74% satisfaction level with assessment and feedback. So why is there a difference and are we still getting it wrong?

More recently, the Teaching Excellence Framework (TEF) has been introduced by the Department for Business Innovation & Skills (2016) incentivising and financially rewarding teaching excellence. The metrics used to "band" and thus proportionally reward institutions who submit to the TEF include NSS data. Therefore in this national climate of ongoing austerity and increasing HE competition, never before has this institutional data been so significant to the sector. Without excellence in teaching being recognised and financially rewarded, HEI's will be less financially stable and less attractive to potential applicants.

This section has introduced the challenging broad political context and climate that HEI's are currently facing. The next section will use this context to explore the pedagogical dimensions of feedback.

1.3 The Pedagogical Picture

Much of the literature around feedback is situated within the context of "assessment". In particular, the concept of formative assessment is often, though not solely, that dimension of assessment which is synonymous with the generation of feedback. According to the seminal work of Black and Wiliam (1998) in their work around feedback within schools, formative activities [via the generation of feedback] allow an individual to change and modify their learning actions to foster progressive learning. Formative assessment is defined by Irons (2008) as "any task or activity which creates feedback (or feedforward) for students about their learning" (p. 7) whilst formative feedback is defined as "any information, process or activity which affords or accelerates student learning based on comments" (Black & Wiliam, 1998, p. 7). Irrespective of the formative-summative divide, the essence of feedback being defined as a process that should be used by students to "…

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enhance their work or learning strategies" remains current (Carless, 2016, p. 1). It is clear that all undergraduate students across the spectrum of disciplines within higher education should be encouraged and supported to learn from all types of feedback opportunities.

Kandiko and Mawer (2013) make clear that fee paying students expect feedback on their performance that is of high quality and in an appropriate format. It is reported that of similar importance to the students engaged in this study was feedback that was personalised as opposed to standardised, and a learning experience that was facilitated by staff for whom the students were confident had manageable workloads. Implicit within the concept of personalised feedback is the notion of the student-educator relationship. Carless (2016) proffers that relational dimensions of "… care, trust, class atmosphere, and relationships …" (p. 2) are crucial to the constructivist development of a learning interaction, and both this work by Carless and that of Zimbardi et al. (2017) make a strong case for the need for further empirical research to be undertaken which demonstrates the impact of feedback on student performance and learning.

The Quality Assurance Agency for Higher Education (QAA) makes clear their quality-based expectations of feedback in HE. They articulate that feedback linked to assessment is itself associated with improved student learning. They state that for the student:

"… individual pieces of assessment provide a source of motivation for study; they promote learning by providing feedback on performance and help students to identify their strengths and weaknesses" (The Quality Assurance Agency for Higher Education, 2012, p. 6).

In his work, Carless (2016) questions this accepted outcome of feedback articulated by the QAA (2012). He suggests that feedback linked to "end-of-semester" (p. 5) work – i.e. assessment aimed at verifying learning – does not offer the student the maximal learning-from-feedback opportunity and that, rather, within semester feedback has greater learning potential. This difference of opinion between a well-published educational expert and the national body tasked with safeguarding educational standards is significant to the HE sector given the practical implications of managing feedback at a local level.

Within each pre-registration healthcare curriculum, there is a clear assessment strategy and it is expected that there is constructive alignment between the teaching and learning methods and these assessment methods (Biggs, 1999). Thus there are clear links established between teaching, learning and formal assessment processes. As discussed earlier, the literature suggests that learning has the potential to result from any feedback

situation, and I believe that feedback itself is not always associated with assessment. I hypothesise that much feedback occurs during "routine" learning situations in the classroom and on the hospital ward, for instance, that are not "assessed" but instead are part of the authentic learning opportunities offered daily to healthcare students. I put forward that these routine feedback experiences that are not couched within an "assessment" framework, are more in line with the "within semester" feedback philosophy supported by Carless (2016) and have the potential to have significant impact on student learning. Within pre-registration healthcare education, all students undertake many hours of learning in a clinical environment; for example, a minimum of 1000 hours for occupational therapy, and approximately 2300 for nursing. This vast number of learning hours within a clinical practice situation is mostly well structured and always "supervised" (directly or indirectly) and, as such, offers an unquestionable opportunity for students to learn from the feedback offered.

The QAA's "UK Quality Code for Higher Education" (The Quality Assurance Agency for Higher Education, 2008) sets national expectations regarding the quality assurance and governance of all higher education awards. It suggests that higher education courses should adopt a structure of distinct units or modules of learning to the academic levels of the programme. Whilst this type of structure is helpful to the management and administration of the course, separate modules of teaching and assessment, and thus feedback, do not always offer a transparent "continuum" of learning to students and do not always encourage "transferable" learning. In my experience, students often view teaching, assessment and feedback in artificial compartments within a modular curriculum, with the end-point of a module usually being an assessment process which verifies the learning acquired from that module. To support learning both within and outside a module within a modular curriculum, feedback needs to be offered at such a time that learning has the "best chance" to occur. If feedback is only offered as a consequence of assessment and at the end of a module, it seems reasonable to suggest (Carless, 2016; Weaver, 2006) that learning will not be maximised as the students are already "moving on" to the next module.

This section has introduced key aspects of pedagogy that relate to feedback. The next section explores these further within the discipline of healthcare.

1.4 Healthcare Context and its nuances

All learning experiences should result in some form of feedback to support effective ongoing learning (Aoun, Vatanasakdakul, & Ang, 2016; Winstone, Nash, Rowntree, & Parker, 2016).

For pre-registration healthcare students, the ability to learn from feedback is not only crucial to their success within the course but imperative to the safeguarding of patients in the workplace (NHS England Commissioning Board, 2015). It is essential that students learn from feedback within both university-based and practiced-based educational settings at pre-registration level in order to graduate as competent healthcare practitioners (e.g. nurses, podiatrists, occupational therapists) that can go on to contribute positively to the healthcare workforce and offer high-quality patient-centred care. Moreover, at a pre-registration level student healthcare practitioners need to begin to develop the skills necessary of a qualified healthcare worker to support their continuing professional development requirements (Health and Care Professions Council, 2012; Nursing and Midwifery Council, 2017).

The expectation of and requirement for both pre-registration and post-registration continual learning to impact on patient care and safety is implicit within the outcomes of the Francis investigation (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) into the abhorrent and unacceptable practice within Mid Staffordshire NHS Foundation Trust that led to unnecessary patient deaths. Whilst the report outcomes explicitly name the professions of medicine and nursing, the allied health professions (e.g. physiotherapy, occupational therapy, operating department practice and so on) are notable by their absence within the report and it is accepted by both regulatory and professional bodies (The NHS Confederation, 2013) that the outcomes of the report must extend to beyond doctors and nurses (Department of Health, 2014). Within the report there are clear failings of qualified staff in relation to leadership and management. Such skills are not only expected of qualified staff, but also of student healthcare practitioners (for example, College of Occupational Therapists, 2014). It is evident that for qualified staff to be competent in such skills on entering their respective professions, these skills must be learned and developed at pre-registration level.

Academic staff resource is expensive. This is often even more so in healthcare education, in comparison to other HE subjects, as staff members are usually recruited from clinical practice, are usually very experienced clinicians and, thus, command a higher salary to transition into a HE career. The majority of academic staff within healthcare education are employed on a senior lecturer scale, with salaries of circa £50k. Within the HEI's school of health-related provision, and in line with work allocation guidance from human resources, staff are transparently allocated a proportionate amount of time within their academic duties for "teaching related activities (TRA)", including assessment, and within this, in line with the HEI's Assessment and Feedback Strategy, providing feedback on assessed work.

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Within the school, lecturer/senior lecturer staff may spend up to 30% of their time engaged in TRA (University and College Union, 2016).

With almost a third of their time being spent on TRA (University and College Union, 2016), it is evident that a huge proportion academic time (and thus financial cost) is used in the "crafting" of feedback. My own experience, coupled with anecdotal evidence from conversations with colleagues from across a range of professions within the school, suggests that students do not appear to be acting on, in some cases, multiple feedback pertaining to the same issue (e.g. structure or referencing style). I am aware that other vocational courses, such as secondary level teacher training, have implemented assessment checklists within their summative assessments in order to compel students to refer to and act on formative feedback but, to date, within my experience this does not happen within healthcare education.

The belief amongst academics (myself included on occasion) and objectively evidenced from within the HEI's virtual learning environment (VLE) is that students do not always access their feedback (Sinclair & Cleland, 2007). This academic belief and published evidence contradicts the more recent work of Zimbardi et al. (2017) who present a synopsis of the published evidence within their empirical work. However, despite this recent published evidence suggesting that on the whole students do access their feedback, students who do not waste the time invested in the feedback by academics. This results in the resource of highly paid academics spending significant time (and thus salary costs) on tasks intended to support continual student learning that do not have the desired outcome. Zimbardi et al. (2017) does go on to present a more compelling argument that, even when accessed, students do not always know what to do with the feedback or they do not have the necessary strategies to use the feedback effectively as the educator intended.

I intentionally used the work "craft" rather than "write". In line with the principles explored by Race in 2005, I believe that providing students with appropriate feedback such that they have the best possible chance of learning from it is, in fact, an "art" (or "craft") rather than a skill that all academics, by the sole notion of being an academic, can do well. Much feedback on learning within healthcare education is, by its nature, offered from within the clinical workplace, by clinicians who support practice education. Many of these clinicians will have undertaken a "mentorship" or "clinical educator" course appropriate to their professional discipline, some of which might be recognised or accredited to a professional and/or regulatory body. Some clinicians may have studied an HEI-accredited module such as "supporting learning and assessment in practice" (Nursing and Midwifery Council, 2008)

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in order to better prepare them for their mentorship/educator role. However, mandatory formal mentorship preparation is not consistent across the healthcare disciplines and there are no clear guidelines with the regulatory guidance (Nursing and Midwifery Council, 2008) as to how educators might be best prepared to offer feedback.

A final and significant factor in the ability of feedback to make a difference to student learning is the student themselves. Rae and Cochrane (2008) suggest that those students who have the skill to critically evaluate their own work are those students who actively learn from the feedback process itself. I suggest that these students who have the ability to critically evaluate their work are likely to be the more able students who, conversely, are those students who (in principle) *need* to utilise the feedback the least in terms of achieving standards. In practice, many educators would wish to seek to guide the more able or "gifted" students to achieve an even higher standard. In reality, because time and resource is spent "crafting" feedback to guide less able students who, it would seem, then may not be able to use the feedback in the way that is intended, educators have less resource to invest in the "average" or "gifted" students. Educators face a real dilemma here and are challenged by how the need and, I suspect, policy to support less able students may be contradictory to the anticipated outcomes.

"Style" of feedback, including aspects of timing, form and language, is a dimension of feedback on which there is much discussion within the literature (for example Lynch, McNamara, & Seery, 2012; Miller, Russell, Cheng, & Skarbek, 2015). The HEI where I work has expectations on academic staff to provide marks and written feedback to the students on summative assessment submissions within three weeks of the submission date. The implication of this timescale is that that students may then use this feedback to help their prospective learning. Whilst academics strive to meet this marking and feedback deadline, the assessment schedule for students often necessitates close submission dates in order to allow the students to focus on practice-based episodes of learning without being consumed by academic work. This means that summative work may be submitted prior to feedback being received by students on previous pieces of work. The impact of feedback being offered when there is limited opportunity to use it in the way that the provider of the feedback intended suggests a mismatch of expectations in addition to the poor utilisation of staff as a resource.

Feedback can take various forms and typically, within the healthcare disciplines in my school, feedback is usually provided by written or audio methods. More traditional written feedback methods are being replaced or complemented by less traditional audio-feedback

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models as there is some evidence to support that this form of feedback is more meaningful to the learner (Merry & Orsmond, 2008). Many assessment methods within healthcare education mirror the expectations and requirements of student healthcare practitioners within the clinical setting and are, therefore, "practical" in their nature. For example, a student physiotherapist might undertake the assessment of a simulated painful knee joint as part of a summative assessment. It is essential that such opportunities are viewed as tools for learning as well as a means of assessment as it is crucial for student healthcare practitioners to recognise the need for and expectation of lifelong learning (Health and Care Professions Council, 2012) within both simulated and authentic clinical environments. Students usually receive written feedback within a few days of undertaking simulated summative assessments within a university setting as much of the draft feedback is crafted at the time of or immediately after the assessment and is very specific to what the examiner observed at the time. It is interesting to compare this style of feedback from a university-based summative assessment task to the style of formative feedback that would be offered to the student in an authentic clinical environment, which would typically be verbal. The form of feedback and its context and timing are worthy of consideration in the context of this research and will inform the discussions in the findings section of this thesis.

1.5 Research Question and Aims

This study's primary research question is:

- What is the perception of the value and impact of feedback on ongoing pre-registration healthcare student learning?

The subsidiary aims of this study are to:

- Identify key features of feedback that pre-registration healthcare students perceive to be effective in supporting their learning.
- Explore how pre-registration healthcare students use feedback.
- Use theories of communities of practice to understand the data generated by the study.

1.6 Contribution to Knowledge and the Structure of the Thesis

This thesis makes a unique contribution to the field of allied health education in relation to the way that feedback is interpreted by students working in this field. Students learn across multiple sites and have a dual role of learner and clinician. This complexity of learning experience and uncertainty of identity affects how students engage with feedback. The study takes a small scale phenomenological approach to understanding the way that feedback is experienced. The thesis argues that there appears to be core aspects of the feedback experience – namely Self, Purpose, Authenticity and Relationality - that are likely

to influence the impact of feedback. This thesis proffers that these aspects are inextricably interlinked with the learning within the health professions which operate as complex communities of practice. This understanding has the potential to inform practical ways in which the core aspects of the feedback experience might be utilised for greatest impact in pre-registration healthcare education.

The argument within this thesis will be articulated using the following structure:

Chapter 1 has introduced the study and the contextual background. It has also stated the aims and objectives of this research, outlined the structure of the thesis and a brief overview of each chapter.

Chapter 2 frames the field of enquiry that this research explores and discusses the evidence-base around situated learning, social learning theory, communities of practice and the pedagogy of feedback. This chapter identifies the gap in the current research and concludes by identifying the aims and objectives of the study.

Chapter 3 discusses the broad philosophical underpinnings of the study and presents a rationale for adopting a phenomenological approach to this research. It specifically explains why a lifeworld style was chosen and moves on to justify the chosen methodology. It presents an outline of the ethical issues related to the study and the methods used to collect the data. The sampling strategy used is also discussed and a rationale is presented for the method of analysis. The chapter concludes with an outline of the findings using template analysis.

Chapter 4 explores the purpose of feedback in the first of four findings-discussion chapters. It discusses the purpose of feedback in a holistic manner, considering the whole lived experience of the individuals. It also provides a rationale for discussing significant themes and subthemes that will be explored more fully in the three subsequent chapters.

Chapters 5, 6 and 7 are findings-discussion chapters each of which takes a particular topic as its focus. These three chapters discuss the themes of "worth and reward", "identity of feedback" and "questions, reflection and ownership", respectively, and synthesise the findings of this research with related published literature.

Chapter 8 provides a summary of the impact of feedback, indicates how the significant findings from this research contribute to new knowledge, and considers the implications of

these to pedagogical practice. This chapter also discusses the limitations of this research and suggests ways forward and recommendations for further research.

1.7 Chapter Summary

This chapter has introduced the broad background to the study and presented an account of my growing personal and professional interest in the subject. It has situated the topic in current political and pedagogical contexts, and crucially introduced the specifics of healthcare education to the argument. In the next chapter I will discuss the evidence-base around the learning theories of situated learning, social learning theory, and communities of practice. I will also consider the pedagogy of feedback, identify the gap in the current evidence and present the aims and objectives of the study.

Chapter 2: Framing the Question – Context and Theory

2.1 Introduction

Chapter one presented the broad context for this research, situating feedback within the current political and pedagogical arenas. This chapter analyses the published literature pertaining to the key issues that influence how feedback impacts on ongoing student learning. In particular, though not exclusively, this chapter explores the evidence that directly relates to healthcare students and that which investigates learning situated in the clinical workplace. This chapter provides a synopsis of the literature that supports the underpinning theory and context of this research in order to locate the study in the wider discipline of education. The rationale for this chapter is to situate this research within the wider literature around feedback and learning, and identify how this research might contribute to this existing knowledge.

Within the context of this research, feedback is considered as the giving or seeking of any comment, opinion or information from at least one person to another person or persons. Additionally and in keeping with Armstrong (2008) this feedback should be in response to demonstration of learning, with learning being defined as "the acquisition of knowledge or skill ... [that can] induce alternative ways of living" (p. 596). There is no caveat as to what form this feedback should take though commonly within healthcare education it might be offered in written and/or verbal form in both academic and practice-based settings. Feedback being offered from an "expert", usually a university or practice educator, to a learner will be the main context in which feedback will be reviewed, however other feedback relationships may also be included, such as peer feedback (Felton, Sheppard, & Stacey, 2012), if they are significant to developing the context of this research.

This contextual chapter will not consider feedback that is automatically and electronically-generated to the student based on purely factual knowledge, such as might occur, for example, in relation to the assessment of scientific and objective anatomy and physiology principles through an online multiple-choice examination. This is because this review of the literature will consider feedback from a theoretical position of social learning and, whilst it could be argued that the lack of a social dimension to automatic feedback justifies the very reason to include it, this is not within the scope and purpose of this literature review. Similarly, nor will this literature review intentionally set out to evaluate the trend of e-

learning. That said, should aspects of e-learning legitimately weave into the review they will not be actively excluded. E-learning is a huge concept in its own right and, although its inclusion might offer a different view of the social aspects involved in feedback, it is outwith the objective of this review.

This chapter begins by outlining the search strategy and presenting a rationale for undertaking a narrative approach to the literature review. It then explores learning through the theoretical lens of situated learning theory (Lave & Wenger, 1991; Wenger, 1998) and presents an argument for this being the theoretical position for investigating the concept of feedback within healthcare education. It contextualises situated learning theory within the wider theoretical discipline of social learning theory, and then explores it more specifically in light of the literature around communities of practice. The chapter moves on to consider what is already known from the literature about feedback practices in higher education. It explores what feedback practices are common within healthcare education taking into account some of the nuances that are associated with healthcare education from a cultural and societal perspective, and it examines the broad literature from the perspective of supporting the feed-forward mechanism to support ongoing learning.

2.1.1 Search strategy

At the beginning of this research the published literature was searched in order to be clear about what was already known about the topics of feedback, assessment and learning. Periodically throughout the course of this research, the literature was searched again in order to identify more recent literature in order that my study remained contextually located in up-to-date evidence. Furthermore, additional literature searches throughout the longevity of this study allowed me to identify and utilise material that supported subsequent topics that were emerging from the data.

With the exception of the requirement to draw on early seminal work to support the theoretical position and methodological approach of this research, the literature that was actively searched was post-1998. The school-based seminal work by Black and Wiliam (1998) established widespread interest in the practice of feedback and it was felt that this influential research established a solid foundation on which to develop my study.

A systematic approach was used to search electronic databases (Table 1) that were relevant to healthcare and/or education.

Table 1: Electronic databases searched by Summon

Australian Education Index
British Education Index (BEI)
Cumulative Index to Nursing and Allied Health (CINAHL)
Educational Resource Information Centre (ERIC)
Science Direct
Scopus

In addition to these electronic databases, other internet sources that were searched throughout the research were Google Scholar, the Department of Health, the Nursing and Midwifery Council, the Health and Care Professions Council, the Royal College of Nursing, the Quality Assurance Agency for Higher Education, and the University of Huddersfield Library Catalogue.

The search terms were intentionally broad (Table 2) in order to capture the relevant literature and Boolean operators were used to maximise the search results.

Table 2: Search terms

Feedback
Feed-forward; feed forward
Learning; student learning; education; higher education
Healthcare; health care
Practice learning; practice-learning; clinical learning; placement; placement learning
Work-based learning; work based learning; clinical practice
Pre-registration; undergraduate
Assessment; summative; formative
Mentor; mentorship; clinical educator; clinical supervision

Literature was retrieved that met the inclusion criteria, and the exclusion criteria enabled literature that was not relevant to the broad purpose of the research to be excluded (Table 3).

Table 3: Inclusion and exclusion criteria

Inclusion criteria
Peer reviewed primary research directly related to the research topic.
Peer reviewed discussion papers directly related to the research topic.
Editorial and opinion papers directly related to the research topic.
English language.
Post-1998.
Exclusion criteria
Conference proceedings.
Research that solely related to clinical simulation.
Research that solely related to distance learning.
Research that concerns students evaluating and/or providing feedback about their learning experience.
Peer reviewed primary research that does not directly relate to the research topic.
Peer reviewed discussion papers that do not directly relate to the research topic.
Material not published in English.

2.1.2 A Narrative Approach

Robust literature reviews are a fundamental tenant of health and social care research in order to develop a comprehensive understanding of the existing evidence within a specific field (Aveyard, 2014; Leach, Neale, & Kemp, 2009). Literature reviews are commonly undertaken in a systematic manner, in order to locate all the evidence within a particular discipline and subsequently critically examine it with structure and objectivity. Hammersley (2001) makes an argument that the level of structure and objectivity associated with a systematic review lends itself well to a positivist model of research, but less so to research that adopts an interpretive epistemological approach, stating that a systematic review "may not be a sensible ideal for studying human social life" (p. 545). He proposes that narrative reviews are, instead, more akin to an interpretive model of research in that they "provide a map of research in the relevant field" (Hammersley, 2001, p. 544) and he enforces the notion that within the human or social sciences the validity of findings are "contextually-sensitive" (p. 547) such that a systematic process of examining the validity of the data is inappropriate. Hammersley (2001) goes on to argue the importance of interpretive research presenting a contextual literature review that demonstrates how aspects of the field relate to one another and that the researcher's own tacit knowledge and experience can influence the review process.

The aim of this research is to explore the perception of the value and impact of feedback on student learning, for which I adopt an interpretive epistemological approach which is discussed in Chapter 3. Given this aim and its subjective underpinnings of perception, and the compelling argument put forward by Hammersley (2001) for a more discursive review of relevant literature within human or social science research, this literature review utilises a narrative approach.

2.2 Learning through the Lens of Situated Learning: A Theoretical Background

Situated learning was first proffered by Lave and Wenger in 1991 as a means by which to explore the contextual relationship between understanding and communication (Lave & Wenger, 1991). Situated learning is historically associated with the apprenticeship model of learning (Fenton-O'Creevy, Brigham, Jones, & Smith, 2015; Lave & Wenger, 1999; Wenger, 1998) and has a historical background in social practice (Van Kleef & Werquin, 2012). Lave and Wenger (1991) examined the social co-participation and social engagements that occur during learning within an authentic context. This seminal work challenged educationalists to consider not only the cognitive aspects of learning but the role that the individual his/herself played within a learning situation. It is this social dimension of situated learning that places situated learning within the "social learning" category of educational theories (Bahn, 2001; Wenger, 1998) and locates feedback overtly into a practice of social engagement (M. Price, Handley, & Millar, 2011).

There is extensive research and writing about feedback (for example Ball, 2010; Clynes & Raftery, 2008; Dearnley, Taylor, Laxton, Rinomhota, & Nkosana-Nyawata, 2013; Gould & Day, 2013) and most of it considers, to a greater or lesser extent, the interplay of individuals within the feedback partnership (i.e. the provider(s) and receiver(s) of feedback). For an educator, the practical task of constructing written feedback for a student using language and structure in keeping with the acceptable norms of a broad and defined society give it a social dimension (M. Price et al., 2011). For the receiver of feedback, it needs to be presented and delivered in a way that is in keeping with their social construct and expectations. The social construct and expectations of an individual in terms of how this fits with a given fragment of society – a community of practice - will be explored later.

Lave and Wenger (1991) clearly document learning as an outcome integral to the social practice of the world in which one lives. They discuss the marginal yet authentic engagement of individuals within a given social construct as "legitimate peripheral

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participation" (p. 35). It seems reasonable to suggest that this peripheral engagement might be of critical importance when explaining the tentative involvement of novice healthcare practitioners at the outset of their professional journey. Equally, students new to a higher education community may feel marginalised and isolated at the beginning of their higher education phase of their ongoing educational journey. Thus, it can be a challenge for student healthcare practitioners to find a "fit" and become clearly "situated" in the new professional or educational communities that they are seeking to enter.

To offer further explanation for their theory of situated learning, Lave and Wenger (1991) draw on the earlier work of Bourdieu (1977). Bourdieu argued that individuals have multiple positions in society, or social space, and that they may be valued not solely in terms of economics or hierarchy, but also in terms of their contribution to a social network. From this, it is proposed that "learning, thinking and knowing are … [activities] … in, with, and arising from the socially and culturally structured world" (Lave & Wenger, 1991, p. 51). They go on to suggest that socially constructed knowledge – and I suggest including that which is socially constructed by defined healthcare disciplines – is also mediated by that society in which it was situated and constructed.

Drawing on the social and cultural dimensions of feedback, the careful choice of spoken word by an educator to provide verbal feedback to a student is socially constructed based on experiences of the individual educator. In addition, and perhaps of equal importance, is the careful consideration of non-verbal aspects of communication during face-to-face feedback opportunities such as the layout of the room, the welcome, the creating of sufficient time for the student and the two-way dialogue usually expected (within western societies, at least) within the meeting. The verbal and interpersonal engagement of the social actors within this feedback situation begins to suggest why learning from feedback has a social dimension to it and why it is important that it is considered within the context of social learning theory.

2.2.1 Situated learning as a social learning theory: a place for healthcare education

The theory of social learning was first widely disseminated by Albert Bandura in 1977 (Bandura, 1977) and is essentially concerned with learning through the process of social observation. Bandura states that within learning there is an interlocking interface between the social environment, social behaviours and the individual (Boyce, 2011) and that it is this very interaction that contributes to the how and what of learning (Bandura, 1986). Bandura

explicitly highlights three dimensions of learning within a social arena: learning occurs through observation, the utilisation of internal mental states are necessary to foster learning, and a change in behaviour is not a guaranteed consequence of learning. This final aspect is interesting as Lave and Wenger (1991) go on to use this to underpin their own description of learning as being the "historical production, transformation, and change of persons" (p. 51), despite Bandura's earlier theory suggesting that change is not a certain outcome.

In consideration of the pre-registration education of healthcare professionals, it is important to recognise and establish the underpinning educational philosophy of these professions in the broadest context. Higher education learning for some students is very theoretical and without obvious direct application; a student who undertakes an economics degree, for instance, has no obvious nor predicted direct application of their learning on successful completion of their course. Conversely, healthcare professions, like other professions such as teaching and law, are seen to be vocational in nature and thus people are drawn into these professions having an understanding of their own suitability for a defined future role. Whilst some healthcare professions are commonly recognised by the lay person, such as nursing for instance, others such as podiatry may be less well accurately understood by the wider population and, in some countries, not established at all. That said, whilst the specifics of an individual profession may not be universally transparent, the fact that they are located within a broad domain of "healthcare" is commonplace.

The concept of healthcare has some common underpinnings. Given that healthcare is, in the purest sense, about the care and nurturing offered to the [mental and physical] health of another, it seems reasonable to suggest that healthcare professions have some commonality of its broad understanding. Such shared understanding of healthcare may be in recognition that healthcare involves interaction with people, that it is pivotal of a desire for non-maleficence and maximising the beneficence of others, and that it involves the acquisition of both profession-specific and interprofessional skills and knowledge. In more recent years factors such as having a need to understand the patient from their own perspective, and the setting of agreed and shared goals with the patient such that intervention is meaningful and functional for the individual patient have become more prominent within healthcare, such that these are now readily recognised as unambiguous features of healthcare disciplines.

Rogoff (1999) augments the earlier social argument for learning by stating that learning from the social world is not simply about the partnerships with which we engage, but that

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as important is the society, the culture, the norm, and the communities within which we operate. Student nurses, for example, will engage in common learning activities in order to develop their professional identity and become socialised into the profession. It is acknowledged that, over time, professions change and they become redefined such that a physiotherapist today has a very different role to one of 10 years ago, and a physiotherapist 10 years hence will have an equally different role to one of today. This is supported by the description by Lave and Wenger (1991) in which they state that learning is "produced, reproduced, and changed" (p. 51) as a defined society evolves. Despite this inevitable and necessary evolution of the individual professions to meet the needs of society, common learning experiences bring people together, unite them in a common purpose, and develop relationships.

Student healthcare practitioners need to be able to relate their learning to the healthcare context in which it will be used once qualified. This is one primary need of knowledge and professional evolution. Students may be able to write an excellent account of the principles of infection control or polypharmacy, and be able to demonstrate good hand washing and drug calculation skills within a university-based setting, but if they do not have the ability to correctly utilise the acquired knowledge and skill in an authentic clinical environment, the learning is effectively useless for its intended purpose. Equally as important is the student healthcare practitioner's ability to work as part of an interprofessional team within the clinical workplace, whilst a student and when qualified, in order to maximise the opportunity for learning and best patient care (Barr & Low, 2012; The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

By the nature of the broad discipline, all dimensions of healthcare education relate, in some way, to people. The development of appropriate anatomical and physiological knowledge in order that the healthcare student can fully understand the healing process following a surgical intervention focusses on factual and accepted knowledge pertaining to the normal person. The progressive acquisition of effective communication skills such that the healthcare student can accurately take a history from an elderly person involves active listening, intelligent and differentiating questioning and is person-centred. A healthcare student's ability to recognise and utilise the distinctiveness of their own professional role, whilst respecting the same of others, in order to be able to effectively contribute to a patient's case conference as part of a multidisciplinary team is an essential skill. An understanding of the commissioning and development of local healthcare services such that the services are best placed to meet the needs of the same local community centres on people within that community. Without the very specific person, people, team or community

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being at the heart of these examples there is a risk that the student healthcare professional could develop accurate knowledge and skill but without a true understanding of its likely application, meaning and relevance to their professional role.

The genuine and reliable context or "situation" of the learning undertaken by healthcare students gives healthcare education its uniqueness from other vocational groups, such as teachers or lawyers for instance. Teachers and lawyers might both argue that they too need to develop effective communication skills with a variety of people but the purpose, reason or "situation" for them doing so differs entirely from that of a healthcare student. Even within healthcare, the different professional groups are likely to have very different reasons for developing a "common" knowledge-base or skill-set and it is this unique "situation" or context around and/or within which learning occurs that sets the professions apart from one another. Even within a common professional group, the situation may change the learning potential based on the socially and culturally constructed aspects of the situation, such as the role played by the social actors within the given community and the underpinning values and beliefs of that distinct group. This now draws on the further work of Lave and Wenger in terms of communities of practice.

2.2.2 Communities of practice in the discipline of situated learning

Lave and Wenger (1991) and Lave and Wenger (1999) expand on the "situation" required for learning within their theory of situated learning. They report that in order for learning to be meaningful it needs to happen within an authentic learning environment, be purposeful in developing authentic knowledge and skills and involve an aspect of critical reflection. As has already been discussed, their situated learning theory suggests that learning is situated not only in society but actually within the history and culture of that society (Van Kleef & Werquin, 2012). Van Kleef and Werquin (2012) explain culture as a system of making sense of a problem or situation and, I suggest, that it can be described as "the way things happen" within and by defined groups. In order to explore the application of this theory to healthcare education one needs only to consider a university setting. Within a university there are many different defined groups and cultures, though an individual might simultaneously belong to more than one. Culture may be associated with gender or religious belief, be linked to a teaching or a research role, be rooted in previous professional practice or be situated in a specific system of work. Cultures pervade as a result of multiple individuals with common and shared knowledge, skills, values, and visions coming together to become a specific "community".

A "community" is not a static entity. Wenger-Trayner and Wenger-Trayner (2015) describe communities of practice being formed by people who engage in a process of collective learning in the search of a shared goal and as defined groups of people who have a shared concern for something they do. They go on to suggest that members of communities of practice learn how to function better as a community and as individuals within the community as a consequence of regular community interaction. Applying this to the learning experience of healthcare students, "communities" are formed by those that have a shared learning experience, though interestingly the learning need not necessarily happen at the same time. As learners begin their higher education journey towards becoming a healthcare professional, they participate in multiple "communities of practice" (Wenger, 1998) along the way. At the outset of their learning journey, students engage (to a greater or lesser extent) in the general university experience (i.e. they become members of the university student community), they participate in the community of being a healthcare student, and they also partake in the community associated with a named profession (e.g. nurse, physiotherapist etc). Learners who have gone before them, or indeed who will come after them, will also be part of the same community due to their shared "community" knowledge, skills, values, systems of working and so forth.

As has already been suggested, the knowledge-base and skill-set of a specific "community of practice" is defined progressively by that community itself. As part of the process of defining its shared meaning and unique identity – for example and in simple vocational terms, how a nursing "community of practice" differs from a physiotherapy "community of practice" – the community itself needs to overcome the competing voices of those stakeholders who might have interest in or influence on that community, for instance, commissioners, policy-makers, service users, regulators, professional bodies and other professions. From the perspective of a healthcare student, a "community of practice" offers a means by which a shared problem, group task or the development of a common skill can be the focus of the "community" and the learning curriculum (Wenger, 1998).

A common curriculum and shared instruments of learning usually leads to the opportunity of an equivalent feedback experience for students within a single "community of practice", however the extent to which an individual can (i.e. is permitted to) or may (i.e. through choice) engage in a "community of practice" is not uniform. As has been described earlier, Lave and Wenger (1991) first coined the term legitimate peripheral participation to describe the usual and expected "novice to expert" or apprenticeship learning trajectory that an individual follows when moving towards becoming a fully participatory member of a "community of practice".

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More recent work, however, has reconsidered this linear trajectory from an alternative perspective. Fenton-O'Creevy et al. (2015) explored participation within a "community of practice" at a variety of levels, and of particular interest is that some of their writing is situated at the academic-workplace interface of healthcare students. They highlight the fact that individuals often partake in multiple communities of practice at any one time and also that an individual may view one community as a necessary means by which to become a fully engaged member of another. Their exemplars (p. 46) include the nursing student who, en route to becoming a fully participating member of a "qualified nurse clinical community", has no choice but to engage with a "student nurse academic community" though at the level of tourist or sojourner, depending on their level of participation within the academic community. Fenton-O'Creevy et al. (2015) suggest possible parallels between the level of engagement in an academic community of practice based on a sense of identity with that community and the type of approach to learning (Race, 2005) employed by the student. This potential correlation is interesting in relation to the likelihood of students engaging in a named community if they visualise their long-term trajectory taking them elsewhere. For instance, a student midwife who sees herself as continuing her academic career post-registration by registering for ongoing study might be more likely to engage with the clinical community at a superficial level, in contrast to a deeper engagement with an academic or even research community of practice because she has a stronger identity and can visualise a vocation with the latter.

Within the remainder of this chapter, the literature that explores the key issues that may influence how students utilise feedback to support their ongoing learning will be reviewed with two underpinning considerations. Firstly, the literature will be explored making explicit reference to relevant social dimensions of learning and the authenticity of such learning. Secondly, the concept of identity and communities of learning practices will be drawn out through the analysis of the literature in order to explore the challenges faced by healthcare students.

2.3 Feedback in Higher Education

Within the educational literature, the concept and exploration of feedback is often situated within the context of assessment, or "verification of learning", (Race, 2005). Both formative and summative assessment practices should give rise to feedback, though feedback offered purposely to support ongoing learning is often more explicitly linked with formative assessment (Clynes & Raftery, 2008; Koh, 2008; Vardi, 2013) which Ecclestone (2007) and

Wiliam (2011), amongst others, describe as "assessment *for* learning". This suggests that summative assessment is not learning-driven, rather seen more as the "end product". Race (2005) adds a third dimension to the "formative-summative" debate by suggesting that formative feedback that is not received with sufficient time for a learner to be able to use it as it was intended (i.e. to inform the next, usually summative, submission of work) results in that intended formative feedback being changed, by the student, into summative feedback. Of more significance here is the fact that the intended formative feedback is then often not read by the student because "the time has passed" to be able to do anything meaningful with it in the student's view, the "end point" has been reached, and they have "moved on" - particularly noticeable within a modularised curriculum (M. Price, Handley, Millar, & O'Donovan, 2010) - to the next aspect of learning. Whilst the opinion that students do not access feedback is challenged in the work of Zimbardi et al. (2017), this ambiguity around the seemingly straightforward process of offering feedback to help a student's ongoing learning is more complex than one might first believe. This will now be explored further by looking at common situations that give rise to feedback.

2.3.1 Feedback situations

As a learner, there is the opportunity to engage with feedback at different points across the learning continuum. As a healthcare professional, an individual's learning continuum usually begins as a novice in the immediate pre-registration years and builds towards that of expert status [often many years] post-qualification. In addition, a required ongoing commitment to lifelong learning (Health and Care Professions Council, 2012; Nursing and Midwifery Council, 2017) to maintain and enhance role-specific knowledge and skills whilst at the same time offering mentorship and role-modelling to incoming learners or less experienced professionals all continue to offer the individual specific "learning from feedback" opportunities post-registration. The suggestion by Hattie and Timperley (2007) that feedback at different points within the learning spectrum may have different purposes is further augmented by M. Price et al. (2010, p. 278) who report that the ongoing "longitudinal development (feed-forward)" is based on the successful and "hierarchical" use of feedback to correct understanding, reiterate and reinforce, identify specific issues and set standards. This notion of there being an incremental structure to maximising the outcome of feedback implies that without previous feedback being in place to correct learning etc, ongoing learning may not successfully occur.

The notion of feedback for corrective purposes provides an interesting platform for exploring feedback in higher education in more depth. M. Price et al. (2010) and M. Price et al. (2011) make explicit the difficulties associated with offering corrective feedback on composite

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assessments, skills or activities, particularly when there is a component of professional judgement involved on the part of the individual providing feedback. If scientific knowledge and objective facts are being assessed it is easy for feedback to offer correction. Conversely, and more commonly as a novice learner progresses towards and beyond becoming a confident and competent graduate (Milligan, 2014), healthcare professionals need to be able to problem-solve and decision-make in the clinical workplace, so implementing reasonable decisions, patient treatment, and care throughout, whilst also being able to demonstrate critical reflexivity. The cognitive and meta-cognitive dimensions involved in these complex processes may validly differ between individuals and it is perfectly acceptable for two expert and autonomous clinicians to clinically-reason the same patient scenario differently and suggest alternative, though both clinically reasonable, forms of treatment. This cognitive dimension of learning from a corrective feedback experience draws on the previously discussed theory of situated learning in that whilst Bandura (1977) suggests that internal cognitive processing by the individual is needed to underpin learning, a change in behaviour is not necessarily a given outcome. This suggest then that there is the potential for incorrect practice to remain despite learning from feedback.

To focus now on the pre-registration educational journey of a healthcare professional. Feedback is associated with many and varied activities within a pre-registration healthcare course. Some of the university-based activities such as seminars and tutorials, written work (Vardi, 2013) and presentations that generate feedback are common to most, if not all, students. Any one of these activities might consider feedback as learning "process", in that it is intrinsic to a formative learning situation, viewed as a "low stake" activity or has less risk associated with it from the perspective of benchmarking learning in line with national standards (The Quality Assurance Agency for Higher Education, 2008) and quality-assuring progression or award. Similarly, any one of these same activities could consider feedback as part of a learning "product" (M. Price et al., 2011), the product typically being associated with final, graded, "end point", summative work that might be viewed by both students and tutors as having a "higher risk" linked to it. In addition to university-based learning opportunities, all pre-registration healthcare education includes a large component of clinically-based learning and assessment, for example students must undertake a minimum of 1000 hours of clinical practice within physiotherapy (Chartered Society of Physiotherapy, 2010) and 2300 hours within nursing (Nursing and Midwifery Council, 2010). It is these authentic clinical experiences that provide a distinct and unique feedback, and thus learning, opportunity for individual healthcare students.

The clinical environment, as "the" genuine setting in which graduates will be working post-qualification, offers a rich, vast location for real world learning within pre-registration healthcare courses. Interestingly, feedback being regularly offered to support ongoing learning in this environment, rather than it being explicitly and only associated with the assessment elements of the placement learning, does not seem to be common practice within all healthcare professions. Personal experience as a previous physiotherapy clinical educator led to my own assumption that other healthcare disciplines would offer a similar model of clinical education – and thus feedback – to that which was the "norm" within physiotherapy. Typically within physiotherapy, students are allocated named clinical educator(s) with whom they would primarily work for the duration of their placement. The named educator(s) are responsible for providing feedback in relation to how well the student is meeting predetermined and/or negotiated specific learning outcomes both informally throughout the duration of the placement, and formally at midway and end points.

Figure 1 suggests some of the commonplace activities from across the healthcare professions that could, or should, give rise to feedback opportunities within both university and practice-based settings. I have intentionally linked the activities to the apparent "risk" that appears to be associated with them, in addition to whether the primary function of learning from the feedback is largely seen as product or process, in order to integrate these important pedagogical dimensions. What is unequivocal across all pre-registration healthcare courses is that learning activities need to be embedded within the curricula in such a way that they explicitly support the development of the required knowledge, skills and behaviours expected of a newly qualified healthcare professional (Health and Care Professions Council, 2009, 2013; Nursing and Midwifery Council, 2010). Since the movement of all healthcare courses into the higher education arena within the 1990's (Roxburgh et al., 2008), and thus the loss of a degree of control (Burke, 2003; Corbett, 1998) which was previously held by the individual professions, there has been a real challenge faced by education providers to ensure that the curriculum continues to serve the ever-changing needs of practice, whilst at the same time ensuring that this is balanced with maintenance of those qualities within the curriculum that demonstrate "graduate-ness" in terms of being fit for a higher education academic award (The Quality Assurance Agency for Higher Education, 2008).

Figure 1: Activities associated with feedback

	High Stakes Activities and Feedback as a Product	Low Stakes Activities and Feedback as a Process
University-based	Summative assessment tasks Final examinations Tutor-driven Might include some peer and self-assessment Graded	"Informal" feedback from peers and tutor within the class "Formal" formative assessments
Practice-based	"Signing off" competencies End of placement assessment Tutor or educator-driven Might include feedback from patients Graded	"Formal" feedback – often mid-way through a placement Ongoing and day-to-day based on observations of performance
Feedback Knowledge, Skills and Behaviours of a (named) graduate healthcare professional		

Researcher's own interpretation, though supported by the work of Ferrell (2012)

One of the key learning opportunities is the ongoing, day-to-day, patient-by-patient feedback that healthcare students have the possibility of receiving in clinical practice. This truly authentic learning environment is difficult, if not impossible, to replicate by even high-technology simulation. Despite Clynes and Raftery (2008) clearly articulating that feedback is the most important component to maximal learning, they suggest that often the focus of the feedback discussions in a clinical environment is centred around the assessment documentation – i.e. product - itself, rather than the learning process and the practise of developing necessary skills, knowledge and behaviours. It is also suggested by Clynes and Raftery (2008, p. 406) that feedback often occurs for nursing students "away from the job" and after the authentic event, and this then offers a very different learning experience to

the that which would be encountered in "real time" at the patient's bedside. M. Price et al. (2011, p. 833) take the learning in "real time" concept to another level in their suggestion that learning from feedback might be significantly later than the feedback itself, in fact describing it as "latent".

Of particular interest here is the consideration of delayed or latent learning (M. Price et al., 2011) within the context of clinical practice. The delivery of healthcare services across an ever-changing social and political landscape means that pre-registration healthcare students are authentically being exposed to different client groups, diverse and changing practices, and varied clinical environments. This means that the precise repetition of an earlier clinical situation that has given rise to feedback might not be forthcoming and, as such, the impact of any overt learning from that earlier feedback situation might not be visible to the student or the educator for some time. This means that, depending on who (i.e. student or educator) is being asked as to whether learning from earlier feedback has been demonstrated (in the broadest sense), there is no assurance that learning has not actually happened though it may not yet be visible. In addition, the progressive development of critical reflection in and on clinical practice may delay the demonstration of overt clinically-applied learning further whilst the student is "making sense" of the feedback and contextualising it within the real world (Rust, O'Donovan, & Price, 2005). This individually considered and possibly latent response to feedback may be wholly appropriate in the clinical environment as a result of the student trying to understand the situation-appropriate cognitive, emotional and behavioural aspects (M. Price et al., 2011) of how to utilise the learning from feedback.

The above scenario assumes that there is the opportunity to learn from feedback within a clinical setting, however in the descriptive questionnaire study involving oral hygiene students, Gordon (2013, p. 269) supports a lack of feedback to students in clinical situations. Despite 86% of student participants indicating that feedback supported their learning overall, only 48% of students reported that they received feedback at each clinical session. One of the tensions highlighted by this research (Gordon, 2013) is that of receiving feedback in the presence of a patient – such that it is timely (Gruendemann, 2011) and authentic and can directly influence care for that individual patient – versus the student feeling inadequate in front of the patient when constructive feedback is given, so implying a reduction in their professional autonomy and their ownership of the clinical situation.

Rushton (2005, p. 509) discusses the meta-analysis work of Hattie in the late 1980's, who identified "feedback [as that which is able] to produce the most powerful single effect on

achievement" and that which must be used to limit the mismatch in learner performance between what is and what should be achieved. The premise of this definition within the clinical setting is supported by, amongst others, Clynes and Raftery (2008), J. M. Sargeant, Mann, van der Vleuten, and Metsemakers (2009) and Duers and Brown (2009). The assumptions being made here are that the feedback is utilised by the learner, however, Irons (2008) suggests that this is not always the case. He suggests that often feedback is not provided with student learning central to it and that, instead, it is produced in response to the university's learning and teaching strategy (for instance in line with the needs of clinical assessments as stipulated by professional, statutory and/or regulatory bodies (PSRBs)), meet audit requirements and to gratify the tutor. More recently, M. Price et al. (2010, p. 283) and M. Price et al. (2011) offer evidence to support feedback being offered, not for the benefit of the student, but for "justification of a summative mark" by the tutor. This 2010 work reported a three-year, multi-centred qualitative study and provides evidence that, in higher education, when the learning-driven, developmental true purpose of feedback is not clear, students will revert to the idea that feedback is for the benefit of the tutor and thus lose their real opportunity for learning from feedback. This emphasises the importance of clearly articulating the purpose of feedback to all parties in order that it had the opportunity of fulfilling its intended role.

The varied extent to which feedback is utilised by the learner in the clinical setting is supported by J. M. Sargeant et al. (2009) who suggests that time constraints may impact on the utilisation of feedback, Clynes and Raftery (2008) who suggest that self-esteem of the student influences its uptake and Lally (2013) who suggests that the relationship between educator and student can influence feedback use. All of these facets will be discussed in more depth now as the literature reporting enablers and barriers to learning from feedback is further explored.

2.3.2 Feedback to help or hinder?

There is current evidence (Winstone, Nash, Parker, & Rowntree, 2017) that key features of a clinical and/or academic environment, in the broadest sense, can act to facilitate or hinder a student learning from feedback. The argument around literacy associated with written feedback offered by Sutton (2012) suggests that students engage with feedback in response to different stimuli with some engaging with feedback at a greater level in response to achieving a higher grade, and others doing so if they expected a higher grade than they achieved. Sutton suggests that feedback literacy is about the ability of a student to be able to "read, interpret and use written feedback" (2012, p. 31), a concept supported by Winstone et al. (2017), that the ability to carry out all three aspects is not consistent in
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and across learners, and is often difficult to master. Furthermore, Sutton (2012) suggests that feedback literacy is socially dependent and framed by given society and culture. This theory is particularly interesting given the individual disciplines within healthcare, each with their own semi-unique professional cultures and traditions.

Sutton (2012) also suggests that the concept of an educational identity – that mode of *being* in higher education – impacts on the social facets associated with learning which, in turn, may help or hinder the development of feedback literacy and thus the ability of the student to engage with feedback. Jonsson (2012) suggests that students may not engage with feedback because of one, or a combination, of the following reasons: 1) its apparent usefulness, 2) its lack of detail or personalisation, 3) its authoritarian tone, 4) they do not know how to act on it, and 5) they do not understand it. These suggested reasons for the lack of engagement by students with feedback are, perhaps, unsurprising – i.e. if a student does not understand the feedback provided they will not be able to accurately act on it. Some enablers and barriers to engaging with feedback that are reported in the published literature will now be explored in more detail.

2.3.2.1 Enablers

Regularity of feedback

In the phenomenological study involving novice dietetic and nutrition educators (Palermo et al., 2013), clear barriers and enablers to effective learning in a clinical environment are suggested. The educators explicitly identify that the delivery of regular feedback is an enabler to learning.

Relationships

One enabler suggested by Lally (2013) and supported by Palermo et al. (2013) is that of a positive relationship between the student and the clinical educator. Not only does the latter state that a degree of empathy is beneficial to the relationship, such that the educator is showing some affiliation with the student, but that often the novice educator – in contrast to the expert educator - is more likely to possess such a quality as they are "newer" to the profession and thus closer to the student's professional trajectory. Furthermore, learners perceive the credibility of the educator as important to the feedback relationship – feedback from an educator that lacks credibility and the student cannot "trust" is likely to be detrimental to their engagement with feedback (D Boud & Molloy, 2013b). A sense of belonging and kinship is one of the most basic human needs (Maslow, 2011, 2013) and for

a student to perceive that there is mutuality between him/her and his/her educator may foster a more positive learning relationship.

2.3.2.2 Barriers

Workload

One of the barriers purported by educators to impact on the provision of feedback to learners is the workload of the educator, in that a demanding workload limits direct engagement with, and feedback to, the student. A demanding workload inhibiting educators in fulfilling their educator role is explicitly reported in around two thirds of the nurse educator participants in the research by McIntosh, Gidman, and Smith (2014). This is an interesting notion because there is compelling evidence (Bennett, 2002; Blakely, Rigg, Joynson, & Oldfield, 2009; O'Connor, Cahill, & McKay, 2012; D. Price & Whiteside, 2016) to support less traditional models of clinical education, including that of a model in which the student takes on all or part of the workload of the educator. This model shifts the clinical work from the educator to the student such that the educator is then "freed up" to better support the student's learning through their adopted clinical caseload. Such models make clear that student supervision should not be in addition to an existing workload, but should replace some/all of it. These clinical education models are often more commonly suggested and utilised when maximising clinical placement capacity is the ultimate goal (for example, the Chartered Society of Physiotherapy, 2014) but the underlying principles of these should not be neglected as a strategy to optimise student learning in all situations.

Feedback goal

Assessment versus learning is a challenge within the clinical learning arena. McIntosh et al. (2014) highlight the assessment of placement outcomes as a challenge to the focus of learning within a clinical placement. They report that the nurse educators perceived that student nurses tended to have a "task-orientated approach" (p. 364) to their learning because placement outcomes [or professional competencies] were being assessed. This is potentially compounded by only 57% of the nurse educators within this research reporting that they perceived their main responsibility within a clinical placement experience as support of student learning. The authors unfortunately fail to clearly document what the remainder of the participants reported as their main priority. The task-orientated focus to the clinical placement by the students together with more than 40% of educator participants perceiving their role not as being learning-centred raises questions as to the collective belief regarding the purpose of clinical placements. It suggests potential tension between the intended purpose of a clinical placement being a vehicle for clinical learning

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(i.e. a process for learning) versus a mechanism by which learning can be verified (i.e. a product of learning). McIntosh et al. (2014) conclude that there might be a need to review the clinical practice documentation within pre-registration nursing to re-focus it on learning rather than assessment, so facilitating students to take more responsibility for their learning.

Feedback as a process is a means through which learning should occur. If the focus of feedback is confirmation of previous learning rather than the encouragement of iterative and ongoing learning from the feedback process itself, learning opportunity may be lost from feedback that is not actively supported with a culture of learning inherently rooted in the clinical placement. To relate this back to social learning theory and, more specifically, the communities of practice work (Wenger, 1998) the social elements of a learning are inherently dependent on the relationships, as discussed earlier, between people within that community.

Learning communities
A shared mind-set between the members of a learning community is part of what underpins the philosophy of that community. It has been argued previously that the people - the social actors - within a specific community of practice have varying and different levels of engagement within that community depending on their alignment, experience and engagement with the common values, beliefs and traditions of that community. Student healthcare professionals want to become members of a professional community of practice – e.g. student physiotherapists want to become members of a physiotherapy community. As such and over a pre-registration timescale, students creep their way inwards from the periphery of a professional community, perhaps within a specific clinical location such as a ward or department, or within a particular organisation itself. If the pervasive beliefs of that community – fostered by the expert clinicians inherent in and central to that community – are principally about students being on placement to have their learning assessed and verified, rather than the facilitation of a learning experience, then a barrier to engaging with clinical feedback is the community of practice itself.

New members to a community of practice are influenced by what is already established. Salminen, Ohman, and Stenfors-Hayes (2016) supports the notion that, particularly for novice healthcare students early in their professional learning journey, students rely on the frame of reference posed to them by more experienced members of that community of practice in order to begin to develop an "in keeping" professional identity for themselves. Students are susceptible to endorsing the role model offered to them by the experts within

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a community of practice (i.e. their educators) and if, as suggested by McIntosh et al. (2014), that role model is focussed on tasks or assessment (i.e. product) at the expense of maximising the process of learning, it is evident that feedback to support ongoing learning will not be culturally driven or explicitly encouraged by that community.

It is interesting to consider the role of the clinical educator within the context of feedback as a learning tool. Healthcare professionals with whom students are often placed in a clinical placement setting are often highly experienced in their chosen healthcare profession – indeed their clinical expertise is often one of the main reasons that students are placed alongside them in practice. However, expertise within one arena does not necessarily make the clinician an expert, or even prepared for taking on a different role, within another. Jetha, Boschma, and Clauson (2016) highlight the lack of preparation that experienced nurses had to enable them to move into the novice educator role. This Canadian review of published literature considers specifically the transition of nurses into a clinical teacher role. This work reports the eagerness and willingness of nurses to contribute to the ongoing education of the nurses of the future. It also suggests that novice nurses believe that they have the skillset required to facilitate student learning, though goes on to identify issues such as belonging to a new environment, relationships with colleagues and students, and professional development as key challenges that manifest within this transition.

Commonality and kinship is important within a community of practice. As was previously argued, a community of practice is said to be construed from common and united values, beliefs, and purpose. With this in mind, the role of the educator is likely to be more challenging within a clinical environment in contrast to within an academic environment. The clinical environment is clearly centred on patient care. The academic environment is clearly centred on student learning. However, when these environments meld – as happens with the clinical educator role - the primary focus of the clinician is no longer patient care but student learning. In reality, of course, this divorce from one role whilst adopting another may not be as clear-cut as is being suggested, but the distinction and purpose is important to make in the context of exploring how feedback might foster learning. This role evolution is supported by the work of Aguayo-González and Monereo-Font (2012) and this new identity is in potential conflict with the primary purpose of the environment within which the clinical educator is working. Jetha et al. (2016) presents a narrative around "professional isolation" (p. 6) that can result from taking on new roles and the amount of "role confusion" (McArthur-Rouse, 2008) that might occur.

A clinical environment is implicitly less supportive of learning than an academic environment by the simple nature of its principal purpose. Clinical educators may be uncertain of their new role and have minimal support in taking it on. Salminen et al. (2016) and Jetha et al. (2016) present evidence supporting the utilisation of transformative learning theories through which individuals draw on previous experiences, beliefs and values in order to establish a new frame of reference. It is evident from this work that a new frame of reference to support a new role does not happen by chance and, instead, it is essential that one actively engages with learning theory to facilitate such transformation. Reflective practice is one strategy within the transformative learning theory "toolbox" that can be utilised to learn from one's own experiences.

Consistency

Another barrier identified by Palermo et al. (2013) was that of inconsistency between the clinical educator and the university academic with regards what is expected of the student. One of the main points of difference appears to be how the student contributes to the overall work of the placement area and how their competence supports transferable and employability skills.

Differing expectations is not unique to learning within a clinical environment. The work of Vardi (2013) indicates that within written assessment there is significant intra and inter-disciplinary expectations of markers. This is an interesting concept as learning outcomes and assessment criteria against which written work is judged are often clear and thus should not be open to subjective interpretation. Of particular interest here is that PSRBs often dictate (very specifically) the skills, knowledge and behaviours that are expected at progression points through the course and, despite this, Palermo et al. (2013) found that there is disagreement between educators with regards the requirements of entry-level competence.

Students are frequently placed with more experienced clinical educators in a practice learning environment as it is understandably believed that these clinicians are the most appropriate people to maximise clinical student learning based on their expert skillset and knowledge-base. Given the earlier discussion around the value placed by the learner on relationships and where novice and expert educators are placed within the community of practice, students may face conflict in the learning environment between the ability to learn the most from the clinical experts with whom they have less affinity versus the need to meet the basic human need of belonging such that, subsequently, self-actualisation of goals might occur.

2.4 The Research Gap

The research that has been examined within this chapter shows that there is uncertainty regarding the consequences of feedback. The discussion in this chapter draws out the challenges around process and product of feedback, and I have related this to the discipline of pre-registration healthcare education. There is current evidence from Winstone et al. (2017) to suggest that there is limited published material that investigates the outcomes of feedback on student behaviour. Behaviour is implicit within ongoing student learning and there is no published material that explores the perceived effect of feedback on the learning behaviours of pre-registration healthcare students. This is a gap in the evidence and my research will be undertaken to address this gap.

The primary research question that this study will answer is:
- What is the perception of the value and impact of feedback on ongoing pre-registration healthcare student learning?

Subsidiary aims of this study are to:
- Identify key features of feedback that pre-registration healthcare students perceive to be effective in supporting their learning.
- Explore how pre-registration healthcare students use feedback.
- Use theories of communities of practice to understand the data generated by the study.

2.5 Chapter Summary

This chapter has provided an evidential framework for this study. It has presented a narrative review of the current and available evidence that surrounds the practice of learning from feedback. It has also considered the theoretical approach of situated learning that supports this specific investigation in the field of pre-registration education. In the next chapter I will present the underpinning theoretical and philosophical positions for my research, and describe the practical methods that were used to collect and analyse the data. I will also consider the role that I play within this research.

Chapter 3: Methodological Approach and Methodology

3.1 Introduction

This study explores the experience and perception of feedback on ongoing learning in continuing full-time healthcare students. This research includes students, and their practice-based and university-based educators, on a range of pre-registration healthcare courses at one UK university. It investigates the feedback experiences of the participants and identifies key aspects of feedback that influence ongoing learning.

This chapter begins by reaffirming the research question and aims that were presented in the previous chapter, and goes on to argue the underpinning theoretical and philosophical positions for my study. The chapter situates this research in the context of interpretive phenomenology, introduces the concept of phenomenology as a methodological approach, and explains my choice of the lifeworld dimension. The practical methods that were used to collect the data are described, including those of ethical approval, the sample and participant recruitment. Template analysis as my chosen method of data analysis is also explained. This chapter concludes with an account of why, given the methodological approach, honest reflexivity by me is important to my interpretation of the data and the development of an argument.

3.2 Background Work to this Study

This research was developed though a pilot study that fostered the iterative development of the study's focus from an initial one of formative assessment and formative feedback, to one of the broader concept of feedback. Information about the pilot study and how its results were used to hone the focus of this study are in Appendix 1.

3.3 Research Question and Aims

The current Assessment and Feedback Strategy within the HEI where I work is clear regarding its expectations about how assessment, and thus feedback, should be used by both staff and students to support prospective learning. This enforced external driver, the gap in the evidence that specifically relates to pre-registration healthcare students, and my

own genuine interest in the field of "assessment for learning" helped me define the primary research question of:

- What is the perception of the value and impact of feedback on ongoing pre-registration healthcare student learning?

Subsidiary aims of this study are to:

- Identify key features of feedback that pre-registration healthcare students perceive to be effective in supporting their learning.
- Explore how pre-registration healthcare students use feedback.
- Use theories of communities of practice to understand the data generated by the study.

3.4 Methodological Approach

3.4.1 Ontological perspective

Ontology is recognised as the branch of philosophy that studies the principles of phenomena and the nature by which they occur. There is debate (Bryman, 2004; Cohen, Manion, & Morrison, 2007; Hughes & Sharrock, 1997) about whether facts/events/experiences truly exist in their own right or whether it is the "knowing" or "perception" of the engager/researcher with the said fact/event/experience that leads to the phenomenon being recognised. The crux of this debate is around whether the phenomena exist independent of the human interaction.

Duberley, Johnson, and Cassell (2012) suggest an ontological continuum, with a realist or objectivist view at one end and a relativist or subjectivist at the other. These extremes of perspective reflect the beliefs by some researchers that, respectively, things do exist independent of human perceptions or that things only result as a construct of human interaction/cognition and without human interaction/cognition would not occur. The polarity of these perspectives means that these extremes are not commonly adhered to within a lot of research with, instead, the researcher more often adopting an ontological perspective that is somewhere within this continuum.

Within this research, the ontological perspective needed to investigate and answer the research questions is not one of an extreme position. Instead, this research will utilise an ontological position somewhere between midway (ontologically neutral) and the subjectivist/relativist end of the spectrum.

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The choice of this ontological position reflects that I believe there to be a necessary subjective dimension to the understanding of how the impact of an interaction (i.e.feedback) may vary between individuals. From my own academic experience, I know that the result of feedback is not homogenous (i.e. that a group of individuals do not respond in an equal way to a consistent feedback experience), and that the impact of a range of feedback situations (e.g. feedback from different people, within different environments and about different topics) does not have a uniform effect on a single individual.

3.4.2 Epistemological perspective

Epistemology is the philosophical study of knowledge and belief, and of how it is unequivocally known/proven that something is true or false (Duberley et al., 2012). An epistemological position is easier to establish for research in the field of, for example, natural science as quantitative empirical methodologies are often favoured within this discipline and therefore truth (or otherwise) more easy to establish. Within the field of social or human science individual interpretation by me as the researcher and also by my research participants may lead to heterogeneous explanations of similar situations and thus what is true or false impossible and unnecessary to establish.

Positivism is positioned at one end of the epistemological range and interpretivism at the other. A positivist approach to research necessitates the employment of methodologies that lack personal aspects and that can be used to test hypotheses generated by sound underpinning reasoning. This is not the approach appropriate to or needed to answer this research question. My research necessitates a theoretical position that encourages and requires the development of knowledge about individuals within specific societal situations (e.g. the novice or expert within the classroom or the clinical practice environment) and as a result of unique experiences (i.e. feedback). It requires the meaning that individuals (e.g. student or educator) ascribe to the components of the learning experience (maybe as a sole part of their world) to be explored and understood - by both them and me – within the context of them understanding their behaviour (i.e. impact) of feedback on learning.

I see the interpretive epistemological stance essential to exploring this research question in order that I can identify what impact feedback has on learning for the individual participant.

3.4.3 Philosophical position

In order to attend to the aims of the research it is important that I justify the theoretical position that I have taken in order to provide a context for the research and methodological choices that I have made. I believe that true understanding of knowledge is the product of a detailed exploration of the experience with those who have lived through the socially constructed event. Additionally, I consider elements that make up that social construction (Burr, 2003) – the actors involved, relationships, the time, the environment etc – all have a role to play in the development of that individual experience. The German sociologist Max Weber postulated a systematic interpretative process within qualitative research methodologies called *verstehen* which allows a detailed understanding to be made by an outsider (me) of how research participants (students or educators) make sense of their own behaviour (i.e. what happens as a result of feedback) by their understanding of the meaning (i.e. value/intention) placed on it (Duberley et al., 2012; Hughes & Sharrock, 1997).

Langdridge (2007) claims that individuals use their bodies to perceive the world, relate to other people and learn about themselves and, I suggest, others. As the aim of this research is to explore the value and impact of feedback from the individual perspective of those central to that feedback experience, it is crucial that their individual lived experiences of feedback are studied in detail. It is asserted that:

> "…rich description[s] of people's experiences, so that we can understand them in new, subtle and different ways …. [allows us to] … use this new knowledge to make a difference to the lived world of ourselves and others". (Langdridge, 2007, p. 9)

An individual's experience of feedback fundamentally underpins my theoretical viewpoint, and the knowledge generated from this research will be borne through the participant's interpretation of their socially constructed experience and my subsequent interpretation of their feedback story. My theoretical position is not to try to apply rules or positivist theory to any given situation or experience (Langdridge, 2007), nor am I intending to formulate rules or general theory from my interpretation and understanding of the experience. Instead, the findings – i.e. my interpretation of the self-interpreted lived experiences of the participants – will be represented only from the perspective of the individual participant.

It is important to consider my own role (Langdridge, 2007) in the research process, particularly given that knowledge will be generated by my personal interpretation of participants' feedback stories. Acknowledgement of my own beliefs and attitudes, assumptions and presuppositions is crucial to ensure that a clear starting point is

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established for the research design (Cohen et al., 2007; Finlay, 2011; Hammersley, 2007; Hughes & Sharrock, 1997). Since moving into an academic role from clinical practice in 1998, I have always been interested in assessment and feedback, undertaking and disseminating a small-scale research study around self-assessment dialogue (Eastburn, 2009) within physiotherapy pre-registration education. Following this small study, and with the majority of my clinical and academic experience being situated, at that point, within a physiotherapy-specific culture, I assumed that other professional groups operated in a similar way to physiotherapy in terms of how educators supported learners within, in particular, a clinical learning environment. Furthermore, and supported by my own actions as a result of being influenced by others (Armstrong, 2008; Gordon, 2013; Kilcullen, 2007) I assumed that other individual educators operated in a similar way to how I had previously done as an educator supporting students in a clinical environment. My view of how best to support learners had been influenced by two major factors; firstly, my own learner experience as a student physiotherapist and, secondly, by the educator role models that helped me develop my pedagogical theory and approach to supporting student learning. My assumptions regarding the "normal" processes involved in supporting healthcare students in clinical settings were challenged when I became more exposed to the academic practices of other healthcare professions. This occurred through my changed professional role which then gave me more exposure to a broader range of professions and the subsequent dialogues that I was having with colleagues from other professional groups about pedagogical diversity across the health profession courses. These assumptions led me to develop an interest in how different professional communities operate and I wanted to gain greater insight into the impact of pedagogical practices.

In addition, as an experienced academic I assumed that students did not actively engage with feedback and were primarily concerned with the mark that they were awarded. My assumption, supported by the work of Sinclair and Cleland (2007), was fuelled by knowing that some students did not access, and therefore could not have read, their electronic written feedback. As someone accountable for managing the workload of academic staff for whom time, as a funded resource, is at a premium, it is important to me as a manager that staff are investing their time in meaningful activities. Meaningful activities are those that have a demonstrable outcome for those that have engaged with them and my assumption was that, despite being heavily resourced, feedback was having a limited impact on ongoing student learning. Collectively, these assumptions support my ontological preference towards the realist end of the spectrum (Duberley et al., 2012), recognising that the behaviour of others – both educators and students - is varied and not uniform.

In summary, the philosophical position that I am taking is that the lived experience of the individual is dependent on aspects of individuality and social construction. An experience creates new knowledge for that individual and this is individually-specific. Finally, my interpretation of the individual's understanding of their experience is influenced by my own assumptions of the educational world. I overtly acknowledge my own educational biases and suppositions and adopt a reflexive approach towards this research in order to mitigate against these in a realistic manner. The detail of my reflexivity is discussed later in this chapter.

3.4.4 Taking a phenomenological approach

Phenomenology is a science that considers the understanding of the "whole" from the subjective perspective of the lived experience. As a qualitative approach, it is rooted in the social, cultural, political and existential aspects of the lived experience in order to give "lived" meaning to situations, and gives voice to the intricacies and less objective aspects of the social world (Finlay, 2011). Phenomenology is concerned with making sense of real "embodied" experiences (Finlay, 2011), and it involves reflection, experience and understanding of everyday experiences from the perspective of the individual. Given that these are the underpinning aspects of a phenomenological approach, this was deemed the most suitable approach to take for this research.

Phenomenology is a human science (as opposed to a natural science) method of research that gives meaning from the process of inquiry. Undertaking research using a context-sensitive phenomenological method allows the development of context-sensitive meaning. Participants attribute their own meaning to their lived experiences and that's what makes interpretive research methodologies (such as phenomenology) rich and insightful. Furthermore, there is evidence from Finlay (2011) that the participants engaged with a phenomenological approach benefit themselves from this involvement. She reports that participants are empowered by and value the opportunity to be "witnessed" and helped to make sense of their situations.

Whilst the lived experiences of individuals can give more generalised insight into a phenomena, it is imperative that I do not over generalise my findings nor remove them from the situational context in which they were generated. Equally, it is crucial that specific phenomena are explored and implicit meaning interpreted, rather than purely recounting the participant's account of the experience. The participant's account of the experience – including their description of what happened within the event, their feelings, and the

situation – is the vehicle for in-depth phenomenological exploration; it is not the end point in itself.

3.4.5 Historical background

As I have already indicated, phenomenology is concerned with the lived experience of the individual or, as J. A. Smith, Flowers, and Larkin (2009) state, "a philosophical approach to the study of experience" (p. 11). There are a number of philosophers who have contributed to the development of phenomenology as a social science. These are now considered in relation to the specific contributions that they bring to the discipline and the influence these contributions made to my development of the methodology. The following section will discuss descriptive phenomenology in order to provide the context for the interpretive phenomenological approach that this study uses.

3.4.5.1 Descriptive phenomenology

Husserl (1859-1938)

It is well acknowledged that descriptive phenomenology was first recognised by Edmund Husserl as a robust methodological approach by which the human sciences may be investigated (Brooks, 2015). Husserl argued that human experiences can only be known and understood by exploration of the lived experience, or "lifeworld". Husserl proffers that exploration of the experience revolves around "intentionality": this is the melding of a conscious thinking about the exploration process and the object of consideration for that process (Sloan & Bowe, 2013; J. A. Smith et al., 2009; Spinelli, 2005). Husserl argues that conscious account of the experience from the individual experiencing the phenomena is critical to phenomenology, and suggests that the focus of the individual is on "what" is being perceived rather than "how" it is being perceived (Brooks, 2015). Husserl's approach was for individuals to focus on and describe in detail the specific features of the experience – he called these features "essences" (Morrow, Rodriguez, & King, 2014) – and he believed that it was possible to isolate the distinctiveness of the experience, or phenomenon, through detailed exploration of these "essences", such that the researcher is able to "give voice" to the original experience itself, without interpretation.

Husserl also posited that any presuppositions that the researcher brings with them to the process of phenomenological inquiry should be intentionally put aside – or "bracketed" – so that a clear, neutral and unbiased view of the lived experience can be exposed. Finlay (2011) describes this bracketing as:

> "pushing aside our habitual ways of perceiving the world … [with the purpose being to exclude our] taken-for-granted assumptions, judgements and theories…" (p. 23).

Husserl argues that this "putting aside" the taken-for-granted aspects of our world allows us to focus on our perceptions of the world (J. A. Smith et al., 2009), and he termed this phenomenological approach epoché.

Following epoché, the process of phenomenology was developed further to support the researcher through a sequential process of description and understanding. Langdridge (2007) reports that a comprehensive description of a lived experience is developed through a process of initially describing the experience, followed by horizontalisation of the experience (treating all experiences equally, without hierarchy) to negate any preconceptions, and then finally verification of the experience (revisiting of the text to postulate meaning). This iterative reduction of our preconceptions to remove them from our description of an experience and negate their impact allows us finally to focus on the experience itself without interference and, thus, the essence of the experience can be explored in its native descriptive form.

The notion of putting aside assumptions and preconceptions is not a consistent belief of phenomenologists, and thus the descriptive methodological approach has been further developed. This development not only allows the recognition of assumptions and preconceptions by the researcher but also permits detailed *interpretation* of the experience itself. This is interpretive phenomenology.

3.4.5.2 Interpretive (or hermeneutic) phenomenology

Heidegger (1889-1976)

Martin Heidegger was a student of Husserl's, and he believed that it was neither entirely possible nor helpful to the process of understanding how experiences are perceived if the experience is divorced from the contextual world in which it sits. Brooks (2015) summarises that this maintenance of connection between "what" and "how" is important to explore "what it means to live in and among a world which is experienced by each individual in their own way" (p. 642), and thus our relation to the world is individually contextual and interpretative. Heidegger (1927/1962) developed this theme of "dasein", or being-in-the-world (Finlay, 2011), reflecting the notion that the person and the world are, together, one entity. This view of investigating human experience led to the recognition of hermeneutic or interpretive phenomenology as a distinct style of phenomenology. Furthermore, Heidegger's phenomenological position explicitly allows for the phenomenologist's interpretation to take

into account their own assumptions (J. A. Smith et al., 2009) as it is believed to be impossible to divorce the body and the mind when investigating human experience (Merleau-Ponty, 1945/1962).

This research explores the feedback experience from the perspective of those experiencing it and thus interpretation, not merely description, of that feedback experience is necessary. It is important that I gain insight into the experience itself taking into account its relational context with the world. I do not wish to divorce the student's experience of feedback from its situational context because the context may give rise to nuances associated with healthcare education that sets this study apart from research that investigates other disciplines. Without being able to explore the feedback experience from its authentic context, it is not possible to consider the data through the theoretical lens of communities of practice, and this is one aim of the study. Furthermore, my own experience as a clinician and educator adds depth to the lens through which this field is investigated, and this is a depth that I want to remain within the method. For these reasons, I chose to utilise an interpretive phenomenological approach.

3.4.5.3 Development of the lifeworld approach

The focus of the lifeworld approach to investigating lived experience (P. Ashworth, 2016) draws on two distinct facets already discussed earlier and recognised as important to broader phenomenological interpretation. Firstly, the lifeworld attitude towards phenomenology recognises the importance of drawing on both aspects of intentionality so that both the "what" and the "how" of a given lived experience are studied simultaneously. Secondly, this approach dictates that a given lived experience, whilst it may be in context, cannot be considered in isolation but posits that it is studied in the context of broader lifeworld.

A specific contribution to interpretive phenomenology was made by Ashworth in his outline of the specific "fragments" (Finlay, 2011) that he believes are essential to the study of any lifeworld experience. He describes there being eight key fragments:

1. Self or selfhood: considers the identity of the person, agency and their voice.
2. Sociality: considers relationships with others.
3. Embodiment: considers the body, emotions and gender.
4. Temporality: considers times, duration, biography, past and future.
5. Spatiality: considers space, place and geography.
6. Project: considers links to other tasks.
7. Discourse: considers language.

8. Mood-as-atmosphere: considers feelings that are woven into an experience.

(P. Ashworth, 2016)

These defined fragments of any lifeworld experience offer a "firmer footing" to the interpretation of lived experience as a human science (Hughes & Sharrock, 1997, p. 137) and serve to offer more objectivity to subjective interpretation. This development of a lifeworld approach recognises the challenges, and often impossibilities, associated with adopting a transcendental phenomenological style by applying epoché (Langdridge, 2007). Instead, it recognises the context that wider social dimensions bring to a specific lived experience and permits the researcher to explore the experience holistically and with some presupposition.

3.4.6 Relevance of lifeworld to this study

As an academic, I bring presuppositions and fore-conceptions to this research. Honest reflexivity will help me manage these but taking an interpretative phenomenological approach in the lifeworld style invites me to utilise these fore-conceptions. I discuss this at the end of this chapter. Whilst it remains important for me to use epoché to help me focus on the experience of the participants themselves, it would be foolish of me to attempt to fully negate my own experiences as a student, clinician and educator within this research. Important is the ability for me to recognise my presuppositions, put them aside, and then attend to them again in light of my interpretative findings. This might help me understand better or differently my preconceptions of the impact of feedback on learning, or recognise preconceptions that I was previously unaware of.

As I have already claimed, interpretation of the particular, as opposed to the general (J. A. Smith et al., 2009, p. 29), is important as this study intends to investigate feedback from the individual perspective of its participants. However, it remains important to recognise that whilst it is my intention to interpret the lived experiences of my participants from their perspective and within the social world within which it occurs, this experience still has a multidimensional relationship to a wider "world" that should not be forgotten. Whilst it will not be possible for me to devise theory from the small data set used in this study, consideration of these relational factors is one way by or from which the particular participant's experience can be explored in order to generate meaning.

The findings of this study are reflective of my interpretation of the subjective experiences of the participants only. Phenomenology respects the differences between people and their

social experiences, possibly of the same or similar events. By its vocational nature, humanistic values underpin the work of all student healthcare professionals. As such, the lifeworld fragments clearly articulated by A. Ashworth and Ashworth (2003) and P. Ashworth (2016) are intrinsic to the role of the healthcare professional and thus the learning experiences of the students. The humanistic values intrinsic to relationships – manifested in the lifeworld fragment of sociality - is of particular importance within and across healthcare. Whether this be the professional relationships between healthcare colleagues or the rapport that healthcare professionals build with their patients, it is likely that relationships may influence learning. Likewise, the culturally-defined taxonomy of the academic world together with that of healthcare can be explored within the discourse fragment of the lifeworld approach. I have already argued situating this study from the position of communities of practice theory and I view the lifeworld aspects of self and sociality as intrinsic to this underpinning theory. Whilst this study is not primarily investigating issues of gender, much of the frontline healthcare work was historically (Reichenbach, 2007) and continues to be done by women (Handley, 2017). Therefore being mindful of the embodiment fragment of the lifeworld approach to phenomenology may allow for the illumination of any nuances around gender.

I believe the lifeworld fragment of spatiality is worthy of specific consideration in my justification for employing this approach. Fundamental to adopting an interpretive epistemological position is the need for me to recognise the role that society plays in the construction of meaning by the participants. The "communities of practice" theoretical position discussed earlier argues that individuals with a common interest/domain (e.g. learning to be a nurse) behave in similar ways and that these behaviours are unique to that community. Therefore, in order that I am able to understand the value and impact of feedback from the perspective of the "communities" of student and educator, it is essential that data are collected in authentic learning spaces as these environments may prove essential to that community. It is also crucial to maintain the authentic construct of the feedback experience such that, as a researcher, I do not alter the "normal" dynamic between the student and educator. This authenticity of space and place bore significant influence on my choice of practical phenomenological engagement, with me selecting to use a mixed approach of indirect and then direct methodologies (Titchen & Hobson, 2011) through my use of participant observation and interviews, respectively, as data collection tools.

Finally, Finlay (2011) extends the human dimension of exploring lived experiences further by claiming that a phenomenological approach to research and therapeutic practice appear

to complement one another. The study of healthcare students within and across various communities of practice needs to be able to account for individualised meaning by the participants. It is the understanding of a specific human behaviour (i.e. what learners do with feedback) that this research intends to better understand using a phenomenological philosophy.

3.5 Research Design

This study is based in a single higher education institution that offers a range of pre-registration healthcare courses. The methodology was developed from a pilot study, details of which can be found in Appendix 1. Throughout the study, robust ethical principles were adhered to.

3.5.1 Ethical considerations
3.5.1.1 Principles of ethics

Confidentiality and conflict of interest
Confidences of participants were respected at all times. This research was undertaken in line with ethical guidelines that underpin robust educational research (British Educational Research Association, 2011).

Participants were made aware in the participant information provided (Appendix 2) that the data collected, in addition to contributing to my EdD thesis, will be used by me for the writing of scholarly pieces (e.g. academic journal submissions and conference presentations) for use both within and external to the University.

All data were password protected on an encrypted storage device and hard copies of any material (e.g. signed consent forms) were kept by me in a locked drawer in an office at the University of Huddersfield, as this is the University at which I am registered for my award. Other than my academic supervisors who had access to participants' personal data only during meetings with me, only I had access to the data. All raw non-anonymised data will be kept until my degree is complete and all anonymised data will be kept for 5 years, and then confidentially disposed of. As a doctoral student at the University of Huddersfield, this is in line with the University's IT security policy, in line with the University of Huddersfield's IT security policy.

The information given to participants made clear that their involvement in this research was without jeopardy. All selected student participants and their educators had the right to

choose not to take part in this research. This was made clear in the participant information sheets. In no way were the learning experiences or opportunities or assessment marks of the students affected by their involvement, or decision to not be involved in this research. As the focus of this research is feedback rather than assessment, the extent to which this was likely to be a factor was minimal but in order to minimise any perceived impact on assessment I undertook the research, where possible, outside of university assessment periods. No incentives were offered to engage participants as this may have been seen as coercion.

To minimise any bias, students with whom I had had any previous contact were excluded from taking part in the study. All staff with whom I had a previous or current working relationship at the time of data collection were also excluded from taking part in the study. These strategies were put in place to minimise the risk of individuals "feeling threatened" by taking part in the research or feeling as though they had been coerced into doing so. This also eliminated the possibility of me identifying issues of "teaching capability" in staff but being unable to address the issues in a satisfactory manner because the issues had been identified as part of this research.

Anonymity

In order to protect participant anonymity at all times, in scholarly writing participants will be referred to by a pseudonym. The university from where participants were recruited will not be named but referred to as "a UK university" or "an English university" and the single trust will be referred to as an "NHS Trust".

Permission

Permission to access all university-based participants was gained from the relevant Head of Department and the relevant subject leaders at the university that the participants were recruited from. Permission to access participants within the single NHS trust was gained from the trust's Director of Nursing.

Following approval from the University of Huddersfield's School Research and Ethics Panel (SREP) – as this is the University at which I am registered for my doctoral award, - permission was sought from the Research and Development Department at the NHS trust (Appendix 8). I outline the ethical approval process in detail below.

Accountability and governance

It is essential that I took responsibility for undertaking this research, acting in an accountable manner and being cognisant of the potential impact of my study on the wider field. As a healthcare academic working in higher education the outcomes of this study could influence both the academic and healthcare sectors. I was responsible for the decisions that I made during the undertaking of this study, seeking guidance from my supervisors as the need arose.

Additionally, the information that participants were given included the name of an independent point of contact with whom they might raise concerns or complain about the conduct of the research should they need to.

3.5.1.2 Ethical approval

Ethical approval was sought by the School of Human and Health Sciences' Research and Ethics Panel (SREP) at the University of Huddersfield, as that is the University with which I am registered for this award. Ethical approval was gained on 10th May 2013. Following successful SREP approval and because the study involved data collection within the National Health Service (NHS) as that [an authentic clinical environment] is where up to 50% of learning occurs for pre-registration healthcare students, approval from the Research and Development Department within a single NHS trust was sought and gained on 6th June 2013. One minor amendment was subsequently made to one of the participant information sheets; approval to make this amendment was gained by SREP on 7th October 2013 and then the Research and Development Department within the single NHS trust on 11th October 2013. No other health-related ethical approvals were needed to undertake this research as it did not involve any invasive procedures, service users, social care settings or vulnerable individuals (Integrated Research Application System (IRAS), 2011). Letters confirming ethical approval and site access can be found in Appendix 8.

3.5.2 Recruiting the sample

The population for this study were all full-time Year 2 pre-registration healthcare students at a single UK university who had a planned placement experience within a single local NHS trust between May 2013 and December 2013 and all tutors (both university-based and practice-based) who supported these students.

From the study population, a purposive sample was chosen. Year 1 academic results from all students were accessed. The students were divided into three groups based on their

average module mark for Year 1 of their course, as presented at the final examination board. The three groups were an average module mark of 0-49%, 50-59% and 60-100%. From these groups, three students were randomly selected from each group, yielding a study sample of 9 students. A purposive (Punch, 2006) sampling approach was used, with a theoretical (Bryman, 2004) methodology. A purposive approach ensured that distinct subgroups (e.g. all disciplines or all levels of study or weaker and stronger students) were included in the sample (Punch, 2006). However, an open-minded theoretical sampling approach was also adopted (Bryman, 2004) in order to acknowledge the truly interpretive approach of the study to ensure that all key concepts were explored and relationships between and within theories uncovered.

3.5.3 Participant observation and interviews

The nine purposively selected students were emailed and invited to take part in an initial interview. The participant information sheets, consent forms and interview schedule are in Appendices 2 and 3. The purpose of the initial interview was to begin to understand the student's educational journey and their feedback experience to date. Seven of the nine students invited to take part in the study gave their written consent to taking part in the research and undertook an initial interview. The interviews were audio recorded and transcribed verbatim by an independent person.

Following the initial interviews, the participants were asked to identify real university-based or practice-based feedback experiences that I might observe. Once an opportunity was identified by the student, they provided me with the contact details of the educator involved in that feedback experience with whom I then made direct contact. Participant observation was only undertaken if both parties consented. The feedback dialogue was audio recorded and transcribed verbatim by an independent person. As I have already argued, it is important that this study generates data (Finlay, 2011) from authentic feedback experiences. Native feedback situations and environments are important to my underpinning phenomenological approach and it was not my intention to directly influence the feedback experience. I employed an outsider observer-as-participant attitude towards my method of participant observation. I was mindful to ensure that my overt observation (Bryman, 2004) did not change the authenticity of the feedback situation, that my presence was as unobtrusive as possible and that I did not contribute (as an academic interested in the topic) to the native feedback process.

Participant observation was chosen as a means by which to generate data from the "social reality" (Bryman, 2004, p. 338) of the feedback experience under investigation. These

observations provided the vehicle by which I could explore an authentic experience through a subsequent interview process. I did not want to simply question students and educators about their feedback experiences, more I wanted to observe these experiences in situated authenticity and then probe the participants about their experience after the event. This allowed me to explore the uniqueness of the experiences observed with the participants and begin to really understand what was meaningful to them as individuals.

Following each participant observation, I separately interviewed the student and educator who had taken part in the feedback experience. The purpose of these interviews was to gain insight into and understanding of the lived feedback experience from the perspective of those involved in it. There was no preconceived schedule for these interviews as it was not possible, nor desired, to predict the issues that might arise from a feedback experience. During the interviews I focussed on generating meaningful data that would help me answer the research question.

3.5.4 Summary of the sample

The seven student participants who gave written consent to take part in the research were each given a pseudonym to maintain anonymity (British Educational Research Association, 2011). Two students from the original nine who were invited to take part in the research did not reply to initial or subsequent emails and they were not pursued any further after three follow-up emails. Table 4 shows the profile of the seven students who gave consent to take part in the research. The seven students were drawn from across the range of healthcare disciplines offered at pre-registration level at the university from which they were recruited. The number of interviews that each student undertook is also noted in Table 4.

Educators in both the university-based environment and the practice-based environment were also potential research participants, subject to them providing written consent. The educators were selected by the students themselves by the nature of an authentic feedback experience being identified by the student. The educator participants were also given pseudonyms to maintain anonymity. Table 5 shows the profile of the educator participants, including whether they were university or practice-based educators and the number of interviews that were undertaken with each of them.

Table 4: Profile of the student participants

Pseudonym	Gender	Educational Background	Band of Year 1 Average Module Mark	Total Number of Interviews
Ann	Female	School leaver: A levels	0-49%	1
Bella	Female	School leaver; A levels	50-59%	6
Carl	Male	Mature student; previous degree	60-69%	4
Dawn	Female	Mature student; BTEC* at college	60-69%	3
Eliza	Female	School leaver; A levels	50-59%	9
Freya	Female	Mature student; Access course	50-59%	1
Gina	Female	School leaver; A levels	50-59%	6

*BTEC – Business and Technology Education Council

Table 5: Profile of the educator participants

Pseudonym	Gender	University-based or Practice-based	Total Number of Interviews
Alan	Male	University-based	2
Brian	Male	Practice-based	1
David	Male	Practice-based	2
Diane	Female	University-based	1
Grace	Female	University-based	2
Rebecca	Female	Practice-based	2
Rob	Male	Practice-based	1
Rose	Female	University-based	2
Susan	Female	University-based	2

The student sample was made up of eight female students and one male student (Carl), as depicted in Table 4. The participants will be drawn on individually throughout this thesis to provide examples of meaning and understanding of their feedback experiences. Ann, Freya and Carl had less involvement in contributing meaningful data to this research than the

other participants. Ann and Freya will be discussed later in section 7.3.1, but Carl will be considered now.

3.5.4.1 Carl

The purpose of this research was not to explore issues of gender but it was to generate rich, descriptive and meaningful data to help answer the research question concerning the perceived value and impact of feedback. Whilst Carl was engaged with the research, following his initial interview he was only interviewed three further times. These three interviews followed practice-based observations and were very short in duration (1 minute, 2 minutes 30 seconds, and 5 minutes) in comparison to those of the other participants.

Carl was very factual in his interviews. His interviews confirmed what I had observed during my participant observation of him but he offered limited description of his feedback experiences. This lack of description significantly restricted the meaning that could be drawn from Carl's data. Carl's data did not contradict the data of the other participants but nor did it broaden or deepen the meaning interpreted from their experiences. Consequently, Carl's data was used within the overall data analysis process but none of his data are used within the findings-discussion chapters (Chapters 4, 5 and 6) of this thesis.

3.5.5 Analysis

The data generated in this study was wholly qualitative in nature, and it was generated by the 45 interviews undertaken with the students and educators. Template analysis (King, 2012; King & Brooks, 2017) was my chosen tool of analysis – a technique rather than a methodology according to (King, 2012) - for several reasons. Firstly, template analysis allows the researcher to bring a priori themes into the analysis process. A priori themes are themes that the researcher hypothesises may emerge from the data. This was important because I wanted to use my experience as a clinician, clinical educator and academic to inform this study. I have previously argued that employing epoché was not my preferred style of phenomenology and likewise, I was not able to negate my own experiences nor that learned from exploring the literature, during the data analysis process. Furthermore, a template analysis technique does not necessitate all individual data sets to be analysed before the data can begin to be explored relative to one another. This means that I was able to begin to draw out themes more quickly than I would have been able to utilising other techniques, such as interpretive phenomenological analysis (IPA) (J. A. Smith et al., 2009).

Secondly, template analysis is said to be suitable for relatively large sets of data (King, 2012) and appropriate for more than circa 10, as is the suggested number of data sets manageable by IPA. My proposed sample of 9 students, each undertaking an initial interview and then potentially another three subsequent interviews following participant observation, would yield 36 separate data sets alone. Interviews with educators would further add to this number, possibly by up to an additional 27. IPA would not be able to manage a data set of this size, though a template analysis process would.

Thirdly, the development of codes and themes within template analysis is an iterative process, initially utilising a small sub-set of data to generate an initial template. This initial template is then used to analyse further sets of data, revising the template accordingly until a final template is devised. There are no prescriptive numbers of themes within a template analysis approach, nor levels of coding. Template analysis also permits for data to be coded to more than one theme, which was important to my research given the insight that I already had in the discipline and the likely links within the data. King (2012) clearly reports that the template is final when there is no further data to code that explicitly relates to the research question (p. 444). A sample of coded data can be seen in Appendix 4, with my initial template and subsequent templates in Appendix 5.

Following a thorough analysis of the transcribed interviews and iterative development of the template, a final template was produced (Appendix 6). The final template demonstrates the following eight themes:
   i.   Purpose of feedback
   ii. Ownership of learning
   iii. Prose of feedback
   iv. People and support structures
   v.   Emotional effects
   vi. Consistency
   vii. Qualities of the learner
   viii. Unity of time

Definitions of these final themes and subthemes within them can be found in Appendix 7. This final template takes into account the coded data from the transcripts of the 45 interviews that were held with the research participants (both students and educators) and reflects all themes and subthemes that are relevant to answering the research question (King, 2012).

Some of the themes and subthemes from the data were unsurprising and well-documented in the existing literature given that the intended purpose of the interview with the participant was to explore a feedback experience that they had engaged with. These themes include the prose and style of feedback (for example, Ball, 2010; Canavan, Holtman, Richmond, & Katsufrakis, 2010; Dearnley et al., 2013; Marden, Ulman, Wilson, & Velan, 2013; Moss, Derman, & Clement, 2012; Race, 2005; Vardi, 2013), the timing of feedback (for example, Bols & Wicklow, 2013; Marden et al., 2013; Molloy, 2009; Poulos & Mahony, 2008; Race, 2005; Zimbardi et al., 2017) and consistency of feedback (for example, Bloxham, 2013). Two themes seemed to underpin much of the data and these have been reflected in the final analytical template (Appendix 6) as integrative themes (King, 2012; King & Brooks, 2017) as it was impossible to discern where and how they exist separately from other themes and subthemes. The two integrative themes are Purpose of Feedback and Ownership of Learning. Purpose of Feedback will be explored in the next chapter, and Ownership of Learning will be explored in detail within a broader context in chapter 7.

3.6 Cautions of Phenomenology

The limitations of this research will be discussed more fully in chapter 8, however it seems appropriate to consider the limitations, or cautions, of utilising a phenomenological approach in this methodological chapter. One main limitation of adopting a phenomenological approach is that it is not possible to transfer or generalise the findings to a wider population. The broad findings of this study will only be directly applicable to those participants from whom the data was collected and therefore the implications of these results to wider society will be unknown. Nor will a phenomenological approach allow me to explore in any depth the impact of societal structures on the experiences of individuals unless they are understood and articulated by the students themselves (issues such as the gendered social relations and class issues, for example). It is imperative that the results are not over claimed in relation to their applicability to a wider population as this will negate the rich understanding of the feedback experience as lived by my participants. Whilst others, particularly those that err towards a positivist epistemological position, may perceive the lack of generalisability of phenomenological findings to a wider population as a limitation of the impact of research, I view this approach as a methodological strength. Understanding an experience from the perspective of those who have experienced it allows me to gain true insight into the values and beliefs of the study participants.

Phenomenology in the context of my educationally-situated professional doctorate needs to be relatively small scale. It would be disproportionate to endeavour to undertake research

on a much wider scale and, as I argued in the previous paragraph, it is the richness of the experience of a few that I want to uncover and begin to understand, not meaning applicable to a wider population. Selecting my sample from a single HEI means that I would be unable to relate the findings to any other HEI but, given my argument that generalisability is not an intended nor unintended purpose of my research, this lacks significance. I should acknowledge, however, that utilising participants that are studying at a single HEI may highlight feedback experiences that are embedded within the culture of that single HEI, and thus illuminate how a particular institutional context shapes the students' experiences of feedback.

Finally, with justified reason given my own clinical background and professional academic role, insight drawn from the findings of this phenomenological research could only be applied, with extreme caution given my lack of generalizability argument, to pre-registration healthcare students. Students from other disciplines may have very different experiences and it is crucial that the nuances of healthcare are recognised when considering the data.

3.7 Trustworthiness

The aim of this research was to understand the perceived value and impact of feedback on learning from the perspectives of those involved with the feedback experience. To achieve this aim it was crucial that I was able to elicit full and accurate detail of participants' perceptions and it is paramount that I am able to be authentic to the voice of the participants within this thesis. This focus on authenticity of voice is significant given that I am presenting my own interpretations of participants' accounts. The trustworthiness of a research design impacts on the worth of the research findings, and Lincoln and Guba (1985) suggest that trustworthiness is influenced by the credibility, transferability, dependability and confirmability of the research. I will now consider each of these dimensions in turn and indicate the strategies that I have used within this research to, collectively, maximise trustworthiness within this research.

Credibility
Credibility concerns the truth of the findings. From the outset of this research I recognised my own presuppositions and fore-conceptions, and my chosen methodological approach of interpretive phenomenology allowed for me to acknowledge these. My use of interview processes permitted an iterative style of questioning. Whilst there was a semi-structured interview schedule for the initial interviews with the students, there was no interview schedule for the interviews that followed the individual episodes of participant observation.
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This purposive lack of structure permitted participants the opportunity to share with me what they perceived to be the important aspects of their feedback experiences, without my imposition of an agenda. This openness to my capturing the voice of the participants increases the "truth value of the findings" (DePoy & Gitlin, 2016, p. 320), supporting the credibility of the research.

Reflexivity and the examination of my own role within this research process (DePoy & Gitlin, 2016) is another way in which I have increased the credibility of this study. Section 3.8 within this chapter discusses my reflexive approach in more depth, but purposive use of my supervisory team in a discussion of my findings allowed me to explore and confirm my interpretations within the process of analysis. Following my creation of the initial template, this template was scrutinised by and discussed in detail with a research colleague with extensive experience of using template analysis (King, 2012; King & Brooks, 2017) such that I could be confident that my interpretation of the data was accurately reflective of the data gathered.

To enhance credibility further, I have situated my research within the context of peer-reviewed published literature, drawing on feedback literature extensively in order frame my study and identify the gap in the current evidence regarding healthcare education. This critical exploration of existing work has allowed me to identify that some of my data is consistent with previously reported findings around feedback. This confirmation of existing knowledge has, in turn, supported the integrity of my research in identifying new knowledge.

Transferability

The purpose of my research was not to generate findings that could be generalised to a wider population (Bryman, 2004) as the lived feedback experiences that this study explored could only ever have meaning for the individual participants involved in them. The social context of the feedback experience provides the experience with the nuances that make it unique to those involved, and I have maintained this social context within my interpretation of the data.

Transferability, as opposed to generalizability, is possible from human science research (DePoy & Gitlin, 2016) and I make selective and tentative suggestions within my findings-discussion chapters (Chapters 4, 5, 6, 7 and 8) as to how my findings might be relevant outside of the social contexts from which they came. These suggestions are intentionally

cautious and serve to offer no more than insight into how these findings might be used to inform further research and influence pedagogical practice.

Dependability

The consistency of findings and repeatability of method enhance the dependability of a research process, so informing its trustworthiness. Within this thesis, I have provided detailed information about the methodological designs employed to gather, analyse and interpret the data generated within my research such that they might be repeated. My use of an experienced researcher to scrutinise my initial template, as discussed above in the "credibility" section, allowed me to confirm the consistency of my findings. My overt process of employing template analysis (Appendices 5, 6 and 7) shows my stages of progression in achieving a final template, and the clear definitions of my themes and sub-themes within these templates enabled me to ensure that I was coding my data consistently.

Confirmability

The confirmability of this study – i.e. the extent to which the data and not the researcher informs the research findings - was enhanced through my use of an experienced researcher to scrutinise my initial template and verify my interpretation of findings for consistency. This verification allowed me to be clear about the definitions of my themes and sub-themes and ensure that I was interpreting the data without bias.

Throughout the research process, I was overt about the presuppositions and fore-conceptions that I brought to this study. I have acknowledged my beliefs (Delamont, 2002) and selected a methodological approach in the form of interpretive phenomenology that permits me to recognise these within the research process. These strategies support the confirmability of my research findings.

3.8 Reflexivity

Presuppositions and fore-conceptions are inherent within my undertaking of this research as an academic with a first career in healthcare. It is essential that I am overtly aware of the beliefs that I bring to this research from experiences within my own social world (Delamont, 2002) and endeavour to minimise any unintentional impact of "me" on the study. Taking an interpretative phenomenological lifeworld approach to this research affords me the gift of utilising my presuppositions and fore-conceptions (Finlay, 2011; J. A. Smith et al., 2009) and, given that it is my own experiences as an academic that has driven my personal

interest in the field of feedback, it is essential that I consider the potential consequences of these within my interpretation of the data.

Being acutely reflexive throughout my research allows me the opportunity to examine the role that I, as student, clinician and/or educator, play within the process. In order to address the aim of this research, it is paramount that I gain depth of understanding about how feedback affects ongoing learning from the perspective of the learner and the educator. To do this, it is important that I do not to impose by own views on the participants and interpret the subjective presentation of the participant's lived experience truthfully, with integrity and without bias. It is crucial that I "tell it like it is for them" (Bryman, 2004, p. 279).

I will now briefly describe my employment experiences and explain how these have added to my familiarity with the research field. As a physiotherapist working solely in NHS clinical settings for 6 years I was, in the latter years, often the named clinical educator for physiotherapy students. I developed my personal model of clinical education based on my own clinical placement experiences – both positive and negative – as an undergraduate student, and by role modelling respected colleagues having observed how they supported student learning in the practice environment. This collective experience shaped my belief and practise of supporting learning, and fostered my desire to move into an academic career.

I have worked as an academic for around 18 years. During this time, I have worked at two HEI's, both of which have roots as polytechnics and both of which adopted the training of healthcare professionals in the 1990's from traditional schools or colleges of health. Prior to healthcare education moving into the (then) polytechnics, the schools or colleges of health were largely linked, and usually geographically so, to an NHS hospital and much of the day-to-day student learning was divided across the clinical and classroom sites. As such, those involved in the education of student healthcare professionals often worked with the learners in both classroom and clinical settings. The move of healthcare education away from clinical establishments into polytechnics divorced the role of the classroom-based educator from that of the practice-based educator, and today there is ever-strengthening partnership working between the two in order to meet regulatory requirements (Health and Care Professions Council, 2009, 2013; Nursing and Midwifery Council, 2010) and maximise the student learning experience. My experience of working in former polytechnic HEIs also means that the vision and business of the HEI was, until more recent years, predominantly teaching-focussed rather than research-focussed. Whilst the research climate across the

sector is now seen as core business to all HEIs (Research Excellence Framework, 2014) with increasing significance being placed on research outcomes and impact by traditionally teaching-focussed HEIs than ever before, my values as an academic remain rooted in maximising the learning experience of students.

Having insight into the feedback experience as a student, as a clinical educator and as an academic placed me in a privileged position. I was able to "see" the feedback experience from the perspective of the student and the educator and this meant that I had to be careful not to adopt any role other than researcher during the study. Haynes (2012) asserts that reflexivity enables the researcher to question their research processes and practices, and the theoretical underpinnings that they bring with them to the study (p. 87). Exploring the lived experience of students through the theoretical lens of communities of practice enabled me to explore the perception of feedback on learning through a non-personal lens, offering another degree of detachment from the data.

I was an overt researcher undertaking participant observations within this study. I used several methods to become more reflexively cognisant within the research process and distance myself from engaging directly in the authentic feedback experiences that I was observing. These methods included not recruiting student participants from the student populations that I directly taught such that I was not compelled to contribute to the feedback dialogue, examining my data in audio and written-form to ensure that my role within the process remained as researcher rather than educator, and keeping notes of my feelings whilst undertaking the research. Finally, I note that my simply being present during an authentic feedback experience was likely to influence the authenticity of the experience. I tried to mitigate for this by observing the students on more than one occasion, such that they became familiar with my presence, but I acknowledge that this would not always have occurred.

The strategies discussed allowed me to develop greater insight into my role within the research process, and the challenges I faced. These strategies were used to help strengthen the sincerity and credibility (Symon & Cassell, 2012) of the research process.

3.9 Chapter Summary

This chapter initially presented a rationale for the methodological approach taken to this research, namely that of interpretive phenomenology through the lifeworld lens. It has discussed the methodologies used to collect and analyse the data, and presented

consideration of the cautions of adopting this methodological approach, including those associated with me as the researcher. It has outlined the themes from the final template, and sketched an overview of the broad findings. The following chapters take the findings grouped around the themes of "Purpose of Feedback", "Worth and Reward", "Identity of Feedback" and "Questions, Reflection and Ownership".

Chapter 4: Purpose of Feedback

4.1 Introduction

The previous chapter presented a rationale for the methodological choices made in undertaking this research. It articulated the requirement of exploring the feedback experience from the perspective of pre-registration healthcare students given that the primary aim of this research was to understand their perception of the value and impact of feedback on their ongoing learning. The previous chapter also presented a rationale for using a template analysis technique (King & Brooks, 2017) to analyse the data, and the final template was presented in Appendix 6.

This chapter is the first of four blended findings-discussion chapters. It will present a whole view of the data from a phenomenological perspective. This chapter will focus on the lived experience of the individuals it draws on. It will establish the bigger picture and set the context of the strategic purpose of feedback. This chapter is organised in a way that explores the purpose of feedback firstly from the perspective of the student and then the educator. This chapter will use examples of data to illustrate findings and it will begin to draw on the lifeworld fractions of phenomenology (P. Ashworth, 2003; Finlay, 2011) that were explained in section 3.4.5.3 of the previous chapter, contextualising the purpose of feedback within the existing healthcare literature. The chapter will conclude by setting the context for the subsequent three chapters.

This chapter draws on examples of data from both student and educator participants. It initially uses data from Dawn, Bella and Eliza to illustrate the perceptions of feedback from the student perspective. The chapter goes on to use data from Rebecca, an educator, to illustrate some of the challenges that educators face in the provision of feedback; this discussion around challenges is augmented with data from Eliza, Gina and Dawn.

Whilst this chapter explores the purpose of feedback in an undivided manner, the following three chapters will integrate key themes and subthemes from the final template to give each chapter a specific focus. Together, these four blended findings-discussion chapters consider unique aspects of the findings that enable this research to make a significant contribution to knowledge.

4.2 The Student Perspective

Purpose of feedback was a consistent theme from both student and educator data. Whilst student participants were not overtly asked about the purpose of their feedback experience, they were able to clearly illustrate a known purpose for the feedback within their general accounts. The reasons given collectively are embedded along the authoritarian-to-nurturing continuum (Figure 2, below) that appears to represent the spectrum of intended outcome(s) of a feedback experience:

Figure 2: Purpose of feedback spectrum
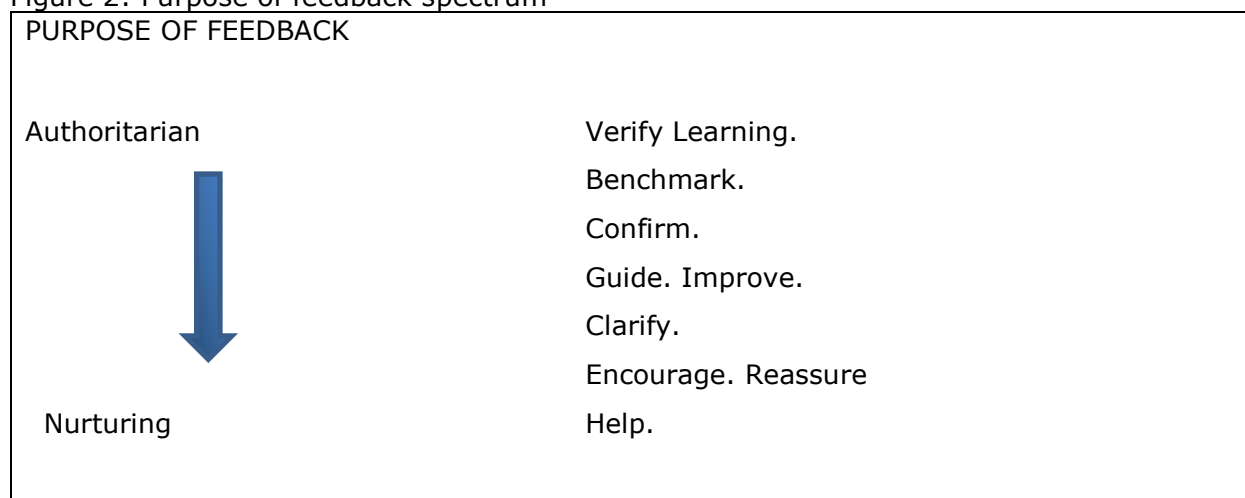
Based on the work of Black and Wiliam (1998), Hattie and Timperley (2007) and M. Price et al. (2011)

A purpose of feedback is illustrated through two related quotes both from Dawn. Dawn is a student who highlights the interwoven relationship between the direct and instructional feedback given to her by an educator and the summative assessment tasks with which students are often preoccupied, potentially at the expense of the learning that was intended by the educator from the process of providing feedback. Of note within this example of data, however, is that it is the student's belief that the educator is also focussed on the summative examination and the likelihood of the student being unsuccessful in this "verification of learning" task, rather than on the learning itself:

> And she [the educator] sort of, because I had a patient with rheumatoid arthritis (RA), and I could tell her what it [RA] was but there were bits I was missing out, and she said "you need to ask [the patient] this question now" and this question and this question and you need to ask whether their arthritis is in a flareup or not … she was able to give me a bit more help but that's the only time I have been in front of … [an educator in a clinical environment] … where I've got that information … (Dawn)

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> It was the beginning of April last year, just before Easter I think it was, and I think she [the educator] was a bit worried that I wasn't going to pass my exams, so I think she sort of just gave me a bit of direction in things … "you need to know this because this is one [pathology] that comes up a lot [in exams]" … (Dawn)

This account by Dawn relates explicitly to the acquisition and development of knowledge and skill that correlates directly to the clinical and profession-specific skills (Kinsella & Whiteford, 2009) required of an ongoing student professional, moving towards and into a qualified role. From a lifeworld viewpoint, the project in which this experience is situated seems clear with, from Dawn's perspective, the educator supporting that same summatively-driven focus that Dawn is occupied with. Whilst Dawn appears fixed on receiving instruction to manage a specific "clinically academic" [lifeworld] project, it would seem that there was no contradictory offer by the educator to explore with Dawn the rationale or reasoning behind the suggestions – or indeed instructions – given. Consequently, as a result of this project with a seemingly agreed purpose, Dawn may be better informed about *how* to manage a particular clinical situation (she has been told *what* to do) but she may have no better understanding of *why* the patient should be questioned in the way that her educator was instructing, nor of the associated problem-solving and clinical reasoning processes. Thus the likelihood of Dawn being able to transfer her learning – if indeed there was anything learned other than to follow instruction – from this lived experience to similar future experiences on the basis of increased understanding, rationale and being able to decision-make, is probably limited.

"Learning by doing" is a philosophy promoted by practical educationalists such as Race (2005). This philosophy can be utilised by learners who are supported to apply newly acquired knowledge and skill and learn from this application experience. There is no suggestion in Dawn's initial quote that she was to be given the opportunity to exploit a "learning by doing" approach to "check out" or confirm the extent or accuracy of any learning. Decision-making and clinical-reasoning skills are fundamental to the role of qualified healthcare professionals and therefore development of these skills is paramount within pre-registration learning (see for example, the Health and Care Professions Council, 2013). Learning by following instructions without the student fully understanding the clinical reasoning behind the instructor's direction of "you need to ask this question now" (see Dawn, above) undoubtedly limits the student's development of sound, evidence-based (Health and Care Professions Council, 2009) decision-making skills. Nor is this passive, task-orientated learning in keeping with undergraduate attributes (The Quality Assurance Agency for Higher Education, 2008) and yet this is what appears to be happening to Dawn in this quote.

The relationship between the people involved in a feedback experience is of interest. These examples of narrative illustrate an interesting dynamic between Dawn and the educator in terms of the sociality dimension of the lifeworld. It would appear that Dawn perceives the educator as, at a minimum, having more knowledge than her and at best, as the expert as it seems that she defers to the educator's instructions passively and without challenge. The personal relational aspects may have been actively influenced by the factor of time, in that one particular situation – or lifeworld project – discussed by Dawn was being seen (it would seem from the perspective of both social actors) in the context of an imminent summative assessment task. Thus, in this instance the project-temporality-social dimensions of the lifeworld seem inseparable. A lifeworld project that was not interwoven with a summative assessment task might have offered Dawn a very different learning experience as the temporality fraction is likely to be different. The urgency of the immediate situation would be absent and Dawn might have a different contextual voice, one in which she views herself as a more active learner, adopting a professional learner identity with greater consideration of the ongoing and reusable skills developing as a consequence of incremental clinical exposure.

The discourse used by Dawn in this narrative is also noteworthy. Despite this account of clear instruction being given on correct assessment skills, she uses language that appears to suggest less forceful action. Her use of the phrase "gave me" seems to reflect the educator offering a gift of guidance rather than a mandatory direction and, as such, somehow seems to soften the account of the educator's actions and adds a level of warmth to the relationship between the two parties. This warmth, or sensitivity, is possibly echoed by Dawn suggesting that she believed the educator to be "worried" about her impending examination performance, reflecting a further "caring" dimension to the sociality layer of the lifeworld than might usually be expected between student and educator. This seems to reflect a potentially multi-layered configuration to the relational properties between two people within a single lived experience. Sociality aspects of the lived feedback experience will be explored further in both this and subsequent chapters.

In a clinical environment, whilst every patient interaction is unique, consequential learning opportunities from these interactions may be similar. Within my interview with Dawn, I specifically asked her whether the particular clinically-situated feedback experience that she and I were discussing was reflective of usual clinically-situated feedback experiences. It was from this prompt that Dawn stated that, within this specific learning environment, the lifeworld project that we were discussing was the sole occasion of her receiving feedback "information" from the educator, and as I have already articulated this seems to be

summatively-driven. Dawn's choice of language when discussing this being the only time that she had received feedback in this setting is interesting. Firstly, she talks of being "in front of" the educator which appears to have a different spatial connotation to being "with" the educator, the latter being a situation in which the players appear to have equal relational standing. Being "in front of" a person portrays images of having to defend one's actions or justify oneself, in addition to an unequal power dynamic between the individuals. This is more noteworthy still in the light of the question asked, which was intentionally simply about comparable feedback experiences. The notion of having to defend oneself in a clinical learning environment is an entirely different lifeworld "self" to that which is open and responsive to learning from a feedback situation. Even if the educator did not intentionally construct the learning space to foster such defensive feelings (Chesser-Smyth, 2005) that are unhelpful to the openness of learning, the fact that it is possible to interpret Dawn's account of the situation in this way suggests that one might have to more closely consider the construction of the lifeworld's feedback "project" in view of its intended purpose.

Dawn's use of language is of interest here. Her use of "information" rather than "feedback" (the language of my question) or "guidance" to describe what she received from the educator might again be suggestive of a power differential between herself and the educator. It might also suggest that Dawn is acutely aware of the purpose of feedback in this example, it being directive and instructional. The educator as the holder of the "information" and Dawn as the receiver of it - at the liberty of the educator - not only suggests hierarchy within the relationship but it also suggests that gaining access to information is not an automatic right of the student, nor necessarily an easy process for the student to navigate. In Dawn's narrative, there is an underpinning sense of her perceiving the educator as a gatekeeper (Reitz, Simmons, Runyan, Hodgson, & Carter-Henry, 2013) to the professional "information" or knowledge that she is acquiring. The notion of the educator as a gatekeeper to the knowledge adds an interesting facet to the lifeworld dimension of sociality, and poses challenges to the learner in his/her quest to move from the periphery of a community of practice into a more central position in order to adopt a fuller role within the community.

Overall, the student participants appeared to have some insight into the academic reasons for receiving feedback (Carless, 2017; C. D. Smith, Worsfold, Davies, Fisher, & McPhail, 2013) but were not always cognisant of the full pedagogical picture. As a Year 3 student and therefore, I postulate, an advanced beginner undergraduate learner (Benner, 1984), a student ought to have a minimum working knowledge of the processes associated with learning from feedback if they are to then effectively use this feedback literacy (Carless,

2017) to progress towards becoming a competent learner and a qualified healthcare professional responsible for their own lifelong learning (Health and Care Professions Council, 2012; Nursing and Midwifery Council, 2017).

To explore student understanding of pedagogy, or assessment literacy (Carless, 2017; Charteris & Thomas, 2017; Vardi, 2013) further, I will discuss Bella. Firstly, based on her general academic grades (Table 4 – page 62) and her overall engagement with learning *per se*, I consider Bella to be an able and motivated learner. She was proactive from the outset in her engagement with this research, contacting me throughout the data collection phase when feedback opportunities arose and, knowing the purpose and method of my research, she actively brokered interviews with her educators on my behalf. During interviews with Bella she clearly articulated her belief that a student was not doing as well as they might if they were not achieving a grade in the first class band. Noteworthy is that Bella made no attempt to refer to a specific maximum grade, simply referring instead to a "first class" band which spans 30% (70%-100%) of the usually available summative marks for undergraduate work. This suggests that Bella was more focussed on the band than the maximum achievable numerical grade. To draw on my own experience as an academic and in line with typical university regulations for award (for example, the University of Huddersfield, 2016b) it is important that students understand the scope of "verifying learning" (Carless, 2016) in so much as they understand what is expected of them. Bella did not articulate her desire to achieve 100% nor enquire as to how she might go about achieving it; this suggests that despite her overall ability to actively engage with learning she was not minded to exploit this to the fullest. Maximal engagement with learning would have involved Bella obtaining guidance as to how she could develop her skills such that she might be rewarded for outstanding performance and achieve 100%.

A second of the students, Eliza, adds to the debate around how much students comprehend about their own role in understanding how to achieve maximum gain from feedback. In the following quote, Eliza is discussing feedback offered to her about how she could improve her essay writing with a more extensive use of published evidence. She shows a clear lack of understanding about the transferability of feedback between tasks:

> Because we're at the end of 3rd year, because we only had one essay left and that was due in a few days after [getting this feedback], I don't suppose it really mattered that there wasn't a massive amount [of detailed feedback] on what to improve on because unless you were going do like a Masters [degree] or whatever, you wouldn't need that skill. (Eliza)

Knowing that Eliza still had other forms of assessment to complete, I went on to ask her whether she thought the comments received about her use of evidence within her essay were applicable to other methods of assessment. Her hesitant response was:

> [Pause] erm, [pause], I suppose a little bit, [pause], with more literature, [pause], but not really because depending on what piece of work it is you're doing depends on how much literature you need. And depending on how many [key] points you have to make depends on how much [literature you need to support] each point. (Eliza)

These quotes show that Eliza views feedback as being explicitly linked to single pieces of work rather than as having the potential transferability from one piece of work to another, both within and beyond her immediate learning trajectory.

Within the same interview, Eliza and I went on to explore the language of this particular piece of feedback. Eliza commented that the educator, Rose, had used "good" to describe the range of literature that Eliza had used to support a discussion about professional legislation. I suggested to Eliza that Rose's use of the word "good" within the feedback, as opposed to "very good" or "excellent", suggests that Eliza had demonstrated this particular ability at an undergraduate level commensurate with a 50% band at her HEI. Eliza's response to my suggestion was "yes, I suppose so". I asked Eliza whether she would have identified the link between the descriptor of "good" and the 50% band had I not highlighted it to which she replied:

> No I wouldn't, no. I might do now [laughs]… and in the academic skills session that I went to, she [the academic skills tutor] really went through the bands of good, very good and excellent, and even though I'd gone to that [session] and heard her say it, when I read my feedback that's not what comes into my head. And it's only because I went to that session that I, kind of, knew about it anyway. I think it does need to be made more of an issue about so that people do, when they do get their feedback, these words actually do mean something [and] they're not just used because "good" is a nice word. (Eliza)

It is evident that Eliza has made voluntary efforts to understand the pedagogy around assessment in order to help her understand the assessment criteria and the language used within feedback. Whilst she theoretically had a better understanding of what Race (2005) describes as academic transparency and Carless (2017) and Charteris and Thomas (2017) as assessment literacy, she then failed to utilise this knowledge as well as she might to make sense of her feedback.

Considering the quotes from Bella and Eliza it seems surprising that individuals with a positive view of learning and a motivated view of "self" are unable and/or unwilling to utilise their understanding of pedagogy to the fullest. Like Bella, I would describe Eliza as a

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motivated learner, and both of these students as having the desire to maximise a learning-from-feedback opportunity. However, despite this learning desire, their engagement with assessment literacy is incomplete.

4.3 The Educator Perspective

Having considered the purpose of feedback from the student's perspective, I will now turn to the educator. Student healthcare professionals spend a minimum of one third of their course learning in the clinical environment (for example, the Chartered Society of Physiotherapy, 2010), with many spending considerably more time in a clinical learning environment (Nursing and Midwifery Council, 2010). It is therefore essential that feedback within a clinical learning space has a clear purpose and that that purpose is understood. The extract of narrative below is from an interview with Rebecca, an experienced practice-based educator. In it she is describing her rationale for giving feedback to students about their practical demonstration of clinical skills in a patient-centred clinical setting:

> You can tell the students who are thinking things through and are taking things on board, erm … because it's just really about reminding them, because there is so much to kind of take in, I think it's kind of unfair to say you didn't do this, you didn't do this, you just need to pick on the most pertinent ones and work on things bit by bit really … and remind them about one or two little things. (Rebecca)

Rebecca is clear in her narrative that the purpose of her feedback was to remind students about previously acquired skills. Of particular interest is her justification for offering what appears to be incomplete feedback. Rebecca perceives herself as being "unfair" to the students by providing feedback on everything that the student needs to improve on. She suggests that she is being kinder to the student by providing feedback on only the main weaknesses of a student's performance, and suggests intentionally electing to incrementally correct their performance. I argue this is a risky strategy in terms of how feedback impacts on learning as students desire honest feedback about their performance (Bols & Wicklow, 2013), and one might argue that incomplete feedback, without it being explicitly signposted as incomplete, is dishonest as it is not representing the *whole* truth. Additionally, there is the chance of students misinterpreting the lack of feedback regarding a specific aspect of their performance as that aspect being accurate when, in fact, using Rebecca's approach, it was simply not commented upon within the feedback at this time as it was less wrong than other aspects. There is no intention by Rebecca to mislead the students with her limited and incremental feedback; on the contrary, she is intending to offer a scaffolded approach to learning (Race, 2005). In reality, however, incomplete feedback by the educator may foster an incorrect belief of accurate practice by the student.

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Omitting to provide complete feedback may also fuel the debate around consistency of feedback (Gordon, 2013). As I have argued, if an educator only provides feedback on some aspects of performance that require improvement, the student may believe that the remainder of his/her performance is accurate. With regards a subsequent piece of work, another educator may provide feedback on a different range of skills or assessment criteria, leaving the student with the belief that there is a lack of consistency between educators. This is, however, not the case; the second educator is likely to be building on actions or learning that the student has implemented following the initial feedback, so allowing the second educator to focus on different aspects within his/her feedback. In the following quote Eliza is discussing her feedback experience pertaining to a single piece of work and makes transparent the cognitive challenges that students face and practical "solutions" that they employ when looking for consistency in feedback:

> I also thought about going to one of the other people [in the academic skills unit] … and seeing if they come up with the same things because, not because I didn't like how he did it, I thought he was really nice with me and what he told me was really useful, but just to see if it does come up with the same things because obviously there's different markers and I don't know who's going to be marking my work and everyone marks it slightly differently even though its supposed to be fair and consistent, so if I go see someone else that, and they do come up with the same, then it might be ok, I am actually on the right lines but if she comes up with something different … I hope it wouldn't be massively different but she just might look at it from a different angle, and then [I would have to] try and put both [perspectives into the work]. (Eliza)

Eliza's narrative shows her seeking feedback consistency whist verbalising her belief that individual markers expect different things from the same piece of work. Eliza's experience is not likely to be unique to healthcare students, rather more commonplace across learners as there is no healthcare-specific focus to her experience of receiving feedback on this occasion. Eliza suggests that, in the past, she has experienced different educators having different expectations, and makes clear the challenge that students face when needing to satisfy the expectation of all potential educators-as-markers within a single piece of work.

The final noteworthy aspect of the quote above from Rebecca, the practice-based educator, is a sense of kindness that appears to come through her dialogue. She makes clear that she perceives providing feedback on all aspects of performance at one time as "unfair", but gives no consideration to the potential converse argument supporting comprehensive feedback. As a healthcare professional, it might be expected that Rebecca proffers a caring approach to those for whom she has responsibility – patients, students or fellow colleagues

– but I challenge that there is unfairness in providing a lack of comprehensive feedback to the student.

This section has highlighted that the purpose of feedback – within the lifeworld "project" – must be made clear to students. If feedback is being offered on only a select number of areas for improvement, students should be explicitly aware of this to minimise the risk of them misinterpreting a lack of feedback on other aspects of work as a positive. It needs to be embedded in the role of the educator to make explicit the purpose and comprehensiveness of the feedback being offered.

4.4 Challenges of Purpose in the Practice Environment

Not only does the purpose of feedback need to be transparent and comprehensive, it also needs to be professionally relevant and genuinely situated. The practice environment as a learning space is imperative to pre-registration healthcare education, with all students being mandated to spend a minimum of 1000 hours (Health and Care Professions Council, 2009, 2013) and around 2300 hours (Nursing and Midwifery Council, 2010) in practice learning. The core purpose, and thus lifeworld "project", of those working in a clinical environment is patient care, not student learning. Practice-based educators are occupied with patient care in a clinical environment and, thus, students entering this clinical learning space are increasingly challenged with regards their role.

For a student, being situated within a clinically-focussed physical environment is likely to shift their allegiance to which community of practice they primarily belong to at that given time (Fenton-O'Creevy et al., 2015). By the act of donning a clinical uniform (or profession-specific equivalent) and being placed, for instance, in a hospital ward environment, the principal social identity that the student is likely to adopt is not one of "student" but of a lifeworld [named professional] "self", albeit in a student capacity. Adopting this "new" social identity of, for example, student midwife imports its own levels of anxiety and this heightened emotional state is one that needs to be managed well by feedback from educators with consistency and honesty, and from within a learning-focused relationship.

The reality of a clinical environment (e.g. hospital ward, outpatient clinic, patient's home) as a learning space makes it a very different learning setting in which to situate a community of practice from that of the academic setting (Wenger, 1998). Within the practice environment, the spatiality fraction of the lived experience is expectedly different from that of the academic setting (Chesser-Smyth, 2005; Melincavage, 2011; Papastavrou,

Lambrinou, Tsangari, Saarikoski, & Leino-Kilpi, 2010). However, the place and geography associated with practice-learning is not the only lifeworld difference between an academic and clinical environment for learning. The medical discourse used within a practice-based learning environment is very different to that with which the student is familiar in an academic setting. The language of the profession often reflects the nuances of the specific community of practice into which the student healthcare professional is migrating, and this taxonomy can be partially unique. Whilst the general language of feedback might remain a familiar factor in the practice-based environment, the "project" dimension of the lifeworld is fundamentally shifted from learning to patient care. Within this unfamiliar environment, the student is no longer at the centre of core business, and the purpose of feedback may be lost in the technical healthcare discourse.

Students are learning away from what might be considered to be their "normal" HE learning space (i.e. the university, akin to the purpose of learning, with its recognised and rigorous academic procedures of control) and the familiarity that goes with that. They are, instead, "placed" in a new learning environment which will almost always pose challenges for the student in relation to some of the factors highlighted by Melincavage (2011). These tensions (Melincavage, 2011) reflect the student being on the periphery of a new community of practice and questioning the legitimacy of their place within it (Lave & Wenger, 1991, 1999) and their right to be part of it.

In the above paragraph, I use the word "placed" intentionally to describe how students migrate into a clinical learning environment because this is mostly done without control or influence of the student themselves. Overall, little or no account of the socialisation elements (Chesser-Smyth, 2005; Papastavrou et al., 2010) of a new environment are considered during the process of allocating students to placements. The primary concern within a healthcare course structure is that the students gain the breadth of relevant clinical experience (for example, the Chartered Society of Physiotherapy, 2010) such that they are best placed for gaining employment on successful completion of their course. This passive placement of students into an unfamiliar learning environment imposes difficulties on the student to articulating their needs for feedback. The student is positioned on the margins of a clinical community of practice, the sociality aspects of the project are unknown, and the educators are primarily concerned with patient care. In this situation, it is hard for the student to articulate their needs of and from feedback and, thus, the purpose may not be clear.

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The purpose of feedback and its transparent relationship to clinical practice adds contextual meaning for the learner and assists in situating it within the constitution of a given practice-based community of practice. The relevance of assessment tasks and feedback to the role of the student as an emerging healthcare professional is of importance and partly expected, but on a number of occasions the students suggested a level of conflict between university and practice-based behaviours. This is particularly interesting from the viewpoint of the lifeworld "project" fraction because this dimension explores the lived experience from the perspective of the activities that are central to the life of the individual (P. Ashworth, 2003). Therefore, if the activities being undertaken are not authentically central to the future lifeworld of the healthcare professional, their validity may be questionable:

> [University] does say that they teach us the gold standard and everything, because we have the time to do that, and in 20 minutes [on placement] you've got to do what you can. Then you've got to be careful that you don't do what you do here on placement, back in the [university environment] because they would be like "why are you doing that?" (Gina)

This quote from Gina suggests a clear differential between what is taught and accepted in an academic setting and what is accepted in a practice-based learning setting. Not only is this quote interesting in highlighting this mismatch regarding application of prior learning, but Gina's choice of language, or lifeworld "discourse", in its description is very interesting. She refers to the knowledge acquired at the university as being the "gold standard" and talks about "being careful" to not expose her below "gold standard" practice-learned methods (e.g. clinical skills) at the university. This choice of description seems to reflect a degree of hierarchy between the two learning settings. It appears that the university-based setting is perceived as that in which students learn to carry out tasks in the model manner, whilst the practice-based setting teaches a suboptimal execution of these skills. The discourse associated with taking care not to expose this (implied) suboptimal practice implies that this learning is subsequently purposefully hidden from the "university" (itself an interesting way to describe those that teach, as though they are viewed as a single entity) and that there is a sense of anxiety about this genuine method of practice being revealed to university-based educators.

This difference between university-learning and placement-learning is echoed by Dawn in the narrative below:

> Because [in the university] we are always afraid that we are always, we are going to do something wrong or we don't know what [condition or problem] we're going to get [a patient coming in with], and I know you get that out on placement but I don't think, because you are able to do your own thing [on placement] and you're not

going to get questioned about what drugs this is or questioned about this patient and why she's got this and why she's got that. I think that's why because if we forget something [in the university] we always think I need to know. But on placement you can sort of go through in your head. (Dawn)

Dawn is discussing her experiences of patient-centred learning and provides a description of how the educators interact with the students in the two different environments. Dawn's description of a practice-based environment generates an image of a environment more akin to learning, and one that appears to provide students with the positive qualities they need to engender their learning (Chesser-Smyth, 2005). Similar to Gina, Dawn reflects an element of anxiety with regard to "getting things wrong" in the university and a sense that the university is the spatial dimension where skills and knowledge need to be consistently correct, in contrast to the placement setting where this need not necessarily be the case.

I suggest that these innate differences may be attributed to the assessment-focussed climate of the university in contrast to the nurturing, assessment-light climate of practice. It is challenging for students to be members of multiple communities of practice. From the perspective of feedback purpose and its impact on learning it would appear that, in these examples, both Gina and Dawn view the university as a place to confirm or verify learning and not akin to making mistakes, and the placement setting as one more favourable to guiding, encouraging and permissive of mistakes, a quality that Race (2005, p. 22) claims is essential for successful learning. This is an interesting antithesis of what might have been expected – at least by me as an academic and previous clinical educator – because the university setting offers the spatial dimension with which the (now final year) students are familiar as part of their "student" community of practice. Within this known community, students learn with (in the main) like-minded peers – seemingly reflected by both students' use of "we" rather than "I" in the above quotes – and I would have expected the students to have been more comfortable making mistakes within this known community. This evidence from Gina and Dawn suggests that educators in both environments need to clearly signal the purpose of feedback to the students such that students gain the maximum value from feedback offered.

4.5 Chapter Summary

The importance of making explicit the purpose of feedback within the lifeworld "project" has emerged within this chapter. Clarity and consistency of purpose appear to be important to structuring the feedback experience such that learning may occur and minimise risk of feedback misinterpretation. This chapter has also initiated a debate around the validity of learning experiences based on learning within different communities of practice. Learning is

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intrinsic to the academic world but less distinct in the clinical world; this will be explored in context within the remaining chapters.

This chapter has not explored individual themes and subthemes that will be drawn on in the following chapters of "Worth and Reward", "Identity of Feedback" and "Questions, Reflection and Ownership". These three chapters will now each give voice to the research participants by bringing together data from their lived experiences, specifically exploring emerging topics that appear less evident within the existing literature.

Chapter 5: Worth and Reward

5.1 Introduction

This chapter is the second of four blended findings-discussion chapters. The aim of this research is to establish the perceived value and impact of feedback on the ongoing learning experience of pre-registration healthcare students. To make a contribution towards achieving this aim, the previous chapter presented a discussion of the purpose of feedback. This chapter will begin to examine the data at a more fractional level, primarily drawing on examples of data from the themes and subthemes of "Emotional Effects", "Prose of Feedback" and "Qualities of the Learner" in order to explore the links between the students' perception of worthiness and the notion of acknowledgement and reward related to feedback. This chapter will also employ the communities of practice literature, particularly in relation to the debate around community boundaries (Fenton-O'Creevy et al., 2015) to understand these lived experiences. It will also explore the role of the students and educators as actors within the context of social learning.

The language used by students within their interviews will be explored in some detail in order to gain greater depth of understanding into the lived feedback experience of the individual student. The literature around the entitlement of students to feedback and moral feedback (Springer, 2008) will be used to discuss the feedback experiences.

This chapter will begin by setting the context of worth and using an example of data from Dawn, a student, to introduce some of the challenges one's own sense of worthiness poses to learning from feedback. This same quote will be referred to several times within this chapter as it illustrates several aspects of discussion. Data from Bella and Gina will also be used within this chapter to illustrate the arguments made, and a discussion of data from Brian, an educator, will allow the educator perspective to be explored. Worth will be considered in relation to "distance" and "self", and the challenges faced by the educator will also be examined.

5.2 Concept of Worth

The intrinsic qualities that the learner brings with them to a potential learning from feedback situation are varied and noteworthy within the interview narratives. The perception that the student has of his or herself is particularly interesting as it appears to include a dimension of confidence or self-assurance. From this position of confidence or self-

assurance there appears to emanate an element of value or worth that the student attributes to their own learning. Examples of student data will examine this in detail.

I interviewed Dawn following my observation of her in a practice-based learning environment. During this observation, I noted that Dawn engaged with an authentic patient intervention that was, in part, observed by an educator but that she failed to take the opportunity to ask the educator for feedback about her performance. This failure to act on an opportunity for receiving feedback was despite the opportunity being realistically present. The following quote from the interview begins with me asking Dawn for clarification as to why she had not sought direct feedback from the educator:

> Me: Why might you not have [asked the educator for feedback]? I know he is busy, but he is helping you and he is helping everybody else as well.
>
> Dawn: But my patient's gone [home], whereas there's people [other students] there with patients who he's focusing on. I don't know, I just… I should do that more.
>
> Me: Right (pause), would you have asked him later on?
>
> Dawn: That's something [I] should do more, ask what have I done right today and what do I need to improve. Because then that helps me – yes, I've learned something. That [feedback conversation with me] was useful, that. (Dawn)

Within healthcare education, feedback to students on their level of clinical performance and ability – usually with a primary intention to improve the competence of the student as a healthcare practitioner (for example, the College of Occupational Therapists, 2016; Nursing and Midwifery Council, 2008), and secondarily as a learner – is integral to patient care. This quote from Dawn suggests that she perceives the main purpose of the environment within which I observed her to be patient care, not learning. She believes the educator to be occupied with offering feedback to other students within the clinical environment who continue to have patients present. This poses an interesting conflict in that, whilst feedback to other students on their clinical skills is, naturally, important to the direct and immediate care of the patients that they are treating (assuming that the feedback being given to these students is on patient-specific issues as Dawn believes), this appears to be at the expense of Dawn's own learning. Dawn is deprioritising her own learning needs in what should be recognised as primarily a student learning space. This further contextualises the dilemma about the role of the student in a practice-learning environment and draws on the argument of the previous chapter about the challenges associated with having multiple "selfs" within a single environment (Fenton-O'Creevy et al., 2015). In relation to Dawn's experience, not only does the educator have a dual role as educator and clinician, Dawn herself is being viewed – by herself at least – as clinician and learner. The tensions associated with being a

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student healthcare practitioner in a clinical environment and being a learner in the same clinical environment will be discussed in more depth later in this chapter.

In the quote above from Dawn, it seems that she is willingly accepting of the practice that the educator is occupied with the needs of other students, albeit (as she views it) in direct response to patient need, as opposed to her needs as a learner. As I have already argued, this is despite the clinical learning environment being labelled as that – a learning environment – and students within this environment having equal rights. It seems that Dawn does not view, either, herself or her ongoing learning need as worthy of receiving feedback from this practice-based learning opportunity, yet she views her peers differently. Dawn's perception of "self" will be explored later in the chapter.

Within my initial interview with another student participant – Bella - she made it clear that she perceived feedback as a reward for her input into a task:

> I think if you get good feedback as well at the end of it [an assessment task], its kind of a reward, you know, you've worked hard and you really want to hear your feedback and just see if it is a good mark, you know, you've really worked hard for it. It's kind of a reward as well, you know, to go through it and think yeah, actually they've [the assessor] identified that I did that well or I didn't do that well or … things like that and just maybe that your work has been recognised because the feedback proves that the person has gone through and they've really looked through it … especially the way it is on Turnitin, you know with the points [script annotations]. (Bella)

There are a number of key factors to note in this narrative by Bella, and these will be explored in turn to understand how feedback is seen as a reward. Firstly, Bella makes a direct link between feedback and effort. She makes clear that she correlates these aspects from the perspective of student effort and educator feedback. Bella articulates that high student effort (presumably also indicated by a favourable summative mark though she does not make this explicit) should result in extensive and helpful feedback. She appears to be suggesting that she has worked hard to produce the work and thus she expects the educator to also work hard to produce the feedback. Examining this from the lifeworld dimension of sociality (A. Ashworth & Ashworth, 2003; P. Ashworth, 2003, 2016), Bella appears to be suggesting a relationship of equal expectations between herself as learner and the educator as assessor in terms of effort within a given task. This relationship equality is despite the actual "power" differential that is present in reality. With summative success ultimately leading to academic and professional award, the educator is Bella's gatekeeper to the profession and the professional community (Reitz et al., 2013) and yet any acknowledgement of this by Bella does not appear to be evident within her narrative.

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As the interview with Bella progressed it emerged that the relationship that she had with the educator was an important facet to her when considering and interpreting feedback. She felt that if the educator knew her well, Bella was more confident in the educator's feedback:

> I think because of the sort of relationship I have with Susan [an educator], I kind of expect her to sort of help me a little bit and give me some relevant advice or lead me the right way. (Bella)

With this in mind, it is then questionable whether feedback from an educator who does not have a similar positive relationship with a student would have a similar effect. This relational aspect of student-educator discourse also offers a different perspective to commonly utilised practices such as anonymous marking or simply marking the work of a student to whom the educator is not known. The next chapter, "Identity of Feedback", will explore the relationship dimension in detail.

The second aspect of interest from the first quote from Bella is the extent to which she is expecting material proof of the educator's efforts regarding their marking and feedback of her work. Bella seems to suggest that she is seeking overt evidence that the educator has invested sufficient time and effort into her work as a reward for her own [Bella's] effort. As the excerpt below from a subsequent interview with Bella shows, she perceives that this is not always the case:

> Also, there's that thing at the back of your mind saying that I spent hours and hours doing that essay and I bet that feedback took 10 minutes, or however, but it doesn't seem like it took a long time. (Bella)

Once again, visualisation of the feedback that Bella is referring to appears to reflect amount or quantity rather than (solely) quality of feedback adding support to the dimension of parity or equality of investment of physical effort by the student and educator. Bella explicitly refers to her perception of the amount of time taken for the educator to provide feedback, a factor mirrored by another student, Eliza, in her discussion around her anticipated feedback from her dissertation. Eliza told me that she was looking forward with interest to reading her dissertation feedback because she had put so much effort into it that she thought the educator should invest time and effort similarly. The key point here is that Eliza, like Bella, appears to suggest an expected parallel between her own investment of time and effort in producing a piece of work and that invested by the educator in their construction of feedback.

What is noteworthy in these examples from Bella and Eliza is an apparent lack of understanding of the extent to which an educator engages with the crafting of feedback (The Quality Assurance Agency for Higher Education, 2008, 2012). Whilst it was not explored as part of this research, it would be of interest to ascertain a detailed perception of the practical processes involved in providing feedback from the perspective of the learner. It would also be interesting to explore the students' perception of the amount of time allocated within an academic workload to provide feedback to a single student. The quotes from Bella and Eliza both imply that the student considers that the educator is ambivalent to providing feedback, as though this is an activity not embedded within their core academic role, but additional to it.

There is recent evidence from Roksa, Trolian, Blaich, and Wise (2016), supported by the earlier work of Ambrose, Bridges, DiPietro, Lovett, and Norman (2010) and Komarraju, Musulkin, and Bhattacharya (2010), that highlights the significance of the educator's academic motivation and learner engagement on the outcomes of students. I hypothesise that if Bella and Eliza view educators as ambivalent in their commitment to providing feedback if the feedback they receive does not meet their expectations, this could have a detrimental impact on their potential learning from this feedback. This line of argument raises further questions regarding how students understand the assessment and feedback practices and the lack of transparency regarding feedback (Carless, 2017; Charteris & Thomas, 2017; C. D. Smith et al., 2013). Furthermore, it suggests that additional investment by the educator is needed to ensure that the students have a more realistic understanding of expectations (Ashwin, 2014; Bloxham & West, 2007; Mckendry & Boyd, 2012).

A final aspect to draw out from the original quote from Bella is her choice of the word "hear" in her description of her desire for feedback. Bella appears to be explicitly suggesting the sense of a person offering feedback to her through heard sound, such that she is hearing the "voice" of feedback and subsequently internalising its meaning. This concept of a person being present within feedback will be explored in detail in the chapter "Identity of Feedback".

5.2.1 Worth and "distance"

In the initial quote from Dawn that I have explored in this chapter, she states:

But my patient's gone [home], whereas there's people [other students] there with patients who he's focusing on. I don't know, I just… I should do that more. (Dawn)

Dawn's use of the phrase "my patient's gone" in an attempt to justify to me why she might not have actively sought feedback from the educator is interesting. Dawn's description that the patient had now left the clinical environment articulates a geographical distance between Dawn and the patient, so reflecting the physicality of the lifeworld "project" that she now finds herself in. More interestingly though, Dawn appears to be signalling a metaphorical distance between the reality of the physical situation and her appetite for potential learning from a clinical feedback experience. This reflection of an experience that has occurred in the past is in line with the lifeworld discourse of "temporality" – concerned with time and sequencing within a lived experience (P. Ashworth, 2016) – as was introduced in Chapter 3, but this seems to be strongly underpinned by Dawn's notion of "self" worth within this discussion. Dawn appears to be suggesting that her worthiness of educator feedback is not legitimate because her main purpose lacks direct clinical need. The relationship between "self" and worth will be consider more fully later in this chapter.

The distance between Dawn and others is interesting. Dawn did not appear to be concerned that this opportunity for authentic feedback would have been lost had she not been encouraged to seek feedback. She uses "people" to describe her fellow students with whom she has the opportunity for a comparable learning experience. It appears that Dawn is distancing herself, intentionally or otherwise, from her peers in that she appears to view them differently to her, and within her description makes no attempt to align her own needs with the needs of her fellow students. The community of practice in which Dawn finds herself as a student healthcare professional should be a common place for peers and a community of defined kinship, with members of that community having comparable anxieties and concerns, and access to similar opportunities and successes. This common understanding within the learner community should be well established given that Dawn has been an integral part of this community for more than two years. However Dawn's apparent distancing herself from her peers suggests that she does not believe that she shares in this kinship as much as one might expect. According to Wenger (1998) Dawn is distancing herself from other learners within her learning community and limiting her participation with these fellow learners, in that she is demonstrating unengaged alignment.

Unengaged alignment (Wenger, 1998) reflects a mode of not belonging to a given community of practice. One undesired outcome of unengaged alignment may include Dawn being unable to share knowledge and exchange information with her community peers. It is important to consider the potential reason for this apparent unengaged alignment, of which

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there might be several facets, but from an educational perspective one of the major considerations is whether Dawn is less engaged as a learner because she is adopting the role of clinician rather than of learner within the clinical learning environment. What I mean by this and I have already argued in the "Purpose of Feedback" chapter is that, within a clinical learning environment as a student healthcare practitioner, a student needs to adopt a minimum of two roles simultaneously, learner and student clinician. It appears that Dawn is favouring the latter at the expense of the former within this overt learning environment. This suggests that Dawn perceives her learning need as secondary to the need of patient care despite it being implicit that the purpose of this particular clinical environment is student learning. Of note is that the clinical learning environment that Dawn was in was geographically placed within an HEI rather than a location whose primary business is healthcare, such as a hospital. As an outsider to the community of practice in which Dawn was operating, this adds further weight to the argument that her learning ought to have been her core focus, though this was evidently not the case.

The challenges associated with being a member of multiple communities of practice is explored by Kubiak et al. (2015). Their narrative offers insight into how a single situation – or landscape - can be viewed very differently by multiple participants. It highlights how an individual participant of a community can both find it difficult to view the said landscape from another perspective and also how he/she might require different skillsets (e.g. styles of communication) in order to work with the individual, and thus different, community members. This would be particularly evident if individual community members occupied different roles within the said community or had different perspectives.

Different perspectives within a single community poses challenges. In considering the situation that Dawn finds herself in is the interesting dimension of the role of the qualified healthcare colleagues with whom she is working. Albeit that her physical clinical learning environment is situated within an HEI, and thus overtly recognised primarily as a "landscape" for student learning, it may be perceived differently by other members of the community. The qualified healthcare colleagues – i.e. other members of the [location-specific] community of practice – working within it may view it's primarily business as healthcare delivery and, thus, perceive the student members of that community not as learners but as healthcare practitioners. Should that be the case, Dawn – whilst being a very able student, she is also one that lacks confidence in herself and her ability – might not feel that she has the skillset or influence as a learner on the periphery of a clinically-focussed community of practice to address or challenge other community members about the deficit in learning opportunity.

To now return to Dawn's description of her feedback experience and its relationship to the distance of time. "Gone" also reflects Dawn's current perception that any potential learning from this feedback situation is no longer useful or is less important as a consequence of there being a passing of time. She appears to view the opportunity for learning from this feedback situation to be no longer present, despite the fact that she states within her last sentence of the quote that that she found the feedback discussion "useful" as a learning tool. This is a particularly noteworthy consideration given the overt and explicit construction of pre-registration courses to support the transferability of learning from one feedback situation to subsequent situations. As one progresses through any career path – as clinician, educator, researcher etc, it is paramount that learning from individual experiences influences future encounters – one of the premises of life-long learning, and a forefather of mandatory CPD (Health and Care Professions Council, 2012; Nursing and Midwifery Council, 2017) – in order that the individual professional and the professional community both continue to develop to meet evolving healthcare and health service needs. Thus, there never ought to be a "gone" opportunity for learning from feedback.

The transferability of learning from feedback is implicit within the integrative "Purpose of Feedback" theme that has been explored in the previous chapter of the same name. For example, if the purpose of giving feedback is to guide knowledge acquisition (e.g. understanding of a theory) or improve practice (e.g. a kinaesthetic skill) (Hattie & Timperley, 2007), there is a reasonable expectation on the part of the student and educator that a subsequent situation will arise in which the learning from this initial feedback situation can be utilised or enacted (Nursing and Midwifery Council, 2010). There is no indication of timescale for this ensuing opportunity, and nor need the subsequent situation be a direct replica of the initial experience, but students need to know how to use the learning, in addition to being able to recognise when it should be used. Often students are confident that their learning trajectory will offer such an opportunity, as is explicit in the quote below from Gina:

> I feel like I actually get something from the [feedback], because he [the educator] goes into quite a lot of detail and I think that's actually quite good to understand why it's [the foot] doing that, and the cause [of the problem] and to have a look at everything as a whole, so it is good to know for next time. (Gina)

In this example, Gina is clear that the feedback received has guided her understanding of a particular clinical situation that she appears to believe she will encounter again and thus the experience is reflected positively, is transferable and has authentic professional relevance. However not all feedback is understood to be as explicitly transferable as in Gina's example.
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The earlier quote by Dawn has already suggested a lack of appreciation regarding the transferability of learning from feedback, in that she suggested a lack of worth in pursuing feedback given the absence of the specific patient to whom it was originally related.

There is a notable difference between the feedback experiences being discussed by Gina and Dawn. The focus of Gina's situation is undoubtedly a clinical situation and specifically patient-focused, offering distance between the feedback topic and Gina as a learner. The situation being discussed by Dawn, however, is more abstract and largely about Dawn herself as a learner. This difference in the nature of the topic being discussed offers some suggestion that matters perceived as less personal to the learner are easier to understand and recognise as transferable as they offer more detachment, or distance, from situation. Conversely, when an individual – as in Dawn's case – is integral to the topic of the discussion, it is understandably impossible for the learner to dissociate the personal "self" from the potential learning from the given situation. This appears to reinforce the illuminating dichotomy associated with feedback around the *clinical scenario* in a learning environment being worthy of feedback (as illustrated by Gina), yet feedback around the *learner as a learner* in a similar learning environment being less worthy of feedback (as illustrated by Dawn). The distance between feedback and "self" will be discussed further in the "Feedback as a threat to "self"" section of this chapter.

5.2.1.1 "Distance" and transferability

There appears to be an emerging relationship between the appreciated worth of feedback and the factors of distance so far explored; dissociation of the learner from the learning community, removal of the personal "self" as a topic of feedback, and feedback remaining unique to the situation it was received in. To add weight to the argument of feedback being transferable across a broad learning trajectory, another participant, Eliza, shared two feedback experiences with me that suggest a link between timing or chronology, and uptake of meaning and learning from feedback that are worthy of further exploration. The first is an example that has already been discussed in the "Purpose of Feedback" chapter in which Eliza found it difficult to transfer summative feedback about the level of criticality in an assignment to the discussion section of her dissertation, which was yet to be submitted, because she perceived these as different "types" of writing. At the chronological point at which the summative feedback was received, the only piece of written work outstanding was her dissertation and thus she viewed no further opportunity to use the feedback received from her assignment. As an academic, it was clear to me that the dissertation was a significant opportunity for Eliza to utilise this meaningful feedback but her interpretation clearly raises a question around transparency, and purpose of feedback. If the transparency

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of potential feedback utilisation is not clear, the potential learning from this feedback may not be maximised.

The concept of transparency is interesting if students are going to use feedback from one learning experience to support learning within another. It is often assumed that students have the ability themselves to interrelate feedback to different situations. This assumption is compounded by the practice that the university uses generic assessment criteria pertaining to level of study (i.e. FHEQ levels 4, 5, 6 etc, (The Quality Assurance Agency for Higher Education, 2008)) that are then related – by the marker - to the assessment-specific learning outcome during the process of crafting feedback. As a result of the generic assessment criteria, the pedagogical language used within crafted feedback ought to be similar such that the student is able to transfer learning from feedback to another task. Despite this, it is clear from Eliza that she is unable to appreciate, let alone apply, the potential transferability of feedback from one assessment task to another because they are labelled differently. It is also noteworthy to recognise that Eliza appears to view feedback on written work only to be pertinent to other written work. The generic assessment criteria themselves make no distinction between the form and type of assessment that is being assessed, though this may be reflected in the specific learning outcomes applicable to the individual piece of assessment. Therefore, the measurable qualities of systematic and comprehensive critical evaluation, skilful communication and accurate referencing of a broad range of sources are features expected within all types of assessment at FHEQ Level 6, that at which Eliza is being assessed.

These examples of data from Eliza and Dawn reaffirm that it is not always transparent to students how transferable feedback is between assessment tasks. This might imply a requirement for overt and meaningful labelling within the feedback process to clearly signpost and direct the students through the "learning from feedback" journey. Signposting and direction might also be an important point of consideration by course teams when planning and implementing educational provision. Greater consideration of what individual pieces of assessment are called in order to maximise the inherent transferability based on assessment "type" may be needed. Explicit signposting of the transferable elements of the assessment-feedback-learning triad might be needed to support students in recognising how and when learning-from-feedback can be applied. Students are rarely required to focus solely on one task within a single community of practice and thus their learning focus is multiple. This focus of attention is further divided when students are required to engage with multiple communities of practice (Fenton-O'Creevy et al., 2015), such as happens with student healthcare professionals.

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The second of Eliza's examples of not being able to recognise the translatability of feedback is embedded within a discussion regarding practice-based learning. Given the earlier argument regarding the mandatory need for CPD as a qualified healthcare professional to maintain professional registration (Health and Care Professions Council, 2012; Nursing and Midwifery Council, 2017) it was surprising to hear Eliza describe placement feedback as having "limited transferability". Her argument was based on objective differences between placement experiences (e.g. client group, environment, location, service need) rather than on the recognition of similarities between the experiences. Students are assessed on consistent profession-specific (within the structure of the course) learning outcomes within a level of study and thus whilst the experience itself will rightly differ between placements in order to develop breadth of knowledge and skill akin to professional standards and regulatory expectations (for example, the Health and Care Professions Council, 2013), the transferability of learning between placements should be evident to the students through the commonality of the learning outcomes.

What is also emerging from within Eliza's apparent unwillingness to consider the extent to which placement-generated feedback has transferability is the longitudinal dimension of learning. The work of Rust et al. (2005) and M. Price et al. (2011) was explored in the "Framing the Question – Context and Theory" chapter and highlights the recognition and significance of latent or delayed learning from feedback. Eliza seems inherently focussed on the course-related clinical experience (i.e. placements) rather than the longer-term perspective of learning to support her ongoing development once a qualified health care professional, despite the fact that she is within six months of qualifying. It would appear that Eliza lacks depth of understanding regarding the longitudinal significance of learning from feedback and is, instead, occupied with its immediate application.

Apparent lack of deep understanding by Eliza gives rise to question how much responsibility is placed on the student his/herself to make sense of a feedback, and thus potential learning, situation. Given Eliza's proactive engagement with her course and largely insightful nature, I was expecting her to make both the implicit and explicit links between placement learning experiences and longer-term gain and/or latent application of learning. It seems, however, that her primary focus was on the immediacy of being able to apply her learning. It has already been argued within "Purpose of Feedback" that feedback and assessment literacy (Carless, 2017; Charteris & Thomas, 2017; C. D. Smith et al., 2013) are areas of pedagogy that need further investment. The narrative from Eliza is further evidence that there is distance between how educators expect students to engage with

feedback and their actual engagement. I suggest that within a high-contact healthcare curriculum, this is an area of knowledge development that tends not to be well scaffolded and lacks priority. Students tend not to be taught how to interpret and consider feedback "in the present" in such a way that the learning from it may be easily retrievable and identified as applicable "in the future". Similarly, students tend not to be taught how to develop this skill of interpreting "now" feedback with the specific purpose of a longer-term gain and nor do educators explicitly do it for them.

Lack of learning from feedback for longer-term gain has consequences. Firstly, the immediate learning opportunities are not being maximised, and secondly – and arguably the more significant factor considering the ongoing professional needs of these students nearing qualification - this is an underdeveloped skill within healthcare education that is not nurtured at pre-registration level. This means that on graduation, healthcare professionals are not best placed to direct their own ongoing learning to support their professional practice. This is therefore another factor that requires consideration by course teams when planning curriculum and assessment.

5.2.2 Worth and "self"

This chapter has already explored the concept of worth and the perceived worthiness of receiving feedback. It will now consider in more detail Dawn's perception of herself as a learner. My objective opinion of Dawn is of an able student who achieves very good summative assessment marks overall, though she can be quiet and somewhat shy. Despite academic achievement evidence to support her ability, Dawn appears to have a differing opinion of herself. The initial quote at the outset of this chapter from my interview Dawn is:

> Me: Why might you not have [asked the educator for feedback]? I know he is busy, but he is helping you and he is helping everybody else as well.
>
> Dawn: But my patient's gone [home], whereas there's people [other students] there with patients who he's focusing on. I don't know, I just… I should do that more.
>
> Me: Right (pause), would you have asked him later on?
>
> Dawn: That's something [I] should do more, ask what have I done right today and what do I need to improve. Because then that helps me – yes, I've learned something. That [feedback conversation with me] was useful, that. (Dawn)

Within this quote, Dawn seems to portray herself as a student healthcare professional who does not view herself or her performance as worthy of educator investment (i.e. feedback) and one of a student who has been reluctant or unable to take responsibility for her own

learning – evidenced by her use of "should" twice suggesting either reluctance and/or inability. Dawn also seems reluctant to take ownership of her learning as she was not keen to practically seek support and feedback, even when encouraged to do so. It is unclear whether this reluctance is due to a lack of confidence, her quiet and shy demeanour, or her lack of ability. What is also interesting is the differentiation that Dawn makes between her lifeworld "self" and her performance. In the final sentence of the excerpt she distinguishes between performance or "skill" and her person as "self". There is a sense that Dawn finds it difficult to separate the two, potentially making constructive feedback personally critical. Personally critical feedback might be perceived as a threat to the "self".

The view that Dawn believes her learning need is of less importance than the need of another student raises legitimate questions about Dawn's perception of herself. It is clear from Dawn's dialogue that she recognises the benefit of actively seeking feedback from educators though, despite this recognition, is usually reluctant to source it. This poses the question of why Dawn is reluctant to seek feedback and gives rise to the examination of how feedback might be a threat.

5.2.2.1 Feedback as a threat to "self"

By considering "self" from a lifeworld position (A. Ashworth & Ashworth, 2003; P. Ashworth, 2003) and using the other lifeworld dimensions to illuminate the perception of "self" in more depth, it is interesting to consider feedback as a threat (or otherwise) in an attempt to explore Dawn's reluctance to seek feedback. Kluger and Van Dijk (2010) suggest that learners who view feedback as a threat to the "self" might exhibit a reduction in their performance (performance in the broadest sense) as a direct result of the said feedback. Their work utilises the theory of self-regulation as posited by Higgins (1998). This theory draws on people being motivated either by prevention tasks, in which the main purpose is to avoid pain or punishment, or promotion tasks which have the main aim of success or achievement. Kluger and Van Dijk (2010) describe the "dangers" of feedback and the "damage" that it can effect on motivation and performance if not managed well.

Consideration of the theory of self-regulation through the lens of the lifeworld concept of "self" is particularly interesting as it adds further exploratory depth to the quote offered by Dawn. Despite Dawn's academic ability as evidenced by high summative assessment grades, she appears to lack confidence in and conviction of her worth with regards to feedback. Using the self-regulation foci model, Dawn could be reluctant to access feedback as she is protective of her vulnerable learner "self", prioritising her security over potential gain:

> The difference between the prevention and promotion foci reflects the basic conflict between the drive to preserve the status quo and the drive to initiate change, or between the need for security and the need for self-actualisation. (Kluger & Van Dijk, 2010, p. 1167)

This hypothesis offers one explanation for Dawn's reluctance. Together with her uncertainty as to which community of practice (or multiples of) she belongs to in the learning environment her attempts to protect herself and limited self-efficacy may explain her hesitant learning behaviour in the university-based clinical learning environment. One suggestion by Kluger and Van Dijk (2010) is that the feedback process should be replaced by a feed-forward interview process that creates "a reflection process that firstly serves the interviewee and his or her needs" (p. 1172), can intentionally draw out the positive aspects of a learning situation and supports the learner in their internal inspection and positive activation of "self".

Whilst this evidence offers only one explanation for Dawn's behaviour, it suggests the potential need for educators to re-consider the branding of "feedback" to support greater actualisation of the learner's "self". Additionally, it opens up a debate about the mechanisms used within the feedback process and highlights the potential use of reflection and questioning to increase learner self-efficacy and agency in the learning process. This will be explored in greater depth in the chapter "Questions, Reflection and Ownership".

5.3 Boundaries of the Educator

It is interesting to consider the role of the educator, and the boundaries that they encounter, within the debate of students' worthiness of feedback and feedback as a reward. The quote from Dawn that has been explored throughout this chapter arose as a result of my observation of her within a university-based clinical learning environment. Dawn was involved in the clinical assessment and treatment of genuine patients and the educator, Brian, was supporting the learning through clinical practice of Dawn and her peers in this environment. Through the "lifeworld" lens of the lived experience (P. Ashworth, 2003, 2016; Brooks, 2015), the spatiality, project and sociality dimensions are all challenged by this situation.

The challenges stem from Brian's role in this authentic learning situation. Brian occupies a central position within two communities of practice – an academic community and a clinical community – and has at least a dual role in supporting Dawn and her peers. Whilst the primary purpose of the clinical learning environment is just that – a vehicle for student

learning – and thus Brian's role within this is that of an educator, the authenticity of the location and situation also forces Brian to adopt the role of clinician. Without there being clarity regarding the purpose of the learning situation – learning or healthcare delivery – as was discussed in the previous chapter, it is difficult for both Dawn and Brian to maintain what should be their primary roles of learner and educator, respectively. Furthermore, Brian is also involved in the assessment – or verification of learning (Irons, 2008) - of Dawn and her peers on other occasions, adopting a third contradictory role. These multiple roles are not synonymous and thus Brian's place within this changing landscape (Kubiak et al., 2015) of a clinical learning environment is one of genuine challenge.

The dichotomy of the educator role in a practice-learning environment is not only evident to the educator, as has already been explored in the quote by Dawn. Whilst focussing only on nursing students within her research, Watts (2011) makes clear within her underpinning literature review the dilemmas faced by student practitioners when exposed to the "unknown world" of placements as a tool for clinical learning. She reflects the importance of students having access to:

> … specifically trained mentors [who] are expected to spend a minimum amount of time with students, facilitating and supporting the student's practice learning …" (Watts, 2011, p. 215).

This makes explicit that the expected role of the educator in a practice learning environment is to support student learning, particularly given that this research also highlights that students are often without their familiar support mechanisms of peers and academic tutors. This expectation draws on the notions of morality (Springer, 2008) and virtue ethics (Earle-Foley, Myrick, Luhanga, & Yonge, 2012) being employed by the mentor or clinical educator (described as a preceptor within the paper by Earle-Foley et al. (2012), so reflecting the professional discourse of nursing), and in particular that of justice. This signals an expectation that all students should receive his or her entitlement to feedback on performance.

Entitlement to feedback is interesting when returning again to Dawn. It appears that Dawn did not perceive herself worthy of or entitled to feedback to support her learning, contrary to the principles of justice and fairness. Equity of the feedback experience within the clinical environment described by Dawn appears to be influenced by the role(s) that she believes the educator to employ and how these might be unintentionally blurred. This challenge of perceiving oneself as worthy of feedback draws on the communities of practice theory and adds weight to the argument that it is crucial that students are signposted to the purpose of

a learning situation, the role of the educator in that situation, and the purpose of feedback offered. This also augments the suggestion of more newly qualified staff being involved in the education of pre-registration healthcare professionals to offer kinship to the student to support a greater sense of belonging (Maslow, 2011, 2013). Without this clarity and support there is a significant risk that students might neglect significant learning opportunities.

5.4 Chapter Summary

As the first of three chapters that explore specific themes and subthemes, this chapter has examined the students' perceptions of worthiness of feedback and its recognition as a reward for effort. It has considered the individualised nature of feedback and given voice to the research participants by using quotes from students to explore their lived experience, drawing heavily on one particular aspect of my interview with Dawn. This chapter has explored how the distance facets of time and authenticity impact on the students' view of feedback, and recognised that learning from feedback may not be immediate. This chapter has hypothesised that limited uptake of feedback may be influenced by student self-efficacy and feedback being seen as a threat.

In exploring the notion that feedback as a reward, this chapter has employed the communities of practice theory to contextualise challenges faced by educators and it has developed the argument introduced in the "Purpose of Feedback" chapter, that students may lack feedback literacy skills and that these skills are needed to maximise their learning.

The significance of relationships has been superficially considered within this chapter. This will now by explored in both greater depth and breadth within the next chapter, "Identity of Feedback".

Chapter 6: Identity of Feedback

6.1 Introduction

This chapter will explore the concept of identity and "person" in relation to feedback, with regards to how feedback is constructed and interpreted by the student – the "receiver" of feedback - and also from the perspective of the educator – the "provider" of feedback. The chapter examines the relationship between these two perspectives. The chapter begins with a quote from Eliza, one of the students, in order to establish a foundation for the issues that it will explore and begin to identify the emergent concepts around identity. Evidence from two other students, Gina and Bella, will also be used within this chapter to support the developing argument. In order to enhance the depth and breadth of the concept of the identity of feedback, this chapter also uses evidence from two educators, Rose and Susan.

Throughout the chapter, appropriate lifeworld concepts will be utilised to offer a lens through which to understand the lived experiences from the perspectives of the social actors, and social learning theory will be drawn upon to situate the findings. The chapter is constructed using the subsections of "The Student Perspective", "Personalisation", "Contribution of a Relationship" and "Feedback as Therapy". This chapter will explore the key foci of the person being "present" within feedback and the language used by the participants in their discussion and description of feedback experiences.

This chapter draws on relevant social learning theory as explored within the "Framing the Question – Context and Theory" chapter to help develop the argument. In particular this chapter will utilise the concepts of situated learning and communities of practice – exploring more specifically the norms of and accepted and expected practises within communities – to explore the data. It is not the intention within this chapter to discuss the form of feedback, such as verbal versus written, in its own right though aspects of style of feedback will penetrate the data and be examined more indirectly within the wider context of identity.

Within this chapter "identity" shall be used to reflect the characteristics of feedback that signify or reflect a person's presence in or role underpinning a feedback situation. It will not be used to solely describe the actuality or physicality of a person being present within a lived experience, though this may be the case on some occasions. Rather, "identity" shall represent the sense that a person was actively involved in the process of feedback - from its crafting through to its receipt and subsequent interpretation - and the consequences and

impact of these identity-focussed attributes. To support this interpretation of identity, the chapter will particularly utilise the lifeworld concepts of self and sociality to explore the lived experiences within the data from the perspective of the individual participants.

6.2 The Student Perspective

6.2.1 Eliza

When discussing the type of feedback that Eliza prefers within my initial interview with her she identified very clearly that her preference was for face-to-face feedback. On further purposive exploration as to her rationale for this Eliza stated:

> It's [face-to-face feedback] more personal. Just a piece of paper or even on the computer, it, yes the person is behind it and they have wrote it, but they're not there and they can't, you can't then turn round and quickly say "oh why did you write that" or even "thank you" just to acknowledge that you've got that feedback. It's just so impersonal getting written feedback. (Eliza)

The socially constructed relational aspects of feedback are prominent and multiple within this quote, and are of significance to Eliza's lived experience of the feedback situation. It is evident that Eliza attributes value to the basic norms within western society of offering gratitude for [the product of] feedback (Bell & Goldsmith, 2013; Friedrich, 2012) from her educator. Additionally, she also has a desire to clarify aspects of her written feedback (Agius & Wilkinson, 2014; Carless, 2016) should she need to by the processes of questioning her educator regarding the feedback, seemingly in order that she has the correct understanding of the feedback.

Within her quote, Eliza does appear to be attributing significant worth to the physical presence of the provider of feedback on this occasion. Firstly, her explicit reference to a lack of presence in her description of "but they're not there" implies disappointment that she is not in a position to explore her feedback further, albeit primarily for clarification purposes. Secondly, her seemingly negative choice of the phrase "*just* a piece of paper" (my emphasis) when discussing feedback in written form, suggests that feedback provided in this form has less meaning for her and she seems somewhat dismissive of its value. Eliza's sense of disappointment in not being able to explore written feedback will be discussed more broadly later but it seems fitting to now consider this quote in the context of anticipated learning culture.

6.2.2 Cultural norms

The quote above from Eliza not only expresses her desire to demonstrate socially accepted, and possibly expected by the student, behaviour in her wanting to thank her educator for feedback – clearly something that she is unable to do if they are not present - but she also appears to be reflecting her interpreted norms of her professional community of practice (Wenger-Trayner & Wenger-Trayner, 2015; Wenger, 1998). Within the majority of healthcare professions, feedback in a practice-based learning environment is typically provided to learners on a day-to-day context, in the formative years by a patient-by-patient manner, and usually in verbal form. Notwithstanding the discrepancies highlighted earlier by Palermo et al. (2013) in terms of the consistency of feedback to pre-registration dietetic students, it remains commonplace within a healthcare community of practice to receive verbal feedback on performance of skill or knowledge, often more overtly related to demonstrable learning outcomes and/or competencies of practice (Health and Care Professions Council, 2013; Nursing and Midwifery Council, 2010). With the exception of mandated, formal and structured feedback meetings during a clinical placement – often termed tripartite meetings (Nursing and Midwifery Council, 2008) - that are often associated with formative or summative grading, regular written feedback within a practice-based setting is not conventional. Whilst there is a degree of dissonance in the literature about the usefulness of tripartite meetings to student learning (Passmore & Chenery-Morris, 2014; Rooke, 2014) their usefulness is accepted in terms of verification of learning.

It is interesting that the lifeworld "project" of the tripartite meeting is not perceived to be learning-focussed. A tripartite meeting typically involves the student, the practice-based educator, and a university-based educator (Passmore & Chenery-Morris, 2014). Given the argument in the previous chapter about the support offered to learning by those with whom the student is familiar, it might have been expected that the familiar university-based educator was well-placed to transform this meeting from one that is assessment driven, into one with a learning focus. I hypothesise that this may, in part, be due to the university-based educator fulfilling more than one role (Reitz et al., 2013) within this "project", and that of assessor appears to take priority over that of educator. This hypothesis draws on the earlier argument of educators enacting within more than one community of practice and the challenge to their role that this poses.

The behaviour of offering verbal feedback to a learner is a conventional strategy adopted in many practice or work-based learning settings, such as education and healthcare. Often described as mirroring an apprenticeship approach to learning (Woolley & Jarvis, 2007), this

model of education is firmly situated within the context of social learning theory and this will now be explored further.

6.2.2.1 Generating authenticity

Situating learning within defined and, in part, unique boundaries offers the learner the opportunity to develop the knowledge and skill that is, in part, unique to the community within those boundaries. I have previously argued that whilst some of the skill and knowledge required of a nurse is equally required by, for example, an occupational therapist, midwife and operating department practitioner to enable them to fulfil their own professional roles. However, in addition to this professionally overlapping skillset, there is equally a clearly-defined specific discipline of knowledge, understanding, competence and application that is unique to each of the professional disciplines. It is this unique discipline that sets apart the different professions and articulates their professionally-restricted community of practice. It is also this uniqueness upon which a feedback experience must draw in order that the novice members of that community develop an understanding about the application of feedback to their specific professional identity. This notion of authenticity of assessment and thus feedback, and potential false authenticity, is a fundamental message from within the student data. The "Purpose of Feedback" chapter introduced an exploration about the authenticity of learning experiences; this section will now explore it in more detail in the light of a developing professional identity.

As discussed within the "Purpose of Feedback" chapter, the following quote from Gina highlighted a clear discrepancy between university and practice-based clinical practices, despite the assumed intention that the former is preparing the student for the latter:

> [University] does say that they teach us the gold standard and everything, because we have the time to do that, and in 20 minutes [on placement] you've got to do what you can. Then you've got to be careful that you don't do what you do here on placement, back in the [university environment] because they would be like "why are you doing that?" (Gina)

In the context of developing a professional identity from the learning experiences that students from specific disciplines are exposed to it is essential that the learning opportunities that students engage with – including that which occurs from exposure to feedback – are genuinely authentic to the reality of the discipline, or community of practice, that they are intending to become a member of. There is evidence (Fenton-O'Creevy et al., 2015; Lave & Wenger, 1999; Wenger-Trayner & Wenger-Trayner, 2015; Wenger, 1998) to support the transition of new members of a community from the periphery to the centre of

that community based on them becoming familiar with the culture of that community and subscribing to its practices, beliefs and values. With this in mind it seems increasingly challenging for a student healthcare professional to transit from the periphery to a more central position within a given community if they are being increasingly exposed to practices and beliefs that are at odds or in opposition to the authentic practices of that community. Gina's example highlights the differences between the two learning environments – the university and "real" clinical practice - and the challenges faced by learners as a consequence of such contesting practices but I pose that this quote reflects something even more fundamental to the ongoing development of identity of a given community of practice.

Work of Kilcullen (2007), Armstrong (2008) and Gordon (2013) around role modelling complements the evidence that expert clinicians and practice educators play a key role in influencing the practices of novices (Arreciado Maranon & Isla Pera, 2015; Dracup & Bryan-Brown, 2004; Hammond, Cross, & Moore, 2016). It is commonplace to recognise that the healthcare students of today are the professionals of tomorrow, and thus within the remit of the qualified healthcare professional, today's healthcare students are also the practice-based educators of tomorrow. With this in mind, it is somewhat concerning that there is such a divide between practices taught and thus expected to be used within academic-based and practice-based settings. Gina does not suggest that the academic division of the community are unaware of the different and commonplace practices within the practice-based community, but she makes explicit that such practices would not be condoned within an academic setting. I suggest that this poses a significant challenge to the developing professional identity of the healthcare student. Much of the assessment feedback that is associated with verification of learning is university-based and yet the student knows that its authenticity to genuine clinical practice – because the practice-based community of practice operates differently – is limited. Superficially the feedback on such practice appears wholly authentic at a strategic level but in the operational reality of the profession it is less so.

This apparent dichotomy of norm within a given healthcare discipline is self-perpetuating if it remains unchallenged. Gina's description of needing to be "careful" so as not to overtly demonstrate and expose the unsupported practice to the other party is interesting. There is a real sense from her description of accepting the fact that particular aspects of practice are hidden *within* discipline from those outside of that particular sub-division – academic or clinical – of a given community. She implies definite actions being taken by students to veil unaccepted practice within an academic environment and condone rather than challenge the differences in behaviour within the professional sub-communities of practice.

6.2.2.2 Taxomony of belonging

The discourse used by Gina within this description is worthy of exploration regarding the concept of identity. Gina appears to superficially distance herself from the actions that she is describing by using "you" in her discourse rather that "I". This suggests that the covert practices that she is exposing are engaged in by others rather than by her. Consciously or otherwise, she perceives herself as a passive observer of this activity, distancing herself from its core, though apparently condoning it by shielding those that do take part. As a passive observer, the extent to which one can fully engage with a community of practice and develop an identity synonymous with that community is limited (Lave & Wenger, 1991, 1999) and it seems that Gina is at odds with where she fits with this wider community.

Furthermore, Gina appears to distance herself from the academic clinical community - i.e. the university-based educators who support students in university-based clinical settings – by the way in which she refers to "they". At the beginning of her quote Gina reflects the presence and inclusion of herself within the actions that she is describing, evidenced by her use of "we". As her narrative develops, her language changes, her collegiality wanes and she appears to distance herself from the behaviour that she recognises as being disparate from genuine healthcare-situated clinical practice. I propose that this distancing adds weight to Gina's sense of ill-fit with her wider professional communities [intentionally plural given my earlier arguments] and challenges her sense of identity, a sense of identity that one might expect to be more firmly developed now within this, her final undergraduate year. Whether it be in an academic or practice-based learning environment Gina will face feedback based on her demonstration of professional competence and disciplinary expectations; she needs to develop strategies to reconcile the practices of the professionally accepted sub-communities she encounters if she is to truly recognise the value of feedback received. Educators from within and across the multiple communities of practice that Gina finds herself in may need to consider how they support her to accept diverse professional practice. This may be a signposting role for university-based educators.

A final consideration of the narrative from Gina is one that might arguably be expected of a final year pre-registration student. Within the quote, Gina's sense of identity seems to be more akin to that of clinical colleagues in practice rather than to align with that of the academic (clinical) community. As a soon-to-be-qualified healthcare professional it is unsurprising that she appears to favour the practices of the clinical community within which she can see herself belonging as a new graduate. It would be unusual, given the usual "second career" move into higher education for most healthcare academics, for Gina to

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preferentially align herself with the practices of the academic community. What is of particular interest though is that whilst Gina recognises the necessary austerity measures regarding patient time allocation in real (i.e. NHS) clinical practice, she fails to suggest any challenge, based on this, to the manner in which students are taught within a university setting in order to maximise authenticity and meaningful professional inclusion in a clinical community of practice.

6.2.3 Alignment and fit

I want now to move on to consider how the importance of a sense of identity appears to influence those seeking to gain membership to a profession-specific community of practice. I am returning again to Eliza and to a feedback interaction that was observed between her and her personal tutor, Rose. Rose is an experienced academic and comes from the same professional background as the course that Eliza is studying. Within her personal tutor meeting with Rose, Eliza was articulating her frustration regarding an interprofessional module for which Rose was the module leader. As module leader and given that this module was interprofessional in nature, members of staff from other disciplines contributed to its delivery. Eliza described the lectures by other members of staff as boring and claimed that they were focused on disciplines other than that of her own studies. She went on to state:

> We are not seeing where [our discipline] fits into it because an [academic from our own discipline] hasn't told us how [it] fits into it … (Eliza)

It appears that Eliza perceives this teaching as not supporting her own professional identity because these aspects of the module are being delivered by colleagues other than from within her own discipline. As an example (and including my own insertion of "nursing" to aid clarity), she is suggesting that only a nurse can deliver material that relates to nursing because only a nurse can make clear the relevance of the topic to the nursing profession. On a superficial level and in the spirit of effective interprofessional and cross-disciplinary working for the greater good of patient care (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) Eliza's view is naive but it illuminates the importance of having an overt confidence in a professional identity when novices are developing a professional role, and a professional presence to students within mixed or interprofessional learning environments.

The importance of students recognising professional relevance and authenticity is furthermore added to by Rose herself. Later in the same personal tutor meeting between Eliza and Rose, they discussed another module that was profession-specific. Within her

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discussion with Eliza, Rose emphasised that the module was "*very* (Rose's emphasis) relevant to [Eliza's professional] practice". By Rose's own emphasis and overt acknowledgement of the profession-specific elements of the course, she is inadvertently drawing attention to the seemingly less favourable and less professionally-relevant aspects. By default, Rose is supporting Eliza's perception that the interprofessional dimensions are of less value to her as a novice healthcare professional than the profession-specific elements of the course because they are less authentic to the profession-specific community of practice into which she is moving.

The integrated care agenda (Collins, 2016; National Collaboration for Integrated Care and Support, 2013) highlights the need for all healthcare professions to not only contribute their profession-specific skills to patient care but also to recognise the need to contribute more generically to holistic patient care. This is such that health and social care is more seamless, patient-focused within a changing health care climate, and cost-efficient. There is international evidence exploring blurred boundary working within healthcare, including use of the Calderdale Framework (Nancarrow, Moran, Wiseman, Pighills, & Murphy, 2012; R. Smith & Duffy, 2010), to ensure that patients are receiving the best care by the right people with an appropriate skillset at a clinically-recognised right time. Based on such work it is paramount that student healthcare practitioners fully understand their role beyond their profession-specific boundary and into wider health and social care.

Rose's unintentional highlighting that the interprofessional module is less relevant to Eliza's professional development than the profession-specific module is of concern. Role-modelling is an important factor within development, both personally and professionally. In considering a role-modelling approach to learning (Armstrong, 2008; Kilcullen, 2007) Rose's apparent belief is troublesome because it may be self-perpetuating within a professional community of practice as new graduates, like Eliza, accept this belief and reinforce it within the community. As Eliza moves from a peripheral place to a more central place within a professional community of practice, she needs to have current and professionally-genuine values. Unintentional learning from unintended feedback is something that educators need to be consciously aware of. The impact of such "learning" from unintended feedback could augment underpinning values and beliefs within a given community of practice that do not develop that community in a positive manner nor meet the healthcare needs of the population.

In order for a community of practice to be reflected as such, that community needs to have a shared understanding of fundamental and underpinning community values and beliefs

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(Fenton-O'Creevy et al., 2015; Wenger-Trayner & Wenger-Trayner, 2015; Wenger, 1998). The needs of healthcare consumers – i.e. patients – and the challenging financial climate in which healthcare services need to be delivered necessitate a different professional view to that experienced during economic buoyancy (Appleby, Ham, Imison, & Jennings, 2010). To meet the financial and consumer demands, healthcare professions need to be able to recognise the diversity of the role that they might play (R. Smith & Duffy, 2010), not only that which is professionally specific. Rose failed to highlight to Eliza the crucial role that the interprofessional module will play within the broad scope of her education toward becoming a healthcare practitioner. It is interesting to consider why this might be so and whether Rose herself did not see the value of the interprofessional aspects of the course or whether she was simply focussed on the profession-specific components.

Both university-based and practice-based educators at a pre-registration level have an important role to play in empowering the next generation of healthcare practitioners. It is essential though that this empowerment authentically reflects the role that the profession has across the spectrum of healthcare. It is crucial that it is not professionally narrow nor unrealistically reflective of the scope and breadth of that profession's contribution to contemporary healthcare service delivery.

6.3 Personalisation

The notion that students expect to receive feedback that explicitly relates to their own work, in contrast to only receiving generic feedback that does not necessarily wholly resonate with their work, is not new (for example, Black & Wiliam, 1998; Johnson et al., 2016; Jonsson, 2012; Juwah et al., 2004; Race, 2005). However, in the quote from Eliza seen at the outset of this chapter she does not appear to be referring to the overt crafting of feedback in relation to her work specifically but rather the interpersonal qualities of the social aspect of a face-to-face interaction:

> It's [face-to-face feedback] more personal. Just a piece of paper or even on the computer, it, yes the person is behind it and they have wrote it, but they're not there and they can't, you can't then turn round and quickly say "oh why did you write that" or even "thank you" just to acknowledge that you've got that feedback. It's just so impersonal getting written feedback. (Eliza)

Whilst the concept of verbal feedback was not individually identified by Eliza within the quote, the contribution of a relationship between the giver (educator) and receiver (Eliza) of feedback was clear. The relational or lifeworld "sociality" aspect of this feedback experience was a direct consequence of the feedback being verbal and thus it gave rise to a dialogic

opportunity. It is this dialogue that seems to have had a meaningful impact on Eliza and there is significant and growing evidence to support this style of feedback (Blair & McGinty, 2013; Bloxham, 2013; Bols & Wicklow, 2013; Carless, 2016; Vardi, 2013). Eliza appears to be identifying the dynamic process of two-way communication as something that she views as important within a feedback encounter. She also argues for the ability to question the provider of feedback through dialogue in order to seek clarification; the use and significance of questions within a feedback encounter will be explored in the "Questions, Reflection and Ownership" chapter.

It is noteworthy that Eliza did not simply make reference to verbal (also described as oral or audio) feedback – the question posed to her by me would certainly have legitimised such a response – but instead draws out the relational elements of the feedback situation that are important to her. It is becoming more commonplace to provide verbal feedback to students via an audio recording (Gould & Day, 2013; Lunt & Curran, 2010) in place of or in addition to written feedback and there is evidence to suggest that healthcare students view it as an effective method of providing detailed feedback (Gould & Day, 2013). The use of audio feedback to written work is becoming increasingly popular across the higher education sector (Zimbardi et al., 2017), though the HEI from where the participants for my research were recruited uses it scarcely across the health provision. I hypothesise that this is likely to be largely due to the lack of exposure to it by educators, but this might offer an explanation as to why Eliza did not explicitly mention this, though nor was she probed to do so.

6.4 Contribution of a Relationship

People within the feedback process are significant within the social aspect of learning. There is a wealth of evidence already published that captures the important role that "people" – particularly educators themselves - have in creating a positive learning environment (for example Armstrong, 2008; Chesser-Smyth, 2005; Gordon, 2013; Kell & Owen, 2009; Kilcullen, 2007; Melincavage, 2011; Papastavrou et al., 2010). The social nature of healthcare as a discipline, akin to other vocations such as teaching, reinforces the role of an effective interpersonal relationship. Embedded within the expectations of a healthcare graduate (Health and Care Professions Council, 2013; Nursing and Midwifery Council, 2010) are interpersonal qualities with both patients and professional colleagues. Poor professional relationships in the workplace – including aspects of communication, leadership, teamworking, respect and trust - were one of the significant failings highlighted by the Francis Inquiry into unacceptable patient care in an NHS organisation (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). This has led to the introduction of a values

based recruitment process within healthcare education and the healthcare workplace (Health Education England, 2016) in order to maximise the recruitment of the right people with the right values and beliefs into training and qualified roles.

Relationships appear to be central to the receipt and utilisation of feedback. The "Purpose of Feedback" chapter has argued for clarity regarding the intended purpose of feedback to augment its appropriate use and it seems that the implicit relationship between giver and receiver of feedback may be crucial within this. Bella was the student who most consistently signified the importance of a relationship to her learning methods. In the following quote she is describing to me a feedback encounter during which she hoped to seek confirmation (though she described this earlier in the quote as clarification) from her university-based educator that she was "doing things right":

> Because I've had her [as personal tutor] for three years she's quite good at guiding me, she tends to guide me from losing my way. Because I've had her for three years she's quite good at making me focus on what I am worrying about." (Bella)

Within this quote Bella appears to be identifying the importance of an established and "knowing" relationship between her and her personal tutor when the purpose of the feedback was to guide her. More specifically, it seems that Bella is attributing this relationship to her personal tutor being consistent over the three years of her course and thus the "knowing" has been incrementally developed over time. This seemingly important concept of knowing the person from whom feedback is being received is recognised by M. Price et al. (2011) and re-emphasised in the work of O'Donovan, Rust, and Price (2015).

The feelings of trust and respect within a relationship appear to be significant to the potential impact of learning from feedback. There is published evidence (D Boud & Molloy, 2013b; Kluger & DeNisi, 1996; M. Price et al., 2010) to support the positive impact that these qualities have on a relationship and there is evidence of the recognition of respect from within my research. In the following quote from Susan, a university-based educator, she is discussing the general qualities of Bella, one of Susan's personal tutees, and their relationship:

> Bella has engaged with tutorials appropriately, and I think she has sought me out and brought her portfolio. She responds to feedback, plans her time well, manages her time well. In terms of the professional relationship, it's been one of respect on both sides … it's just mutual respect I think. (Susan)

Within this quote Susan describes Bella as an organised and proactive student. It appears that "mutual respect" for such self-management strategies is important to Susan within the

lifeworld "project" of sourcing feedback. There is an implicit suggestion within this quote that Susan also possesses such personal qualities, views them in high regard and rewards Bella for her self-regulated learning by acknowledging these [to me]. The qualities of the learner with respect to self-regulation will be explored in more detail within the "Questions, Reflection and Ownership" chapter.

Kinship within a learning environment is important. Within the chapter "Worth and Reward" I argued that this kinship might be augmented within a practice-based environment by more recently qualified "novice" staff being involved in the process of practice-based education. This might strengthen the sociality aspect of the feedback experience and foster a greater sense of belonging within a likeminded community of practice.

6.5 Feedback as Therapy

The "Methodological Approach and Methodology" chapter introduced the significance of a "lifeworld" approach to understanding the feedback experience of students within pre-registration healthcare education. Core to adopting this approach to phenomenology is the exploration of the students'' "self" as it is their unique experience that this research seeks to understand. As a healthcare professional herself, Finlay (2011) suggests that trying to understand the lived experience of an individual using a phenomenological approach is not dissimilar to engaging in therapeutic practice as one is trying to understand the "self" of the social actors within these individual experiences. Whilst the next chapter, "Questions, Reflection and Ownership", will explore this therapeutic analogy in detail within the context of using a questioning approach within the feedback process, it is noteworthy in the context of this chapter to acknowledge whether this view of feedback is unique to healthcare because of the caring relationships that are implicit within healthcare disciplines (Health Education England, 2016) or embedded across the wider discipline of education because of sociality of the feedback experience.

The lifeworld dimension of "sociality" – concerned with relationships – appears to be significant to the lived feedback experience of both students and educators. If a feedback experience includes a therapeutic level of purpose, this is a dimension not usually considered by educators nor readily available unless the feedback process offers a dialogic opportunity.

Finally, learning opportunities may not always give rise to a desired emotional response. Particularly in the practice-based environment, the lifeworld "embodied" experience – i.e.

the emotional experience – may also be significantly different to that which might be anticipated "because it's scary having patients…" (Gina). This embodied dimension to a learning experience is one that cannot be accurately mirrored or realistically simulated in the university-based setting in order to effectively prepare learners to cope with the emotional facets associated with "real" clinical practice. Without a "real" patient being present the authenticity of the relationship between the patient as care-seeker and the student as [student] care-giver can never be replicated fully. Consequently, the limbic responses such as anxiety associated with this lived experience (Melincavage, 2011) cannot be genuinely elicited in a simulated environment and the student is unable to emotionally "feel" what it is like to treat a patient or manage a patient's care until they are in that genuine situation. This means that university-based educators with whom students have, on the whole, a more familiar relationship have limited scope in the extent to which they can support of students with their emotional responses associated with practice-based learning. I suggest that this might, therefore, be an argument for the role of tripartite visits – discussed earlier in this chapter – to purposefully shift from one typically linked to grading to one of emotional student support.

6.6 Chapter Summary

This chapter has argued the significance of people and relationships to the feedback experience. It has explored the concept of person and sense of identity to the value and impact of that feedback, and recognised the worth of dialogue within the feedback process. This chapter has used communities of practice theory and lifeworld dimensions, particularly that of sociality, to understand the lived experiences of feedback from both students and educators. From this theory, it has drawn attention to the importance of authentic practice such that students are best prepared for "real" professional practice and not challenged by a dichotomy of university-based versus practice-based differences.

This chapter has also revealed that learning experiences may elicit emotional responses. Dialogic feedback experiences may give rise to exploration and management of these responses, potentially through a therapeutic lens. This notion of feedback as therapy will be examined further in the next chapter, "Questions, Reflection and Ownership".

Chapter 7: Questions, Reflection and Ownership

7.1 Introduction

The aim of this chapter is to analyse the data around the use of questions and questioning within feedback experiences. It will explore how questioning is linked to a reflective paradigm and consider whether there appears to be any connection between the use of a questioning style or approach to feedback, reflection, and the ability of the student to take ownership of their learning.

This chapter begins with an overview of the purpose of reflection within healthcare education. It then explores the characteristics of the learner and makes extensive use of data from Dawn to support its argument. It also discusses Ann and Freya in the context of them disengaging with the research. The chapter explores how learner characteristics might impact upon the desire or ability to engage with reflection, and it draws on evidence from three educators - Alan, Susan and Diane - to illustrate educator-led strategies to support learning. The chapter moves on to a detailed exploration of how the methodological strategies that are used to scaffold learning might be purposively utilised to promote engagement and self-regulation of learning. The therapeutic aspect of feedback that has been introduced within the chapters "Purpose of Feedback" and "Identity of Feedback" will be discussed in more detail. At the core of this chapter are examples of data which will be explored through the phenomenological lifeworld (A. Ashworth & Ashworth, 2003) lens of "self" and used to situate and contextualise the discussion.

7.2 Reflection

Reflection is an active process that allows individuals the opportunity to learn from their experiences. It is a purposeful activity in which a learner is demonstrating direction and ownership of learning. It is both implicit throughout and explicit (p. 10) within the professional standards that must be upheld to practise as a registered healthcare professional (e.g. Health and Care Professions Council (2013)) in the UK. There is an abundance of established literature around the process and use of reflection in healthcare education including that of Moon (2006), Gibbs (1998), C. Johns (2002 and 2009) and Ghaye and Lillyman (2006) together with the introduction of newer models of reflection to support practice-based learning such as that offered by Barksby, Butcher, and Whysall (2015). Johns (2009) "Model for Structured Reflection" (MSR) is of particular interest in understanding the interplay between reflection, reflexivity and learning. In the MSR

proffered by Johns he is clear in his description of the model – or iterative reflective process – is that it is used in a purposeful and "vision driven" manner. This particular concept of reflection is congruent with it being an active process that one engages with intending to achieve a tangible feed-forward outcome. Outcomes of reflection will now be explored further in the context of health and social care.

7.2.1 Outcomes of reflection

Outcomes of reflection are particular to the "self". The product of active reflection will always be context, learner, situation, and purpose specific, whatever the discipline of learning. This is congruent with the principles of social learning theory as it situates the reflective opportunity – and thus the potential "learning from reflection" experience - at the very heart of the social encounter. The context and situational aspects of pre-registration learning within the health and social care disciplines may mean that the product or outcome of active reflection is not solely beneficial to the learner. It may also benefit the wellbeing of the patient or the reputation of the profession. For example, a student nurse who reflects "in action" (D. Boud, Keogh, & Walker, 1985) and questions his own drug calculation skills whilst administering medication to a patient, does so with the primary outcome of ensuring patient safety and clinical effectiveness. Secondary outcomes from this situation of reflection "in action" may include maintaining the reputation of the (student) nursing "profession" and the university at which the student is studying. For the student nurse himself, he will hopefully learn from his reflection on this potential "near miss" drug error such that he is able to put learning strategies in place to prevent the possibility of similar occurrences in the future.

If another student were faced with administering the same medication to the same patient in the same clinical situation, the "learner" aspects of the situation in terms of the skillset that the second student brings with her may vastly alter the potential learning opportunity. This second student may be very confident in her drug calculation skills and reflection "in action" for this student may simply confirm her accuracy of administration. Whilst the lifeworld "project" aspects of this hypothetical clinical example are constant, it demonstrates the difference that the individual "self" as a learner may bring to the learning experience.

7.3 Ownership and Reflection

Cashell (2010) defines reflection as having a positive relationship with learning and personal development within the broad context of healthcare education. I have already made a case throughout this thesis that reflection is a fundamental requirement to support the ongoing

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learning and professional registration of qualified health professionals (Health and Care Professions Council, 2012; Nursing and Midwifery Council, 2017). The outcome of taking ownership of one's learning may not always be in the feed-forward positive sense – one may equally take ownership of their learning by making an active decision not to engage with a learning process. This learning process could be feedback. This raises an interesting debate about the inherent academic relationship between ownership and reflection. Within pre-registration healthcare education, there is both historical (D. Boud et al., 1985) and current evidence (Bulman, Lathlean, & Gobbi, 2014; Fragkos, 2016) to support the integration of reflection within the curriculum but it need not have the desired impact on the responsibility and drive for learning.

7.3.1 The students who dropped out

Two students who were initially recruited to take part in this research disengaged after undertaking their initial interviews with me. These students are Ann and Freya. Table 4 in section 3.5.4 details their profiles. Both appeared very keen to take part in the research initially, with Freya being the first student recruited almost immediately on me sending out my participant recruitment request and Ann being so willing to take part that we met away from the university during her summer vacation. Despite multiple attempts by me over a number of weeks after the initial interviews to contact and re-engage Ann and Freya in the research such that I could explore feedback experiences with them, both failed to respond to any further contact. These are two students who initially appeared very interested and motivated and then this interest and motivation was suddenly lost. Conversely, the other five students who continued to engage with this research did so eagerly, particularly noticeable in the case of Bella and Eliza who were consistently keen to discuss a wide range of learning experiences that involved some form of feedback.

Deep intrinsic qualities of students may account for differences in student engagement. These qualities are those that external factors are difficult to influence within the "self" such as an "embodied" lifeworld sense of achievement from helping a researcher [me] collect data; these qualities are deep-seated within the individuals' disposition. Had a sense of accomplishment for helping another person [me] been the primary gain following their initial interview – rather than, for example, a sense that time has been taken away from other important and more personal tasks – and had this gain been intrinsically valued by Ann and Freya as fundamental embodied components of their "self", they may have continued to engage with the research. This is only one possible hypothesis as to why Ann and Freya may have disengaged with the research. Another may be that the content of their initial interview gave rise to uncomfortable feelings of "self" within or at the boundary of
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(Fenton-O'Creevy et al., 2015) one or more of the multiple communities of practice in which they find themselves: "self" as a learner, "self" as student healthcare professional, or indeed "self" as a committed and active research participant.

What is important to the "self" is obviously different between individuals. Everyone is motivated and driven by different factors and priorities at chronologically different times and Ann and Freya possibly prioritised "outcomes" of or gain from achievement differently to, for example, Bella and Eliza who were highly engaged participants. This hypothesis is simply that because the disengagement of Ann and Freya meant that no further data were gathered from these students and therefore there was no opportunity to explore this supposition any further.

7.3.2 The impact of motivators

The remaining five students each appeared to be motivated in their goal to make progress towards becoming a qualified healthcare professional. I want to make a clear distinction here between motivation and confidence because whilst all five students (Bella, Carl, Dawn, Eliza and Gina) appeared motivated by something to achieve their goal of successfully completing their pre-registration course, not all appeared confident in their ability to achieve this goal. This distinction is important because the motivation to engage in an activity has been shown to have an effect on confidence levels. Kluger and Van Dijk (2010) and more recently Jiang and Kleitman (2015) report that perception of confidence tends to be task-focussed and thus directly situated in the social construct within which it occurs.

Jiang and Kleitman (2015) examine the purposely divorced motivational aspects of self-protection and self-enhancement and relate these to motivation. They found that individuals who were motivated to be self-protective (i.e. their primary motivation to succeed in a task/situation was to protect themselves from failure) tended to demonstrate lower confidence levels, whilst those whose motivation was self-enhancement (i.e. their motivation to succeed in a task/situation was to enhance themselves further) or with a desire to increase their self-esteem demonstrated higher confidence levels. This demonstrates the importance of recognising the underpinning want of motivation from the perspective of the learner's "self" in order that it can be more accurately understood in relation to their level of confidence. Furthermore, these authors claim that judgements about confidence that are made "in vivo" (Jiang & Kleitman, 2015; p. 222) – i.e. during the task - predispose immediate reflection [on action] in response to engagement with a cognitive skill. They suggest that this is a positive action that subsequently promotes further learning based on the confidence outcome. This suggests that both higher and lower
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confidence level can have a direct effect on learner motivation, albeit based on different motivational drives. This augments the argument presented in the "Worth and Reward" chapter around the potentially detrimental effects of feedback that is not well managed.

7.3.2.1 The significance of others

The influence of people and relationships will now be explored with regards to ownership. It is clear that Dawn is motivated by external factors, with little or no regard of her own "self" gain. Whilst an able student based on her summative assessment profile, Dawn lacks confidence in her own ability and yet remained motivated to complete her course. This first quote from Dawn highlights the importance of her daughter as an external motivator in her strive for success:

> I always have my daughter at the back of my mind, sort of like you're going to be able to make her life better by reading it [the course material] and doing it [reading] and passing your exams and stuff, so that's always been there. (Dawn)

The importance to Dawn of enriching her daughter's life through her own success is evident within her quote. Interestingly, in this response to my question about what motivators she has, Dawn does not reflect any of her own personal gains, only those by proxy of her daughter. Dawn is motivated to succeed for external gratification rather than intrinsic reward. This suggests that Dawn is validating herself and her achievement not by rewarding her "self" but by the "sociality" aspect of the lifeworld in the form of others, in this case her daughter, as an alternative reward. Dawn's worth as a mother to be able to provide for her daughter is more motivational to her "self" than gain as an individual learner. It seems that the mother "self" of Dawn is more important to Dawn than the learner "self". This echoes the earlier argument regarding Dawn that was presented in the "Worth and Reward" chapter.

Another example of Dawn's narrative suggests her need for external acknowledgement of success. In this example Dawn is describing how and why a particular verbal feedback experience was useful to her:

> Because it was somebody else [a lecturer] understanding that I have learnt my theory and everything that they've taught me…

Followed by:

> She [the lecturer] started with the really positive elements …. And she were impressed because maybe the couple of months before the exam, she was really worried about me, thinking she's not going to be able to do it [pass the assessment]

> … and I think it's been really useful for me to know that I'm doing something right. (Dawn)

In this quote Dawn views external verification of learning by an educator as important. The first part describes that a useful feedback experience to Dawn is one in which she gains external confirmation of her learning. Dawn makes no reference to the authenticity of the feedback with regards her own developing professional practice, nor of how the feedback helped her to confirm previous learning or scaffold further learning (Race, 2005). For Dawn, it appears that the only focus was external confirmation of knowledge. Noticeably here is the implied passiveness of the learning process by Dawn's use of the phrase "everything that they've taught me"; self-regulation and ownership of learning will be considered further in the next section.

The second part of this quote further supports the value that Dawn places on the behaviour of another, in this case the lecturer, in recognition of her learning. Dawn's use of the phrase "she were impressed" suggests that she perceives the positive acknowledgement of her learning favourably and that she gains reward and pleasure in her actions of learning being externally recognised. Furthermore, at the end of the quote Dawn makes explicit the value that she places on having her learning verified as correct as part of the feedback experience. Whilst this is perhaps not surprising of any learner, it strengthens the argument that, in Dawn's case, external confirmation of success is of particular importance to her "self".

These quotes appear to demonstrate Dawn as perceiving her successes as being primarily significant to others – her daughter and her lecturer – in contrast to her verification that they are fundamentally beneficial to Dawn herself. It seems that in this discussion she is unable or unwilling to recognise achievements for her as "self" implying that her own personal presence and gain from the feedback experience is, at best, less important. In consideration of lifeworld dimensions (A. Ashworth & Ashworth, 2003), the lack of a presence of "self" within her achievements could reflect Dawn's lack of confidence in herself and/or genuine lack of acknowledgement that she herself is important and worthy in the context of the outcomes of learning. Here, and also earlier in this chapter, I have discussed issues that appear to reflect how Dawn views herself as a learner in terms of a clear "learner" identity; this concept will be discussed in the next section.

The two quotes from Dawn are also interesting when considered together. In the first quote, Dawn places her daughter central to her own learning agenda. In the second quote, she focusses on the impact her learning had on her lecturer, i.e. the gain for Dawn was that her

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lecturer was impressed by her learning. Together, these suggest that Dawn's "self" is influenced by how she believes others perceive her and that relationships are important to her. Dawn appears to be covertly veiling her own gains from learning with the identity of others – her daughter and lecturer. In considering an identity, Dawn certainly recognises herself as a mother to her daughter within the known "community" of a family with which she is familiar. Dawn is confident in this maternal role and motivated to ensure that her daughter is well-provided for. The construct of "mother" would not have been inherent within Dawn's "self" and would have been learnt by her in those initial days, weeks, months and years of her daughter's life. As supported by Christie, Tett, Cree, Hounsell, and McCune (2008) it is likely that the social structures, or communities of practice, with which she was familiar influenced her formation of this new "self as mother" identity. This structural influence of a community of practice appears to be significant in the adoption of a new identity.

In contrast to feeling comfortable as a mother, Dawn does not appear to view herself primarily as a learner. I have already claimed in the "Worth and Reward" chapter that Dawn does not appear to perceive herself as worthy of feedback that relates to her as a learner. In a learner-focussed clinical setting Dawn's view was that the educators should be prioritising giving feedback to other students who were currently treating patients at the expense of putting her "self" as a learner at the centre of the feedback opportunity. When exploring her educational background in my initial interview with her, Dawn discussed her educational journey to date and she explained that she felt that an earlier further education environment had not suited her learning style:

> It was really, because I'm not an A [grade] student and I think there was a lot of focus on the top students and me being more a B, C, wasn't, I didn't feel that I was in the right environment or the lecturers didn't sort of, sort of just pushed me to one side because I wasn't one of them top students … so it was very difficult for me to have a rapport with the lecturers and to really help me really. (Dawn)

Dawn's narrative highlights that she has previous experience of perceiving herself as different to other learners and that this was seemingly reinforced by, in her view, the behaviour of educators during her further education college years. Dawn saw her peers in the further education college as students who were higher-achievers than her (despite her now being identified by me as an able student) and she believed that the educators invested time in these "top students" to her detriment. Whilst I did not pursue her view of other students with Dawn, she did not freely mention the support she saw being given to students who were less able than her. It is likely that weaker or less able students also had time invested in them by the college educators – as this is certainly where maximum

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support tends to be invested in higher education (Thomas, Hill, O' Mahony, & Yorke, 2017) given the goals set for and by academic institutions – and that often this is the student group who appear to be worthy of academic investment. The apparent lack of investment by others in Dawn as a learner during her further education years and the relationship that she felt she had with her educators has not allowed her to develop a positive learner identity, moreover it appears to have reinforced a negative perception that is continuing into her pre-registration healthcare education.

Dawn's relationship with her "self" as a mother in comparison to her "self" as a learner is worthy of further scrutiny. As a mother Dawn has a community of practice in the nature of her own family and wider society as a point of reference. In contrast, as a learner Dawn has experiences of being an outsider. Dawn's use of the phrase "just pushed me to one side" suggests that she feels as though the academic community within which she was learning did not value her as a learner, and suggests that this generated an emotional response. It appears that Dawn has not had the positive influence of an academic community within her educational history by which to develop as a learner. Dawn is the first member of her family to go to university and therefore she does not have a firm point of reference nor a positive societal or community influence by which to role model (Eick & Reed, 2002) her learner identity (Reeves, 2009). Rather the opposite of feeling valued as a mother, her worth as a learner has, in fact, been dismissed by others and therefore subsequently by her.

7.3.3 Developing a learner identity

Exploring the concept of "self" through the lens of learner identity offers an illuminating view of Dawn's situation. Drawing on the "theory of situated learning" described by Lave and Wenger (1991), it is recognised that the developing "self" is shaped by the social practices with which one actively participates. I intentionally focus on active, rather than passive, participation here because in order to achieve maximum [potential] gain from learning (Mackaway, Winchester-Seeto, Coulson, & Harvey, 2011) one needs to be able to recognise those practices which have the greatest potential impact. In order to be able to recognise and maximise learning as an outcome of a [socially constructed] experience (Kolb, 2015), a learner needs to have the skills and desire to be able to forensically explore the processes and outcomes of the experience – a process that requires active engagement. In order to develop the "self" as a learner – and thus develop a learner identity (Christie et al., 2008) - it is important to be able to identify when learning has occurred, what the learning is and be able to purposively use these positive learning strategies to support goal-orientated, or "vision-driven" (C. Johns, 2002) ongoing learning.

In order for a learner to be able to use the skills and strategies that are most likely to have the greatest positive impact on their ongoing learning, it is essential that he/she is firstly able to identify these particular strategies. Issues regarding the identification of strategies will be considered later in this section but educator expectations regarding such strategies will first be discussed.

Educators expect that students are able to use the feedback offered to them to independently identify which tools and strategies are likely to have the best outcomes for them, thus the greatest impact. This suggests that, by the direct action of the educators, they want to foster an autonomous and independent learner in the students (Mckendry & Boyd, 2012), despite this sometimes being at odds with early acquisition of professionally-constructed competencies (p. 216). One example of this is that, on offering feedback to Eliza about her research-focussed written work and particularly about how she was using quotes from her research data within her writing, her educator, Alan, made it explicit that he expected her to act on, and take responsibility for and ownership of the feedback that he had offered her. Following the feedback offered by Alan and the assumed "sense making" of this feedback by Eliza, their discussion included Eliza making suggestions as to how she felt that she should move forward with this piece of work. Alan then simply stated to Eliza:

> The ball is back in your court now. (Alan)

It is noteworthy here that Alan appears to purposively not verify Eliza's understanding of his feedback. The fact that his response does not include an overt correction of her suggestions implies that her ideas appear reasonable to him but there is a risk of misinterpretation by both Eliza and Alan in this scenario. Without overt dialogue to establish a "shared understanding" (Blair & McGinty, 2013) about the meaning - both intended and interpreted - of what is offered in the feedback, both parties are making an assumption that the other is accurately understanding them. Following my observation of the feedback experience between Eliza and Alan, Alan is clear in his subsequent interview that he believes the intended message of feedback is not always accurately understood by students:

> Some feedback that we [educators] give doesn't do justice to the students because they don't understand the feedback. It's waffle, it's academic speak. (Alan)

The earlier "Purpose of Feedback" chapter has argued that clarity as to why feedback is being offered is fundamental to student learning. When I directly explored this particular feedback experience further with Alan he was very clear about what his intention was in supporting Eliza with her writing:

> [I] wanted to nudge her towards [making the changes], but not be directive. Students need to do some of their own thing. (Alan)

This quote indicates that Alan's intention in this instance was one of guidance and encouragement, providing evidence to confirm that he was not intending to verify Eliza's ideas about how to change her work as correct. This quote also indicates that Alan believes that students need to take responsibility for their own learning. There is a genuine challenge for educators who need to empower learners to take more responsibility and ownership for their learning because it is a skill needed on qualification (Health and Care Professions Council, 2012; Nursing and Midwifery Council, 2017), and yet they need to retain sufficient opportunity to "check out" student understanding for risk of misinterpretation.

The acquisition of appropriate learning strategies are needed for effective learning. Several times within this chapter Dawn has been discussed in a manner that highlights her skills as a learner. In the context of seeking external verification of learning, Dawn said:

> … and I think it's been really useful for me to know that I'm doing something right. (Dawn)

Dawn's apparent lack of being able to "know" for herself whether the skills that she is demonstrating are correct or otherwise begins to expose her inability or unwillingness to critically explore and self-regulate her learning. This lack of "self" knowing is accentuated by the earlier discussion about Dawn's measure of success and motivation in which she requires others to profit from her learning, rather than seek and recognise gain as a learner herself. Together, these examples appear to present Dawn as a learner who does not to use analysis or reflection of "self" to help focus and direct her ongoing learning.

It is crucial that healthcare students are able to recognise and attend to the strategies that enable learning and capitalise on their gains, not least because it is a post-registration regulatory expectation (Health and Care Professions Council, 2012; Nursing and Midwifery Council, 2017). I argued earlier that it is not unreasonable for Dawn to validate her successes by the impact that these have on other people, such as her daughter. However, it is essential that learning strategies are developed for the benefit of "self" if they are needed to support professional engagement and mobility within a professional community of practice. It is clear that some students recognise and understand what strategies work best for them - or are essential requirements of learning within a given community of practice - in their quest to maximise learning outcomes:

> They [qualified clinicians] just reflect on themselves because I think that's what you've got to learn [to do] when you're out in practice. You reflect on yourself … because you're not always going to have, you don't have somebody there when you're out in the real world. (Dawn)

In this quote, Dawn appears to acknowledge the fundamental skill of reflection in the "toolbox" of ongoing learning strategies required of a qualified healthcare professional. It is important that Dawn is able to recognise this fundamental requirement at this final stage of her pre-registration education in order that she is best prepared for the authenticity of the professional workforce. Learning through submissive methods does not prepare pre-registration healthcare students well for what is expected of them post-qualification. Without the skills to identify, direct and engage in ongoing learning, qualified healthcare practitioners will find it difficult to evidence their necessary learning and thus maintain professional registration. Healthcare regulators are not solely seeking factual information at the point of re-registration (HCPC) or revalidation (NMC) that states an encounter with learning opportunities, instead they are seeking evidence that learning has occurred from active engagement with these learning opportunities and that a registrant's professional practice has developed as a consequence of this engagement. This further supports the notion that for learning to occur, the socially constructed lived learning experience needs to be explored in detail by the learner and for this to happen, learning must be active.

The position one has within a community of practice is also affected by active learning. As a member of a community of practice, the development of one's own professional practice as a consequence of actively engaging with socially constructed learning opportunities begins to alter one's position within that said community. Over time, the community of practice is influenced, manipulated and "co-constructed" (Hammond et al., 2016) by newer members who have actively engaging with learning as a member of that community. As a result, the fundamental "being" of the community itself begins to change. In order that, as qualified healthcare practitioners, new graduates are able to begin to move from the periphery of a community of practice towards its centre – so reflecting the developing kinship with fellow members (Wenger, 1998) in terms of skills, values and behaviours, and begin to influence the specific construct of that community – they need to be able to direct and govern their own learning. The outcome of learning as one moves from novice student to experienced student through to [novice] qualified healthcare practitioner (Arreciado Maranon & Isla Pera, 2015; Benner, 1984; Dracup & Bryan-Brown, 2004; Hammond et al., 2016) needs to be on self-direction and self-regulation, both of which rely fundamentally on personal exploration and self-verification of learning. These depend on the individual healthcare practitioner's ability and willingness to take ownership of their own learning.

Christie et al. (2008) articulate that "learners are not passive recipients of teacher knowledge, but co-producers of meaning" (p. 568). With the importance of taking ownership for one's own learning and co-production of meaning in mind, I want to revisit this quote from Dawn in which she describes why she perceived a particular verbal feedback experience as useful:

> Because it was somebody else [a lecturer] understanding that I have learnt my theory and everything that they've taught me… (Dawn)

It appears that Dawn viewed her role within this specific feedback experience as largely passive. She states that she has learnt her theory which suggests her acquisition of factual knowledge rather than of the inquisitive and analytical exploration of clinical information that one might expect of a final year pre-registration healthcare student. Dawn's acknowledgement that she now has confirmation that she has accurately learnt "everything that they've taught me" appears to situate the responsibility for controlling her learning onto her educators. There appears to be no overt desire from Dawn to engage with the development of a true learner identity nor with the co-construction of professional healthcare knowledge. Dawn appears to be divorcing herself from taking ownership of her learning by the language that she uses, expecting to be passively taught through being involved in the experience alone (Mackaway et al., 2011) rather than by active learning within and from the experience in support of contributing to the ongoing development of profession-specific knowledge (Christie et al., 2008). I have already made a case for the need for active learning to underpin professional healthcare practice and this will now be explored in more detail, focussing on the individual learner.

7.4 Developing a Self-Regulated Learner

Cashell (2010) suggests that reflection is a coping mechanism - particularly in relation to negative clinical outcomes - that qualified radiotherapists use to help manage difficult aspects of clinical practice that they encounter. Whilst this empirical work was profession-focussed, in light of the fact that all healthcare professions manage profession-specific difficult clinical situations, there is no reason to suggest that these findings may not be relevant to other professional groups. What is interesting about this work is that it reports that one barrier to engaging in active reflection is the reluctance to show or fear of showing weakness to others. It suggests through a quote from one participant (Cashell, 2010, p. 134) that this is particularly so for someone "new" to a professional community. More recent work by Bulman et al. (2014) supports the notion that reflection has the potential to be an emotionally-laden activity and, I propose therefore, one that should not be

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undertaken lightly or without appropriate support. Whilst reflection should be used to critically explore the "self" within experiences, doing so may give rise to feelings of unease. I argued earlier in this chapter that learners whose primary goal is self-protection tend to have lower confidence levels than their counterparts who are driven by self-enhancement (Jiang & Kleitman, 2015). I now submit that this additional layer of low confidence, together with the existing desire to protect the "self" by avoidance of exposing one's vulnerability through reflective engagement, strengthens the notion that new members of a community of practice may not be open to reflective engagement.

Transposing this to the context of a learner and a professional community of practice presents a situation in which the student healthcare professional is, as a "new" member, on the margin of a community (Lave & Wenger, 1999), unwilling to or being fearful of exposing their weakness (Cashell, 2010) and therefore not effectively engaging in active reflection. Conversely, more expert clinicians are situated more centrally within a community of practice (Fenton-O'Creevy et al., 2015), become increasingly confident in their reflective skills (Cashell, 2010) and recognise the professional gain from such inward-looking analytical learning tools. For students who are "new", unfamiliar or uncomfortable with a community of practice within which they are situated, the dilemma is then how they might best be supported to overcome fear, and permitted – possibly encouraged – to potentially show their weaknesses by engaging in reflection. Engagement in reflection would provide a vehicle for the students to learn from their critically-explored experiences and become empowered to take more ownership of their learning (D. Boud et al., 1985) – skills necessary of a graduate healthcare professional.

The findings of this research have argued that for learning to be authentic and meaningful for future healthcare practitioners who are required to make clinical decisions and problem-solve patient-by-patient on a daily basis, it needs to involve active engagement (Mackaway et al., 2011) on the part of the learner. To put this in context, whilst the rote learning of anatomical knowledge and physiological principles might provide a firm foundation for understanding the cardiac system and homeostasis, this is without value if the nurse cannot then utilise this underpinning knowledge within an authentic clinical situation. Without a pre-registration healthcare student consciously attending to an experience before (to plan), during (to reflect and modify) and after (to analyse and action plan) it (D. Boud et al., 1985), the opportunity for the student to maximise learning from exploration of the experience is lost. A questioning approach might be used to assist students with this self-regulated analytical process.

7.4.1 Use of questions

A significant theme that emerged from the data is how and why questions were used within the lived feedback experiences that this research explored. This theme arose from both students and educators and was identified in both university-based and practice-based settings. It is a well-established practice to use questions within healthcare education to guide a student through the process of reflection in order to give authenticity to their learning experiences and to help the student take ownership of their learning. Reflective models vary in format (e.g. Barksby et al., 2015; Branch & Paranjape, 2002; Hannigan, 2001; C. Johns, 2002) but all use a questioning style to help structure the learner's exploration of an experience.

The use of a questioning style within feedback is overtly supported by one of the university-based educators, Diane. Diane stated that she poses questions within her feedback because she "does not want to be doing all the work for the students" by offering them the answers in the form of instruction. It is interesting that Diane's initial focus for her use of questions was around who was taking responsibility for the learning. Diane appears to want to empower her students to be responsible for their own learning – a requirement of graduate healthcare practitioners (Health and Care Professions Council, 2013; Nursing and Midwifery Council, 2010) – but this seems to be a secondary outcome after her primary concern about her own academic workload. Diane was very clear about not wanting to undertake the instructional workload herself rather than recognising the opportunity to use a questioning style to facilitate a deeper level of enquiry in the student.

Another academic, Susan, discussed her explicit and purposive use of questioning to help students reflect on their progress. Whilst it was evident that Susan expects students to engage in the agency of learning from feedback, she described herself as wanting to be a "therapist" to the students when she first moved from clinical practice into higher education. She explained to me that it took some time for her to realise that she had to focus on the academic rather than pastoral dimensions of learning and signpost the students to other services when their need was pastoral:

> [You are] in a semi-therapeutic mode when you are supporting someone because you are helping them find their own answers, aren't you? (Susan)

It is clear from Susan that she views her role within a feedback situation as offering guiding empowerment to the student. Core to her approach is her own professional clinical background that was focused on enabling individuals to maximise their quality of life through their own actions and engagement. This is interesting as educators tend not to be

taught the attributes of "skilled facilitation" (p. 1230) necessary for reflection despite this being a clear requirement of successful academic and clinical educators from the post-registration nursing work of Bulman et al. (2014). Based on her previous clinical role and insight associated with it, it seems that Susan is able to recognise that she has been able to transpose her enabling model of healthcare – in contrast to a biomedical model of healthcare that is often implicit within some professional disciplines - into the educational arena. As such, Susan is able to utilise quasi-therapeutic skills with students to promote ownership of learning.

True to all reflective models is guidance of the learner through some form of explorative structure, as has already been discussed with the MSR by Johns (2009). Evident in several reflective models, including that of Johns (2002 and 2009), are a formalised set of questions to guide the learner. These questions guide the learner through both an introspective and outward-looking account of a socially constructed experience such that they have the best opportunity for maximum learner outcome. Bulman et al. (2014) cite the 1998 influential work of Brockbank and McGill who claim that the use of dialogue and questioning is pivotal to critical thinking and explorative reflection, and their own work further supports the impact that a questioning dialogue can have on the development of a learner.

The work of colleagues in the university whose primary role is to help students develop their academic skills is interesting. One colleague, Alan, explicitly reported that he "works and teaches through provocation" in that he purposively uses challenging questions with students in feedback situations in order to empower them to take responsibility for their own critical review of their work. Alan's language is of interest in that even though he is talking about empowering the students, he still refers to him "teaching" rather than to the student learning. Situating this in the context of lifeworld "sociality" (A. Ashworth & Ashworth, 2003), this questions whether Alan perceives a power differential between teacher and learner, in contrast to the partnership that was seen earlier in the quasi-therapeutic example by Susan. Susan's language of "supporting" learners in the context of the feedback process suggests more of an equal relationship and appears to shift the balance of responsibility to the learner. Her pedagogical style appears more enabling in its focus and, through this, is more encouraging and scaffolding (Kelsey & Hayes, 2015) to the [learning from] feedback experience.

In their nurse education work, Kelsey and Hayes (2015) describe scaffolding structures as non-permanent tools that support and guide student learning, rather than as permanent

features or ones that dictate learning. They consider reflective tools as one way by which scaffolding may occur. With the support of Hargreaves (2004) who suggests that the product of learner reflection is often modified in practice to meet assessment criteria, Kelsey and Hayes (2015) go on to suggest that reflection in healthcare education may, in fact, constrain learner development rather than foster it. Of particular note here is the underpinning work by Hargreaves (2004) and Hannigan (2001) who both suggest that learners may falsify their outcomes of reflection in order to evidence what they believe their educators want to see. Such false learner practice would prohibit genuine learning from an experience and presents as a challenge for educators if reflection is to be used to successfully scaffold and enable the ongoing learning of healthcare practitioners. Bulman et al. (2014) suggest that often the institutional culture – or culture within a community of practice – needs to be explored further in order that the real value of reflection can be optimised by it being genuinely embedded into its "being".

7.5 Chapter Summary

This chapter has explored the relationship between the facets of questions, reflection and ownership in the support of learning from feedback. It has used quotes of data, and social learning and communities of practice theory to contextualise this exploration and understand the lived experiences of the participants.

This chapter has identified that reflection tends to be structured in a questioning manner and that some educators use questions within feedback as a matter of course. The underpinning purpose for educators using questions within feedback appears to be inconsistent, with some educators using it to empower the learner and others using it to help manage their own workload. This chapter has also provided evidence to suggest that reflection does not always result in a positive gain for the learner and there is concern by some learners, particularly those new to a community of practice, about how engagement with reflection might expose their weaknesses.

Throughout this chapter the need for healthcare students to develop skills of ownership and learner self-regulation has been underpinned by regulatory requirements. This chapter has argued that it is important that students invest in their learner "self" to help them form positive learner identities. Reflection is a tool by which one might impose one's own verification of learning in order to develop a stronger learner "self". Finally, this chapter has argued that outcomes of engagement in reflection may assist novice learners to become fuller members of a community of practice.

Chapter 8: Synthesis of Findings and Conclusion

8.1 Introduction

This study is concerned with exploring the lived experience of feedback from the perspective of those directly involved in it. I claimed in the "Framing the Question – Context and Theory" chapter that there is a gap in the evidence with regards the consequences of feedback on student learning. The primary aim of this study was to understand the perceived value and impact of feedback on ongoing pre-registration healthcare student learning.

This chapter draws together the significant findings of this research and indicates how these findings contribute to new knowledge. It discusses the implications of this new knowledge within the agency context of pre-registration healthcare education. This chapter also discusses the limitations of this research and, based on the findings of this study, suggests recommendations for further research.

The chapter begins with a reminder of both the wider context of the research and my personal interest in the topic. It discusses the key findings of this research and provides an argument that there appear to be a number of fundamental facets that my participants perceived significant to their ongoing learning. Based on the experience of my participants, I put forward a model to depict the requirements and relationships between these to support the value and impact of feedback on the ongoing learning of pre-registration healthcare students.

8.2 Revisiting the Context and Personal Interest

The Teaching Excellence Framework (Department for Business Innovation & Skills, 2016) considers metrics that are reliant on successful student learning. The National Student Survey (Higher Education Funding Council for England, 2014) has for many years captured data from students that allows them the opportunity to rate aspects of their course and wider learning experience that are associated with assessment and feedback. There is extensive published literature on feedback (for example Bols & Wicklow, 2013; D Boud & Molloy, 2013a; Clynes & Raftery, 2008; Diamond, 2004; E. Smith & Gorard, 2005; Vardi, 2013; Zimbardi et al., 2017) some of which supports the notion that students are often more focused on "verification of learning" (Black & Wiliam, 1998; Hattie & Timperley, 2007; M. Price et al., 2011) than learning from the feedback received from the marker. Feedback
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is not only associated with assessment and awarding of a mark, and within the healthcare disciplines it is commonplace for feedback to be offered throughout the course in both university-based and practice-based learning environments. In order for students to develop the lifelong learning skills expected of them as a qualified healthcare professional (Health and Care Professions Council, 2012; Nursing and Midwifery Council, 2017), they need the opportunity to develop these in a safe, "low risk" environment (Ferrell, 2012) that will offer them the opportunity to learn.

Learning from feedback is crucial to the development of skills and knowledge both specific to the professional healthcare disciple that the student will enter on qualification, and generic across many of the healthcare disciples (Health and Care Professions Council, 2009, 2013; Nursing and Midwifery Council, 2010). It is essential that educators of pre-registration healthcare students understand as fully as possible the value and impact of their pedagogical practice to support maximum student learning (Nursing and Midwifery Council, 2008).

Workload priorities also necessitate the need to explore the outcomes of interventions such as feedback. Academics in higher education are expected to manage competing work streams and this means that time, as a resource, must be well-managed. As practice-based educators in a healthcare setting whose main concern is patient care, it is essential that time invested with students is well employed and with meaningful impact. Consequently, educators who support pre-registration healthcare student learning in either an academic or clinical environment must use their time wisely.

Graduates of pre-registration healthcare courses need to not only be fit for their academic award (The Quality Assurance Agency for Higher Education, 2008) on successful completion of their course, but also fit for practice such that they are able to make a meaningful contribution to healthcare delivery as a qualified professional. It is essential that their pre-registration learning experience prepares them for the requirements of ongoing registration as a qualified healthcare practitioner and therefore the authenticity, breadth, scope and integrity of the learning experience is fundamental to this. This means that pre-registration healthcare learning needs to include the profession-specific knowledge and skills but also the skills that graduates require to examine their own skillset and direct their own learning needs as a registrant practitioner (Health and Care Professions Council, 2012, 2013; Nursing and Midwifery Council, 2010, 2017).

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This research has explored the lived experience of feedback through the "voice" of the students and educators engaged in the process. Taking an interpretive phenomenological approach to this research has allowed me the privilege of understanding the experience from the perspectives of the participants. As an observer of genuine feedback interactions I was able to explore with the participants the nuances that were specific to healthcare education, as well as more generic educational aspects.

8.3 Contribution to knowledge

From the lived experiences of the participants who took part in this research there appear to be a number of intertwined core facets that together seem to influence the value and impact of feedback on ongoing learning for pre-registration healthcare students. These will now be considered in turn.

Relationality

Utilisation of the community of practice theory by Wenger (1998) allowed this research to identify the challenges that these student participants encountered in relation to feeling part of a likeminded community. The "Identity of Feedback" chapter explored the tensions felt by the participants when being peripherally located in multiple communities of practice and the sense of ill fit that this generated. As novice healthcare practitioners there was evidence from the student narratives that feedback within a new environment often created an embodied, or emotional, response (Christie et al., 2008; J Sargeant, Mann, Sinclair, Vleuten, & Metsemakers, 2008; J. Sargeant et al., 2011) as the student strove to belong.

Belonging to a community of practice with a common purpose was a challenge for some of the students. In particular, I provided evidence from Dawn who experienced tension which appeared to stem from her being unsure about her purpose within a learning situation. The lifeworld "sociality" aspects – which I will call "relationality" to communicate the meaning of the relationship between aspects – of Dawn's experience were significant to the perceived impact of her feedback experience. This research has illuminated disconnect with regards the primary purpose of a learning situation, with clear tensions between healthcare delivery and learning, and inconsistencies between authentic clinical practice and university-based clinical practice. It is fundamental that learning environments are clearly labelled as such in order that students understand that their role within them is learning. This links to evidence from the research data that signals that students do not always recognise potential feedback situations, there is ambiguity regarding purpose of feedback and that learning from feedback is not always immediate.

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This research has also highlighted that there is a gap between the situated position of a novice and an expert within a single community of practice. The community of practice in which a student is placed to learn needs to be learning-focussed and clearly articulated by educators as a learning space. Educators need to give students permission and encouragement to expose their learning needs without being fearful and take ownership of their ongoing learning such that they are fit for practise as a healthcare professional on qualification.

Purpose

This thesis has presented a chapter on the "Purpose of Feedback" which articulates the difficulties that students face in understanding feedback and the lack of clear direction that some students appear to experience when engaging with feedback. This research has shown that it is essential that the behaviour of educators is intended and their feedback intentional as there is some evidence that the language used by educators may have unintended consequences. There is suggestion from the research data that this is more acute if there is no opportunity for the student to clarify their understanding of feedback through dialogue with an educator.

This research gave rise to surprising evidence that some students and educators align feedback with therapy. My adoption of a phenomenological approach to this research, through which the participants were invited to discuss their lived feedback experiences, was welcomed by some as a form of healing. This is interesting from the perspective of my participants being situated within a healthcare discipline in which nurturing and caring are expected. As my participants were all drawn from a healthcare background, my research is unable to indicate whether this finding is unique to healthcare or more widespread. It does, however, highlight the multi-layered interpretation of feedback by its users, suggesting that feedback may have more than one purpose. Furthermore, the descriptions of experiences brought to life through the phenomenological approach show the ambiguity and contradictions regarding the purpose and essence of feedback due to the complexity of the experiences explored.

Self

This research has identified a significant tension for students between their quest to take ownership of their learning and seek direction and explicit guidance from an educator. Whilst discussing this within the "Self", this is undoubtedly also linked to "Purpose",

providing an illustration of how these aspects of the feedback experiences are entwined within one another. There is evidence that students are challenged by defence of their performance versus engagement with feedback for learning. Also implicit within the "Self" and interlinked to the "Purpose" is the extent to which students and educators are feedback literate such that they can accurately and effectively engage with feedback. This highlights potential differences between in the individuals' "self" within a single community of practice, often adding a dimension of power or "gatekeeping" to the feedback experience.

Authenticity

Authenticity of the learning experience is a consistent message that has emerged from this research. Unsurprisingly, students desire learning experiences that are authentic to their intended professional practice. This research provides evidence to indicate that students are challenged by those learning experiences that do not mirror genuine clinical practice, and it has exposed the false authenticity within some aspects of university-based practice learning.

8.3.1 Proposed model of integrated feedback

Self, Purpose, Authenticity and Relationality appear to be difficult to divorce from one another in the context of learning from a feedback experience such that it has the opportunity to support ongoing learning. With this in mind, Figure 3 offers a crude visualisation of how these appear to be linked in the context of this research.

Figure 3 on the following page shows the multiple **communities of practice** as the foundation of the model. These communities of practice should be learning-focussed, offering opportunity for safe questioning and dialogue, and promoting an ethos or culture of reflection as the norm. Both student and educator members of these communities of practice need to be appropriately feedback literate in order that they are clear about the purpose of a given feedback experience and have the skills necessary to support an agentic approach to ongoing learning.

Into the multiple communities of practice fits the **self**. The self represents the student, who needs to ensure that they remain learner-focused within the learning-focussed communities of practice. The self needs to push the boundaries of self-actualisation, at the expense of remaining secure, in order that they maximally gain from a feedback experience. The self needs to perceive his/herself as worthy of feedback.

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Figure 3: Model of integrated feedback

Into the self is situated the feedback experience. Without a clear **purpose** of feedback and it being explicitly related to the **authenticity** of intended healthcare practice, the perceived value and impact of the feedback on ongoing learning is unlikely to be maximised.

8.4 Professional relevance and implications

The four aspects of the model of integrated feedback that this research argues are fundamental to the perceived value and impact of feedback have relevance and significance for the education of pre-registration healthcare students, and their ongoing learning. These will now be explored.

Educators within learning-focussed communities of practice need to use a questioning approach within their feedback to students to empower the self, and foster self-actualisation. Furthermore, if the purpose was clear, a questioning dialogic style of feedback

might support the student in taking ownership of their ongoing learning, a quality necessary for registrant practise.

This research has shown the phenomenological descriptions of feedback experiences to expose ambiguity and contradictions through narrative that has captured layers of complexity. It appears that both the student and the educator need to be clear about the purpose of feedback; consequently there is a reciprocal requirement in a feedback situation for the purpose to be made explicit to the student and the student to request feedback for a specific purpose.

The gap between the position of a novice (i.e. student) and an expert (i.e. practice-based educator) within a single community of practice can be significant. This makes a case for a more recently qualified healthcare professional being formally involved in practice-based learning in order to bridge that gap. Based on the work of Wenger (1998), this newly qualified graduate might be a "skilled broker" (p. 109) between student [novice] and educator [expert], in that they straddle the boundary (Fenton-O'Creevy et al., 2015) of the learning-clinical communities of practice, strengthen the relationship between individual members of the single community of practice, support the student with emotionally-laden learning processes, and offer the student a greater sense of belonging due to kinship.

The discussion of purpose of feedback suggests that educators need to ensure that feedback is crafted in a way that promotes active learner engagement. Passive student behaviour is unlikely to be modified unless feedback facilitates it. A questioning approach to feedback may foster active engagement by the student. Given that healthcare students are mandated to be able to regulate their own learning once qualified, there is evidence (Winstone et al 2017) that agentic engagement in dialogue is an intrinsic part of successful feedback.

Pre-registration healthcare students need to be better skilled in the way that they engage with feedback. Students need to be conversant with how they source, interpret and use feedback (Sutton, 2012; Winstone et al., 2017; Winstone et al., 2016) such that they develop feedback literacy competence. Feedback literacy skills may be developed by educators supporting students to "action plan" from feedback, so utilising an agentic approach to learning. The principle of "action planning" to foster engagement with feedback is relevant within both university-based and practice-based environments, may involve the use of a dialogic approach and a questioning style – within both verbal and written feedback methods - and it is implicit within the culture of autonomous learning for a registrant healthcare practitioner. This strategy would allow for the variation in cultures found within

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and across the communities of practice in which students find themselves to be utilised such that they provide the authenticity of a socially constructed culture to frame the learning from feedback experience. Furthermore, an "action planning" approach is wholly supportive of the learner "self" of the student.

The findings advocate for the role of the tripartite meeting between student, practice-based educator and university-based educator to be more overtly focussed on the learning process rather than the verification of learning, given that the wider practice-based education experience itself should be centred on learning. This may give rise to the opportunity for the "therapy" purpose of feedback to be explored to support the student in the process of self-actualisation.

As a general comment, feedback experiences need to be more explicitly linked to "learning" rather than assessment. Learning needs to be more consistently and overtly recognised, by both students and educators alike, as an ongoing process rather than as a product.

8.5 Limitations of this research and recommendations for further work

One of the significant limitations of my research is its small scale. The study is based on five students from across four disciplines within allied healthcare pre-registration courses in one institution. Following initial recruitment, the sample size was reduced by the disengagement of Ann and Freya following their initial interviews. This continued disengagement meant that there was no opportunity to explore why these two participants did not want to remain engaged in the research. This is obviously a limitation of this research, though clearly one that is very difficult to overcome when methodological design is reliant on human participation.

There is cautious suggestion in the literature by Winstone et al. (2016) that gender might influence the readiness of students to engage with feedback. Whilst it was not the aim of my research to consider gender, it is important to note that the majority of my student participants were female. Whilst this female dominance is, in fact, reflective of the healthcare workforce, there remains the possibility that my data may be reflective only of a female perspective. Gender differences in perception may be an area for further study.

A phenomenological approach to research explores the lived experience of individuals and, by the nature of this, it would be difficult to engage large numbers of participants. The

findings of my research can only be related to my sample which is a limitation, though I believe that I have been able to accurately understand the lived experiences of feedback of these individuals through this methodological approach.

A larger sample of participants might allow for my claim for knowledge to be attributable to a wider population. That said, it is likely that the methodological approach and research design would need to change to support the management of a larger data set if that was a future plan. This would likely lose the real essence of understanding the lived experience from the perspective of the participant which would fundamentally alter the aim of this research.

A recommendation for future research may be exploration of specific healthcare disciplines in order to investigate differences and similarities in perception and use of feedback. This might give rise to findings that could help educators manage the feedback experiences of students within uni-professional and interprofessional contexts.

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Appendices

Appendix 1: Pilot Study Information

Research questions

At the outset of this research the central research question was:

What is the value and impact of formative assessment and formative feedback to the learning experience of students?

At that time, this primary research question was guided by the following specific questions within the pilot study:

What worth do learners and educators place on formative assessment and formative feedback within and across the learning spectrum?

What role does formative assessment and formative feedback play in the "teaching" experience of the educator?

Is there difference or similarity between the worth placed on formative assessment and formative feedback by learners and educators?

Is there difference or similarity between practice-based educators and university-based educators as to the role and merit of formative assessment and formative feedback?

How is formative assessment and formative feedback used to support the summative assessment process across the spectrum of education?

What are the key features of formative assessment and formative feedback across education and how can these be implemented more widely?

Ethical approval

Ethical approval to undertake the pilot study was sought by the School [of Human and Health Sciences]'s Research and Ethics Panel (SREP) at the University of Huddersfield, as that is the University with which I am registered for this award. Ethical approval was gained on 24th April 2009.

Process of the pilot study

The pilot study involved student participants that were in their final year (during 2008-9) of undergraduate physiotherapy and/or podiatry students, and their educators. These two student cohorts were chosen as a convenience sample because both cohorts were relatively

large and readily accessible (Cohen et al., 2007) to me. In addition, there was a clinical facility within the university in which some of the students undertook authentic clinical experiences and this offered me a vehicle by which to pilot the participant observation of my methodology without the need for NHS ethical approval (Integrated Research Application System (IRAS), 2011). The educator participants were those educators who supported the student participants in university-based and/or practice-based learning environments.

Data collection was a threefold process involving an anonymous electronic questionnaire, participant observation and a student focus group.

Electronic Questionnaire

All student participants (n=80) were invited to return an anonymous electronic questionnaire via Blackboard, the university's virtual learning platform at that time. The students were sent an email by me explaining the purpose of the anonymous electronic questionnaire and detailing what they were being asked to do. This email also explained that by returning the questionnaire, informed consent was assumed. The electronic questionnaire data were analysed using Statistical Package for the Social Sciences (SPSS) and content analysis (Bryman, 2004).

Participant observation

Year 2 academic summative profiles of all the student participants were accessed and, based on these profiles, three student participants were purposively selected by an independent person. These students were purposively selected so that one student had average (modal) module marks in the 40% band or less, one student had average (modal) module marks in the 50-60% bands and one student had average (modal) module marks in the 70% band or above. The three selected student participants were invited by me, via an explanatory email and an information sheet, to be observed and video and/or audio recorded in at least one authentic university-based or practice-based learning setting during which they were to receive feedback. At the time of undertaking the pilot, I perceived it essential that participant observation was tested in at least one university-based and one practice-based setting in order that any authentic spatial variations might be tested. The educator participant from whom the student participant was to receive feedback was also emailed directly by me and provided with an information sheet inviting them to be observed and video and/or audio recorded. Informed written consent was gained from all observed participants. The video and/or audio participant observation recordings were transcribed by

an independent person and the data analysed using a content analysis approach (Bryman, 2004).

Focus Group

The three observed students were invited (by email, with accompanying information) to attend a focus group which was audio recorded. A focus group schedule was devised and informed written consent was gained from all participants. The focus group had three purposes. Firstly, it allowed the opportunity to ask whether the question set within the electronic questionnaire was sound (i.e. logical, without ambiguity, complete). Secondly, it provided me with the opportunity to test the methodology of organising and running a focus group and managing the subsequent data. Finally, it gave me the opportunity to discuss with the three observed students their perspective of the observation. The focus group recordings were transcribed by an independent person and the data analysed using a content analysis approach.

Findings and methodological outcomes of the pilot study

The pilot study highlighted key aspects of the methodology that needed further consideration. Firstly, the response rate to the electronic questionnaire was very low at 32.5% (n=26). During the focus group, the student participants suggested that if they had known who the researcher was and had met them prior to receiving the questionnaire they would have been more likely to complete it. This allowed me to consider alternative methods of engaging with the students for main study. Secondly, the questionnaire illuminated that 92.3% of electronic questionnaire respondents (n=24) viewed themselves to be solely or equally strongest in clinical practice (as opposed to academic work alone). This suggested that it was imperative for me to include feedback experiences within authentic practice-based learning environments during the data collection process, particularly given that these environments are the crux of what makes healthcare student education different to that of other university undergraduate students.

Results

There were core themes that emerged from the content analysis. A discussion of each is below.

Same Difference?

Students view formative assessment and formative feedback synonymously, irrespective of whether the [formative] feedback is associated with formative or summative assessment methods. Students do not associate "formative" with "learning" and "summative" with
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"verification". Students are instead more likely to simply reflect that "formative" does not contribute towards a final grade/award classification:

Formative assessment is a method of testing students on topics that they have learnt so far that do not count towards final marks. (Student)

Analysis: there appears to be an unclear and/or artificial and/or unnecessary differential between formative assessment and formative feedback. Also, students fail to recognise implicit learning opportunities.

Implications: feedback – whether it is associated with summative or formative activity – should be at the core of a learning opportunity and this opportunity needs to be made explicit to students.

Message Understood?
Students verbally (e.g. "Yeah"/"Hmm"/"Yes"/"OK") and non-verbally (e.g. nodding) suggest to tutors that they understand the feedback being given but then explicitly demonstrate that they have misinterpreted what is being said and/or remain unclear by the subsequent questions they ask:

… ethics section is superficial … (Educator)
It needs to be a lot longer … (Student)

Analysis: whilst the tutor is implying that the work needs to be different, the student is interpreting the message as it needing [only] to be longer.

Implications: if there is no opportunity to ask questions (e.g. if the feedback offered is in the written form alone), messages may be "lost in translation" from tutor to student. Students then, whilst they believe to have understood the message correctly, actually retain an [ongoing and] incorrect understanding of the message. Feedback needs to be overt and explicit.

What is our Ethos?
Students and tutors both demonstrate an explicit assessment-driven, as opposed to learning-driven culture. Students clearly want to simply pass assessment tasks and the literature supports this (e.g. Ecclestone and Pryor (2003), and Davies and Ecclestone (2008)). Tutors are also [subconsciously] promoting an assessment-driven culture:

It's going to be capped at 40[%] regardless … (Educator)

Analysis: the tutor is prioritising the summative mark likely to be achieved over the ongoing learning opportunity offered.

Implications: students and tutors are at risk of actively nurturing (implicitly or explicitly) an assessment-driven culture over a learning-driven culture, at a detriment to the latter.

What Rules?
Students receive mixed messages from tutors in relation to what is expected of them and experience varied practices used by tutors to assess and provide feedback:
Again it's not me that's marked it, I'd have just … (Educator)

Analysis: the tutor is outlining inconsistencies between markers by suggesting that s/he would have done something different had s/he marked the work.

Implications: if the expectations and practices of assessors are different, students will find it impossible to understand the "rules of the [assessment] game" as the "rules" are likely to be constantly changing. This is unfair to the students.

Conclusions and the Next Steps
The findings of the pilot study led to the initial central research question being reviewed and honed to:
What is the perception of the value and impact of feedback on ongoing pre-registration healthcare student learning?

The additional research questions were reviewed to:
How do healthcare students use feedback?
Do healthcare students understand what is intended by feedback?
What do educators intend students to "do" as a result of feedback?
Does previous academic experience or level of attainment influence the impact of feedback?
What feedback experiences and behaviours influence ongoing learning?
Is there a need for quality assurance processes for feedback and learning in practice-based and academic settings?

Given that the primary research question had been honed to understand perception of experience, it was felt that the questionnaire served very limited purpose towards answering this question. Rich descriptive data was wanted to understand the lived experience of the students and educators. There are significant limitations regarding how
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useful a questionnaire would be towards this (Bryman, 2004) and this methodology was removed from the main study.

Key findings:

Formative assessment and formative feedback activities do not appear to have a consistent intended effect on the student learning experience.

The current "formative" focus of the research needs to be reviewed whilst the "feedback" element needs to be explicitly strengthened in the main study.

"Modes" of feedback need to be explored more robustly within the ongoing research such that the need for dialogue between the student and the tutor in order for the student to verify understanding can be investigated.

The ongoing research needs to fully explore the overt and covert "cultures" and practices associated with assessment and feedback from both a student and a tutor perspective.

Appendix 2: Participant Information Sheets

Student participant information sheet

Feedback: its real value and impact on student learning.

Dear Student

You are being invited to take part in a research project that is being undertaken to discover the value and impact of feedback on student learning. Before you decide to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

What is the study about?
The purpose of this study is to explore the experience and perception of feedback on ongoing learning. This research is part of my Doctor of Education (EdD) award at the University of Huddersfield.

Why have I been approached?
This research involves full-time healthcare students currently in Year 2 at the ████████ ██████████. You have been asked to participate because I want to gather data from students on a range of healthcare courses and with different academic experiences.

Do I have to take part?
No. Your involvement in this research is entirely voluntary and your decision. If you decide to take part you will be asked to sign a consent form, and you are free to withdraw at any time without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

What exactly am I being asked to do?
You are being asked to do 3 things:
   1. Firstly, undertake a semi-structured interview with the researcher (me) about your school/college/university history and previous assessment and feedback experiences. The interview will be very informal and it will be audio recorded. There are no right

or wrong answers to the questions – I simply want to gain insight into your previous experiences. This should take no longer than 30 minutes.

2. Secondly, I want to observe you receiving feedback from a tutor/educator/mentor (educator) in the University and/or in practice. I want to observe you on at least 3 separate occasions. As well as observe the interaction between you and your educator, I want to audio record the interaction and make some notes. I will not contribute to the discussion that you are having with your educator in any way, I simply want to observe and record what I see. This will take as long as the discussion that you were having with your educator would normally take and it will take place in the environment in which it would normally occur.

3. Thirdly, undertake another interview with me after each observation to explore some of what I saw and/or you experienced during the feedback discussion that I observed. Again, the interview will be very informal, it will be audio recorded, and there are no right or wrong answers to the questions. Each interview should take no longer than 30 minutes.

Will this affect my course or ongoing studies?

No. This research is completely separate from any aspect of your course and in no way will the results of this research or your involvement influence the outcome of your academic or practice-based work, the mark that you receive for any aspect of your course, or the chances of your success in gaining your award.

Why is this work important?

This work is important because I want to find out how students view and use feedback.

Will people know that I have been involved?

The people who will know that you have been involved are me and the educator(s) with whom you are having feedback discussions, as they will also be asked (by me) to give consent to being involved in the study. All information disclosed within the research will be kept confidential, except where legal obligations would necessitate disclosure to appropriate personnel.

What will happen after I have completed the research?

After the research has been completed, I will analyse the data. The data will be anonymised, so that there is no way of identifying you. Once I have completed the data analysis, I will make a summary of the results available to anyone who wants them.

The research data will be used by me to write my EdD thesis, journal articles, create academic posters and conference presentations for use both within and outside of ██

██████

Do I need to give consent or sign anything?

Yes, you will be asked to sign to indicate written consent to being involved in the research before the first interview.

What if I change my mind about being involved later on?

If you change your mind about being involved in this research, you can withdraw at any time without giving a reason. You need to contact me directly (my details are below) to withdraw your involvement and your data will be removed from the research.

Who will have access to the data?

The only person who will have access to the data is me, and any identifying material (e.g. name) will be removed to ensure anonymity. Within the writing of my EdD thesis, journal articles etc, it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form. All electronic data will be kept by me on a password protected computer or encrypted storage device. Any hard copy of the data will be kept in a locked drawer at the University of Huddersfield. After I have completed my EdD award and the analysed summary of results have been made public, all data will be confidentially destroyed in line with University policy.

Is there anyone that I can go to if I have any concerns?

If you have any questions at any point, please contact me directly and I will answer them as well and as honestly as possible. When I have analysed the data, you will be given the opportunity to have a written summary of the findings and given the opportunity again to ask any questions.

If at any point you feel that your questions are not being answered or you wish to raise concerns or complain about the conduct of the research, an independent point of contact who has nothing to do with this research is Marilynne Kirshbaum, who can be contacted on m.kirshbaum@hud.ac.uk or 01484 471277 or room R1/29.

This project has been approved by the School Research Ethics Panel and has Research Governance approval from ███████████████████ NHS Trust.

Researcher Contact Details:

| Researcher: | Sara Eastburn |
| Email: | s.eastburn@hud.ac.uk |

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Telephone number: 01484 472911
Room: R1/26

Educator participant information sheet

Feedback: its real value and impact on student learning.

Dear Colleague

You are being invited to take part in a research project that is being undertaken to discover the value and impact of feedback on student learning. Before you decide to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

What is the study about?
The purpose of this study is to explore the experience and perception of feedback on ongoing learning. This research is part of my Doctor of Education (EdD) award at the University of Huddersfield.

Why have I been approached?
This research involves full-time healthcare students currently in Year 2 at the ▇▇▇▇▇▇▇▇ ▇▇▇▇▇▇▇▇, and the tutors/educators/mentors (educators) who support these students. You have been asked to participate because you are offering feedback to one (or more) of the students that have agreed to be involved in this research.

Do I have to take part?
No. Your involvement in this research is entirely voluntary and your decision. If you decide to take part you will be asked to sign a consent form, and you are free to withdraw at any time without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

What exactly am I being asked to do?
You are being asked to do 2 things:
1. Firstly, I want to observe you giving feedback to the student in the University and/or in practice. I want to observe the student receiving feedback on at least 3 separate occasions, and at least one of these occasions will involve you. As well as observe the interplay between you and the student, I want to audio record the interaction and make some notes. I will not contribute to the discussion that you are having in any

way, I simply want to observe and record what I see. This will take as long as the discussion that you were having with the student would normally take and it will take place in the environment in which it would normally occur.

2. Secondly, undertake an interview with me after the feedback/observation to explore some of what I saw and/or you experienced during the discussion with the student. The interview will be very informal, it will be audio recorded, and there are no right or wrong answers to the questions. Each interview should take no longer than 30 minutes.

Why is this work important?

This work is important because I want to find out how students view and use feedback in both university and practice-based settings to inform policies and practices.

Will people know that I have been involved?

The people who will know that you have been involved are me and the student(s) with whom you are having feedback discussions. All information disclosed within the research will be kept confidential, except where legal obligations would necessitate disclosure to appropriate personnel.

What will happen after I have completed the research?

After the research has been completed, I will analyse the data. The data will be anonymised, so that there is no way of identifying you. Once I have completed the data analysis, I will make a summary of the results available to anyone who wants them.

The research data will be used by me to write my EdD thesis, journal articles, create academic posters and conference presentations for use both within and outside of the University.

Do I need to give consent or sign anything?

Yes, you will be asked to sign to indicate written consent to being involved in the research before the (first) observation.

What if I change my mind about being involved later on?

If you change your mind about being involved in this research, you can withdraw at any time without giving a reason. You need to contact me directly (my details are below) to withdraw your involvement and your data will be removed from the research.

Who will have access to the data?

The only person who will have access to the data is me, and any identifying material (e.g. names) will be removed to ensure anonymity. Within the writing of my EdD thesis, journal articles etc, it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form. All electronic data will be kept by me on a password protected computer or encrypted storage device. Any hard copy of the data will be kept in a locked drawer at the University of Huddersfield. After I have completed my EdD award and the analysed summary of results have been made public, all data will be confidentially destroyed in line with University policy.

Is there anyone that I can go to if I have any concerns?
If you have any questions at any point, please contact me directly and I will answer them as well and as honestly as possible. When I have analysed the data, you will be given the opportunity to have a written summary of the findings and given the opportunity again to ask any questions.

If at any point you feel that your questions are not being answered or you wish to raise concerns or complain about the conduct of the research, an independent point of contact who has nothing to do with this research is Marilynne Kirshbaum, who can be contacted on m.kirshbaum@hud.ac.uk or 01484 471277 or room R1/29.

This project has been approved by the School Research Ethics Panel and has Research Governance approval from ███████████████ NHS Trust.

Researcher Contact Details:

Researcher:	Sara Eastburn
Email:	s.eastburn@hud.ac.uk
Telephone number:	01484 472911
Room:	R1/26

Appendix 3: Consent Forms and Interview Schedule

Consent form

University of HUDDERSFIELD
Inspiring tomorrow's professionals

CONSENT FORM

Title of Research Project: "Feedback: its real value and impact on student learning".

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate. If you require any further details please contact your researcher.

I have been fully informed of the nature and aims of this research ☐

I consent to taking part in it, and to my involvement being audio-recorded ☐

I understand that I have the right to withdraw from the research at any time without giving any reason ☐

I give permission for my words to be quoted (by use of pseudonym) ☐

I understand that the information collected will be kept in secure conditions for a period of five years at the University of Huddersfield ☐

I understand that no person other than the researcher and supervisors will have access to the information provided ☐

I understand that my identity will be protected by the use of pseudonym in any report and that no written information that could lead to my being identified will be included in any report ☐

If you are satisfied that you understand the information and are happy to take part in this project please put a tick in the box aligned to each sentence and print and sign below.

Signature of Participant:	Signature of Researcher:
Print:	Print:
Date:	Date:

(one copy to be retained by Participant / one copy to be retained by Researcher)

Consent Form: Version 1 (26/4/13)

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First student interview schedule

This is a semi-structured interview schedule in order that both breadth and depth of data may be generated. The follow series of questions (1, 2, 3 etc) may be augmented via the prompts indicated (a, b, c etc) if necessary and/or appropriate. If the student begins to talk about something that is not covered within the schedule and the researcher thinks it is/might be relevant, the student will be encouraged to continue to discuss it. Researcher will introduce self, explain process including use of pseudonyms within data, gain written consent.

Audio recording – start.

Thanks very much for taking part in this research. These questions are about your education and feedback, and there are no right/wrong answers.

1. Can you tell me your name and what course you are studying? Why did you choose this course?

2. Can you describe your education pattern/history before starting your current course?
   a) School/college/6th form etc
   b) A levels/Access course/Foundation year etc

3. Did you enjoy school/college?
   a) What made it enjoyable/Why did you dislike it?

4. What were your strengths and weaknesses in school/college/Year 1 of the course?
   a) What were you good/not so good at?
   b) How did you know that these aspects were your strengths and weaknesses?

5. How would you describe yourself as a student/learner?
   a) Just get by/average/strong student
   b) What makes you describe yourself in this way?

6. Did you receive feedback on your work at school/college/Year 1?

7. Consider some feedback that you have found useful – can you describe it?

8. Consider some feedback that you found unhelpful – can you describe it?

9. What makes feedback useful to you? What makes it unhelpful?
   a) Type/timing of feedback/strengths & weaknesses of the work/pointers for improving further/user friendly/audio/written/immediate

10. What sort of feedback do you prefer? Why do you prefer this sort of feedback?

11. If you were to receive the most helpful feedback that you could imagine, can you describe it to me?

12. What do you expect from feedback?

13. What would disappointing feedback be like to you? Describe.

14. From the feedback that you have received so far at school/on the course etc, can you see any patterns that influence your learning?

Thank you for answering the questions.

End.

Second student interview schedule (post-observation)

This is a semi-structured interview schedule in order that both breadth and depth of data may be generated. The follow series of questions (1, 2, 3 etc) may be augmented via the prompts indicated (a, b, c etc) if necessary and/or appropriate. If the student begins to talk about something that is not covered within the schedule and the researcher thinks it is/might be relevant, the student will be encouraged to continue to discuss it. If significant things are observed, these may also be asked about.

Audio recording – start.

1. Can you describe for me what that discussion with your tutor/educator/mentor was about?
2. How did you find it? Was it useful? How do you know if it's been helpful or not?
3. Why/why not? Try to be a specific as you can.
4. Is there anything significant that you remember from the discussion? Why is it significant?
5. What was good about your discussion with your educator/tutor/mentor?

End.

I: so, when we were in clinic and you had to chat with [Brian], and you have chap the boots and was it something on his heel that he had? I can't remember … and then when you said to me afterwards that you felt that you wouldn't have got much feedback or as much out of clinic if I'd not been there, what did you mean?

R: we don't tend to do that the end, I don't go up to them and say "oh, how did I do today?" Or "are there any areas that I need to brush up on a bit better?". We just don't do it.

I: why don't you do it?

R: I don't know. I don't know whether it's something like because quite shy or sometimes you finish and then they just disappear. At 12:15 they are straight off. You don't see them. So it's like a bit of both really, my personality and them rushing off.

> Commented [SE1]: 6.2.1 Confidence.

> Commented [SE2]: 7.3.1.1 Staff not available at end of clinic for FB.

I: if you did ask and did say to them more or less what I said, what did I do well at and what do I need to keep working on, how do you think that would affect your learning?

R: it would give me a better focus, something that they could say "well, you are doing this really well so keep doing that, but there's this bit that you need to read up on, more on this condition or" so it would be beneficial really.

> Commented [SE3]: Specifics and purpose.

I: does anybody, and I know it was [Brian] that we were talking about their but do any of the other members of staff, do they interact differently with you in clinic, if you'd have had somebody else?

R: no I don't think so, they all sort of do that. The same sort of thing.

I: do you ever get formal feedback during clinic?

R: Not during clinic. Erm, we tend to just get it after our exam, the clinic exam. We just sit and they say "I marked you with this mark, and the other person marked you with this mark". And they tell you this is what you did well and this is what you needed to have done to get a higher mark.

> Commented [SE4]: Form – verbal. 2.1.2 What and how. Also Purpose of FB.

I: Usually when do you have those clinic exams?

R: about May/June time.

I: And would you have had feedback before May June time about how you are doing clinic?

R: I only had it once I remember. That was with [another educator]. And she sort of, because I had a patient with rheumatoid arthritis, and I could tell her what it was but there were bits I was missing out, and she said "you need to ask this question now" and this question and this question and you need to ask whether their arthritis is in a flareup or not, and she was able to give me a bit more help, but that's the only time I have been in front of a lecturer in clinic where I've got that information obviously apart from [Brian] last week.

I: Why do you think [the other educator] thought it was right to give you feedback in that way in relation to the patient with rheumatoid arthritis?

R: It was the beginning of April last year, just before Easter I think it was, and I think she was a bit worried that I wasn't going to pass my exams, so I think she sort of just gave me a bit of direction in things, and but you need to know this because this is one that comes up a lot.

I: Okay

R: and she was able to write things down, and it was quite good.

I: So did she write feedback down for you? Or was it more about the patient?

R: No, more about the patient and questions that I should have asked and things like that.

I: And another then after your exam, do you ever get written feedback on clinic?

R: No never, no

I: Okay. Someone showed me this the other day, it was from education, let me show you it. And we don't use these in physio either, it's something they use in education, so remember this is teacher trainers, and they use it if someone is observing them, so if they were being observed as a teacher in a classroom pupil which I suppose is comparable to us been in clinic, then the person who is observing them makes some

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comments in the box and gives them some feedback as to things that they have done well, key strengths, and then gives them specific targets for development. And things to action or things to improve on. Do you think something like that would be helpful?

R: Yes, but it's whether they would have the time to fill that in because there is a lot of us and sometimes were working in pairs so I don't know whether it would be right for them to stand in front of both of those and give one person feedback another person feedback. I don't know.

Commented [SE1]: 7.3.1 Lack of staff time.

I: I must admit when [I saw this] I thought yes, because we don't do this in physio, we have students on placement, but we do give some feedback but probably not after every patient so it's not too dissimilar to what goes on in podiatry. But when she showed me this I thought it's quite useful because it reminded me of the assessment when you do a written piece of work and you get that feedback sheet, I assume you get feedback sheets in podiatry, maybe at the front of your assignment?

R: Yes

I: it reminds me of that, because on the feedback sheet we use it talks about things you've done well and also how to improve, and they are the bottom bits of this really

R: yer. I would be quite good them, to do, I just don't know whether they put enough lecturers in clinic.

Commented [SE2]: 7.3.1 Lack of staff time.

I: Do you think thats it, because there was only 4 in clinic on Monday, ...

R: there are about eight or nine in my group, and there are two groups, main groups, and others who just fill in,

I: maybe it is about not enough members of staff who are in clinic because they're looking after 10 students or something and obviously they got to be split in the clinic between eight or 10 students so there is only so much they can do, I get that, but you know what I'm trying to work out is how best you guys use the feedback that you get to improve or influence your learning. And if you're not getting any feedback, then

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you're not learning from that patient experience.

R: No. I think I take away, because sometimes you think "oh I have done this really well" but then there are other times when you think that everything went wrong. ==So I think it were good for [Brian] to sort of say, well you got all the information you needed, you got your diagnosis there. But obviously you didn't recognise it yet, so that was good because I thought that I had, you know, just not done very well (laughs).==

Commented [SE1]: 2.3.3 Overt Feedback.

...

I: What was it about the situation that you would have wanted feedback about?

R: Erm, just on how I had performed, because I always focus on things that, oh I that went wrong, and then I forget that I actually did the whole assessment right and I think she was pleased that that bit because when I was telling you about it she sort of like, but when I got that bit, it was only that little thing about what treatment and the active ingredients was what she was wanting and I couldn't remember the active ingredients. ==So I think she's going to forget about all the things that I have done right and focus, she just seemed to focus on that one thing.== She was like "you can't recommend that treatment or recommend that product because you don't know the active ingredients so therefore you don't know whether it" whereas like, maybe I should have asked whether I needed to know all these active ingredients and everything to move on.

Commented [SE2]: Wants tutors to be pleased/impressed.

I: Why didn't you ask?

R: I don't know.

I: What stopped you?

R: I think I had a lot of, I had to write a GP letter and I ended up staying behind and then I had to go and find her to to sign off this thing so I think it was

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sort of, because I was so behind and it was 12:30 or something, and I ended
up having to get [an educator] to sign, just so that I could go for my
dinner. I think sometimes it is time, and then sometimes it's myself.
Sometimes it's just because they're not available to get feedback
because she just sort of gone.

I: For you to ask her for feedback would she have needed to have done
anything differently? Other than being there?

R: I don't know. Because sometimes she can, I think it just, I don't know
whether it's just her but sometimes feel a bit like I don't want to go
and ask her.

I: Why not?

R: She shouts me down.

She shouts at you?

Yes. Sometimes she is quite stern (laughs) and you can sometimes tell in
her face what she's thinking, whether she's thinking good things or
oh god, how has she got to this point?

.....

R: In the afternoon, I was thinking of doing this one test because they
have this knee pain and I thought I'll do this twist test and see if it is
something to do with the medial side and then, I'm like this, debating
whether to do it and then he came and eventually said "have you done
of valgus stress test?" And I went, oh, I was going to do that. I think
maybe that if I'm thinking about I should just go and do it, and then I
showed him what I was doing and he got pain. He told me to hold the
leg further role and I had done it differently to how he had taught me
but I still elicited pain from doing it. But then he sort of did it himself
then like I was, so I thought I'd done it wrong, but then afterwards in the
group thing, he was saying you did well because when you did the
valgus stress you

Commented [SE1]: &.3.1 Lack of time.

Commented [SE2]: Unapproachable staff.

Commented [SE3]: Shouts. Style.

Commented [SE4]: Stern. Style.

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did elicit pain even though you weren't putting a lot of pressure on and then I had to then show other members of the group how I'd done it because he said you can do it that way or you can do it the other way.

> **Commented [SE1]:** 2.3.2 Used as exemplar. 2.3.4 Implied FB (though thought had done it wrong so misinterpreted).

I: And how did that make you feel

R: well I thought I had done it wrong, at first because I thought he is doing it differently but afterwards when he confirmed that I have done it right I was, that's good,

I: why did you think you've done it wrong

R: because he then went and did it himself, the patient had said oh yes that hurts when I done it so I think the him to then, come and do it again, I don't know whether he was trying to say you can do it this way as well and you still get the pain, but I don't know, I thought I'd done it wrong.

> **Commented [SE2]:** Misinterpretation of FB.2.3.4.1

I: Did he say you did it wrong?

R: No, but it was just the way he sort of just came and did himself. I thought, oh well, I don't know what he was getting.

> **Commented [SE3]:** 2.3.4.1

....

R: and we get feedback of patients sometimes as well, because I had, we were doing lots of nails, just like simple treatments really, but then they walk out and say nobody is recommended this to me before or I've never had this long, they liked the experience of it after the initial "we are students, can we treat you?" (laughs) a lot of them walked out with smiles on their faces. They appreciated that we treated them as individuals not just do nails and get out. That's what happens in the NHS, they don't have time, do they? We do get

> **Commented [SE4]:** FB from patients.

feedback like that from patients, they say "I'll give you a 10!". They joke about it and everything. We are more relaxed when we are out

> **Commented [SE5]:** FB from patients.

on community then we are in clinic, we are all anxious (I: on clinic?) Yeah, sometimes we don't want to go in

I: Why don't you want to go in?

Because we are always afraid that we are always, we are going to do
    something wrong or we don't know what we're going to get, and I know
    you get that out on placement but I don't think, because you are able to
    do your own thing and you're not going to get questioned about what
    drugs this is or questioned about this patient and why she's got this and
    why she's got that, I think that's why because if we forget something we
    always think I need to know. But on placement you can sort of go
    through in your head.

I: is everyone the same

R: We are all there walking up to clinic thinking I don't really want to do today,

I: interesting.

Commented [SE1]: Clinic environment stressful. 8.1.2

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Appendix 5: Initial and Subsequent Templates

Initial template with definitions

PURPOSE OF FEEDBACK (Integrative Theme) – data that reflects an intended use of outcome from feedback.	
Authoritarian	Verify Learning.
	Direct. Guide. Improve.
	Clarify.
Nurturing	Encourage. Reassure

1. STYLE OF FEEDBACK – method and manner in which feedback is given or received.

    1.1. Specificity – data that refers to feedback being detailed.

        1.1.1. Transferability – data that suggests (explicitly or implicitly) that feedback can be used elsewhere; feedback not solely applicable to a single event/assessment/setting etc.

        1.1.2. What and how – data that makes clear reference to feedback indicating what was done well (or what was done poorly) and how this should be continued (or corrected).

        1.1.3. Lack of knowledge of expectations – data that illustrates that students are not aware of or do not [fully] understand what is/was expected of them by others.

    1.2. Relevance to Practice – data that suggests an explicit application to clinical or professional practice (or the practice of learning).

        1.2.1. Reflection – data that makes explicit reference to reflection (in/on action), or looking back, evaluating, or learning from.

        1.2.2. Authenticity – data that discusses simulated learning or learning that has a genuine and valid relationship to or purpose within a healthcare profession and/or healthcare setting.

    1.3. Form of Feedback – data that discusses the form and shape of feedback, such as verbal, written, templates, Turnitin etc.

    1.4. Qualities of Feedback – data that makes reference to other objective characteristic of feedback such as it being personalised, balanced, constructive, affirming, only a grade etc.

    1.5. Timing - any data that makes reference to time and/or chronology of feedback or learning.

    1.6. Language in feedback (This might end up being an integrative theme) – data that explicitly illustrates the vocabulary used within feedback.

2. SUPPORT STRUCTURES – systems in place, or used by students, to support learning.

 2.1. Relationships – data that reflects a supportive or unsupportive link between the student and at least one other person.
  2.1.1. Positive relationships with educators – data that makes reference to a professional and supportive relationship between student and educator.
  2.1.2. Respect – data that highlights deference, or regard, between two individuals.
  2.1.3. Influence of others (family, family, peers) – data that suggest that individuals other than the [participant] student and formal educator(s) may have an effect on the student's learning.

 2.2. Course Related – data that relates to aspects that clearly sit within the course that may influence learning.
  2.2.1. Conflicting roles – data that suggests a real or potential struggle by the same person acting as both educator and assessor.
  2.2.2. Academic support – data that makes explicit reference to the support offered by university-based staff.
   2.2.2.1. Lack of staff time – data that states that staff members do (or do not) have sufficient time to support students with feedback.
  2.2.3. Support on placement – data that relates to the support offered to the student whilst on placement.

3. EMOTIONAL EFFECTS – the feelings and reactions experienced.

 3.1. Personal Criticism – data that makes reference to feedback feeling like a personal criticism.

 3.2. Limbic Responses (panic, frustration, disappointed, pride, hatred etc) – data that uses emotive adjectives.

 3.3. Reward and Motivation – data that makes reference to feedback being perceived as a reward or in return for someone else's actions (e.g. such as reading and marking the work) which, in turn, acts as a positive motivator itself.

4. CONSISTENCY – the reliability of feedback and marking.

 4.1. Expectations of Educators (links to 1.1.3 somehow) – data that relates to the way educators articulate the objective expectations or their own expectations to students.

 4.2. Fairness – data that discusses students being treated with parity.

4.3. People are Different (personalities etc) – data that highlights that students are able to recognise that human difference can affect consistency.

4.4. Academic/University guidelines/control – data that refers to academic regulatory or quality assurance mechanisms that might influence consistency.

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5. INTRINSIC QUALITIES OF THE LEARNER – features of the student that may influence the situation.

5.1. Control of Own Learning – data that illustrates a known ability by the student to affect their own learning.
   5.1.1. Knows preferred styles – data that shows the student has an insight into what methods and strategies support his/her learning.
   5.1.2. Study skills – data that makes reference to skills used, or otherwise, to facilitate learning.
   5.1.3. Seeks support – data that refers to the student seeking help, or otherwise, to facilitate learning.

5.2. Self-Perception – data that reflects the student being aware of aspects of his/her personality.
   5.2.1. Confidence – data that refers to the student being self-assured, or otherwise.
   5.2.2. Expectations of self – data that refers to the student's own anticipated standard of learning and achievement.

5.3. Motivation (This might end up being an integrative theme) – data that reflects the student's ability to encourage his/herself.

Template – version 2 with definitions

A. PURPOSE OF FEEDBACK (Integrative Theme) – data that reflects an intended use of outcome from feedback.

Authoritarian   Verify Learning.

                       Guide. Improve.

                                           Clarify.

Nurturing   Encourage. Reassure

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1. STYLE OF FEEDBACK – method and manner in which feedback is given or received.

   1.1. Specificity – data that refers to feedback being detailed.
      1.1.1. Transferability – data that suggests (explicitly or implicitly) that feedback can be used elsewhere; feedback not solely applicable to a single event/assessment/setting etc.
      1.1.2. What and how – data that makes clear reference to feedback indicating what was done well (or what was done poorly) and how this should be continued (or corrected).
      1.1.3. Lack of knowledge of expectations – data that illustrates that students are not aware of or do not [fully] understand what is/was expected of them by others.

   1.2. Relevance to Practice – data that suggests an explicit application to clinical or professional practice (or the practice of learning).
      1.2.1. Authenticity – data that discusses simulated learning or learning that has a genuine and valid relationship to or purpose within a healthcare profession and/or healthcare setting.

   1.3. Form of Feedback – data that discusses the form and shape of feedback, such as verbal, written, templates, Turnitin etc.
      1.3.1. Typology – the physical font used within [written] feedback, including colour etc.
      1.3.2. Exemplar – data that refers to a student or an aspect of their work being used as an example to other students (e.g. to demonstrate a learned skill).
      1.3.3. Overt – data that refers to feedback being open, direct and explicit.
      1.3.4. Implied – data that refers to students interpreting meaning (and thus gaining feedback) from other behaviours.

   1.4. Qualities of Feedback – data that makes reference to other objective characteristic of feedback such as the amount, it being personalised, balanced, constructive, only a grade etc.
      1.4.1. Personal – the person behind the feedback is "visible" (E: 528; Carl: 265).

1.4.2.   Personalised – feedback that is specifically constructed for the individual student.

1.5. Language in feedback - data that explicitly illustrates the vocabulary used within feedback.
   1.5.1.   Understandable – data that suggests understanding, or otherwise, of the words and meaning of feedback.

2.   PEOPLE AND SUPPORT STRUCTURES – individuals, and other systems, that support learning.

2.1. Favourable relationship with educator – data that makes reference to a positive and supportive relationship between the student and educator.
   2.1.1.   Respect – data that highlights deference, or regard, between two individuals.
   2.1.2.   Confidence – data that refers to the need to have faith in the person providing feedback.
   2.1.3.   Trust – data that describes the importance of trust between individuals.

2.2. Influence of others (family, friends, peers) – data that suggest that individuals other than the [participant] student and formal educator(s) may have an effect on the student's learning.

2.3. Conflicting roles – data that suggests a real or potential struggle by the same person acting as both educator and assessor.

2.4. External occupations – data that refers to the use of social activities, sport, music and similar as a support mechanism.

3.   EMOTIONAL EFFECTS – the feelings and reactions experienced.

3.1. Personal Criticism – data that makes reference to feedback feeling like a personal criticism.

3.2. Limbic Responses (panic, frustration, disappointed, pride, hatred etc) – data that uses emotive adjectives.

3.3. Reward and Motivation – data that makes reference to feedback being perceived as a reward or in return for someone else's actions (e.g. such as reading and marking the work) which, in turn, acts as a positive motivator itself.
   3.3.1.   Praise – data that explicitly relates to praise, or similar.

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3.4. Lack of confidence by the patient – data that makes reference to any apparent lack of confidence in the student by the patient.

4. CONSISTENCY – the reliability of feedback and marking.

   4.1. Expectations of Educators (links to 2.1.3 somehow) – data that relates to the way educators articulate the objective expectations or their own expectations to students.

   4.2. Fairness – data that discusses students being treated with parity.

   4.3. People are Different (personalities etc) – data that highlights that students are able to recognise that human difference can affect consistency.

   4.4. Academic/University guidelines/control – data that refers to academic regulatory or quality assurance mechanisms that might influence consistency.

   4.5. Matching of grades to feedback – data that makes explicit reference to feedback matching grades (might link to 2.6).

5. QUALITIES OF THE LEARNER – features of the student that may influence the situation.

   5.1. Control of Own Learning – data that illustrates a known ability by the student to affect their own learning.
       5.1.1. Learning styles and study skills – data that shows the student has an insight into what methods and strategies support his/her learning and appropriate study skills.
       5.1.2. Seeks support – data that refers to the student seeking help, or otherwise, to facilitate learning.
       5.1.3. Reflection – data that makes explicit reference to reflection, (in/on action), or shows the student looking back, evaluating or learning from experiences.

   5.2. Self-Perception – data that reflects the student being aware of aspects of his/her personality.
       5.2.1. Confidence – data that refers to the student being self-assured, or otherwise.
       5.2.2. Expectations of self – data that refers to the student's own anticipated standard of learning and achievement.

   5.3. Motivation – data that reflects the student's ability to encourage his/herself.

   5.4. Enjoyment – data that indicates that a student gains enjoyment from a learning and/or feedback experience.

5.4.1. Challenge – data that shows a student gains enjoyment from a challenging situation.

5.5. Pedagogical Knowledge - data that shows the student has an understanding of [some] pedagogy.
   5.5.1. Purpose of feedback – data that shows the student has insight and understanding of the purpose of the feedback opportunity/experience.
   5.5.2. Justifies feedback – data that demonstrates the student attempting to explain and/or justify and/or rationalise the feedback provided [to them] by another person.

5.6. Influencing – data that demonstrates a student wanting to influence other learners.
   5.6.1. "Parental" role – data that demonstrates the student taking on the role of parent within a student-to-student relationship.

6. UNITY OF TIME – concept of past, present or future and/or duration and/or time.

   6.1. Child-like – data that makes explicit reference to being treated like a child or reverting [back] to childhood.

   6.2. Past experiences – data that refers to previous experiences shaping expectations.

   6.3. Timing of feedback – data that makes reference to time and/or chronology of feedback or learning.
      6.3.1. Lack of staff time – data that states that staff members do (or do not) have sufficient time to support students with feedback.

   6.4. "Balancing" time – data that refers to other "life roles" (e.g. father, mother, carer, bread-winner) occupying time.

   6.5. First impressions – data that refers to the [lasting] influence of the first impressions [of a person].

7. CONDITIONS – external, environmental and societal factors.

   7.1. Situation – data that refers to the physical circumstances associated with feedback.
      7.1.1. Convenience – data that refers to the ease with which feedback is accessed.
      7.1.2. Physical environment – data that refers to a specific and named feedback environment (e.g. clinic, placement).

   7.2. Culture – data that makes reference to specific [professional] culture(s) or the philosophy of a particular community.
      7.2.1. "Fitting in" – data that refers to wanting to have a place.

7.2.2. Hierarchy – data that reflects an order [of importance or command].
7.2.3. Like-minded peers – data that suggests commonality with peers can influence learning.

7.3. Power dynamics – data that suggests real or perceived differences in the power held by individuals.
7.3.1. Bullying – data that makes explicit reference to bullying.

Template – version 3 with definitions

A. PURPOSE OF FEEDBACK (Integrative Theme) – data that reflects an intended use of or outcome from feedback.

Authoritarian

Teach

Nurturing

Verify Learning.

Guide. Improve.

Clarify.

Encourage. Reassure

Help.

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1. STYLE OF FEEDBACK – method and manner in which feedback is given or received.

   1.1. Specificity – data that refers to feedback being detailed.
      1.1.1. Transferability – data that suggests (explicitly or implicitly) that feedback can be used elsewhere; feedback not solely applicable to a single event/assessment/setting etc.
      1.1.2. What and how – data that makes clear reference to feedback indicating what was done well (or what was done poorly) and how this should be continued (or corrected).
      1.1.3. Lack of knowledge of expectations – data that illustrates that students are not aware of or do not [fully] understand what is/was expected of them by others.

   1.2. Relevance to Practice – data that suggests an explicit application to clinical or professional practice (or the practice of learning).
      1.2.1. Mirrors teaching – data that describes feedback is using the same format as the teaching process (constructive alignment).
      1.2.2. Authenticity – data that discusses simulated learning or learning that has a genuine and valid relationship to or purpose within a healthcare profession and/or healthcare setting.
         1.2.2.1. False authenticity – data that shows that (so called) authentic practice learning experiences might differ from real-world experiences.

   1.3. Form of Feedback – data that discusses the form and shape of feedback, such as verbal, written, templates, Turnitin, demonstration etc.
      1.3.1. Typology – the physical font used within [written] feedback, including colour etc.
      1.3.2. Exemplar – data that refers to a student or an aspect of their work being used as an example to other students (e.g. to demonstrate a learned skill).
      1.3.3. Overt – data that refers to feedback being open, direct and explicit.
      1.3.4. Implied – data that refers to students interpreting meaning (and thus gaining feedback) from other behaviours.
         1.3.4.1. Misinterpretation – data that show the real or potential misinterpretation of implied feedback.

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1.4. Qualities of Feedback – data that makes reference to other objective characteristic of feedback such as the amount, it being personalised, balanced, constructive, only a grade etc.
    1.4.1.   Personal – the person behind the feedback is "visible" (E: 528; Carl: 265).
    1.4.2.   Personalised – feedback that is specifically constructed for the individual student.

1.5. Prose of feedback - data that explicitly illustrates the vocabulary, use of language and sentence structure within feedback.
    1.5.1.   Understandable – data that suggests understanding, or otherwise, of the words and meaning of feedback.
    1.5.2.   Derogatory – data that makes reference to belittling, rude or insulting language within feedback.
    1.5.3.   Personal – data that makes reference to personal or sensitive issues (e.g. "don't have any more kids").
    1.5.4.   Behaviour – data that describes the behaviours associated with the way in which [verbal] feedback is given (e.g. calm, laughing, shouts, non-verbal communication).
    1.5.5.   Use of Questions – data that describes the use of questions within [verbal] feedback.

2. PEOPLE AND SUPPORT STRUCTURES – individuals, and other systems, that support learning.

2.1. Favourable relationship with educator – data that makes reference to a positive and supportive relationship between the student and educator.
    2.1.1. Respect – data that highlights deference, or regard, between two individuals.
    2.1.2. Confidence – data that refers to the need to have faith in the person providing feedback.
    2.1.3. Trust – data that describes the importance of trust between individuals.
    2.1.4. Approachability – data that refers to educators being approachable or otherwise.

2.2. Influence of others (family, friends, peers) – data that suggest that individuals other than the [participant] student and formal educator(s) may have an effect on the student's learning.
    2.2.1.   Feedback from the patient – data that makes reference to the patient providing implicit or explicit feedback to the student.
    2.2.2.   Working with others – data that suggests that working with others (e.g. in a pair or a group) may alter the learning experience.

2.3. Conflicting roles – data that suggests a real or potential struggle by the same person acting as both educator and assessor.

2.4. External occupations – data that refers to the use of social activities, sport, music and similar as a support mechanism.

3. EMOTIONAL EFFECTS – the feelings and reactions experienced.

3.1. Personal Criticism – data that makes reference to feedback feeling like a personal criticism.

3.2. Limbic Responses (panic, frustration, disappointed, pride, hatred etc) – data that uses emotive adjectives.
    3.2.1. Treating patients is scary – data that suggests students are scared, or similar, by the process of treating patients.

3.3. Reward and Motivation – data that makes reference to feedback being perceived as a reward or in return for someone else's actions (e.g. such as reading and marking the work) which, in turn, acts as a positive motivator itself.
    3.3.1. Praise – data that explicitly relates to praise, or similar.

3.4. Lack of confidence by the patient – data that makes reference to any apparent lack of confidence in the student by the patient.

4. CONSISTENCY – the reliability of feedback and marking.

4.1. Expectations of Educators (links to 2.1.3 somehow) – data that relates to the way educators articulate the objective expectations or their own expectations to students.
    4.1.1. People are Different – data that highlights students are able to recognise that human difference can affect consistency.
        4.1.1.1. Clinicians differ – data that refers to clinicians doing things differently (e.g. clinical reasoning process, treatment techniques).
            4.1.1.1.1. Conformity – data that shows the student wanting to conform to a particular [clinician's] way of doing something.

4.2. Fairness – data that discusses students being treated with parity.

4.3. Academic/University guidelines/control – data that refers to academic regulatory or quality assurance mechanisms that might influence consistency.

4.4. Matching of grades to feedback – data that makes explicit reference to feedback matching grades (might link to 2.6).

5. QUALITIES OF THE LEARNER – features of the student that may influence the situation.

   5.1. Control of Own Learning – data that illustrates a known ability by the student to affect their own learning.
       5.1.1. Learning styles and study skills – data that shows the student has an insight into what methods and strategies support his/her learning and appropriate study skills.
       5.1.2. Seeks support – data that refers to the student seeking help, or otherwise, to facilitate learning.
       5.1.3. Reflection – data that makes explicit reference to reflection, (in/on action), or shows the student looking back, evaluating or learning from experiences.

   5.2. Self-Perception – data that reflects the student being aware of aspects of his/her personality.
       5.2.1. Confidence – data that refers to the student being self-assured, or otherwise.
           5.2.1.1. Critical of self – data that shows the student being critical of his/herself.
       5.2.2. Expectations of self – data that refers to the student's own anticipated standard of learning and achievement.
           5.2.2.1. Knows limitations – data that shows the student is aware of his/her limitations.

   5.3. Motivation – data that reflects the student's ability to encourage his/herself.

   5.4. Enjoyment – data that indicates that a student gains enjoyment from a learning and/or feedback experience.
       5.4.1. Challenge – data that shows a student gains enjoyment from a challenging situation.

   5.5. Pedagogical Knowledge - data that shows the student has an understanding of [some] pedagogy.
       5.5.1. Purpose of feedback – data that shows the student has insight and understanding of the purpose of the feedback opportunity/experience.
       5.5.2. Justifies feedback – data that demonstrates the student attempting to explain and/or justify and/or rationalise the feedback provided [to them] by another person.
       5.5.3. Understands feedback process – data that shows the student understands how feedback should be delivered.
       5.5.4. Explicit demonstration of learning – data that refers to the educator expecting the student to make his/her learning explicit for the benefit of the educator.

   5.6. Influencing – data that demonstrates a student wanting to influence other learners.
       5.6.1. "Parental" role – data that demonstrates the student taking on the role of parent within a student-to-student relationship.

5.6.2. Guiding – data that shows the student using a guiding/corrective/suggestive style of feedback to support a peer.

5.7. Wants to please – data that shows the student wanting to please or impress others.

6. UNITY OF TIME – concept of past, present or future and/or duration and/or time.

6.1. Child-like – data that makes explicit reference to being treated like a child or reverting [back] to childhood.

6.2. Past experiences – data that refers to previous experiences shaping expectations.
   6.2.1. Clinical performance – data that shows the student's clinical performance and/or expectation is shaped by previous clinical experiences.

6.3. Timing of feedback – data that makes reference to time and/or chronology of feedback or learning.
   6.3.1. Lack of staff time – data that states that staff members do (or do not) have sufficient time to support students with feedback.
      6.3.1.1. Availability – data that highlights that staff are [physically] unavailable for feedback.
   6.3.2. Frequency – data that makes reference to the frequency of feedback.
   6.3.3. Acceptability of style – data that suggests a link between the timing of feedback and the style of feedback being more/less acceptable to the student.
   6.3.4. Worthiness – data that shows the student views his/herself as more/less worthy of feedback (e.g. if their patient has left the clinical setting, the student is now less worthy of feedback because other students still have patients and are therefore more worthy of tutor feedback).

6.4. "Balancing" time – data that refers to other "life roles" (e.g. father, mother, carer, bread-winner) occupying time.

6.5. First impressions – data that refers to the [lasting] influence of the first impressions [of a person].

7. CONDITIONS – external, environmental and societal factors.

7.1. Situation – data that refers to the physical circumstances associated with feedback.
   7.1.1. Convenience – data that refers to the ease with which feedback is accessed.
   7.1.2. Physical environment – data that refers to a specific and named feedback environment (e.g. clinic, placement).

7.2. Culture – data that makes reference to specific [professional] culture(s) or the philosophy of a particular community.
   7.2.1. "Fitting in" – data that refers to wanting to have a place.
   7.2.2. Hierarchy – data that reflects an order [of importance or command].

7.2.3. Like-minded peers – data that suggests commonality with peers can influence learning.

7.3. Power dynamics – data that suggests real or perceived differences in the power held by individuals.

7.3.1. Bullying – data that makes explicit reference to bullying.

Template – version 4 with definitions

A. PURPOSE OF FEEDBACK (Integrative Theme) – data that reflects an intended use of or outcome from feedback.

Authoritarian

Verify Learning.

Benchmark.

Confirm.

Guide. Improve.

Clarify.

Encourage. Reassure

Nurturing

Help.

B. OWNERSHIP OF LEARNING (Integrative Theme) – data that shows a student taking responsibility for and being in control of their own learning

1. PROSE OF FEEDBACK – the vocabulary, use of language and structure or form within feedback.

   1.1. Specificity – data that refers to feedback being detailed.
       1.1.1. Transferability – data that suggests (explicitly or implicitly) that feedback can be used elsewhere; feedback not solely applicable to a single event/assessment/setting etc.
       1.1.2. What and how – data that makes clear reference to feedback indicating what was done well (or what was done poorly) and how this should be continued (or corrected).
           1.1.2.1. "Can't be bothered" – data that illustrates that students imply an attitude that "markers can't be bothered" to offer specific feedback when it is absent.
       1.1.3. Lack of knowledge of expectations – data that illustrates that students are not aware of or do not [fully] understand what is/was expected of them by others.

   1.2. Relevance to Practice – data that suggests an explicit application to clinical or professional practice or the practice of learning.
       1.2.1. Mirrors teaching – data that describes feedback as using the same format as the teaching process (constructive alignment).
       1.2.2. Authenticity – data that discusses simulated learning or learning that has a genuine and valid relationship to or purpose within a healthcare profession and/or healthcare setting.
           1.2.2.1. False authenticity – data that shows that (so called) authentic practice learning experiences might differ from real-world experiences.

1.3. Style of Feedback – data that discusses the form, shape, method or manner of feedback, such as verbal, written, templates, Turnitin, demonstration etc.

    1.3.1.   Exemplar – data that refers to a student or an aspect of their work being used as an example to other students (e.g. to demonstrate a learned skill).

    1.3.2.   Physical appearance – data that describes the amount and/or physical presentation of feedback.

        1.3.2.1.   Not indicative – data that discussed whether the amount of feedback provided to the student is indicative of the quality of their work.

    1.3.3.   Overt – data that refers to feedback being open, direct and explicit.

        1.3.3.1.   Understandable – data that suggests understanding, or otherwise, of the words and meaning of feedback.

            1.3.3.1.1.   What's not said – data that refers to what feedback does not explicitly say.

            1.3.3.1.2.   Assumed meaning – data that refers to students interpreting and assuming meaning from other behaviours.

            1.3.3.1.3.   Misinterpretation – data that show the real or potential misinterpretation of feedback.

    1.3.4.   Derogatory – data that makes reference to belittling, rude or insulting language within feedback.

        1.3.4.1.   Own description – data in which the student describes their own work in unfavourable terms.

    1.3.5.   Sensitive – data that makes reference to personal or sensitive issues (e.g. "don't have any more kids").

    1.3.6.   Behaviour – data that describes the behaviours associated with the way in which [verbal] feedback is given (e.g. calm, laughing, shouts, non-verbal communication).

1.4. Design of Feedback – data that makes reference to other intended objective characteristic of feedback.

    1.4.1.   Personal – data that discusses the importance of the person behind the feedback being "visible" (E: 528; C: 265).

    1.4.2.   Personalised – data that describes feedback that is specifically constructed for the individual student.

    1.4.3.   Honest – data that refers to honesty within feedback.

    1.4.4.   Balanced – data that discusses an equilibrium across the components of feedback.

    1.4.5.   Use of questions – data that describes the intended use of questioning within [verbal] feedback.

2. PEOPLE AND SUPPORT STRUCTURES – individuals, and other systems, that support learning.

2.1. Favourable relationship with educator – data that makes reference to a positive and supportive relationship between the student and educator.

    2.1.1.   Respect – data that highlights deference, or regard, between two individuals.

2.1.2. Confidence – data that refers to the need to have faith in the person providing feedback.

2.1.3. Trust – data that describes the importance of trust between individuals.

2.1.4. Approachability – data that refers to educators being approachable or otherwise.

2.2. External influencers – data that suggests other factors may have an effect on the student's learning.

2.2.1. Influence of family, friends and peers – data that suggest family members, friends or fellow students may affect the student's learning.

2.2.2. Feedback from the patient – data that makes reference to the patient providing implicit or explicit feedback to the student.

2.2.3. Working with others – data that suggests that working with others (e.g. in a pair or a group) may alter the learning experience.

2.2.4. External occupations - data that refers to the use of social activities, sport, music and similar as a support mechanism.

2.3. Conflicting roles – data that suggests a real or potential struggle by the same person acting as both educator and assessor.

3. EMOTIONAL EFFECTS – the feelings and reactions experienced.

3.1. Personal Criticism – data that makes reference to feedback feeling like a personal criticism.

3.2. Limbic Responses (panic, frustration, disappointed, pride, hatred etc) – data that uses emotive adjectives.

3.2.1. Treating patients is scary – data that suggests students are scared, or similar, by the process of treating patients.

3.3. Reward – data that makes reference to feedback being perceived as a reward or in return for someone else's actions (e.g. such as reading and marking the work).

3.3.1. Praise – data that explicitly relates to praise, or similar.

3.3.2. Grade for effort – data that suggests a grade could/should/might reward and correlate to the effort and/or time invested in work by the student.

3.4. Lack of confidence by the patient – data that makes reference to any apparent lack of confidence in the student by the patient.

4. CONSISTENCY – the reliability of feedback and marking.

    4.1. Expectations of Educators (links to 2.1.3 somehow) – data that relates to the way educators articulate the objective expectations or their own expectations to students.

        4.1.1. People are Different – data that highlights students are able to recognise that human difference can affect consistency.

            4.1.1.1. Clinicians differ – data that refers to clinicians doing things differently (e.g. clinical reasoning process, treatment techniques).

            4.1.1.2. Conformity – data that shows the student wanting to conform to a particular individual's way of doing something.

            4.1.1.3. Fairness - data that discusses students being treated with parity.

    4.2. Academic/University guidelines/control – data that refers to academic regulatory or quality assurance mechanisms that might influence consistency.

    4.3. Matching of grades to feedback – data that makes explicit reference to feedback matching grades (might link to 2.6).

    4.4. Staff preparation for marking – data that refers to members of staff being prepared for or taught how to mark.

5. QUALITIES OF THE LEARNER – features of the student that may influence the situation.

    5.1. Skills of Learning – data that illustrates some of the skills needed by a student to affect their own learning.

        5.1.1. Learning styles and study skills – data that shows the student has an insight into what methods and strategies support his/her learning and appropriate study skills.

        5.1.2. Seeks support – data that refers to the student seeking help, or otherwise, to facilitate learning.

        5.1.3. Reflection – data that makes explicit reference to reflection, (in/on action), or shows the student looking back, evaluating or learning from experiences.

    5.2. Self-Perception – data that reflects the student being aware of aspects of his/her personality.

        5.2.1. Confidence – data that refers to the student being self-assured, or otherwise.
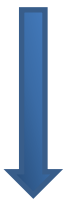
            5.2.1.1. Critical of self – data that shows the student being critical of his/herself.

            5.2.1.2. Worth – data that shows the student views his/herself as more/less worthy of feedback (e.g. if their patient has left the clinical setting, the student is now less worthy of feedback because other students still have patients and are therefore more worthy of tutor feedback).

5.2.2. Expectations of self – data that refers to the student's own anticipated standard of learning and achievement.

    5.2.2.1. Knows limitations – data that shows the student is aware of his/her limitations.

5.3. Motivation – data that reflects the student's ability to encourage his/herself.

5.4. Enjoyment – data that indicates that a student gains enjoyment from a learning and/or feedback experience.

    5.4.1. Challenge – data that shows a student gains enjoyment from a challenging situation.

5.5. Pedagogical Knowledge - data that shows the student has an understanding of [some] pedagogy.

    5.5.1. Purpose of feedback – data that shows the student has insight and understanding of the purpose of the feedback opportunity/experience.

    5.5.2. Justifies feedback – data that demonstrates the student attempting to explain and/or justify and/or rationalise the feedback provided [to them] by another person.

    5.5.3. Understands feedback process – data that shows the student understands how feedback should be delivered.

    5.5.4. Explicit demonstration of learning – data that refers to the educator expecting the student to make his/her learning explicit for the benefit of the educator.

5.6. Influencing – data that demonstrates a student wanting to influence other learners.

    5.6.1. "Parental" role – data that demonstrates the student taking on the role of parent within a student-to-student relationship.

    5.6.2. Guiding – data that shows the student using a guiding/corrective/suggestive style of feedback to support a peer.

5.7. Wants to please – data that shows the student wanting to please or impress others.

6. UNITY OF TIME – concept of past, present or future and/or duration and/or time.

6.1. Child-like – data that makes explicit reference to being treated like a child or reverting [back] to childhood.

6.2. Past experiences – data that refers to previous experiences shaping expectations.

    6.2.1. Clinical performance – data that shows the student's clinical performance and/or expectation is shaped by previous clinical experiences.

6.3. Timing of feedback – data that makes reference to time and/or chronology of feedback or learning.

    6.3.1. Lack of staff time – data that states that staff members do (or do not) have sufficient time to support students with feedback.

6.3.1.1. Availability – data that highlights staff [physically] availability for feedback.

6.3.1.2. No confirmation of learning – data that suggests that staff have no time to check whether skill/knowledge has been learned from feedback.

6.3.2. Frequency – data that makes reference to the frequency of feedback.

6.3.3. Acceptability of style – data that suggests a link between the timing of feedback and the style of feedback being more/less acceptable to the student.

6.3.4. Lack of time to act – data that shows a student has insufficient or limited time to act on feedback due to the timing of the feedback itself.

6.4. "Balancing" time – data that refers to other "life roles" (e.g. father, mother, carer, bread-winner) occupying time.

6.5. First impressions – data that refers to the [lasting] influence of the first impressions [of a person].

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7. CONDITIONS – external, environmental and societal factors.

7.1. Situation – data that refers to the physical circumstances associated with feedback.

7.1.1. Convenience – data that refers to the ease with which feedback is accessed.

7.1.2. Physical environment – data that refers to a specific and named feedback environment (e.g. clinic, placement).

7.2. Culture – data that makes reference to specific [professional] culture(s) or the philosophy of a particular community.

7.2.1. "Fitting in" – data that refers to wanting to have a place.

7.2.2. Hierarchy – data that reflects an order [of importance or command].

7.2.3. Like-minded peers – data that suggests commonality with peers can influence learning.

7.3. Power dynamics – data that suggests real or perceived differences in the power held by individuals.

7.3.1. Bullying – data that makes explicit reference to bullying.

Appendix 6: Final Template (Version 5)

PURPOSE OF FEEDBACK (Integrative Theme)

Authoritarian

Nurturing

Verify Learning.

Benchmark.

Confirm.

Guide. Improve.

Clarify.

Encourage. Reassure

Help.

OWNERSHIP OF LEARNING (Integrative Theme)

---

8. PROSE OF FEEDBACK

8.1. Specificity
   8.1.1. Transferability
   8.1.2. What and how
      8.1.2.1. "Can't be bothered"
   8.1.3. Lack of knowledge of expectations

8.2. Relevance to Practice
   8.2.1. Mirrors teaching
   8.2.2. Authenticity
      8.2.2.1. False authenticity

8.3. Style of Feedback
   8.3.1. Exemplar
   8.3.2. Physical appearance
      8.3.2.1. Not indicative
   8.3.3. Overt
      8.3.3.1. Understandable
         8.3.3.1.1. What's not said
         8.3.3.1.2. Assumed meaning
         8.3.3.1.3. Misinterpretation
   8.3.4. Derogatory
      8.3.4.1. Own description
   8.3.5. Sensitive
   8.3.6. Behaviour
   8.3.7. Convenience

8.4. Design of Feedback

8.4.1. Personalised

8.4.2. Honest

8.4.3. Balanced

8.4.4. Use of questions

8.5. Identity of Feedback

9. PEOPLE AND SUPPORT STRUCTURES

9.1. Favourable relationship with educator

9.1.1. Respect

9.1.2. Confidence

9.1.3. Trust

9.1.4. Approachability

9.2. External influencers

9.2.1. Influence of family, friends and peers

9.2.1.1. Like-minded peers

9.2.2. Feedback from the patient

9.2.3. Working with others

9.2.4. External occupations

9.3. Conflicting roles

10. EMOTIONAL EFFECTS

10.1. Personal Criticism

10.2. Limbic Responses (panic, frustration, disappointed, pride, hatred etc)

10.2.1. Treating patients is scary

10.3. Reward

10.3.1. Praise

10.3.2. Grade for effort

11. CONSISTENCY

    11.1.   Expectations of Educators
       11.1.1.   People are Different
          11.1.1.1. Clinicians differ
          11.1.1.2. Conformity
          11.1.1.3. Fairness

    11.2.   Academic/University guidelines/control

    11.3.   Matching of grades to feedback

    11.4.   Staff preparation for marking

12. QUALITIES OF THE LEARNER

    12.1.   Learning styles and study skills
       12.1.1.   Seeks support
       12.1.2.   Reflection

    12.2.   Self-Perception
       12.2.1.   Confidence
          12.2.1.1. Critical of self
          12.2.1.2. Worth
       12.2.2.   Expectations of self
          12.2.2.1. Knows limitations

    12.3.   Enjoyment
       12.3.1.   Challenge

    12.4.   Pedagogical Knowledge
       12.4.1.   Purpose of feedback
       12.4.2.   Justifies feedback
       12.4.3.   Understands feedback process
       12.4.4.   Explicit demonstration of learning

13. UNITY OF TIME

    13.1.   Past experiences
       13.1.1.   Clinical performance

    13.2.   Timing of feedback
       13.2.1.   Lack of staff time

Appendix 7: Definitions of Final Themes and Subthemes

B. PURPOSE OF FEEDBACK (Integrative Theme) – data that reflects an intended use of or outcome from feedback.

Authoritarian

Nurturing

Verify Learning.

Benchmark.

Confirm.

Guide. Improve.

Clarify.

Encourage. Reassure

Help.

C. OWNERSHIP OF LEARNING (Integrative Theme) – data that shows a student taking responsibility for and being in control of their own learning

---

1. PROSE OF FEEDBACK – the vocabulary, use of language and structure or form within feedback.

   1.1. Specificity – data that refers to feedback being detailed.
      1.1.1. Transferability – data that suggests (explicitly or implicitly) that feedback can be used elsewhere; feedback not solely applicable to a single event/assessment/setting etc.
      1.1.2. What and how – data that makes clear reference to feedback indicating what was done well (or what was done poorly) and how this should be continued (or corrected).
         1.1.2.1. "Can't be bothered" – data that illustrates that students imply an attitude that "markers can't be bothered" to offer specific feedback when it is absent.
      1.1.3. Lack of knowledge of expectations – data that illustrates that students are not aware of or do not [fully] understand what is/was expected of them by others.

   1.2. Relevance to Practice – data that suggests an explicit application to clinical or professional practice or the practice of learning.
      1.2.1. Mirrors teaching – data that describes feedback as using the same format as the teaching process (constructive alignment).
      1.2.2. Authenticity – data that discusses simulated learning or learning that has a genuine and valid relationship to or purpose within a healthcare profession and/or healthcare setting.
         1.2.2.1. False authenticity – data that shows that (so called) authentic practice learning experiences might differ from real-world experiences.

1.3. Style of Feedback – data that discusses the form, shape, method or manner of feedback, such as verbal, written, templates, Turnitin, demonstration etc.

    1.3.1.   Exemplar – data that refers to a student or an aspect of their work being used as an example to other students (e.g. to demonstrate a learned skill).

    1.3.2.   Physical appearance – data that describes the amount and/or physical presentation of feedback.

        1.3.2.1.   Not indicative – data that discussed whether the amount of feedback provided to the student is indicative of the quality of the their work.

    1.3.3.   Overt – data that refers to feedback being open, direct and explicit.

        1.3.3.1.   Understandable – data that suggests understanding, or otherwise, of the words and meaning of feedback.

            1.3.3.1.1.   What's not said – data that refers to what feedback does not explicitly say.

            1.3.3.1.2.   Assumed meaning – data that refers to students interpreting and assuming meaning from other behaviours.

            1.3.3.1.3.   Misinterpretation – data that show the real or potential misinterpretation of feedback.

    1.3.4.   Derogatory – data that makes reference to belittling, rude or insulting language within feedback.

        1.3.4.1.   Own description – data in which the student describes their own work in unfavourable terms.

    1.3.5.   Sensitive – data that makes reference to personal or sensitive issues (e.g. "don't have any more kids").

    1.3.6.   Behaviour – data that describes the behaviours associated with the way in which [verbal] feedback is given (e.g. calm, laughing, shouts, non-verbal communication).

    1.3.7.   Convenience – data that refers to the ease with which feedback is accessed.

1.4. Design of Feedback – data that makes reference to other intended objective characteristic of feedback.

    1.4.1.   Personalised – data that describes feedback that is specifically constructed for the individual student.

    1.4.2.   Honest – data that refers to honesty within feedback.

    1.4.3.   Balanced – data that discusses an equilibrium across the components of feedback.

    1.4.4.   Use of questions – data that describes the intended use of questioning within [verbal] feedback.

1.5. Identity of Feedback - data that discusses the importance of the person behind the feedback being "visible" (E: 528; C: 265).

2. PEOPLE AND SUPPORT STRUCTURES – individuals, and other systems, that support learning.

2.1. Favourable relationship with educator – data that makes reference to a positive and supportive relationship between the student and educator.

2.1.1. Respect – data that highlights deference, or regard, between two individuals.

2.1.2. Confidence – data that refers to the need to have faith in the person providing feedback.

2.1.3. Trust – data that describes the importance of trust between individuals.

2.1.4. Approachability – data that refers to educators being approachable or otherwise.

2.2. External influencers – data that suggests other factors may have an effect on the student's learning.

2.2.1. Influence of family, friends and peers – data that suggest family members, friends or fellow students may affect the student's learning.

2.2.1.1. Like-minded peers – data that suggests commonality with peers can influence learning.

2.2.2. Feedback from the patient – data that makes reference to the patient providing implicit or explicit feedback to the student.

2.2.3. Working with others – data that suggests that working with others (e.g. in a pair or a group) may alter the learning experience.

2.2.4. External occupations - data that refers to the use of social activities, sport, music and similar as a support mechanism.

2.3. Conflicting roles – data that suggests a real or potential struggle by the same person acting as both educator and assessor.

3. EMOTIONAL EFFECTS – the feelings and reactions experienced.

3.1. Personal Criticism – data that makes reference to feedback feeling like a personal criticism.

3.2. Limbic Responses (panic, frustration, disappointed, pride, hatred etc) – data that uses emotive adjectives.

3.2.1. Treating patients is scary – data that suggests students are scared, or similar, by the process of treating patients.

3.3. Reward – data that makes reference to feedback being perceived as a reward or in return for someone else's actions (e.g. such as reading and marking the work).

3.3.1. Praise – data that explicitly relates to praise, or similar.

3.3.2. Grade for effort – data that suggests a grade could/should/might reward and correlate to the effort and/or time invested in work by the student.

4. CONSISTENCY – the reliability of feedback and marking.

   4.1. Expectations of Educators – data that relates to the way educators articulate the objective expectations or their own expectations to students.
       4.1.1.   People are Different – data that highlights students are able to recognise that human difference can affect consistency.
           4.1.1.1.   Clinicians differ – data that refers to clinicians doing things differently (e.g. clinical reasoning process, treatment techniques).
           4.1.1.2.   Conformity – data that shows the student wanting to conform to a particular individual's way of doing something.
           4.1.1.3.   Fairness - data that discusses students being treated with parity.

   4.2. Academic/University guidelines/control – data that refers to academic regulatory or quality assurance mechanisms that might influence consistency.

   4.3. Matching of grades to feedback – data that makes explicit reference to feedback matching grades.

   4.4. Staff preparation for marking – data that refers to members of staff being prepared for or taught how to mark.

5. QUALITIES OF THE LEARNER – features of the student that may influence the situation.

   5.1. Learning styles and study skills – data that shows the student has an insight into what methods and strategies support his/her learning and appropriate study skills.
       5.1.1.   Seeks support – data that refers to the student seeking help, or otherwise, to facilitate learning.
       5.1.2.   Reflection – data that makes explicit reference to reflection, (in/on action), or shows the student looking back, evaluating or learning from experiences.

   5.2. Self-Perception – data that reflects the student being aware of aspects of his/her personality.
       5.2.1.   Confidence – data that refers to the student being self-assured, or otherwise.
           5.2.1.1.   Critical of self – data that shows the student being critical of his/herself.
           5.2.1.2.   Worth – data that shows the student views his/herself as more/less worthy of feedback (e.g. if their patient has left the clinical setting, the student is now less worthy of feedback because other students still have patients and are therefore more worthy of tutor feedback).
       5.2.2.   Expectations of self – data that refers to the student's own anticipated standard of learning and achievement.
           5.2.2.1.   Knows limitations – data that shows the student is aware of his/her limitations.

5.3. Enjoyment – data that indicates that a student gains enjoyment from a learning and/or feedback experience.
  5.3.1. Challenge – data that shows a student gains enjoyment from a challenging situation.

5.4. Pedagogical Knowledge - data that shows the student has an understanding of [some] pedagogy.
  5.4.1. Purpose of feedback – data that shows the student has insight and understanding of the purpose of the feedback opportunity/experience.
  5.4.2. Justifies feedback – data that demonstrates the student attempting to explain and/or justify and/or rationalise the feedback provided [to them] by another person.
  5.4.3. Understands feedback process – data that shows the student understands how feedback should be delivered.
  5.4.4. Explicit demonstration of learning – data that refers to the educator expecting the student to make his/her learning explicit for the benefit of the educator.

6. UNITY OF TIME – concept of past, present or future and/or duration and/or time.

6.1. Past experiences – data that refers to previous experiences shaping expectations.
  6.1.1. Clinical performance – data that shows the student's clinical performance and/or expectation is shaped by previous clinical experiences.

6.2. Timing of feedback – data that makes reference to time and/or chronology of feedback or learning.
  6.2.1. Lack of staff time – data that states that staff members do (or do not) have sufficient time to support students with feedback.
    6.2.1.1. Availability – data that highlights staff [physical] availability for feedback.
    6.2.1.2. No confirmation of learning – data that suggests that staff have no time to check whether skill/knowledge has been learned from feedback.
  6.2.2. Frequency – data that makes reference to the frequency of feedback.
  6.2.3. Acceptability of style – data that suggests a link between the timing of feedback and the style of feedback being more/less acceptable to the student.
  6.2.4. Lack of time to act – data that shows a student has insufficient or limited time to act on feedback due to the timing of the feedback itself.

6.3. "Balancing" time – data that refers to other "life roles" (e.g. father, mother, carer, bread-winner) occupying time.

Appendix 8: Ethical Approval and Access Letters

University of
HUDDERSFIELD

inspiring tomorrow's professionals

10 May 2013

TO WHOM IT MAY CONCERN

Subject: **Ms Sara Eastburn – University of Huddersfield**
Research Project: **"Feedback: its real value and impact on student learning"**
Reference: **SREP/2013/31**

Ms Sara Eastburn, the holder of this letter, is a research student at the University of Huddersfield, where she is currently pursuing a doctorate on the above topic.

Ms Eastburn's research has been through the School Research Ethics Panel (SREP) and her project was approved on 10 May 2013.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.

3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts

6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

7. I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

If you require any further information in relation to this letter, please do not hesitate to contact me.

Yours faithfully

Prof Nigel King
Chair, SREP
School of Human and Health Sciences
Direct Tel: +44 (0)1484 472812
Email: n.king@hud.ac.uk

Queensgate Huddersfield HD1 3DH UK Telephone +44 (0) 1484 422288 Fax +44 (0) 1484 516151
Vice-Chancellor: Professor Bob Cryan DL BSc MBA PhD DSc

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06 June 2013

Ms Sara Eastburn
Head of Division of Health and Rehabilitation
School of Human and Health Sciences
University of Huddersfield
Queensgate
Huddersfield
HD1 3DH

Dear

ID: 1083 Feedback: its real value and impact on student learning

The Research and Development department has considered the following documents in support of your application for approval to undertake the study on the premises of ████████████████████████ Trust:

Document	Version	dated
Protocol	1	16-05-13
Consent Form	1	26-04-13
Participant Information Sheet Educator	2	10-05-13
Participant Information Sheet Student	2	10-05-13
Uni SREP approval		10-05-13
IRAS SSI Form		17-05-13

Your study now has R&D approval on the understanding and provision that you will adhere to the following conditions:

That the research should:

i. Comply with the requirements of The Research Governance Framework for Health and Social Care (2nd DH 2005);
ii. Comply with regulatory requirements and legislation relating to: Clinical Trials, Data Protection, Health and Safety, Trust Caldicott Guidelines, and the use of Human Tissue for research purposes;
iii. Be conducted in accordance with: ICH Good Clinical Practice and/or the MRC guidelines for good clinical practice (as appropriate);
iv. Not commence until it has received written approval from a UKECA recognised Research Ethics Committee (REC) and that any REC imposed conditions of that approval are implemented;

You must also:

v. Request written approval for any change to the approved protocol/study documents that you or the Chief Investigator wish to implement;

1. Ensure that all study personnel, not employed by ███████████████████
   ████████ Trust, hold either an honorary contract with the Trust or a letter of
   access issued by the Trust, before they have access to any facilities, patients, staff, their
   data, tissue or organs;
2. Complete the Research Governance interim and final reports as requested;
3. Submit monthly recruitment and screening data to R&D (if applicable).
4. Comply with our audit and monitoring procedures as required.

Please note:

5. The use of medicines not in the hospital formulary for the purpose of research is
   restricted to trust approved trial protocols only. Continued use of them outside or at the
   end of a clinical trial will require a formal application to and approval from the Medicines
   Management Committee. Trial participants should be made aware of this situation.

**This approval letter constitutes a favourable Site Specific Assessment (SSA) for
this site**

Please be aware that the R&D department has a database containing study related
information, and personal information about individual investigators e.g. name address,
contact details etc. This information will be managed according to the principles established
in The Data Protection Act.

Yours sincerely

███████████████

Director of Research and Development

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Letter of access

12 June 2013

Miss Sara Eastburn
University of Huddersfield
Queensgate
Huddersfield
HD1 3DH

Dear Miss Eastburn

Letter of access for research : 'Feedback: its real value and impact on student learning'

This letter confirms your right of access to conduct research through ███████████
████████████████████████ Trust for the purpose and on the terms and conditions set out
below. This right of access commences on 10 June 2013 and ends on 31 March 2014 unless
terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of
permission for research from this NHS organisation. Please note that you cannot start the
research until the Principal Investigator for the research project has received a letter from us
giving permission to conduct the project.

The information supplied about your role in research at ███████████████████████████
█████████ Trust has been reviewed and you do not require an honorary research contract with
this NHS organisation. We are satisfied that such pre-engagement checks as we consider
necessary have been carried out.

You are considered to be a legal visitor to ████████████████████████████████████ Trust
premises. You are not entitled to any form of payment or access to other benefits provided by
this NHS organisation to employees and this letter does not give rise to any other relationship
between you and this NHS organisation, in particular that of an employee.

While undertaking research through ██████████████████████████████████ Trust, you
will remain accountable to your employer the University of Huddersfield but you are required to
follow the reasonable instructions of ███████████████ in this NHS organisation or those
given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of
or in connection with your right of access, you are required to co-operate fully with any
investigation by this NHS organisation in connection with any such claim and to give all such
assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with ████████████████████████████████████ Trust policies
and procedures, which are available to you upon request, and the Research Governance

Framework.

You are required to co-operate with ████████████████████████████████ Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on ████████████████████████████████ Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

████████████████████████████████ Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

████████

Director of Personnel & Development ████████████████████████████████

cc: R&D office at ████████████████████████
        ████████ Trust

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Email dated 7th October 2013

Revision to previously approved SREP Application (previously approved 10-May-13) - Sara Eastburn (EdD Student) - APPROVED - Feedback: its real value and impact on student learning (Ref: SREP/2013/31_Rev)

To: Sara Eastburn
Cc: Jane Tobbell; Karen Ousey

07 October 2013 09:47

Dear Sara,

Dr Karen Ousey, Chair of SREP, has asked me to confirm that the revision to your previously approved SREP application, as titled above, has received full ethical approval.

With best wishes for the success of your research project.

Regards,

Kirsty
(on behalf of Dr Karen Ousey, Chair of SREP)

Kirsty Thomson
Research Administrator

: 01484 471156
: K.Thomson@hud.ac.uk
: www.hud.ac.uk

School of Human and Health Sciences Research Office (HHRG/01)
University of Huddersfield | Queensgate | Huddersfield | HD1 3DH

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ID: 1083 Feedback: its real value and impact on student learning

The Research and Development Department at the single NHS Trust provided continued approval to undertake the study on their premises on 11th October 2013 following amendments made to a single participant information sheet.

This approval was signed by the Director of Research and Development.