FRIENDSHIPS AND THE COMMUNITY OF STUDENTS: PEER LEARNING AMONGST A GROUP OF PRE-REGISTRATION STUDENT NURSES

Background to the study.

Organisation of the thesis.

This thesis is presented in three sections, each section being a stage in the research process: making clear the fore understandings with which the work is approached; interrogation of the social world and finally, reflecting with new insights on the initial approach. The sections relate to a framework suggested by Ashworth (1987). The following introduction provides an overview of the chapters within each section. According to Johnson (1995) ethnography is not necessarily constrained by conventional chapter headings such as literature review, method, results, discussion and so on, rather it is more important for a good ethnography to tell a story "supported by appropriate data and making relevant comparisons with other literature as it moves through a narrative" (p32).

Introduction

This research seeks to explore the nature and value of peer learning for a group of pre-registration nursing students and specifically aims to examine a group of student nurses in order to inquire whether they learn from each other and if so, how, when and where this takes place. Secondly, the work aims to discover more about the process used by those nurses while engaging in peer learning and to unearth their perceptions of and value systems ascribed to this type of learning. In this context the students engage in peer learning as they learn from and through each others' experience. This research is set against the backdrop of recent changes within nurse education in the United Kingdom. In 1999, the Peach report made several main recommendations regarding the future of pre-registration nurse education, including the integration of knowledge and skills through balanced time in

theory and practice together with the fostering of interpersonal and practice skills through experiential and problem-based learning (UKCC 1999). In this case the fellow learners are a group of pre registration student nurses enrolled on a programme leading to registration as Adult Branch nurses with a Diploma level academic qualification. The curriculum (based on the Fitness for Practice recommendations within the Peach report) convenes the group (known as a base group) together throughout the course at regular intervals, and utilizes a strategy of problem based learning as part of a range of teaching and learning strategies in order to help the students to acquire the knowledge required by a qualified nurse. It is important to differentiate peer learning from other mechanisms which involve students in learning from each other. For example, peer teaching or peer tutoring is a far more formal and instrumental strategy whereby advanced students or those further on in progression, take on a limited instructional role (Boud, Cohen and Sampson 2001). In other words, the more senior students are used to formally teach various aspects of the curriculum to more junior students.

Whilst the literature regarding experiential learning makes it clear students can and should benefit from learning through primary experience, it seems that there is an emerging body of literature which asserts that students are also able to learn from each other's experiences. This notion of learning from and through another's experience is a central concept of the focus of this research. Although individual students will have their own personal experiences from clinical practice other students may benefit and use the shared examples in order to learn. Students may use another's experiences in both academic and clinical contexts; hence this work explores peer learning in both settings and has the potential to contribute to the generation of a deeper knowledge base in this area.

Whilst experiential learning is known to play an important part in nurse education, student peers may learn from each other in other ways which, to date, have not been fully explored. Some previous work has made tentative suggestions that student nurses learn from each other and find this learning

valuable (Melia 1984, Davies 1993) but very little is known about the mechanisms used by student nurses in learning from their peers. This research seeks to discover more about the process of peer learning in both academic and clinical contexts. Through taking an ethnographic approach using direct observation and conversation the student experience of peer learning is revealed. Throughout this thesis the researcher acts as interpreter of the student experience presenting a novel perspective on the data and uses a research framework as proposed by Ashworth (1987).

The position of the researcher also plays an important part in the research in that not only do I want to develop my understanding of the student experience, but also I want to provide others with my insights as a researcher through reflexivity. Therefore, like many other nursing researchers (Olesen and Whittaker 1968, Seed 1991, Gray 1997) I shall be writing in the first person, and including my thoughts about what is being found, thought or constructed through the research. The position of the researcher is also crucial in that the students under study and the researcher are inextricably linked. The relationship between researcher and participants is explored in some detail. Time is also taken to provide the reader with my personal location and journey to the research.

Chapter Two explores what is already known in the form of a literature review (conducted before and during the research). The review is divided into two clear sections examining student learning in general terms and the second section explores work more specifically related to learning to be a nurse. The literature is related to my preconceived ideas or fore understandings. The importance and relevance of the fore understandings in relation to the thesis is explained. Chapters Three and Four are concerned with what Ashworth suggests is the second stage of the research process: interrogation of the social world. Chapter Three outlines the philosophical assumptions that underpin the research method, approach to the participants and highlights concerns about uncovering tacit knowledge and gaining access to the back stage world of the students. Chapter Four discusses the reality of undertaking

the research and includes details regarding ethical approval and gaining consent from research participants. The chapter also discusses the issue of participant observation in relation to the research and outlines how data collection and analysis were undertaken. Data includes audio tape recordings from clinical practice and the classroom, field notes recorded in both settings and reflexive thoughts. There is discussion regarding the nature of the connections made between the data and the subsequent development of themes in the findings.

Four clear themes emerged from the data: friendships and peer learning, the importance of story telling and peer learning, the process of peer learning in clinical practice, and peer learning and professional socialization. A further emerging theme was also evident within the data from which tentative conclusions can be drawn: peer learning in the academic setting. (These are discussed as emerging themes which requires further research, and can be found in Chapter Nine.) Each theme is presented as a chapter in its own right together with discussion which locates the emerging theory within existing literature (theory). Each chapter of findings is also related back to the initial fore understandings with the subsequent development of new fore understandings.

Chapter Five establishes clear links between friendship and learning. The findings indicate that friendships facilitate an 'ask anything' culture within clinical practice. The students form their own community offering each other mutual practical help and asking questions of each other. The students seek each other out to ask questions rather than appear foolish in front of the qualified staff. Students perceive each other as being of equal status and being all in the same boat.

The findings described in Chapter Six demonstrate the importance of story telling to peer learning. Peer learning through story telling is evident in both academic and clinical settings. In clinical practice students chose to share their stories away from the bedside and after the work was finished; in other words, the students separated learning and working. Story telling in class is

associated with learning about the emotions of nursing. Students in the study are able to learn vicariously through the experiences of their peers. Shared clinical practice enhances learning through story telling as students use imagination and contextual knowledge to fill in the gaps left by the story teller. Practice encounters are shared in the classroom and the emphasis is on learning practice but in the classroom.

The mechanisms associated with peer learning in clinical practice are unearthed (Chapter Seven) and show that students ask each other questions as a way of confirming what they already know. The students use their peers to provide confirmation that they were on the right lines. They formed ideas concerning the solution to their own problem prior to asking the question, and framed questions in order to elicit a positive response. The students in the study used peer learning to teach each other clinical skills; helping each other through the procedure by using coaching and instruction. Clinical skills such as undertaking dressings were seen as the legitimate role of the qualified staff; however when observing their peers the students did not challenge practice; competency was assumed. The data shows clear links between confidence and learning. The students adopted a front of confidence to gain access to patients in order to refine their skills; aiming for fluid and speedy performance so as to appear confident in front of each other, the qualified staff and patients. However, the notion of chronological seniority is challenged. Seniority is contextual rather than being time served on the programme; students are seen as all holding important knowledge which is not dependant on length of time on the course.

In addition to learning clinical skills from their peers, the findings demonstrate how students acted as role models and helped each other to become socialised into the profession. This is the subject of Chapter Eight. In clinical practice the students passed on vital survival skills concerning the intricacies of each clinical placement. Those who had been on the ward slightly longer than other students were seen to ‘know the ropes’; this contextual knowledge was seen as more important than being senior in terms

of time spent on the programme and hierarchy. However, the third years were accessed by junior students who wanted to know that it would be like to be a third year student. The junior students used the senior students to prepare themselves for the time when they would be third years. The students often struggled to find the nursing role and experienced blurred boundaries between the work of students and the unqualified health care support workers. In particular the students were unsure of the value of undertaking what they saw as unqualified support workers' nursing (bathing, feeding and dealing with personal needs); when they would not necessarily practice such skills once qualified.

The third and final stage of the research is to reflect with new experience on the initial approach (Chapter Nine). The chapter explores issues relating to reflexivity, method, interpretation, the impact of the researcher on the research and the impact of the research on the researcher. Areas of emerging findings for future research are presented. Finally, new fore understandings are revealed and conclusions drawn.

SECTION ONE

Making clear the fore understandings with which the work is approached.

Ashworth (1987) asserts that researchers approach a field of enquiry with preconceived ideas. These ideas are borne out of the experiences, values and personal location of the researcher. It is important that the researchers' ideas are made explicit at the start of the research and held open to challenge and revision throughout the research. This section of the thesis will iterate the preconceived ideas or fore understandings (as Ashworth terms them) with which I approached this work. My fore understandings developed as a consequence of both personal experience as a student nurse, qualified nurse and educator but also from reading and reviewing the literature. This section of the thesis consists of two Chapters, one of which relates to personal location, setting the scene for the research and expresses the research aims and questions. The second Chapter reviews the literature regarding learning and more specifically learning to be a nurse.

Chapter One

Framing the research and personal location

This chapter explores facets of personal location associated with my professional role together with my beliefs and understanding of research and in particular the relationship between these facets. It is important to articulate my world view and basic belief system as this is seen as a vital part of the research process (Denzin and Lincoln 2000). Therefore, this chapter attempts to clarify and articulate my journey to this research together with reflections on my beliefs about the research process. Reflexivity requires critical examination at all stages of the research process and may lead the researcher to change some aspect of research design. By detailing decisions which are taken, a clear and logical journey is outlined, which is an important strategy for achieving rigour in qualitative research (Northway 2000). Reflexivity may also promote personal growth and self actualisation on the part of the researcher (Lamb and Huttlinger 1989). Therefore, the thesis is part of my personal development as a researcher and educator; my personal development being just as important as the findings of the research.

Koch (1999) argues that in recent decades nursing research has shifted to include interpretive approaches with a two fold result: firstly, increased understanding of our clients or community and secondly, our reflections as researchers. The results which Koch describes mirror the philosophy behind this research in that not only do I want to increase my understanding of the experiences of the students that I teach, but I also want to provide others with my insights as a researcher through reflexivity. Koch goes on to say that knowing our own position on the nature of reality helps us to understand what happens when we research, how we make sense of the data generated, and if appropriate the selection of the interpretive frameworks to guide our analysis. Therefore, the first stage is to locate my own position.

For me there are three equally important facets that influence my personal location (with regard to this research): I am a Nurse, an Educator and a

Researcher. Undoubtedly my prior experiences have shaped my world view; I do not come to this research without background and it is important to acknowledge and describe this. Lamb and Huttlinger (1989) explain that nurse researchers have the special task of examining how they may have been influenced not only by their personal values but by those associated with the culture of nursing and nursing research as well. The culture of nursing as I practiced and experienced it is unique to me; it is important to consider the impact of my history in terms of how my world view of nursing was developed.

My journey to becoming a Nurse began in 1984 at the age of seventeen. My own nurse education took place in the South of England and the curriculum followed the recommendations of the Platt Report (1964) that the standard of entry to nurse education should be five subjects at Ordinary Level. Unlike the present day where the recommendation is to enable students to have prior learning and experience accredited to enable them to access nurse education (UKCC 1999). Previously in 1977, the Government accepted that there should be one statutory body for Nursing and Four National Boards. The English National Board syllabus leading to registration included a period of training which then consisted of 156 weeks, with the total amount of time allocated for study blocks being not less than 24 weeks and an introductory course of six to eight weeks. A modular system of training was used whereby elements of theory were taught in the classroom followed by eight weeks of related practice on the wards. The nature of the theory for any one block or module varied but typically the majority of time in the classroom was spent learning about the nursing care of specific kinds of patients, for example: care of the breathless patient, care of the diabetic patient and so on. The classroom theory was mainly delivered by nurse tutors with some sessions delivered by medical doctors and other health professionals. The teaching in the clinical setting was undertaken by qualified nurses although some wards were supported by a clinical teacher. Essentially the role of the student nurse was one of apprentice, working as a member of the ward team and learning

on the job. I can remember some particularly good nurse tutors and staff nurses who helped me to learn in the practice setting. I can also still recall some influential student nurses who were more advanced in their training and who supported me in clinical practice. I do not recall any students from within my own cohort, my peers from either theory or practice who I would consider influential in my learning. There may of course be several reasons for this: my memory may be flawed; there may not have been any or I may have valued the help of the senior students far more. However, it is important to acknowledge my background and experiences as a student have undoubtedly informed my approach to this research and the development of my philosophical standpoint and preconceived ideas about what it is like to be a student nurse. I qualified as a Registered Nurse in 1987.

After moving to North East Wales in 1987 I worked as a staff nurse in a private hospital. It was while working here that I began my journey to becoming an educator. In 1986 the UKCC issued a document entitled: Project 2000: a New Preparation for Practice which would see major changes to nurse education in the United Kingdom. Included within the proposals was that the student nurse should be recognised as a learner rather than a worker and as such should be supernumerary for all but the final six months of the training period and would be paid via a non-means tested bursary paid by the Department of Health. Furthermore, student nurses would study at a higher academic level: a Diploma in Nursing and programmes of nurse education would be delivered by Institutes of Higher Education rather than at Schools of Nursing attached to Hospitals. Later there would also be a requirement for teachers of nursing to hold a degree, this in itself would have a great influence over my journey to becoming a lecturer. In 1992 I met a lecturer from a local HEI and she was interested in helping our hospital to become a placement for student nurses. However, she needed to be sure that we were capable of being a suitable learning environment and that as qualified nurses we could teach and assess students appropriately. The lecturer became an influential educator for me; she motivated me to learn and convinced me that

I should study for a Diploma in Nursing with a view to being able to act as a mentor to student nurses. I finished my Diploma studies in 1996 and started to teach students in practice. However, I had been bitten by the bug of learning and soon decided that I wanted to concentrate more on teaching and less on being a nurse so I set about undertaking a degree in nursing with the firm view that I wanted to become a full time lecturer. I worked as a ward sister and studied part time; I too was learning and working. I completed my degree in 1998 and secured my first teaching post in 2000.

Finding a way

Like many others embarking on this journey I found that deciding on a research approach was not without its difficulties. In order to find a way I immersed myself in the literature pertaining to nurse education and sought advice from colleagues with greater expertise. However, rather than providing the clarity I sought, it seemed that the more approaches I read about or discussed with colleagues; the greater the number of seemingly suitable approaches were open to me to use within my research. Many of the research approaches could be transposed on to my work. I found myself looking for the easy option (if indeed there is such a thing), rather than trying to find the most appropriate approach for my research question. I soon realised that in order to decide on an approach it was necessary to firm up the research question. Initially I had been reviewing the literature on nurse education in general without a specific purpose. I needed to decide what it was that I wanted to study. Koch (1999) suggests that as nurses we often ask questions that are better answered interpretively; asking our clients to tell us their stories about what it is like, what are their experiences and what are their interpretations. This subsequently leads us to seek the most appropriate method to answer the questions: “What is happening here?, What sense can I (as a researcher) make of this?” This notion helped to refine my search, since I now wanted to find out what was happening when student nurses were together in groups, both in the academic and practice setting. I wanted to

understand what was going on in terms of learning from each other. Furthermore, I realised that although surrounded by student nurses almost every day, I knew very little about the impact that they have on each others' learning. According to Bjornsdottir (2001) research needs to be an integral part of everyday nursing practice, a way of posing questions and reflecting on answers. Therefore it seems applicable to study a group of students who are a part of my everyday practice; in other words, to study the very students who surround me every day and form the everyday practice of my work as an educator. As a nurse educator I am rooted in the business of seeing the whole person; this notion filled my practice as a nurse and inevitably infiltrates my work as a teacher. I engage with my students constantly trying to push their thinking; creating teachable moments in order to promote their understanding. I consider the dialogue as crucial to my teaching but it is unclear whether the students see it as central to their learning. Therefore, by studying an ordinary, typical group of students and our journey it is hoped that elements will be unearthed which may be applied to nurse education more generally.

In my work as a lecturer in nursing I am surrounded by student nurses every day, I am steeped in nurse education. I meet student nurses during their assorted programmes leading to first level registration; I am responsible for facilitating their learning. Sometimes this provides me with a snapshot of individuals as our paths cross temporarily at various stages of the curriculum; in other cases I facilitate the same group of students for the entire three years of their academic programme. In each case I am always fascinated by how these individuals learn to become nurses, sometimes against all odds. Unlike some other students in higher education, student nurses learn in two settings: practice and classroom. Many are mature students with children who juggle the demands of student and home life, financial sacrifice is not uncommon.

As soon as I started to think about undertaking a research degree I was fairly certain that I wanted to have a greater understanding of how the students I teach every day learn to become nurses. The initial inquiry took the form of a

literature review exploring student nurses learning networks. This enabled me to see what was already known about learning to be a nurse. My early literature reviews highlighted that much has been written about various aspects of student nurse life, including studies in clinical practice and in the classroom. However, it seems that less attention has been paid to researching from the students' perspective. Areas which are widely researched include the role of mentors, the impact of socialisation and the role of educators. However, there appeared to be a gap in the literature concerning peer learning in nurse education. Student nurses are surrounded by other student nurses (peers) yet there has been little research which seeks to understand the impact of fellow students on learning. Reading and reviewing literature helped me to form a view about which approach I should take and also helped me to understand that reviewing literature is in itself a process which takes place not only prior to the study but also can be used to inform the data analysis and act as a source of data in its own right. Therefore (in response to this) throughout the thesis, literature will be used to provide an overview of the main concepts associated with the research focus and to substantiate a particular stance adopted in the choice of methodology and finally to explore and expand on the discussion of the findings.

I decided, therefore, that I wanted to study peer learning amongst student nurses, from their perspective, in order to add to the body of knowledge concerning this aspect of learning to be a nurse. Therefore my preliminary research questions were:

- Are student nurses learning from each other?
- When and where does this learning take place?

Following the literature review these questions were subsequently refined. The main purpose of the research is that it will inform learning and teaching practice (my own and that of others). Application of the research findings may have a wider sphere of influence beyond nursing.

Establishing the research approach: Why ethnography?

Holland (1999) explains that until the late 1990s the examination of nurses and their cultural world remained virtually unexplored and suggests that there is a need to view nursing through a different lens. Holland asserts that nursing is a cultural system with the arrangements for the socialisation of new members being an important aspect of its structure (1993). Therefore it seems that there is a need for educators to have a greater understanding of the processes involved as students have to learn the cultural rules during their transition through the programme of nurse education. In particular, Holland argues that ethnography is especially valuable to nursing because it "addresses both the means of developing a research culture whilst also being a tool to explore the culture of nursing itself" (Holland 1999. p231). From a personal perspective it is important that the research approach enables the study of students that I teach regularly in order to discover their experiences of nurse education and in particular the impact of their fellow students on those learning experiences. Therefore the method should minimise the distance between the researcher and the participants (students); reflect my philosophical beliefs (about individuals and their place and value within the research process); allow for the observation of students in a variety of settings (participant observation) and be sympathetic to the aims of the research. Therefore, from these key requirements ethnography is the research approach which most closely reflects these philosophical ideals.

Ethnographic studies involve immersion in the culture to be studied and ethnographers are compelled to participate (Peacock. 1986). Within this study the immersion within the culture is established. Holland (1999) explains that the ethnographer adopts a dual role of participant and researcher within the research itself and this enables the meaning to be constructed by both the informants and the researcher together through the developing interactions and their relationship with one another. In her study Holland argues that being known to the students as a teacher and being a nurse herself, enhanced

the shared understanding of the cultural world; furthermore, this is seen as strengthening the research. Peacock (1986) argues that the ethnographer does not simply gather facts, rather his study is of and among humans and therefore, detachment is impossible to sustain; he is inevitably involved. However Allen (2004) points out that the practice of ethnography requires careful attention to issues of identity and social status and the role of the researcher in the generation of data. This statement is an important point to consider and one which is discussed further in Chapter Three. Ellis and Bochner (2000) argue that the emphasis placed on the research varies between the research process (graphy), on culture (ethnos) and on self (auto). Whilst this thesis is not an autoethnography, in this case all three elements are visible within the thesis since it seems that all three are closely linked and together form the whole. Ellis and Bochner (2000) make no comment about whether one element is more important than another, however Allen (2004) warns against an over emphasis on self; a point which is discussed more fully in Chapter Nine.

Ethnography refers to the description of people and the cultural basis of their peoplehood (Peacock, 1986) and according to Vidich and Lyman (2000) are thought to be atheoretical being concerned solely with description and is often associated with anthropology. In ethnography the researcher uses participant observation in order to understand the world of others (Leininger 1998. Johnson 1997. Lathlean 1996). According to Lathlean (1996) there is a range of comparative involvement and subjectivity through to comparative detachment and objectivity in participant observation; a point which is fully discussed later. Ethnographic studies are particularly important in nursing research since they focus “on the wholes in the life experience” (Leininger 1998. p31), indeed, Leininger goes on to say that ethnography offers the hope of “developing substantive, empirical and abstract nursing data in the field” (p33). However, whether or not ethnography does this may depend on the researcher and the approach taken. Ethnography is viewed as analogous with nursing in that (for me) ethnography is about entering the life world of the

informant or research participant to obtain their world view. Leininger refers to this as "getting to the truths of the what, why and how of people's lifeways and the thoughts, feelings and actions that accompany such living (Leininger 1998. p34). It seems to me that this is exactly what nurses (should) do in forming the therapeutic relationship. However, Leininger seems to assume that there is only a single objective description of the social world; one which the researcher is able to reliably capture. Recent trends in ethnography oppose such a belief. Trends in ethnography are explored further in Chapter Three: Planning the ethnography.

Research focus: To explore peer learning amongst student nurses. The student experience is interpreted as revealed through observation and ethnographic conversation in order to achieve a greater understanding of peer learning. The research strategy is rooted in participant observation and is essentially an interpretive ethnographic approach (both of which are explained in later Chapters). The study is qualitative in nature and consists of three stages offered by Ashworth (1987) as a framework for the conduct of this interpretive ethnography. The three distinct stages to the research being: making clear the fore understandings with which the work is approached; interrogation of the social world with which the researcher is concerned and finally, reflecting, with new experience on the initial approach (Ashworth. 1987). The work is presented using these three stages.

Research Aims:

This research has three main aims:

- To explore the experiences of a group of student nurses in order to enquire whether student nurses learn from each other and if so, how, when and where this takes place.
- To discover more about the process used by those student nurses whilst engaging in peer learning in both academic and clinical contexts.

- To reveal the students' perceptions of and value systems they ascribe to learning from each other.

Theoretical framework

The nature of this research means that it is impossible to separate the research aims and my own professional experience. In the early stages of this process I struggled with the notion of objectivity within the research. Initially when I started to write down my thoughts and reactions to the literature I did not consider my ideas to be important. Rather they were just my initial reactions to the literature based on my own experiences as a lecturer and many years previously as a student nurse. My reactions served no purpose. However, while I was considering my approach to this research I was drawn to the work of Ashworth (1987) who explains that initial reactions and thoughts are in fact important, and can be put to use within the research. Professor Peter Ashworth is a member of the Institute for Learning and Teaching in Higher Education; his main area of work is in the philosophy of psychology but his empirical work is in the areas of higher education and nursing. Indeed he acts as referee for several peer reviewed nursing journals (Journal of Advanced Nursing, Nurse Education Today and Journal of Clinical Nursing). His first degree is in psychology and his own doctoral thesis focuses on the personal changes which students undergo in the process of teacher training; his professional life is especially concerned with the promotion of human science and the development of research techniques based on existential-phenomenological thinking (Personal correspondence 2006). One of the main reasons I found his work so influential is that it explores two areas which are central to this thesis; namely, education and student nurses.

Ashworth (1987) argues that when approaching any area of study, even those which are unfamiliar, entails a set of presuppositions about its nature: fore understandings. He presents a useful model indicating a way of practising qualitative research which includes tests of the adequacy of descriptions. Indeed, Ashworth asserts that using his approach helps to ensure that

"prejudices do not determine results, that the descriptions are not arbitrary and that the findings are valid" (p8). His three stage model lends itself well to my research question; allows and enables me to make known and utilise my fore understandings, and helps me to gain a better understanding through reflection. The three stages of his model are making clear the fore understandings with which the work is approached; interrogation of the social world and finally, reflecting with new experience, on the initial approach. The model is practical in its approach and "makes sense", and therefore seems appropriate for my research.

Ashworth (1987) suggests that there is a constant process of interpretation and revision of fore understandings during the research process. In order to achieve understanding, the interpreter must not only engage in a dialogue with the text but must also examine explicitly the origin and validity of the fore understandings present. Ashworth (1987) argues that some fore understandings are general whilst others are more focused; and there are some which entail the felt, personal involvement of the researcher in the subject matter of the research.

Initially I approached the work with six fore understandings:

1. That in terms of learning in clinical practice, student nurses learn from each other; using mechanisms which have not been fully explored and are poorly understood. Moreover, students value peer learning in the clinical setting.

   This first fore understanding developed as the literature review progressed. It became clear that very little had been written which seeks to explore the notion of students learning from each other. However, since it is generally accepted that students value clinical learning over and above the learning which takes place in the classroom (Smith and Stephens 2001); it seems logical to assume that they would value peer learning in clinical practice in much the same way.

2. Dialogue plays an important part in peer learning for student nurses in practice.

   This second fore understanding developed from reviewing the literature pertaining to nurse education, although some work within Higher Education generally also highlights the importance of dialogue to learning. Initially I considered the dialogue within clinical practice to be highly valued because I anticipated it would be essential to learning to be a nurse.

3. In terms of learning outside the clinical domain, student nurses do not value learning from each other in small groups in the same way as they value peer learning in practice.

   This is an important point; it highlights my own perceptions concerning the primacy of clinical learning and perhaps is a result of my own history as a student nurse. At the beginning of the research my view was that learning from peers in clinical practice is somehow different to learning from peers within the classroom setting. I was looking to the research to find some insights into whether my fore understandings were borne out by the students and if so, to highlight the ways in which the learning is different.

4. Mechanisms such as problem based learning purport to develop learning through dialogue whereby students challenge each other.

   From my own experiences this is not the case; it is lecturers that provide the challenge, rather than the students themselves.

5. The notion of shared learning (with other branches) in nurse education is a misnomer, particularly when students are expected to undertake shared learning early in the common foundation programme.

6. Interprofessional learning may enhance the value students ascribe to learning from each other in groups.

These fore understandings are important to acknowledge because they may influence the research in so much as they may lead me away from the students' experience. Ashworth and Lucas (2000) emphasise that it is the research participant's experience which should be revealed, not the researcher's expectations. Therefore, making the fore understandings explicit at the start of the research is essential in ensuring that the research is not prejudiced by the researchers' preconceived ideas.

Whilst each of the fore understandings is important and carries equal weighting in my mind, this research focuses on the first four. The reasons for this include the fact that the curriculum in which the group of students under study is engaged does not feature any inter professional or multi disciplinary sessions where students from professions other than nursing are learning together. I wanted to examine the reality of the students' education, rather than looking elsewhere for students I did not know. Additionally, whilst shared learning with students undertaking programmes leading to registration as child health and mental health nurses does feature within the curriculum, I felt that the opportunities for observation were fewer than if I remained with adult branch students. These initial fore understandings are used as the framework to direct the observation of student nurses in academic and practice settings.

Ashworth is not unique in his use of the notion of prior experience, fore understandings and background. Much of the literature has been informed by translated work of German philosophers; Heidegger, Husserl and Gadamer. Fleming et al (2003) highlight the fact that these works have all been translated from the original German and have therefore been subject to interpretation, since each translation has a slightly different focus. Indeed Koch (1999) refers to these original works as "impenetrable texts" (p28), and

suggests that much of what has been written about them in nursing research is unreflective and regurgitated and often unrelated to the specific inquiry. Since I do not speak German I am not able to provide my own interpretation of their work and so must rely on the work of others. However, when trying to read translations I found that I agreed with Koch, finding much of the concepts and ideas impenetrable and difficult to understand. Koch (1999) explains that it was not the intention of Husserl, Heidegger and Gadamer to provide a research approach but to reflect on the nature of reality (ontology). For Koch this refers to the general orientation to life and asking "What does it mean to be a person?" According to Koch if Husserlian thinking is applied, the researcher would ask about the meaning of human experience; leaving personal thoughts and experiences aside so as not to contaminate the data. But for me this seems impossible, since separating myself from the research process is unattainable. I cannot set aside what I have experienced as if it were unimportant. Secondly, Koch goes on to describe an alternative research position where we are neither inside nor out, "we are in our culture as it is in us…it is a world that we live and, as we live it, it is a world that we are" (p24). For me this seems an important philosophical position. We cannot live in isolation from the world, we are bound together. Koch explains that Heidegger and Gadamer take this second "hermeneutic" position. Furthermore by accepting this hermeneutic premise means that people are seen as self interpreting. Therefore, I bring my preunderstandings to the research. The Heideggarian position is that as an interpreter I participate in making data, precisely because the hermeneutic circle cannot be avoided (Koch 1995).

Researcher participant relationships

According to Gillespie (2002) there is a new emphasis on the centrality of the student-teacher relationship that is egalitarian and liberating for both student and teacher. Gillespie describes the concept of student-teacher connection as

a partnership which supports co participation in the learning process and is characterised by a high degree of mutuality. Mutual knowing, trusting and respecting, and communicating are said to be essential to the formation of student-teacher connection (Gillespie 2002). Gillespie demonstrates that within connected relationships students feel at ease, valued and respected; experience positive self regard and the relationship affirms the students as people, learners and nurses and that this in turn supports the learning process. Similarly, a key finding by Jinks (1997) demonstrates clear links between caring for students and caring for patients. In her study Jinks explores the interrelationships between student-centered teaching and learning and patient centered care. The study showed inconsistencies in the nature of student centered teaching, the nurse teachers interviewed however, demonstrated that individualism, humanism and empowerment are perceived as key factors in both patient centered care and student centered learning (Jinks 1997). These features are also important to me as an educator. I am clearly linked to the students within this study; I spent six months developing relationships with them as a teacher prior to undertaking this research. I know them as people. I see the students as co researchers in the sense that we are learning together. Although I have a responsibility to the students, to facilitate their learning; I do not see our relationship as hierarchical; although I acknowledge that I remain in a position of power. However, I am assuming that my students feel the same; unlike Gillespie and Jinks I have not explored whether they perceive this to be the case. However, Gillespie describes relationships between students and teachers which takes place within a clinical setting; where students and teachers work together in clinical practice. Never the less the concept of connectedness may be transferable to other settings where there are student teacher relationships. Gillespie urges teachers to consider the balance of power within student-teacher relationships and comments that factors including the teachers' use of their knowledge within the relationship, their willingness to be known as a person and nurse, and their predominant role, have been noted to influence the nature of the student-teacher

relationship. She goes on to say that connected teachers are a positive influence on students' professional socialisation and should consciously create opportunities in which students can access their embedded knowledge. The influence of nurse teachers on student learning has been shown to be under estimated; in fact nurse teachers were the most significant people to the students in Jinks' study (1997). This notion of the power base between students and teachers is particularly pertinent to this research as I am studying a group of students who is known to me and I would like to think that I uphold Gillespies' notions within my own practice. This concept is deliberated upon further in Chapter 4.

Student profile

The group is typical of the entire cohort being made up of thirteen women and two men. The ages of the individuals on commencing the course ranged from eighteen to forty-five and are also representative of the cohort. Some of the students had previous experience within healthcare as auxiliary nurses, health care assistants, care workers or carers in the community (six students), whereas others had no previous health care experience (nine students). Many of the students had children and had waited for what they considered to be the right time to commence nurse education. Three students left the course within the first year.

Information regarding the students who provided key information can be found in Appendix Five (Page 287.).

The context of the students

The students in this study are on a programme of pre-registration education leading to a Diploma level qualification in Adult Nursing. They are part of a larger cohort of students who all commenced the course at the same time. Student nurses in the United Kingdom study to be registered as Children's nurses, Mental Health nurses, Learning Disability or Adult nurses. The curriculum closely followed the recommendations made within the Fitness

for Practice report (UKCC 1999) therefore the students spent fifty percent of their time in clinical practice and fifty percent of their time within the university to study the theoretical aspects of nursing. According to Watson, Stimpson, Topping and Porock (2002), this change towards equal time spent in clinical practice and theory was designed to give greater emphasis to clinical skills development. The students within this study were allocated to one of three NHS Trusts across the region; within those Trusts, the students attended clinical placements in five sites. Whilst in clinical practice the students are taught by clinical staff however the nature of practice learning is often ill defined. Mentorship appears to be the preferred approach to providing students with support and guidance and in many cases encompasses the activities associated with learning, teaching and assessment of practice (Andrews and Roberts 2003). Students are assessed in clinical practice by their mentors.

Within the context of this curriculum specific practice based learning outcomes have to be achieved by the students to enable them to progress throughout the programme; and in particular to move from the common foundation programme (the first year) on to the branch programme (years two and three). (Later, these practice based learning outcomes would be replaced by the NMC, introducing standards of proficiency.) The development of learning outcomes to be achieved in clinical practice emphasised the need for students to develop clinical competence. However, Ashworth and Morrison (1991) point out that the notion of competence is somewhat nebulous: a wide concept which embodies the ability to transfer skills and knowledge to new situations. Furthermore, Ashworth and Morrison are of the opinion that competence must not be the only basis for educating nurses, indeed they go so far as to say that the emphasis on competence is a major hindrance to educators because if competence is seen as the outcome of behaviour, not a mental skill, then the things which are central to teaching and learning may be lost (Ashworth and Morrison 1991). The revised standards of proficiency

issued by the NMC (2004) would indicate that the initial concerns outlined by Ashworth and Morrison have not been addressed.

Mentors are expected to address the learning needs of students in practice settings, but Andrews and Roberts (2003) point out that in reality students call on a variety of individuals during their placement experience depending upon who can best service their needs at any one time. Therefore students may learn from unqualified staff and fellow students (peers). However, little is known about these informal learning networks; hence the need for this study.

Students within this study were allocated into learning groups whilst in university, typically containing between twelve and eighteen students. According to Ashworth and Morrison (1991) the outcomes of nursing practice are typically the work of a group of nurses, nurses work in teams (some of which include other professional disciplines) and they suggest "no specific individual's mental powers or personal skills have to be the source of a successful outcome, nor does any aspect of good nursing care have to be traceable to an individual" (p258). Therefore, it seems that this separation of the cohort into smaller learning groups is justified, since it may prepare the students for their future team roles. The group meets regularly together with the same lecturer (known as a base group facilitator) throughout the three years of the programme. The students progress through the course together on the same journey towards the goal of becoming qualified nurses. Whilst their experiences will be individual there is a common goal to qualify as Registered Nurses. There is an expectation that the students will work together in groups to provide suggestions or solutions to the real life problems with which they are presented. The curriculum within the university predominantly used the learning and teaching strategy of problem based learning. Typically lessons take the format of problem based learning sessions, although the group was also involved with seminars (with other base groups) and lectures to the entire cohort.

Characteristically, problem based learning is a three stage process; in the first session students are expected to examine the case, trigger or scenario and identify cues, facts and inferences from the given information (Andrews and Jones. 1996). In the second session the students revisit and refine their ideas about possible solutions to the problem (Blackford and Street. 1999). In the third session students present the new knowledge to each other which them to synthesise and test new knowledge. Savin-Baden (1999) is of the firm opinion that the groups in which the students work must be effective; although she acknowledges there is little research into the roles and relationships that take place during problem based learning. Therefore, this thesis may provide some insight into peer relationships and their impact on learning through group work and problem based learning sessions.

In addition to this the students also provide each other with feedback from their practice encounters and share their experiences largely through story telling. Therefore the literature regarding story telling is explored within the literature review. Although the students go out into practice at the same time; they are allocated different clinical placements. Each clinical placement (a ward, clinical department or primary care setting) dictates the numbers of students they can take at any one time and this is usually dependent on the numbers of mentors available to work with and assess students. The students may be on a clinical placement with other students but not necessarily from the same base group, or indeed the same cohort or programme of study. As programme progresses so the students will work with different students on a variety of placements. Students within this curriculum however, always return to the same constant base group.

In the case of this curriculum, problem based learning as a method is not formally assessed. Indeed the base group facilitator plays no part in the formal assessment of the students in the base group to which they are allocated. The marking of theoretical assignments takes place blindly across the cohort. This is an important point and one which influenced the decision to research students who were known to me. The relationship between the

researcher and the group under study, and in particular the power base of that relationship is crucial to the research process. The researcher respondent relationship is fully discussed in Chapter 3.

Conclusion

This Chapter has outlined my personal location and journey to the research. My personal philosophical values concerning the approach to the research are established through acknowledging my prior experiences and placing the thesis within the current context of nurse education. In particular I have iterated the six fore understandings with which the research was approached; the first four of which, together with the research aims form the central tenet of the thesis. Having decided on the research approach it was important to review what is already known about student learning, and in particular, learning to be a nurse; therefore a review of the literature forms the basis of the next Chapter.

Chapter Two

Literature review

Introduction

Initially reading and reviewing the literature enabled me to gain theoretical sensitivity but throughout the study I found myself returning to the literature, undertaking constant comparative analysis. The literature is reviewed in two distinct categories: the pedagogy of student learning; in other words literature pertaining to learning in general terms and secondly, learning to be a nurse. The literature relating to research methods is included within Chapters Three and Four (Planning the ethnography and Living the ethnography, respectively). Whilst there is an abundance of literature regarding how student nurses relate to mentors during clinical learning; the literature relating to mentorship is not included within this review. This is largely because the literature relating to mentorship does not shed any light on the focus of this thesis; namely how students learn from each other. Within the first section here the literature explored is further divided into four key areas or concepts namely: deep and surface approaches to learning, developmental learning, experiential learning, group work and vicarious learning. These concepts appeared regularly throughout the literature reviewed and each concept is seen as influential to the research. Included in the main concepts are several important sub themes, within the concept of deep and surface approaches to learning for example, is the sub theme of attaining deeper learning. Within the concept of experiential learning the sub themes of learning through and from experience; learning as understanding and learning through doing are examined. Similarly, within the concept of group work an analysis of three further sub themes is undertaken: discourse, language and dialogue. The second section of the literature review explores the more specific work relating to learning to be a nurse and contains the following seven key concepts: nursing knowledge; professional learning; non formal learning; experiential learning in nursing; vicarious learning through story telling in

nursing; peer support and professional socialisation (with the sub theme of peers as role models). A critical overview is provided together with a summary of the review. The refined research questions, which were developed following the review are presented.

Search Strategy

Databases searched included those pertaining to education as well as nursing and included British Education Index, British Nursing Index together with global searches through CINAHL. Although my research is conducted within England, I felt it was important to glean an understanding from what had already been investigated more widely. Key words used to conduct the computer based searches initially included student nurse learning, nurse education, learning for professional practice, peer learning, peer learning in nurse education, peer teaching, learning from each other, co operative and collaborative learning. No chronological time limit was set on the parameters of the search in order to ensure that any older, but none the less important literature was included. In addition I also read other doctoral studies examining similar areas. The search unveiled a vast amount of literature, much of it concerning mentorship and support provided by qualified nurses to students. Whilst this was interesting and provided me with a good basis for learning amongst student nurses, I felt that the search lacked focus and was too broad, however, this initial trawl of the literature was crucial in helping me to firm up the research question and further focus the review. The literature was collated into themes and is presented here together with appropriate critical comment and discussion.

Section one: The pedagogy of student learning

Deep and surface approaches to learning

It appears that there are three broad areas which have been the focus of student learning to date: those which identify or seek to identify the

characteristics of student learning irrespective of subject under study; those seeking to identify the stages of intellectual development of students in higher education, again where subject is not taken into account and thirdly studies which explore the stages and processes whereby “novices” become “experts”. These studies are often applied to specific knowledge or subject domains.

Marton and Saljo (1976) argue that there are two basic approaches to learning among students reflecting different intentions; known as deep and surface approaches to learning. The surface approach is characterised by memorising unconnected facts to be reproduced at a later date. The deep approach is concerned with making sense, is more conceptual in nature and requires meaning to be transformed. A student using a predominantly surface approach tends to learn in a superficial manner with an emphasis on rote learning. Students using a deeper approach have an intrinsic interest in the subject and needs to understand what is learned through reading and research (Snelgrove. 2004). Higher education fosters a deep approach to learning however, within nursing surface approaches or rote learning are also considered to be important. For example, as Jinks (1997) points out, the learning of psychomotor skills entails being able to recall or to do things quickly, automatically and without thinking. Within the realm of clinical practice, such speedy and efficient performance of clinical skills is paramount.

Dreyfus and Dreyfus (1980) developed an influential stage model from studies of skill acquisition in airline pilots, chess players, automobile drivers and adult learners of a second language; which outlines the process of development from novice to expert. (Occupations which are diverse and not all of which are relevant to higher education.) They suggest that as we experience different situations, rather than using formal rules to guide our actions this is replaced by intuitive thinking. Experts are said to perform at an intuitive level without conscious decision making taking place. Benner (1984) applied the Dreyfus and Dreyfus model to nursing and her work has

often been used as a theoretical framework for pre-registration programmes. Benner identified five levels of competence: novice, advanced beginner, competent, proficient and expert. Expertise is learned through a linear process and takes place over time. However, although Benner acknowledges the need for critical reflection in order to progress up the scale; she does not make it clear how to move between the levels of proficiency.

It should also be remembered that the educational context has an impact on the students' conceptions of learning and the approaches taken to learning. This notion is explored in a phenomenological study undertaken in Finland with sixty nursing students by Eklund-Myrskog (1997). The study used interpretive phenomenology asking students to say how they learned new things and how they knew when they had learned something. The paper presents only a single example of data for each of the five identified conceptions of learning. However, the author provides tables which infer that many students in the study experienced a similar way of learning; although evidence from the students themselves to support the assertions made is minimal. It is also unclear how the author constructed the tables from the data. Eklund-Myrskog asserts that the educational framework in which the student learns has an impact on the approach taken to learning. Five conceptions about learning are identified ranging from remembering and keeping something in mind; through learning in terms of understanding and knowledge application; through to learning in terms of getting a new perspective and forming a conception of one's own (Eklund-Myrskog. 1997). Generally students took a deep approach to learning at the end of the programme than at the beginning. Students related learning to ways in which they tackled different learning tasks. Similarly, Alexander (2001) argues that programmes of study force the students into learning often in a superficial way and may even prevent them from achieving true mastery of the knowledge that forms the basis of their work (with children). Alexander (2001) suggests that childcare students are merely developing a set of performance skills that enables them to imitate what they see happening in

the workplace. In Eklund-Myrskogs' study students conception and motives for learning were determined by the demands and expectations they experienced within the framework of their school. In other words, students would often concentrate on learning and understanding what they thought would be evaluated within that frame of reference (Eklund-Myrskog. 1997).

Sub theme: Attaining deeper learning

Students are said to be able to deepen their knowledge and understanding through engagement in authentic tasks in real settings. Learning is achieved through imitation, communication and co operation and becoming a cognitive apprentice to more expert practitioners. Andrews and Roberts (2003) explain Vygotsky's concept of the zone of proximal development (ZPD) whereby a child's mental performance can be assessed in two ways. Firstly, the traditional method of assessing responses through I.Q. tests and secondly the level at which the child can function while participating in instructional interaction; termed by Vygotsky as the zone of proximal development. In order for maximum learning to take place, teaching must be at the ZPD. Teaching at too low or too high a level will not increase learning; too low nothing new will be learned and too high will go over the students' head (Andrews and Roberts 2003).

According to Vygotsky higher mental functions have their origin in human social life. Problems are solved as a child works with a more competent partner; the problems with which the child is faced become increasingly complex; this promotes understanding. The more experienced partner uses support and encouragement to extend the child's level of skill (Vygotsky 1978). The key to learning is threefold: social interaction with another, the cultural environment and the importance of the task. Vygotsky outlines four stages of the zone of proximal development. In the first stage the performance is assisted by someone else: parents, teachers or peers. Initially the child imitates the other persons' performance; as the task progresses the child learns the relevance of each of the component parts of the task through

conversation. In the second stage, the child begins to direct the activity with their own speech, consistently talking to themselves. Control passes "from the expert to the apprentice. What was guided by the other is now beginning to be guided by the self" (Tharp and Gallimore. 1998. p102). In the third stage, the task is executed in a smooth and integrated manner as the child leaves the zone of proximal development and enters what is termed the developmental stage for that task. Finally, in the fourth stage, the de-automization and recursion occur. Changes in the environment, individual stress, physical trauma may all lead to a de-skilling. In order to overcome this, individuals will return to the second stage of external speech.

> "Making self speech external is a form of recursion often effective in restoring competence. A further retreat to that point in the zone – consciously recalling the voice of a tutor – is an effective self control technique" (Tharp and Gallimore. 1998. p104).

Andrews and Roberts (2003) make the point that Vygotsky's work; although originally written about child development, may have significance for nurse education since many of the concepts he describes could be applied in particular to learning in the clinical environment. However, it may be easier to identify the use of the ZPD when students are learning psychomotor skills compared to what they are learning within the classroom. Therefore, it will be interesting to see if these concepts described by Vygotsky are visible within the study of this group of adult learners.

Experiential learning and reflection

Deweys' early work examined the importance of experience in education. He suggests that experience alone is not enough for learning to take place, rather it is the quality of the experience which matters (Dewey 1938). He argues that observation alone is useless; it is necessary to understand the significance of what we see, hear, touch. Furthermore, the role of the educator is crucial in

selecting the kind of experiences which will promote further learning in the student. According to Dewey it is up to educators to apply direction and challenge in order to promote growth and development. Educators use their greater maturity of experience to evaluate the experience of the learner in a way that he can not do for himself, it is the business of the educator to see in what direction the experience is heading. Dewey's work speaks of the educator as the adult and the learner as a child. However, it would seem that the concepts he discusses are applicable to learners who are adults.

Kolb (1984) and Gibbs (1988) describe experiential learning cycles, whereby learning takes place through and from personal experience. Kolb suggests that reflection is interrelated to the learning process as reflection enables learners to move from concrete experience to an abstract conceptualisation of that experience, on which future actions and subsequent experiences are based. For Kolb experiential learning involves personally experienced events being stored in episodic memory and over time, used to construct generalised knowledge structures in semantic memory.

The concept of reflection is not new; as early as 1933 Dewey described reflection as "active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further considerations to which it tends" (p9). According to Dewey experience has two elements; the experience itself and the careful thought and consideration about what the experience means. Using reflection to learn is different from merely thinking things over. Schon (1983) purports that there are two types of reflection: reflection in action and reflection on action. Reflection in action is described as spontaneous, the practitioner does not stop to think, but recognises a new situation or problem and thinks while acting in a seamless manner. Reflection in action is said to be the best method of developing knowledge in a practice discipline; although he offers little practical guidance on developing reflective skills. Reflection on action is a retrospective contemplation of practice which leads to a better understanding (Schon. 1983).

There appears to be a gap within the literature concerning clinical supervision and Adult branch student nurses. (Although there is much which focuses on clinical supervision and qualified nurses. The reasons for this remain unclear however; it could be argued that the provision of clinical supervision to students should follow after supervision is available to qualified staff. The notion of purposeful dialogue is a recurring theme as a method of promoting experiential learning amongst student nurses and indeed there is a strong focus within the curriculum on reflection for the students in the study.

Sub theme: learning through and from experience

1. Learning as understanding

Learning is also described by some authors as a hermeneutic or interpretive process (Ashworth 2004. Nehls 1995). According to Ashworth the learner is primarily an inquirer whose prior understandings are of prime importance as the individual comes to the educational situation with different experiences or understandings. Furthermore, these understandings are unique and launches each individual on what Ashworth terms as a "trajectory of interpretation" which in turn leads to varied outcomes as far as their perspective on the material is concerned. This notion of learning as interpretation is important because it forms a consistent thread within this research. The students are seen as interpreting in order to learn and I in turn use interpretation to learn from and about them. Ashworth does however acknowledge that in order for learning to take place, the individual must approach the expert micro-culture in the attitude of someone attempting to understand. In addition to this essential attitude towards understanding he suggests that in order for learners to interpret (and therefore learn from) another's experience, the individual must be attuned to the other's discourse. Therefore learning does not necessarily take place through doing, indeed Ashworth asserts that it is conversation and questioning through conversation which forms the ideal circumstance for interpretation. Students are said to compare the meanings of their own life world to those offered through the conversation and therefore

learning is seen as a more intimate and personal process (Ashworth 2004). These concepts are mirrored by Nehls (1995) who suggests that learning takes place through dialogue and attention to caring practices. She argues that through description and hermeneutical analysis of experiences the students are able to derive meaning from what is imminent in nursing. The narratives teach and evoke reflective thinking about aspects of nursing practice that are often absent in text books or difficult to grasp without practical experience. However, Coles (1989) is critical of this view and argues against such unpicking of nursing practice, suggesting that deconstruction of the human experience in this way reduces the meaning and impact of the experience. For Nehls the classroom is seen as a forum for interpretive thought where fundamental philosophies of narrative pedagogy are uncovered for teachers and learners. This reciprocal approach is one which sits well with my own philosophical stance: teacher and student learn together through the sharing of practice based encounters.

2. Learning through doing

Learning by doing is a concept developed by Wenger (1998) who suggests that learning is part of our everyday lives. Wenger presents four premises about what matters about learning, the nature of knowledge, knowing and knowers. Firstly, we are social beings and this is a central aspect of learning. Secondly, knowledge is a matter of competence with respect to valued enterprises and therefore, thirdly, knowing is a matter of participating in such enterprises and involves active engagement in the world. Finally, Wenger says that our ability to experience the world and our engagement with it as meaningful, is ultimately what learning is to produce (Wenger 1998. p4). For Wenger learning is not a separate activity, it is not something we do when we do nothing else. This is an interesting point since with regard to nurse education and learning in clinical practice; learning is often reported as a separate activity to nursing care, and is often described as taking place when the work has finished.

Learning is characterised by interacting with the world and with each other and Wenger suggests that learners engage in legitimate peripheral participation as apprentices within communities of practice. Whilst interacting and working in the world we tune our relations with each other and with the world in order to learn. It is this collective learning which Wenger suggests results in "practices that reflect both the pursuit of our enterprises and the attendant social relations; the practices become the property of a kind of community, created over time by sustained pursuit of shared enterprise" (Wenger p45). Therefore, Wenger terms these communities "communities of practice". Based on this definition student nurses may not necessarily belong to a community of practice, since when in the classroom "shared enterprise" may or may not exist and when in clinical practice they are scattered between different communities of practice and may not be perceived as legitimate members of the community. Furthermore, there may be additional difficulties facing student nurses in joining the clinical community of practice. For example, Wenger describes the concept of practice as "including both the explicit and the tacit. It includes what is said and what is left unsaid, what is represented and what is assumed, subtle cues, untold rules of thumb; most of which may never be articulated, yet they are unmistakable signs of membership of the community of practice" (p47). In nursing in particular, there may be many unwritten, implicit rules for the student to overcome.

In order to understand any situation involving several people it is necessary to focus on the situation itself and the transactions of the participants throughout the period of inquiry. In addition to this it is important to consider the contribution of the situation to the learning careers of the participants (Eraut 2000). From a situational perspective knowledge is already present in established activities and cultural norms, and imported through the contributions of new participants; but Wenger questions whether new participants do in fact contribute to new knowledge, arguing that they become encultured into maintaining the status quo. According to Eraut, from

an individual perspective some of the newcomers' knowledge is resituated in the new setting and integrated with other knowledge acquired through participation. However, this notion relies on appropriate and active participation which may not happen for all individuals within a group in the classroom (or indeed in clinical practice). Eraut argues that knowledge is expanded, modified or transformed according to the magnitude of the impact of the situation. However it may be possible that it is memory which is expanded and not necessarily knowledge. Some events remain unchanged in memory for several years without ever reaching a personal understanding or meaning. If learning is always situated in a particular context as Eraut suggests; then this raises questions about why only some knowledge is resituated. By definition, that which is not resituated must just be stored in memory until such times as deliberation takes place or until a similar context presents itself when the learning can be used, developed and restored as new knowledge. In some cases, (particularly within nursing practice) similar contexts may never be subsequently encountered and deliberation may not be achieved.

Group work

It is suggested that people are more likely to remember what they learn in small groups; such learning involves both cooperative and collaborative learning (Will 1997). However, Topping (2005) asserts that many schools think they are implementing such learning strategies when all they are really doing is putting individuals together and hoping for the best. Although the cohort for this study was separated into (smaller) base groups there appeared to be no rationale as to how the groups were arrived at; perhaps an approach which is little better than hoping for the best. Will (1997) explains that cooperative learning in groups reinforces the learning of each member of the group through discussion and peer review whilst learners work together on a

given task. Collaborative learning is explained as knowledge that is socially constructed and assumes the negotiation of different perspectives (Will 1997). Therefore it will be important for this thesis to explore whether the students under study are working cooperatively and, or, collaboratively since there may be implications for the delivery of the curriculum.

Group work and cooperative learning is expounded by Slavin (1996) who presents four major theoretical perspectives on cooperative learning and achievement. He explains that motivational perspectives on cooperative learning focus mainly on the reward or goal structures under which students operate. The only way that the team can succeed is to ensure that all group members have learned; the group does this by explaining concepts to one another, helping one another practice and encouraging one another to achieve. The second perspective suggested by Slavin is that of social cohesion whereby students will help one another to learn because they care about one another and want one another to succeed (Slavin 1996). When group members sub divide the topic into tasks within the group, the students undertake their investigations and then present their findings to the class as a whole. This, he suggests creates interdependence among group members; the idea being that if students value their groupmates, and are dependent on one another, they are likely to help and encourage each other to succeed. However, one problem acknowledged by Slavin with this method is that students have limited exposure to material other than that which they studied themselves, so learning gains on their own topics may be offset by losses on their group-mates topics. This concept would seem to be important in terms of the impact of group work on student learning. However, Slavin's studies comment on School and College participants and may not be transferable to adult education. Jinks (1997) explains that traditionally the art and science of helping adults to learn (andragogy) has been viewed as something separate and different to that of helping children to learn (pedagogy); and that nurse education may not necessarily favour an approach steeped in andragogy.

Slavin (1996) also outlines cognitive and developmental perspectives on group work. The cognitive perspective holds that that interactions among students will in themselves increase student achievement due to mental processing of information as opposed to motivations. Students will learn from one another "because in their discussions of the content, cognitive conflicts will arise, inadequate reasoning will be exposed, disequilibration will occur and higher quality understandings will emerge" (Slavin 1996. p49.). However, the underlying assumption is that this will occur without any intervention from teachers. One of the most powerful methods involved in the cognitive perspective is suggested as cognitive elaboration (Slavin 1996). An effective means of elaboration is suggested as explaining material to someone else; students gaining from cooperative learning activities are those who provide elaborate explanations to others (Slavin 1996). This notion is supported by Parr and Townsend (2002) and Schwartz (1995) who suggest that when working and discussing in groups individuals undertake cognitive restructuring. This is said to result from incorporating ideas that contradict current schema. The restructuring may come from providing explanations to others whereby the act (perhaps in the context of justifying personal views of sharing expertise) leads to greater understanding on the part of the giver and to demonstrable cognitive gain (Schwartz 1995). Topping (2005) suggests that rather than putting individuals together and hoping for the best; peer learning cognitively involves conflict and challenge together with support and scaffolding from a more competent other, necessitating the active management of activities to be within the zone of proximal development of both parties. This suggests that hoping for the best is far from ideal and implies that careful facilitation of learning is required. However, what is most interesting is that again this work concerns the study of children in groups yet clearly, some elements seem to be transferable to adult learning. If such work is applicable to adult learning then this may be an important point to acknowledge because methods which encourage students to provide such

elaborate explanations to each other should be encouraged. This may have implications within nurse education.

Developmental perspectives are linked to theories of cognitive development; whereby interaction among children around appropriate tasks increases their mastery of critical concepts. Slavin (1996) outlines the work of Vygotsky (1978); whereby problem solving under adult guidance or in collaboration with more capable peers extends the child's zone of proximal development. Collaborative activity promotes learning because children of similar ages are likely to be operating within one another's zone of proximal development. However whether this notion is applicable to student nurses requires further research. Perhaps there are similarities in the cognitive development of adults and children.

Problems associated with using group work over a longer period are reported by Spalding, Ferguson, Garrigan and Stewart (1999). They suggest that where social cohesion within the group is good, the learning experience is enhanced and conversely, where not, students are deprived of an effective learning experience (Spalding et al. 1999). They go on to suggest student led group work structured around open ended tasks appears to be the best vehicle for the exchange of experience and facilitation of personal reflection. Tasks and activities which foster group discussion are said to include problem solving activities such as scenarios, brainstorming, syndicated work, group presentations, case studies and simulations. Furthermore, students in Spalding et al's study were able to articulate their expectations and concerns about group processes. There are direct similarities from this study to the concepts suggested within the literature on problem based learning and may serve to explain how the process benefits student learning. Interestingly, in Spalding et al's study (1999) twelve PGCE students evaluated the role of group work and stated that the hands on experience offered by placements was more highly rated than the opportunities for reflection offered by the group. This is not dissimilar to the attitude displayed by student nurses when discussing the

usefulness of classroom versus practice. For example, Smith and Stephens (2001) demonstrated that students recognised skills, attitudes and behaviours acquired in clinical practice to be more profound and lasting than those acquired in the University.

Eraut (2000) argues that participation in discussion often involves thinking about the topic, rapid comprehension of what is said and rapid decision making about when to speak and what kind of contribution to make. In each case he suggests that there appears to be more than one mental process in action; some individuals make considerable use of explicit knowledge while others rely mainly on tacit knowledge. He goes on to say that whilst these processes are distinguishable from one another, little is known about how they interact. Eraut also questions whether knowledge is personally or socially generated. Learning is always situated in a particular context; comprising not only location and a set of activities in which knowledge either contributes or is embedded but also a set of social relations which give rise to those activities. Therefore it is uncertain as to whether knowledge is individually or socially constructed within a culture (Eraut 2000). This thesis seeks to explore the question of the nature of knowledge for student nurses.

In Savin-Baden's study students (from a variety of courses in higher education) used problem based learning groups to enable them to make sense of interrelationships between problem solving processes, prior experience and new material being learned. Through dialogue with peers, students are able to consider how to tackle the given problem and thus integrate that which had been incomprehensible and unfamiliar into their life worlds (Savin-Baden. 1998). Savin-Baden suggests that the dialogue and learning is linked to the notion of students developing a learner identity. Kendall and Wickham (2001) are highly critical of the notion of identity within cultural studies, as they argue it is an ill defined concept lacking in precision and detail; allowing commentators to "fix the entity rather than engaging in a description of that entity's relationship to its putative class or classes" (p157). None the less, Savin-Baden's work may have implications for nurse education in that

student nurses may need to think purposefully about practice with other student nurses in order to gain understanding. Further more, such dialogue may be more useful if it takes place outside of the clinical setting. This notion adds further weight to the need for more research into peer support amongst student nurses.

Sub theme 1: Discourse and peer learning in groups

Dialogue between students is often referred to as discourse within the literature on learning in Higher Education. Many studies suggest that students are able to learn vicariously through such discourse (Ashworth 2004. Ellis, Calvo, Levy and Tan 2004. Northedge 2003. Harden 2000. Nehls 1995. Diekelmann 1990, 1993). The discourse is sometimes shared through conversations, narratives, testimony or stories and these terms are sometimes used interchangeably. Learning is sometimes perceived as having taken place when students are able to participate in the specialist discourse of a knowledge community (Northedge 2003). Northedge (2003) points out students cannot always participate in specialist discourse because they find it difficult to understand; this is largely due to a backdrop of unspoken assumptions which provide the frame of reference within which it becomes meaningful. He goes on to say that frames of reference are elusive and called into play by subtle cues, often taken for granted by members of the knowledge community which prevents students from understanding and hence from participating.

Students may also choose not to engage in discussion, but this is not considered by Northedge. Ellis et al (2004) explain that higher education students may deliberately opt out of discussion or may use the discussion to develop generic communication skills, or as a way of finishing a task. This, they suggest, indicates a lack of intention to understand the project more fully through discussion. Additionally some students will say something during discussion (even if it is not relevant) in order to appear interested and engaged with the subject.

Sutherland (1999) presents multiple case studies of the learning of mature adult students on a professional course and demonstrates that students needed to be assignment driven. Although, presentations which were not marked were seen as a valuable learning experience; listening to other students undertaking their presentations was positively received but this depended on the quality of the presentation and the topic content.

Morris and Turnbull (2004) outline an approach taken using inquiry based learning where parallel resource sessions were introduced to the curriculum. Parallel resource sessions are described as between two and four concurrently taught sessions relating to specific themes. Students take turns in representing their inquiry-based learning group at each parallel resource session. The attendee was then required to relate the parallel resource session content back to the larger inquiry-based learning group. Furthermore, this dissemination activity was designed to take place in the absence of academic staff. Morris and Turnbull (2004) conducted their study over four months and involved students from across four consecutive student intakes. A purposive sample of 240 students participated in the study. Data were collected using direct observation of both parallel resource sessions and tutor less dissemination feedback to the larger inquiry based learning group, together with focus group interviews. On describing their findings Morris and Turnbull suggest that there appears to be a difference in the process of learning between the parallel resource sessions and the dissemination sessions. They observed that students enjoyed a particular style of parallel resource session where the teacher used personal experience to illustrate points and where the group was encouraged to be participative. However, the students found it difficult to replicate this kind of teaching style to their peers; although the authors acknowledge that second year students were better able to apply the theory of the parallel resource session and disseminate this within their group. This finding is not surprising as novice students may not necessarily have the library of experiences on which to draw to illustrate their feedback, furthermore; they were not prepared for this teaching role within the curriculum. However, Morris and Turnbull do not go on to consider this point. Additionally, students found it easier to replicate information which had been delivered in a more traditional lecture format; finding it easier to relay

information in a descriptive manner with little interpretation or application required. The students here may have been relying on surface approaches to learning, as described by Marton and Saljo (1976) although the link to surface learning is not explored by Morris and Turnbull.

Different behaviours were also observed during sessions. Students appeared to be attentive and enjoyed the parallel resource sessions and made copious notes, whereas participant behaviour in non-facilitated feedback sessions is described as contrasting dramatically. Written notes were rarely taken and non-attentive behaviours were observed; indicating what Morris and Turnbull refer to as a lower value that participants placed on their own and their peers' contribution. Students in the study expressed the view that they were uncomfortable with being used as teachers and questioned the intrinsic worth of this approach. Students felt that the process of disseminating information to their peers was stressful and that lack of content knowledge was detrimental to their ability to feedback information. Morris and Turnbull suggest that students made a conscious decision to only present familiar material and go on to say that students felt they were letting the group down, particularly with regard to material relevant to assignments, if they did not provide high quality feedback (Morris and Turnbull 2004).

Sub theme 2. The importance of language in learning

According to Bjornsdottir (2001) as members of a culture not only do we learn language as a tool to express our thoughts but additionally we learn different ways of speaking or different discourses. According to Bjornsdottir culture is a set of shared meanings, assumptions and understandings which have developed historically in a given community. Thompson argues that culture is not genetically transmitted from one generation to the next; they exist through the fact that they are communicated. Language is more than simply the ability to use words, language refers to a complex array of interlocking relationships which form the basis of communication and social interaction (Thompson 2003). Likewise, Vygotsky (1978) describes language as a cultural tool which not only serves to develop and share knowledge amongst the members of a community,

but also as a psychological tool for structuring the processes of individual thought. Importantly Vygotsky asserts that there is a relationship between social activity, where individuals interact (termed intermental activity) and personal cognitive capability (individual intramental ability). He suggests that through involvement in joint activity children come to generate new understandings and ways of thinking. Language enables us to provide others with narrative or stories which help to make sense of our lives or aspects of them. When students undertake story telling or reflexivity the implication is that all parties involved in a conversation share a degree of responsibility for constructing the meaning within that verbal encounter (Thompson 2003). Thompson goes on to say that one way of understanding this joint construction of meaning is to recognise that meaning is emergent through the process of interaction. Through detailed scrutiny of language it is possible to gain insight into social interaction and communication (Thompson 2003).

Mercer (2000) describes exploratory talk as that in which partners engage critically but constructively with each other's ideas. Here relevant information is offered for joint consideration. Ideas may be challenged and counter challenged, but if so, reasons are given and alternatives provided. Joint progress is achieved through agreement. Reasoning is visible in the talk and is therefore publicly accountable. These are sophisticated concepts and somewhat surprising considering Mercers' work studies children. If children are capable of such developed ways of thinking and working it seems reasonable to assume that the same is true for adults. Rojas-Drummond and Mercer (2003) point out that whilst exploratory talk represents an effective way of using language to think collectively, we are seldom taught about ways of talking effectively together. They also suggest that through exploratory talk children are able to carry on a kind of silent rational dialogue with themselves.

Savin-Baden (2000) explains a concept which she terms learning in relation, in which the notion of voice is central to the learning process. It is argued that it is through the students' ability to speak for themselves and to find and use

their voice that the student is able to articulate what it means to learn in relation. Through working together in small groups the students explore personal and peer perspectives and individuals challenge each other's assumptions, explore and critique material together (Savin-Baden 2000).

Identity is constructed through social interactions and is therefore fluid and changing rather than fixed. Because identity is linked to social interaction, it involves communication and language. Communication and language play a key role in constructing and maintaining a sense of identity (Thompson 2003). Identity also affects our communication and language in the sense that the identities of the participants within a social interaction will play an important part in setting the context for whatever communication takes place. Shared meanings which constitute a culture are manifested in day to day actions and interactions within the culture. We act in accordance with cultural norms and in so doing allow the culture to influence our behaviour. The cultural norm also becomes a reality through our actions (Thompson 2003). Culture and identity play an important role in shaping and maintaining social order on a macro and micro level.

Sub theme 3: Dialogue and learning

Many practices and traditions are shared in discussions, conversations or story telling. Story telling in particular is said to be an accessible and powerful tool which contextualises and humanizes nursing knowledge leading to a deeper understanding of self and others (Bowles 1995). Indeed Bowles is of the opinion that it is student nurses in particular who benefit most from engaging, listening and telling stories; since it is student nurses who most require conceptual clarity on the nature and function of nursing. Learning is facilitated through stories about caring and nursing which in turn provides students with a connection to the profession as a whole together with valuable educational experiences which can later be applied to practice (Bowles 1995). This link between discourse and forming of identity is also discussed by Savin-Baden. Savin-Baden's research demonstrates that

dialogue amongst students using problem based learning methods facilitated 'sense making' (Savin-Baden 1998). Students used problem based learning groups to enable them to make sense of interrelationships between problem solving processes, prior experience and new material being learned. Through dialogue with peers the students were able to consider how to tackle the given problem and thus integrate that which had been incomprehensible and unfamiliar into their life worlds (Savin-Baden 1998). This is not dissimilar to findings generated by Parr and Townsend (2002) who suggest that peers provide cues to fellow group mates which serve to activate inert knowledge. Knowledge is used when rehearsing or responding to questions and this consolidates the knowledge. They go on to say that restructuring of knowledge can occur through the process of cognitive conflict or providing explanations to others. Savin-Baden suggests that the dialogue and learning is linked to the notion of students developing a learner identity. Kendall and Wickham (2001) suggest that identity is often used inappropriately within cultural studies being referred to as a sense of self, and results in a process of oversimplification and over extension. In short, they contend that " 'identity' is a troublesome term, short-cutting thought and accurate description, and giving a false sense of the mastery of an analytical category over a material reality" (p157).

This research may serve to explain the role and perceived value of peer support and investigate how this might be facilitated within nursing curricula. Links between peer support in both the classroom and practice areas should be investigated.

Interestingly, in a study of childcare students Alexander (2001) outlines a teaching and learning strategy used, which she terms "research and present", whereby students are expected to research a particular topic or body of knowledge and present their findings to their peers. A convenience sample of sixteen and seventeen year old students were studied using ethnographic observations together with interviews. Alexander (2001) explains that the tutors used this approach believing that this teaching strategy encourages

students to become more independent and resourceful in their learning. However, Alexander then goes on to outline how students found this activity difficult, because they did not know what the tutor wanted from them. Indeed, Alexander argues that students saw even research based work as being a task that they had to get right in order to fulfil the course requirements. The students did not perceive the knowledge itself as intrinsically valuable (Alexander 2001), a concept which is also explored by Morris and Turnbull (2004). Alexander also suggests that students wanted to fit in and would comply with questionable practice. However, no examples from the data are provided which would substantiate this important claim. This raises questions regarding the value systems students ascribe to various learning activities. Students may not value knowledge gained from each other in the same way as that which is derived from lecturers or practitioners in the clinical setting. Further work is required in order to investigate the kinds of learning that takes place between students during practice placements and that which occurs within the academic setting; something which this thesis hopes to achieve.

Vicarious learning

Experiential learning theory suggests that personal and direct experience is necessary in order for learning to take place. However, much of this literature was written before the technological revolution and today there is a developing body of literature which explains virtual or "e" learning environments in relation to vicarious learning. In other words there are different forms of experience and raw or first hand experience may not be the only mechanisms by which students can engage in experiential learning. Payne (2003) outlines four dimensions or layers of a *form* of experience: the *body*, in *activity types*, with *participatory styles* or performances, as lived ontologically by *historical subjects* (p528 Italics as used by Payne.). For Payne, ontology denotes the ways in which human experience is structured. He argues that our underlying personal, social, economic, geographical,

cultural and historical background affects how we constitute and reconstitute our experiences. Behaviour is patterned, coded and routinised by these factors, shaping who and what we are; we are socially constructed through our experience (Payne 2003). He goes on to say that reality is socially constructed, as individuals and groups we actively construct our experiences and express their significance through actions. Therefore Payne warns against the over use of the electronic medium. In particular he discusses the use of technology in teaching environmental education but he argues that these principles apply elsewhere within education. When using technology and virtual learning Payne argues "environments other than the computer one fade away in to the background. This intensified and individualised reconstruction of the self is due largely to the immersion of the subject(s) in an assortment of plastics and microchips that merely act to transfer information and act as an artificial conduit of the self. The more frequent this form of experience, the more likely is the ontological correction of the acting self over time…with the dilution and devaluing of experiences of other environments" (p531).

Fox (2003) presents another view of vicarious learning in relation to intercultural training. Fox describes vicarious learning as using the medium of human imagination to allow one to learn through the experiences of another. This approach is explained as one which engages human imagination in a safe environment before, during or after actual cross cultural experience. The imagination is used to provide a virtual experience. Furthermore it is suggested that the imagination generates a virtual reality of vivid graphics which cannot be reconstructed on the computer screen or the silver screen. Fox suggests that carefully selected literature may be a means of engaging culture learners in critical reflection in ways which minimise stress and improves the individuals' ability to cope with cross cultural adjustment. Fox clearly links vicarious learning with reflective practice. However, Fox does appreciate a place for personal experience arguing that unless the subject has passed through the experience it may all seem very unimportant and

theoretical; and therefore abandoned by the human memory. The key seems to be getting at the emotions without the benefit of actual experience; engaging the mind and emotions of learners in a transformative process. In Fox's view it is the trainer in cross cultural learning who frames and debriefs such experiences in a way that genuinely leads to intercultural comfort and competency. Fox alludes to Mezirow's theory of perspective transformation whereby the facilitator introduces a level of dissonance into the learners' psyche in order to create a teachable moment. In terms of intercultural preparation, Fox purports that learning must begin with the experiential in order to awaken an affective response and only then can knowledge be implanted in ways that are memorable and transformative (Fox 2003). It is argued that the method is one of discovery where the teacher is a fellow explorer who facilitates the process of uncovering truths. For Fox the emotions are crucially important because engaging in emotion is a means of discovering and embedding cognitive principles in the active learner. Fox makes further use of Mezirow's theory again as it is Mezirow who suggests that as a component of the learning process, cultural disequilibrium is the catalyst for change and it is the emotions which serve as the driving force pushing the participant to become competent.

In relation to nursing it could be argued that student nurses are learning to belong to a new and different culture; what Wenger refers to as a community of practice. Although (as stated earlier) it is not clear whether student nurses do wholly belong to such a community. However, it is clear that they make great efforts in order to fit in and belong. Therefore much of what Fox suggest in terms of cultural learning could apply to student nurses. However, Fox often alludes to Mezirow's model of reflexivity. Mezirow (1981) identified seven levels of reflexivity with perspective transformation taking place only at the highest levels. The levels are sequential and increase in complexity. Indeed Mezirow asserts that the first four levels involve what he terms as reflectivity, affective reflectivity, discriminate reflectivity and judgmental reflectivity and these are conscious thought processes. It is the

higher order levels of conceptual, psychic and theoretical reflectivity which together are termed critical consciousness. Fox does not state how individuals arrive at the higher levels. It is not clear whether the facilitator plays a role in helping students to achieve the lower levels first before moving on to perspective transformation. Furthermore, it is debatable whether all students are able to reflect at the highest levels. Therefore Fox's use of Mezirow may be inappropriate.

Another view of vicarious learning is presented by Cox, McKendree, Tobin, Lee and Mayes (1999) who demonstrate vicarious learning through an empirical study of 54 undergraduate students with varied backgrounds. Students in the study were randomly assigned to one of four experimental conditions, with six students assigned as a control group. Experimental groups were tested in a computer laboratory in groups of between eight and twenty. Pre and post test instruments were devised and administered. The research setting is contrived, as opposed to natural; although the impact of the environment on the research participants is not discussed. In the study vicarious learning is said to be the potential benefit to learners of being able to observe or 'listen in' on experts or their peers as they discuss a new topic. Cox et al aimed to discover whether and how dialogue can be helpfully 're-used' by others; the extent to which vicarious learning might be facilitated by observing experts or by observing peers. The research used an experimental procedure in a computer laboratory with four experimental conditions and one control group. The study outlines two main findings which demonstrate that students do 're-use' dialogue of others and the authors suggest that this demonstrates that the effort of understanding or comprehending dialogue, does not override its educational usefulness (Cox et al 1999). They go on to acknowledge that the educational value of the tutor-student dialogue derives from aspects not tested by the research. They tentatively suggest that the value may lie in the student centeredness of the dialogue and the manner in which the tutor conveys rhetorical issues to the student. In other words, how issues in the domain are talked about and what kinds of questions get asked.

This would seem to concur with Jinks' findings. The second finding of the study was that un-annotated, diagrams alone were surprisingly effective in helping students to learn. The findings of the effectiveness or otherwise of student-peer dialogue was inconclusive in terms of vicarious learning. This study examined vicarious learning in the domain of sentence parsing and syntax tree diagram construction but it is interesting to note the impact of the student-tutor dialogue in promoting vicarious learning. Dialogue between one student and a tutor in front of a group of students may be important for student nurses in terms of vicarious learning. Cox et al acknowledge that more work is required in order to explore vicarious learning amongst peers. Due to the experimental nature of the research, the reader is left wondering what the respondents thought about the learning which took place within each experimental group. It would have been useful if Cox et al had adopted a multi method approach and used some qualitative data to support their empirical findings from the respondent perspective.

Section Two: Learning to be a nurse

Nursing knowledge

Nursing knowledge may often go unnoticed. As Liaschenko (1998) points out nursing knowledge is often only expressed amongst nurses and whilst some of this knowledge is highly visible within the culture of nursing (and therefore is accorded legitimacy and authority); large portions remain invisible and silenced. She goes on to explain that in medicine knowledge can be represented and made visible to the public eye and is therefore recognised by contemporary society; consequently society only acknowledges that which can be represented as knowledge, therefore that which is not represented does not count as knowledge and is readily dismissed, ignored or not seen. According to Liaschenko this has particular significance to nursing as a mainly female dominated profession because the knowledge which women have about the world and how it works is obtained from local practices and oral traditions; and is largely discounted as knowledge. This is because

women do not speak from what she terms as the dominant discourse of scientific knowledge and their knowledge may lack authority as a result.

Four kinds of knowledge are identified, each of which involves witnessing and telling: knowledge of therapeutic effectiveness, knowledge of how to get things done, knowledge of patient experience and knowledge of the limits of medicine (Liaschenko 1998). Knowledge is viewed from the framework of testimony reinforcing her notions of oral traditions. Testimony is carefully defined as involving bearing witness as the means of access to knowledge as well as the telling of that knowledge; "to give testimony is to speak the truth of some phenomena" (p12) to an audience. This is similar to the notions of exploratory talk suggested by Slavin (1996).

Professional learning

Eraut (1994) and Schon (1987) suggest that professional practitioners have a specific and unique way of learning. Eraut postulates that professionals learn on the job by deliberating on specific events, termed case specific learning. However, he acknowledges that cases have to be viewed as special rather than routine and time must be set aside to deliberate their significance in order for learning to take place (Eraut 1994). Schon (1987) suggests that the knowledge on which professionals draw is broad, deep and multi faceted; moreover, the problems which professionals face are complex and messy. Schon describes this as a topography of high, hard ground overlooking a swamp. On the high ground problems may be solved by the application of research based theory and technique; whereas problems in the swampy lowlands are confusing and defy technical solution. He goes on to say that ironically problems of the "high ground" nature tend to be relatively unimportant to individuals and society in general; but in the swamp lay the problems of greatest human concern. Professional practitioners can not solve problems solely by applying theories of techniques derived from the body of professional knowledge; there is more to it than that. For Schon the messy

problems present practitioners with indeterminate zones of practice where professional use a core of professional artistry.

> "Artistry is an exercise of intelligence, a kind of knowing, though different in crucial respects from our standard model of professional knowledge. It is not inherently mysterious; it is rigorous in its own terms; and we can learn a great deal about it…by carefully studying the performance of unusually competent performers" (Schon 1987. p13).

In order to learn professional artistry, a learning environment which encourages learning by doing should be created this means an environment which is low in risk. Schon argues that there are two kinds of practice situation, each requiring the practitioner to use a different form of knowing. The first is the familiar situation where problems are solved by routine application of facts, rules and procedures derived from the body of professional knowledge. Secondly, there are unfamiliar situations where the problem is not initially clear and there is no obvious fit between the characteristics of the situation and the available body of existing knowledge.

Learning for practice is said to take place in one of three ways. The practitioner may learn the practice on his own, although Schon acknowledges that this is rare. Learning alone has the advantage of freedom to experiment without the constraints of received views. However, the disadvantage is that each student is required to reinvent the wheel, gaining little or nothing from the accumulated experience of others. Secondly, the learner may become an apprentice to a more senior practitioner offering direct exposure to the real conditions of practice and patterns of work. Importantly, Schon points out that most offices, firms, factories and clinics are not set up for the demanding tasks of initiation and education because pressures for performance tend to be high; time is at a premium and mistakes costly. Also senior professionals have learned to expect apprentices to come equipped with rudimentary practice skills (Schon 1987). Thirdly, the student may enter a practicum: a setting designed for the purpose of learning a practice, in a context that approximates a practice world. Here students learn by doing. However Schon does not offer any specific examples of low risk practice settings. The notion

of creating a learning practicum suggests that the practice setting is malleable according to the learners' ability, which of course is not the case. Conversely, high risk practice settings may produce practitioners who are more able to learn by doing; which may not always be true.

Eraut suggests that there are different kinds of professional knowledge which can often be found on examination of training courses or curricula. Knowledge is likely to be labelled and packaged according to traditional assumptions about how and where it will be acquired. Eraut explains that mapping out knowledge in this way is problematic. Firstly, because large areas of know how are omitted from training, and where common knowledge exists it is structured, labelled and perceived differently. Secondly, much professional know how is implicit, posing the question: how much know how is essentially implicit, and how much is capable with appropriate time and attention of being described and explained? (Eraut 1994).

Eraut (1994) identifies six types of knowledge:

1. Situational knowledge i.e. the way people conceptualise situations, think about them and "read" them. This knowledge is acquired as people learn about situations through personal experience of them, rather than studying them from afar. Such knowledge may be built up through both purposive and accidental means, purposive because much discussion and deliberation is required; and accidental because intuitive assumptions are used.
2. Knowledge of people and the basis on which one gets to know and make judgements about people.
3. Knowledge of practice which includes not just simple factual information but also knowledge of possible solutions or actions which might be implemented in any given situation. This is said to be a vital component of effective decision making and inherent within problem solving.
4. Conceptual knowledge, including formal and informal theories which guide much of our behaviour but may, again be tacit. When concepts are learned in an academic context they may be under critical control but are not necessarily

5. Process knowledge or how to do things or get things done.
6. Control knowledge. Controlling ones' self, having self awareness of personal performance, self assessment and management.

Eraut argues that knowledge can be used in four ways: replication, application, interpretation and association. He suggests that interpretation and association are more typical of the way a practitioner uses their knowledge base. It is not clear whether all six categories of knowledge hold equal weighting in terms of professional practice. Those learning professional practice may not necessarily posses all six types of knowledge.

However, in more recent work Eraut acknowledges that his ideas regarding knowledge in a professional context have developed. In 2000 he provides two parallel definitions of knowledge; namely codified knowledge and personal knowledge. Codified knowledge is subject to quality control by peer review, debate and editors; furthermore it is given status through incorporation into curricula. This type of knowledge includes propositions about skilled behaviour but not skills or 'knowing how'. Personal knowledge is described as the cognitive resource which a person brings to a situation, enabling both thought and performance. Eraut goes on to outline a typology of informal

learning which distinguishes between implicit learning, reactive on the spot learning and deliberative learning.

It seems there is little literature which attempts to explain the mechanisms by which student nurses learn in the clinical setting. Further more it seems that there is a paucity of literature from the student perspective.

Dialogue between student nurses and more experienced practitioners has been highlighted as a useful mechanism to support student learning. Spouse (1998) suggests that a mediator is necessary to help students to translate general (formalised) knowledge into practice settings. In a longitudinal study investigating professional development of pre registration nursing students Spouse (1998) indicates the importance of sponsorship by a clinical member of staff and participation in what she refers to as legitimate peripheral activities. However, Spouse does not go on to specify what such activities might be. One strategy which mediators employ is purported to be scaffolding (Spouse 1998). Scaffolding is said to take place within sponsored nursing activities; in other words when the mediator and student are working together; and builds on the important concept of Vygotsky's work on the Zone of Proximal Development (ZPD), where speech becomes a tool to facilitate learning and development. Scaffolded activity does not always have to be supervised but Spouse acknowledges that it should be planned in order to help the learner see the relevance of their knowledge in waiting. Being verbally guided through a whole process (clinical activity) ensures that learning is structured by being encouraged to think aloud. This type of dialogue Spouse refers to as proleptic instruction or coaching which helps knowledge in waiting become knowledge in use. By guiding students through activities using proleptic instruction the learner extends their perceived level of skill and so the learner is more able to fulfil their potential (Spouse 1998). However the notion of appropriateness to steer student nurses through dialogue remains unconsidered. Whilst qualified nurses may be engaged in proleptic instruction with students Spouse does not say whether others may act in this capacity. It may be possible for other students who are more

advanced in the programme to verbally guide more junior students through clinical activities.

Similarly, in later work Spouse (2001a) expounds the notion of purposeful dialogue and suggests that work placed learning must include opportunities for challenge and resolution through discussion. It is suggested that the key element is the collaborative nature of the interaction between practitioner and student. The dialogue that takes place between mentor and student relies on the mentors' ability to think aloud; the learner then internalises the dialogue, identifies questions that promote recognition of significant earlier learning or to seek new information that explains their experiences (Spouse 2001a). Spouse (2001a) employed a phenomenological longitudinal study to investigate factors influencing the development eight pre-registration nursing degree students during their practice experience. Although the findings discuss the students' experiences in clinical practice, the study was conducted within the researcher's academic institution. Whilst qualified staff acting as mentors may be influential in helping students to learn other members of the clinical team may also act in this capacity. Other student nurses in particular may have a role in collaborative interaction. However, Spouse does not consider this point.

Drawing on earlier work, Spouse (2003) utilises a flexible research method based on two essential approaches: ethnography and phenomenology to examine student nurses in naturalistic settings in a longitudinal study. The focus of the work examines the clinical learning activities of a small group (n = 6) of student nurses undertaking a pre registration degree course. Each case study is presented as an exemplar of students' professional development. A number of factors important to student nurses' clinical learning are outlined (some of which are reported elsewhere; for example: Spouse 1998, 2001a). However, here my comments are related to specific findings describing peer support and peer learning. Spouse appears to tentatively propose that peer support is more important to some students than to others and suggests that reliance on peer support may be age related as the younger students

participating in the study demonstrated an increase in the amount and type of support gained from peers. However, Spouse does not elaborate on this point in discussion of the findings as different themes are presented for each case study (in order to reflect the individuals and their journeys to becoming nurses), but this does not help to explain the initial suggestion. Specific perspectives of older students are described, whereby older students, particularly those who did not live in student accommodation, found that they did not have the same contact with their peers. One student felt alienated by her peer group because she was several years older than most of her fellow students, having little in common with them. Similarly on clinical placements mentors (who were the same age) were separated by their status within the organisation. Spouse does not expound on this concept to fully discuss the implications of how students are, or should be, grouped together in terms of age in order to promote peer learning.

Non formal learning

Eraut (2000) suggests that informal learning is often treated as a residual category to describe any kind of learning which does not take place within, or follow from, a formally organised learning programme or event. However, Eraut argues that this definition belies the importance of informal learning because informal learning covers a continuum from implicit to deliberative learning. Implicit learning is said to happen when there is no intention to learn and no awareness of learning at the time it takes place. Between implicit and deliberative learning a middle category of reactive learning is suggested. Reactive learning is explained as being near spontaneous in nature and unplanned, the learner is aware of it but the level of intentionality is debatable and varies. This learning is also difficult to articulate explicitly without setting aside more time for reflection. However, this then makes the learning more deliberative. Planned non formal learning is deliberative (Eraut 2000).

Eraut (2000) clearly links implicit learning to tacit knowledge. Our lived experiences are stored within long term memory, although this may not be a conscious or deliberate process. We link several memories and accumulated experiences of several episodes together to help us in future action. However, there is no conscious awareness of this happening (Eraut 2000). This notion would seem to imply that reflection which uses past events involves memory in a similar way. It also suggests that reflection in order to learn is not a single or linear process.

Episodic memory may be used for specific, personally experienced events whereas semantic memory is for generalised knowledge that goes beyond the specific episode. Importantly, Eraut (2000) suggests that there is traffic between the two forms of memory. He argues the same episode may contribute to performance both implicitly (within episodic memory from direct experience) and explicitly (within episodic and / or semantic memory). For example: episodic memory may be used to recognise a new but comparable practice encounter where a previously used decision option is used; the individual may realise that the match between the practice encounters may not be exact and that therefore a repeat of the decision option may not be the best action. Here tacit knowledge would be used. Eraut goes on to say that when public, prepositional knowledge is fed into semantic memory and subsequently called upon for performance; this kind of knowledge is useful for clarifying the meaning of events; but further deliberation is necessary, otherwise the knowledge is too abstract to be used. Tacit knowledge is used when situations demand rapid action or are too complex to be fully analysed. However, in this explanation Eraut assumes that these practice encounters have to be personally experienced. At no time does he consider whether learning from another's experiences is possible or if such vicarious experiences could be used within memory in a similar fashion.

Experiential learning in nursing

The work of Benner (1984) is well known within nursing as individuals develop from novices to experts. Throughout the five stages outlined by Benner the perspective of the individual alters; the expert having a library of experiences on which to draw. Experts are said to have total mastery and this is demonstrated by the speed and flexibility of their actions; they are able to zero in on a problem straight away. Learning through and from experience is enhanced by reflection (Benner 1984). However, Benner's work is not without critics as the thinking processes by which nurses decide on the most appropriate care for patients may not be adequately described by the reflective practitioner concept. Lauder (1994) considers whether the process of deliberation is in fact more complex than simply reflective activity; and argues that the reflective moment separates thought and behaviour. A nurse's practical wisdom being characterised by a complex combination of doing and thinking, which in clinical situations can not be separated into theoretical and practice components. Indeed, Lauder suggests that to do so reduces and fragments the unity of clinical experience.

Similarly, Arbon (2004) comments on Benner's work and says that she implies that the journey to expertise is a linear process, cumulative in nature, temporal and dependent on the interaction that seems to occur between exposure to clinical forms of experience and learning. He goes on to say that this concept of expert practice does not seem to adequately explain the experience of nurses as they interact with patients in different settings in different circumstances. Arbon suggests that nurses bring to practice understandings about people and situations that they use in their work; these are grounded in the understandings about the lived world that they have developed in all its forms. He also points out that the nursing literature to date, has largely failed to capture the influence of other (non-clinical) experience(s). Over recent years there has been a shift in emphasis from learning psychomotor skills through development and subsequent application of scientific forms of knowledge towards the application of nursing

knowledge to practice. Alongside this shift there is a contemporary focus on producing skilled graduates; effective decision makers who take appropriate action in clinical situations. In short there has been an overriding concern with safe practice.

Arbon argues for a broader understanding of experience. His study explored the role of meaning and understanding drawn from experience in all its forms for a group of ten nurses each with at least ten years experience. Semi structured interviews building on the concepts of hermeneutic phenomenology were conducted and participants invited to relate how events from their lives influenced their understanding of patients and nursing practice. Whilst excerpts are provided from the research transcripts the paper does not describe the research participants in detail. For example, no data is provided to indicate whether the respondents were male or female. The impact of gender on the findings requires further clarification.

For Arbon becoming experienced is not a linear process. He refutes the notion that experience will necessarily lead to improved practice and eventually (in a linear fashion) to expertise because this does not reflect the complex understandings that nurses have about their practice across fields or in differing circumstances and with different people. Arbon suggests that experienced nurses:

> "carry the caring and connecting characteristics of their practice with them and these are not diminished significantly in differing contexts. Being experienced in nursing can be conceptualised as a way of being, a positioning of oneself in practice or an outlook and for experienced nurses, is connected to an understanding of who they are, what motivates them, and what they find fulfilling" (Arbon 2004. p155).

Expertise is context dependent whereas being experienced is an existential phenomenon. To perceive nurses merely as experts, may confine them to existing in a world where in practice much is taken for granted and so, there is little left to be learned (Arbon 2004). This notion of routinised action is also explored by Eraut (2000) who suggests that action is described as routinised when actors no longer need to think. For Eraut we begin by

following others and using checklists; this is followed by repetition of the action until the individual no longer needs the other person or checklist, then a further stage is reached where an internalised explicit description of the procedure also becomes redundant and eventually falls into disuse (Eraut 2000). He argues that routinisation can apply to complex as well as simple skills. Furthermore, routines are interrupted by short periods of problem solving where difficulties are resolved or decisions made to adapt to changes in the external context.

In order to facilitate the development of nurses Arbon makes three suggestions. Firstly, he suggests that nurses develop caring and connecting attributes not simply because they have experience but because they have begun to draw on that experience in a different way over time. Therefore, it may be possible to develop experiential features for some nurses through modification of teaching and learning approaches. However, it is not clear why only some nurses may benefit from his suggestion and not all. Arbon does not go on to say which teaching and learning approaches require modification or may be beneficial. Secondly, he suggests that some nurses may benefit from a restructuring of practice settings. However, clarification of what this actually means is lacking and in reality, changing clinical learning practices may not be readily accepted by those who undertake teaching in the practice setting. Finally, Arbon believes that encouraging new nurses to reminisce and make effective use of the understandings generating about themselves may help. Reminiscence requires reflection on our own meaningful experience and provides the foundation of a developing understanding of self that can be applied to practice (Arbon 2004).

Vicarious learning through story telling in nursing

In particular, Spouse demonstrates the importance of learning through story-telling to other student nurses and to lay housemates. Spouse asserts that often the curriculum for student nurses precludes them from developing supportive, consistent and constant peer groups who can be accessed for

support and learning. Students within her research met in small seminar groups during the third year of the programme. Students found it helpful to share experiences that they found uncomfortable or incomprehensible, and used the seminar group to compare their own feelings with those of their peers. Story-telling is suggested to allow the students to construct and rehearse their thinking and provided opportunities for students to learn from each other. Spouse suggests that sharing experiences in this way is important for students because the stories carry a reality which is engaging for students. Students engaged in their story at any point by clarifying and enlarging various aspects, or rehearsing parts that were especially pertinent. Students in the study used the story-telling and sharing of experiences to develop concepts of themselves in different roles according to who they were talking to. The story teller develops new insights to the situation based on the suggestions and sense making activities of her friends. The group then benefits by developing a collective understanding. Indeed, those of the group who have not participated in the same nursing activity can gain what Spouse refers to as a "vicarious learning experience" which helps them formulate suitable actions when they have to face similar situations. This notion of vicarious learning is important to this thesis and Spouse's study is influential in that it highlights one possible mechanism by which peer learning takes place within classroom settings.

The interaction between students during story telling appears to be crucial in terms of debating and defending a perspective in order to develop new perspectives and frameworks for thinking and acting. The students' ability to use language appropriate to their peers seemed to be important for the students, it allowed them to internally verify whether they were performing at the appropriate level, and helped them to develop self confidence and critical thinking. Indeed, Spouse suggests that this kind of peer learning seems to be an essential component of learning to nurse from two perspectives: the opportunity to share understanding and to learn from each other, and to ease the process of becoming nurses (Spouse 2003). If these assertions regarding

the influence of peers on learning are correct then again consideration should be given regarding how to make best use of peer groups within educational programmes leading to nurse registration. Spouse does not say whether seminar groups featured in any other years of the students' academic programme or whether such groups should be used elsewhere.

Story telling is also examined by Bowles (1995) who purports that students learn vicariously during story telling as the narrator must "recognize and reflect upon her life positions, roles and motivations, and in so doing create an opportunity for the narrator and the audience alike to develop new perspectives" (Bowles 1995 p368). However, it is not clear if this change in perspective occurs by accident or whether the students need some help to turn the learning opportunities into learning. Interestingly, in his discussion paper whilst suggesting that story telling is important as a means of preserving cultural identity within nursing Bowles omits to say whether or how he uses stories within his own practice as a nurse educator.

Northedge (2003) is of the firm opinion that students are unable to make use of discourse by themselves, finding it difficult to understand. For Northedge it is the teacher who is key to enabling learning through discourse because it is the teacher who is already a speaker of the specialist discourse. The teacher lends the students the capacity to frame meanings they cannot yet produce independently. It is the teacher who opens up the conversation and shares a flow of meaning; the students join with the teacher in sharing meaning and they also share something of the frame of reference that sustains it (Northedge 2003). Stories are suggested as the perfect vehicle for initiating and sustaining the capacity to frame and generate meaning together with others; something which Northedge terms intersubjectivity. It is the teacher who helps the students move from the frame of every day language towards the discourse of the specialist knower. He suggests that this development takes place as the teacher poses questions and introduces new elements and takes the students on an excursion into specialist discourse to experience how meaning is made there. The students internalize the questions asked, forms of

evidence and arguments deployed, types of conclusion arrived at and history of previous debates; through participation. The teacher judiciously chooses the stories to include a range of issues, debates and voices to enable the students to develop a sense of the nature of the knowledge community and its discourses. As students become more experienced in thinking about the stories Northedge suggests they make links to their own actions and decisions and so learn from each other. Interestingly, he asserts that the students are invited to think about issues in ways that correspond to the thinking of experts within the care community. However, this notion is questionable since he implies that the teacher is automatically an expert and precludes the students from acting in this capacity for each other. It could also be argued that Northedge's theory is flawed because as the teacher selects the excursions, the teacher is in control; therefore it is the teacher's thinking to which the students are exposed. Furthermore, the paper is based on his own experiences of wanting to be 'taught', not spend time exploring collaboratively with what he terms "uneducated peers"; his preconceived ideas concerning teaching and learning may have been influential in the conduct of the study and in the findings, resulting in a biased view, but this is not explored by Northedge.

The stories shared by students can provide a method of establishing the development of professional socialization as language becomes more nurse-like. For example, Orland-Barak and Wilhelem (2005) in their phenomenological study of twenty four stories of clinical practice from novice student nurses in Israel; stories are described as being characterized by structured, step by step accounts of care procedures and of psychomotoric aspects of nursing practice. In other words, the students were recounting events as if reading from a prescriptive clinical protocol but the stories were devoid of reflections at deeper levels of thoughts and feelings. However, to expect more than this of novices may be an unrealistic expectation on behalf of the authors. Orlak-Barak and Wilhelem (2005) go on to suggest that it is the importance which the students ascribe to voicing instrumental aspects of

their practice in order to begin making sense of their learning which is valuable. Indeed they discuss the role of the lecturer at length in terms of allowing the voices to be heard and helping students to transform instrumental orientations into more professional understandings of practice. However the paper does not describe whether this transformation happened within the students studied. No examples from the data are provided to demonstrate whether or how such transformation took place. This would seem to imply that it is not enough to study student learning in isolation because the learning may be dependent on other factors such as the relationship with the lecturer and fellow students.

Similarly Nehls (1995) and Diekelmann (1990, 1993) also explore the link between students and teachers during learning. Nehls outlines an approach to learning which she refers to as narrative pedagogy; where teachers seek to establish partnerships with students in a lifelong quest for knowledge. Reciprocity is emphasized to form a community of learners. Together the community explores how and in what ways one becomes a nurse. The teacher uses narrative to reinforce the centrality of the lived experience and learning is said to take place through dialogue and attention to nursing practices (Nehls 1995). The underlying assumption to this concept is that the teacher is also a learner. As teacher and students share personal practices, the students come to appreciate that nursing knowledge can evolve by reflection on experience. By examining their own experience as well as that of others is suggested that the students begin to recognise where they need to focus their attention. The narrative pedagogy seeks to establish dialogue and connections between members of the group which enables the students to see the importance of reflecting on practice not just to learn but to contribute to nursing knowledge. Diekelmann asserts that nurses do not teach as teachers teach; rather their teaching is informed by their practice of nursing. She goes on to say that there is a clear link between thinking, language and our experiences arguing that “in our conversations we both shape and are shaped

by our language. This experience of the language of nursing is one we all share" (Diekelmann 1990).

Whilst the relationship between students and teachers may impact on the value ascribed to story telling, it seems that students also require a social connectedness to be established amongst the group. Davidson (2004) uses a phenomenological study of ten female students with a mean age of 29.5 years in focus groups to evaluate perceptions of story telling as a method of learning. The study revealed three central themes which emphasis the importance of personalised learning, participatory learning and group trust. Social connectedness appeared to be important to the students in terms of maintaining each other's confidentiality. The assertion is that as trust developed within the group, more intimate stories were shared. However, it is not clear whether these more intimate stories had a greater or lesser impact on learning. The exclusively female sample may also have implications for the findings but Davidson does not explore the impact of gender. The study was also assumably conducted within the United States of America (the reader is left to assume this from the place of work declared in the author's details) as the place of the study is not declared. The place of study is important contextual information since the culture of story telling as a teaching method appears to be much more accepted within the United States; therefore having an impact on the transferability of findings elsewhere.

Peer support

There is little evidence to support or refute the concept of peer support amongst student nurses although emotional support may be an important aspect of peer support as described by Campbell, Larrivee, Field, Day and Reutter (1994). However in terms of the role of peer support and promoting student learning more work is required. Emotional support amongst student nurses is examined in one Canadian study by Campbell et al (1994) however, the educational system for nurses is different to that within England and

therefore some of the findings may not be transferable or generalisable. Campbell et al (1994) conducted a longitudinal study using a total of 131 student nurses undertaking a baccalaureate programme and found that two major factors influenced students learning in clinical settings: the clinical instructor and peer support. Three dimensions of peer support are identified: facilitating learning, providing emotional support and assisting with physical tasks. The purpose of the study was to determine how students became socialised into nursing, and how their attitudes and values changed over time. Clinical instructors who worked alongside student nurses in the practice area are identified by the students as the individuals most critical to the learning process. Students in the study identified few negative attributes associated with their clinical instructors. This finding is not surprising since students are unlikely to criticise those who will supervise them in practice.

The study makes use of semi structured interviews (n = 50) and open ended self report questionnaires (n = 81), the authors acknowledge using an interview guide based on Melia's earlier research but do not tell us how the original work is adapted. The guide was further revised between the first and second year to elaborate on emerging themes, but again these themes are not revealed. Campbell et al do expand on the three elements of peer support and suggest that students facilitated learning in each other in assisting peers whilst preparing to give care, sharing experiences, so as to appear confident in front of the instructor. This type of rehearsal is identified as evident in the second year of the programme. However, it could be argued that the students were merely rehearsing what Melia refers to as the professional version of nursing. In other words the students were telling the instructor the "correct way" as opposed to the "real way". However, this point is not considered by Campbell et al. The research strategy used by Campbell relies entirely on questionnaire and interview to elicit the student views but students were not observed in practice settings. The perceptions of what the students thought was happening are presented as fact, which may or may not be the case. Direct observation of the students may have helped to verify the findings.

Therefore more work is required in order to establish a greater understanding of peer learning in clinical settings.

Facilitating learning was recognised by student nurses from the second year of the course onwards. Students depend on each other sharing experiences which the students assert helps them to learn. Students observed each other performing skills and gave each other feedback in a positive and supportive way. By the third year students used each other more as a resource sharing knowledge, experience and expertise; as opposed to answering each others questions. They appeared to work as a group to promote learning becoming independent of the clinical instructor but increasingly interdependent on each other. By the fourth and final year students saw each other as astute and critical in their thinking, excellent sources of current knowledge and were using each other as a resource.

In the provision of emotional support the students in the study demonstrated a sense of what Campbell et al (1994) refers to as family. The students felt that peers understood them in a way that no one else could possibly understand. Peer support was seen as an important mechanism in getting each other through.

Campbell's study was carried out in Canada where the educational system for student nurses is different to that within England therefore, some of the findings may not be transferrable or generalisable. However, there may be elements of the work which may be applicable to nurse education in England; particularly those which relate to the role of the clinical instructor together with the findings related to peer support. Campbell's work does not give any indication of whether the students supported each other universally both in the classroom and in the clinical area. Neither is there any discussion surrounding the modus operandi of the support; for example do fourth year students facilitate learning and assist with physical tasks of third years, third years for second years and so on? It is unclear which tasks in particular students relied on each other for or whether these were limited to the practice domain.

Professional socialisation and student nurses

Student nurses engage in two discreet worlds during their pre-qualification period: the worlds of theory and practice. Melia (1984) describes these two worlds as segments; findings of her research demonstrates that there is an education segment within nursing which is promoted through schools of nursing and which students see as the professional version of nursing. Secondly the findings show a service segment of nursing which is concerned with getting work done. According to Melia, students must necessarily pass between the two segments and perceive a gulf between the education and service sectors. In a later publication (based on the same interview data) Melia challenges the notion that nursing students participate in a true apprenticeship, whereby students learn from working alongside expert craftsmen suggesting that student nurses learn largely from unqualified personnel and moreover spend little time working alongside staff nurses (Melia 1987). Melia's study focuses on the occupational socialisation of nurses and the dilemmas student nurses face whist learning and working. Although not a specific aim of the work, the study does highlight a number of issues associated with the impact of fellow students in learning to be a nurse. For example, Melia describes situations where student nurses co operate together to organise themselves in order to get the work done, but although this is briefly described, details of how this organisation takes place, or the impact of such situations on student learning are not discussed. More details are provided concerning what is termed a quasi-apprenticeship aspect of nurse training where senior apprentices teach junior apprentices. Melia suggests that whenever students needed to know how to do something they are more likely to seek help from a fellow student. Although the types of knowledge gained in this manner is not considered. Students in the study also revealed a tendency to model themselves on more senior students. There is also a tentative suggestion that senior students viewed and used the junior students in a similar manner to staff nurses. Melia notes that some senior

students tended to move away from engaging in patient care before they joined the ranks of the trained staff, preferring to do more technical work and leave the basic nursing to the up and coming juniors. This notion requires further study particularly to establish how students move along the continuum from junior to senior learner, and how the requisite skills are learned. It is interesting to note that Melias work is based on informal interviews with student nurses, taking the form of a conversation conducted away from the clinical setting. An agenda is used to guide the interview but largely students were allowed to dictate the content of the interview. Melia does not observe students in practice to verify or refute the students' perceptions, but accepts them as they are presented.

Johnson (1993) examines Melia's use of informal interviews in some depth and he argues that whereas Melia contends that informal interviews are a form of participant observation; that because her approach was planned and systematic; the interviews were therefore formal and structured. Johnson (1993) goes so far as to suggest that Melia is using ethnographic language to infer that her method was closer to the field or work setting of the student respondents than was actually the case (some of Melia's interviews took place in her own flat and not in a clinical setting). However, whether this devalues the findings is debatable. In terms of my own work, Melia's study has influenced my choices concerning where the study should take place, being firmly rooted in the two segments which Melia describes: education (the classroom) and clinical practice.

Other influential studies of professional socialisation of student nurses have been conducted in the United States (Olesen and Whittaker 1968 and Davis 1975). Although the system of nurse education is different from that within England the work provides some important insights into learning to be a nurse. Both Olesen and Whittaker and Davis acknowledge that the stages of professional socialisation which they outline are not meant to be viewed as taking place in a chronological sequence of events. The process of

socialisation occurs as the lay ideas of nursing are gradually subsumed by the ideas of the profession, as the profession expresses them.

Peers play an important role in the socialisation process and according to Olesen and Whittaker this influence begins before the programme of nurse education commences as we form a view of what nursing is, or should be, based on conversations with family members, those who are already nurses and the media. They go on to say that "in talking to these significant others the students created existential situations in which they literally brought a future nursing self into objective consciousness by engaging in such dialogues and by taking the view of parents, girlfriends and others on becoming a nurse" (Olesen and Whittaker 1968. p98). In their study, fifty three percent of the students said they had friends who had already gone into nursing; indicating the importance of peers before entering formal nurse education.

Davis (1975) asserts that there are six stages to professional socialisation beginning with initial innocence, where the lay imagery prevails; through to incongruity when what the students experience as nursing does not match up with their lay images. The students then begin psyching out what is required of them. Davis suggests that students who are able to psych out the instructors are those who are "cosmopolitan girl, usually one of upper-middle class background…with a high degree of verbal facility and even more important, well-cultivated feminine skills and sensitivities in what may be termed the diplomatic niceties in interpersonal relations" (Davis 1975. p125). Psyching out involves learning to recognize what the instructor values and including such attributes in personal practice and dialogue. Students then engage in role simulation in clinical practice and Davis acknowledges that this is hardly distinguishable from psyching out. Role simulation is thought to involve the student play acting the role of the qualified nurse, a role with which students are seldom comfortable. Finally, students undergo provisional and stable internalization. During provisional internalization the student adopts the language and discourse of the profession, although the students are

aware that they are using the words which teachers want them to use. The parlance is used as a front to please the instructor. Over time the provisional internalization becomes stable. This can only take place away from the controlling influences of the school and is an important part of the initial period after qualification (Davis 1975).

Some British studies suggest that a large proportion of student nurses' learning takes place outside the mentor mentee domain (Andrews and Chilton 2000. Wilson 1999). In particular Wilson outlines two types of mentorship; the formal "appointed mentor" and informal relationship termed "discretional mentorship". Within discretional mentorship Wilson identifies three levels of support. At a functional level the student initiates a once only or single issue contact; a middle order, whereby contact is not necessarily initiated by the student, but is said to involve more than a single issue contact. Interestingly, such contacts are perceived by mentors as noteworthy relationships. Finally Wilson describes a deep level of discretionary mentorship which is long lived and perceived to be of mutual benefit and intensity for both participants. Wilson's findings would seem to add weight to those of Melia and develops some of her initial findings. For example, Wilson demonstrates that junior student nurses find auxiliaries and other student nurses as approachable although they are less knowledgeable and trustworthy than staff nurses. Some insights into the mode of peer learning are provided by Wilson's work as findings state that junior students actively seek out senior students in an ad hoc fashion, as and when support is required; it appears that senior students rely on each other in much the same way. Importantly Wilson also tentatively suggests that some senior students feel a duty to supervise more junior students. However, these important concepts are not explored or developed further.

Sub theme: Role modeling and student nurses

The effects of qualified staff on student learning (in terms of role modeling) are well documented. However, much less seems to be written about the

effects of fellow students as role models. Gray's (1997) study of the professional socialisation of student nurses describes how students were surprised by how much they learned from their peers, indeed the students in her study comment that they learned more from their peers than the qualified staff. Fellow students were seen to have more time to teach, were better at explaining things, were able to pass on hints and tips and were friendly and approachable. The students in Gray's study easily identified those fellow students who were keen to share their knowledge and skills from those who had no interest in helping them to learn. Unfortunately, whilst Gray devotes much time to describing these important findings, the impact of fellow students on learning is not discussed in the conclusions. However, it should be acknowledged that this was not one of the aims of the research.

The key characteristics of students as role models which Gray outlines are also supported by Parr and Townsend (2002) who suggest that modeling effects are more likely to occur if the peer model is competent, credible and enthusiastic. In addition to this it is important for the learner to perceive that she is similar to the fellow student. Watching similar others succeed at a task is said to assist learners to increase their self efficacy and helps them believe that they too can be successful (Parr and Townsend 2002).

Critical overview of the literature. (Table 1)

Deep and Surface approaches to learning.

	Sample	Method	Critique
Marton & Saljo 1976.		Phenomenological approach	Seminal work, often quoted spawned further studies. Asked students to read and interpret text and described two approaches: deep and surface.
Snelgrove 2004.	75 undergraduate 214	42 item questionnaire. Used SPSS	Questionnaire distributed during common foundation programme, some students only six months into the

	diploma students.	to analyse data.	programme. Chronological development may also serve to explain the tendency towards deeper learning at the end of the study, but this is not discussed.
Jinks 1997.	224 students 20 nurse teachers 76 education managers	SAQ survey. Interviews. Questionnaire. Produced both qualitative and quantitative data. Used data triangulation.	Highlights the importance of nurse teachers in the practice of students. UK study of nurse education managers, nurse teachers and students. Pilot study in 2 institutions first. Studied Diploma level students undertaking a previous curriculum. There may be different priorities with newer curricula relating to learning.
Dreyfus and Dreyfus 1980			Novice to expert study looked at a variety of professionals not all of which relate to nursing.
Benner 1984	Over 1200 Qualified nurses	Questionnaire and interview. Some direct observation.	Influential American novice to expert study. Not clear how learners move through levels of proficiency. Examined qualified nurses but the model has been adopted by pre-registration curricula (including within the School under study). Her list of definitions of practical nursing knowledge does not include psychomotor skills.
Eklund - Myrskog 1997	60 student nurses (age and gender not declared)	Phenomenographic approach: interviews at the beginning and end of training.	Examined Swedish speaking student nurses in Finland: unclear whether language and translation may have been an issue. Impact of chronological development not discussed. Presents only a single example of data for each of the 5 identified conceptions of learning. Weakens the

			strength of claims made.
Alexander 2001	Nursery nursing students aged 16-20 all female.	Broadly ethnographic: observation and interview technique. Details are lacking.	Paper based on her PhD study. Makes little reference to data from either classroom or practice. Suggests the course pushes students into superficial modes of learning, but the programme is largely competency based so perhaps this finding is not surprising.

Deep and surface approaches to learning:

The studies show that globally there is concern regarding students' abilities to use deep approaches to learning. The studies reviewed tend to use phenomenological methods, but not all studies refer to data within the publications. The age of the respondents within these studies is often not declared making it difficult to know whether chronological development is a factor in achieving deeper levels of learning. In some cases there is minimal presentation of data which weakens the claims made. From the studies reviewed it remains unclear whether nurse education fosters deep or superficial approaches to learning.

Experiential learning and reflection.

Experiential methods are widely used within nurse education. However it remains unclear whether all nurses; including students can reflect on practice in a manner which results in improved outcomes for patients. Literature which explores how students learn and master the art of reflection and then subsequently improve their practice is lacking. Within nurse education the work of Benner is particularly influential yet she conducted her research with qualified staff who she saw as novices at the point of qualification. Therefore it seems that the widespread use of this model in pre-registration curricula is inappropriate.

Learning as Understanding.

	Sample	Method	Critique
Ashworth 2004			Discussion paper drawing on the work of Heidegger.
Nehls 1995.	Work uses graduates and those already qualified.	Uses philosophical frameworks including phenomenology, pragmatism, feminism, post modern and critical social theory.	Provides a North American perspective of philosophical underpinnings of narrative pedagogy; may indicate the more acceptable nature of storytelling in the Canada. Discusses the strengths and benefits of this approach in Nurse education. Working with graduates and those already qualified may be a prerequisite for this approach: more experiences on which to draw. Acknowledges that often story telling is viewed as unscientific or immature by critics.

Learning as understanding may be more popular in terms of a concept within North America as narrative pedagogy appears to be more readily accepted there as a mechanism of teaching and learning. Neither of the two studies reviewed provide guidance as to how to facilitate this kind of teaching and learning approach. The fact that Nehls uses qualified nurses may indicate that this approach is unsuitable for student nurses, but this requires further research.

Learning through doing.

	Sample	Method	Critique
Wenger 1998			Suggests that learning is not something we do when we are doing

			nothing else: interesting since in nursing the working is often separated from the learning. Explains the need for a community of practice into which newcomers gradually become absorbed. However, this notion is questionable for student nurses. Also asserts legitimate peripheral participation is required; but it remains unclear what this constitutes.
Eraut 2000		Theoretical analysis of issues and phenomena arising from empirical investigations.	Suggests that knowledge is expanded according to the magnitude of a situation; but it could be memory which is expanded rather than knowledge as some events remain unchanged and unchallenged in memory. Does not consider that another's experience may also help an individual to learn.
Cope, Cuthbertson and Stoddart 2000	Random samples one pre Project 2000 group (who had already qualified) one from Project 2000 curriculum.	Semi structured interviews	UK based study. Presents more data from the Project 2000 group making the results appear more significant. Using a group that has already qualified may have affected the results as memory may be flawed. But this is not considered.

These three works are important because they highlight some issues within nurse education. However, only one is a research report and there are issues

concerning the impact of potentially flawed memory on the study findings. The work indicates that further research is required to ascertain the impact of learning through doing for nurse education.

Group work.

	Sample	Method	Critique
Will 1997			An American exploratory paper. There may be cultural and or geographical aspects to how people behave in groups which is not discussed.
Topping 2005		A review of developments in Peer learning 1981-2006	States that the review is concerned with the developments in peer learning however, he devotes much of the paper to discussing peer tutoring and peer assessment which is suggested as being more formal and different to peer learning. He tends to focus on developments within school age children rather than further or higher education.
Slavin 1996	Not declared.		Provides an American perspective on school and college students, therefore work may not be transferable elsewhere. It is unclear if the findings apply to adults.
Parr and Townsend 2002		Used a constructionist perspective.	Studied children and state that examples are provided from the classroom to highlight issues, but no hard data can be found within the paper. They review 112 other papers to arrive at their claims.
Spalding	12 PGCE	Series of questionnaires	Discusses findings in broad terms but

et al 1999	students: no further details provided.	at the start of the course, after 6 weeks and again at the end. Also used some interviews (no details provided).	presents no data to substantiate claims. Asserts that mature learners are better able to talk about their learning therefore makes bold assumptions regarding the impact of maturity.
Eraut 2000			
Savin-Baden 1998	Not discussed		Presents the findings of the study only in this paper.

The studies reviewed here indicate that much of the work carried out has to date focussed on group work and children or adolescents; and it remains unclear whether groups of adults will learn from each other in the same way. The maturity of the learner may have an impact on the manner of learning within groups but this requires further investigation before clear conclusions can be drawn.

Discourse in peer learning.

	Sample	Method	Critique
Northedge 2003			Explores the role of the lecturer as an expert, suggests that the lecturer is crucial in helping student to assign meaning. Does not provide advice concerning how lecturers develop these skills or whether all lecturers are able to teach in this way he tends to assume that all teachers can reframe ideas that emerge from

			the group.
Ellis et al 2004	54 students 3 subject tutors. 'E' commerce students	Qualitative approaches with quantitative analysis. Open ended questionnaire plus three 30 minute interviews with tutors.	An Australian study which explores how students learn through discussion. Provides extensive detail concerning the piloting of the questionnaire which is a strength of the paper. Used SOLO taxonomy to structure the hierarchy but does not explain what this is. Categories were agreed by the researchers but not verified by respondents. Provides tables to show only representative data for the questions asked.
Sutherland 1999	17 nurse tutors aged 20-40. 2 male, 15 female. UK study	Semi structured interviews providing qualitative data.	Asked 26 questions but reports on what is considered to be the most noteworthy (according to the researcher). Provides mainly summaries of the data rather than specific examples to support the claims.
Morris and Turnbull 2004.	Purposive sample 240 students UK.	Direct observation and focus group interviews. Use a range of qualitative evaluation approaches from educational research but essentially this was a thematic analysis.	The study explores the impact of inquiry based learning in nurse education. Students were given the opportunity to discuss the themes derived from analysis but it is not stated whether any themes were altered as a result of this process. Links to surface approaches are not explored. Novices may use discourse in groups less because they have fewer examples on which to draw but the impact of this is not explored.

From these four papers it clear that the manner of learning in groups remains a subject which requires further clarification. Specific examples are lacking from the studies reviewed which indicates the need for more research which highlights the student experience within groups generally and within nurse

education more specifically. Two of the studies involve undergraduate students but only one of these applies to nursing.

The importance of language in learning.

The literature reviewed in relation to language was mostly grey literature. Much of the work relates to the developmental study of children (Vygotsky 1998, Mercer 2000, Rojas-Drummond and Mercer 2003). However, it appears that many of the concepts highlighted could be applied to learning amongst adults; Vygotskys' concept of the Zone of Proximal development seeming to be particularly applicable to the way in which student nurses learn; as suggested by Spouse (2001a) and Andrews and Roberts (2003). The work of Mercer and Rojas-Drummond and Mercer explores language in learning from an international perspective and suggests that children can learn to use exploratory talk providing the teacher intervenes in a certain way. More work is required to see if the same is true for adults and if so, there may be implications for nurse education.

Dialogue in academic learning.

	Sample	Method	Critique
Bowles 1995			Presents a discussion paper exploring the value of story telling as a professional development tool. Weakness of the paper is that he omits to say whether or how he used story telling within his own practice. Data is limited.

Savin-Baden (1998), Parr and Townsend (2002) and Alexander (2001) also refer to dialogue in learning. Dialogue may be an aspect of establishing learner identity but whether this is true of all learners including mature adults requires further work before strong conclusions can be drawn. There is a lack of studies and therefore examples from within nurse education.

Vicarious learning.

	Sample	Method	Critique
Payne 2003			Explores environmental education and the role of experience. Implies that there are different forms of experience and first hand experience may not be the only mechanism by which individuals learn.
Fox 2003			Uses fiction to prepare students for an intercultural experience. An American paper which suggests that imagination can provide a virtual experience. What he suggests in terms of cultural learning could be applied to nursing and preparing students for clinical practice. Makes inappropriate use of Mezirow.
Cox et al 1999	54 undergraduate students : variety of backgrounds from Halls of residence.	Quantitative experiment. 4 experimental conditions and 1 control group. Students tested in a computer lab in groups of between 8-20. Pre & post test instruments devised.	Contrived research setting. Lack of information regarding the student perceptions due to experimental nature of study. Students re-use the dialogue of others and find listening to dialogue between teacher and students helpful.
Spouse 2003	Six student nurses	Longitudinal ethnographic and phenomenological study	Refers to students sharing stories as having a vicarious learning experience.

From the papers reviewed it seems that the notion of vicarious learning is an emerging concept within education generally. However, Spouse is the only literature reviewed which refers to student nurses as having a vicarious learning experience. Her study suggests that student nurses can learn through

hearing the experiences of others. She makes a fleeting reference to vicarious learning, although this was not a formal aim of the study it would have been beneficial if this important point had been expanded upon.

Professional Learning.

Spouse writes extensively (1998, 2001a, 2003) about professional learning using data obtained from a longitudinal study within the UK. The main issue being that small sample sizes (6-8) and restricted geographical area of the study (to the UK) limits the transferability of the findings. Her work uses the student experience well to highlight issues of professional learning. Schon (1984, 1987) and Eraut (1994) have written seminal work outlining the unique nature of professional learning.

Vicarious learning through story telling.

	Sample	Method	Critique
Spouse 2003			
Bowles 1995			
Northedge 2003			
Nehls 1995			
Orland-Barak and Wilhelem 2005	24 student nurses from Israel.	Broadly phenomenological, qualitative content analysis of stories. Used a matrix to arrive at themes from analysis. Unclear if these were shared with participants at any stage.	Students asked to write their stories down for the purposes of the research. It is unclear if written and verbal story telling differs in nature and or complexity. States reflections of novices were devoid of deeper levels of thinking; perhaps unrealistic to expect anything more of novices.

Diekelma nn 1990		Heideggarian principles.	North American perspective. Position paper. Emphasises the importance of language in education and practice. Does not consider the perspectives elsewhere regarding narrative pedagogy. Her works resonates with me.
Diekelma nn 1993	21 teachers 21 students	Heideggarian phenomenology. Interviews. Undertook a 7 stage Heideggarian hermeneutic analysis.	Data presented together with analysis but details concerning the 7 stages of analysis are sparse.
Davidson 2004	Purposive sample 10 students. Study from the USA. Females 19-54 years old mean age: 29.5. 8 Caucasian, one mixed race, one Asian.	Based on Heideggarian hermeneutics. Focus group held in classroom. Content analysis of data.	Provides good detail of sample and methods of data analysis. Emphsises the importance of social connectedness of the group. Peers provided support but whether or how this was kinked to learning is unclear. Findings are not generalisable. Need to see if findings are supported in practice when students work with patients & others. Tentative links to vicarious learning: those who listen to others' stories. Weakness of the paper is that it does not consider why some students do not share stories and whether they can still have the vicarious learning experience.

The studies reviewed indicates that story-telling and the learning that takes place as a result is growing in importance globally, although there appears to be a greater acceptance of the notion amongst the United States of America and Canada. Sample sizes tend to be small and this limits the transferability

and generalisations that can be drawn from the work. It is clear that learning through story telling is possible and often valued by participants and teachers as a method. However exactly how stories are beneficial requires further work.

Peer support:

Campbell et al (1994) undertook a study of 50 student nurses (plus an additional 81 open ended questionnaires) on a 4 year Baccalaureate programme in Canada. This is one of the few studies which begins to make links between peer support and peer learning. The educational system in Canada is different to that within the UK: clinical teachers accompany students into practice and this may limit the transferability of findings. Peer support is well described. A weakness of the paper is that there is no observation of students in practice to verify the interview and questionnaire data. The study used semi-structured interviews based on Melia's work, but no details are provided. The students did not identify any negative aspects of clinical instructors but this is not surprising, since they still had to work with the instructors throughout the programme.

Professional Socialisation.

	Sample	Method	Critique
Melia 1981	40 student nurses	Informal interviews. Grounded theory.	Johnson suggests that she uses ethnographic language to suggest that the interviews took place closer to the field than is actually the case.
Melia 1984.	Based on the 1981 study		Informal interviews guided by an agenda, the agenda was moved around and altered and not always completed depending on the initial responses. Study took place in the UK at a time when nurse

			education was based around an apprenticeship system. May impact on the transferability of findings. Good examples of data used to support claims.
Olesen and Whittaker 1968	NB: worked under the guidance of Davis (1975) who also collected some of their data. Numbers are not provided but all were female.	Longitudinal study in United States. Participant observation. Phenomenology but suggest that the report is a sociological one.	An early study of professional socialisation amongst student nurses. Followed one class throughout the three year programme in class and practice. Sometimes they focussed on the group as a whole and sometimes on specific individuals. State that they allow the data to speak for themselves. Made relationships with the students: 'we-ness'. Influential for my study.
Davis 1975	All females late teens, early 20s.	Longitudinal 5 year study. Survey and panel depth interviews. Student nurses are used as an example of professional socialisation.	

Melia's work on the professional socialisation of student nurses is seminal and often quoted despite being written at a time when the nurse education system within the UK was different to that of today. It seems that her findings still hold true. Other work from the United States uncovers similar findings to that of Melia which indicates that perhaps professional socialisation occurs in similar ways regardless of geographical location but a comparative study in both locations would help to investigate this further.

Summary and links to fore understandings

Much is already known and documented about the stages of intellectual development amongst Higher Education students; novice to expert studies being particularly influential in nursing and nurse education. However, as this review has shown such studies are not without their critics as it is thought that the novice to expert doctrine does not fully explain the complex professional development of nurses, experience does not necessarily lead to improved practice in a linear fashion. More detailed explanations are required. Non formal learning in particular has been a neglected area of research and its importance subsequently underestimated. However, the primacy of first hand experience prevails and it is clear from the literature particularly relating to Higher Education Students that it is possible to learn from another's experiences. The implications of such vicarious learning for nursing students is central to this thesis inquiry. The literature here has been particularly influential in helping to form the view (which is expressed as a fore understanding) that student nurses do learn from each other, but the mechanisms are poorly understood. Therefore, the research questions focus on the mechanisms and value of peer learning (for the students in this study).

Vicarious learning seems to be linked to story-telling and dialogue, sometimes referred to as narrative pedagogy, where language is important in terms of sharing stories, the forming of identity as nurses and the consideration of practice. Hence my second fore understanding that dialogue plays an important part in learning to be a nurse. Some teaching and learning strategies use dialogue in groups where students are expected to engage in challenge and support of each others' ideas. The curriculum in which these students are engaged uses problem based learning, a method thought to be rich in such dialogue. Problem based learning is suggested to enable the students to develop a strong sense of identity through the interrelationships in the group in order to solve problems and integrate what has been learned. I would like to learn more about how my own students use problem based

learning to learn from each other. Essentially, these fore understandings combine to form the stated aims of the research.

Much has also been written concerning group learning. Following the literature review it is clear that students do learn from each other. Learning in groups is said to be significant and social cohesion within the group also appears to be important to student learning. However, much of what has been written relates to studies conducted on children. It is clear that students gain a great deal of support from their fellow students, seeing each other as approachable and valuable resources. It remains largely unclear what students are learning from each other, whether there are any patterns visible in this learning and whether this kind of peer learning happens in both clinical practice and in the classroom. This research seeks to provide valuable insight into these issues and contribute to the body of knowledge regarding peer learning in nurse education. This leads to the research questions:

- What are the students learning from each other in clinical practice and in the classroom?
- What are the mechanisms of peer learning as used by this group of students?
- Do these students value peer learning in both settings?

SECTION TWO

Interrogation of the Social World.

Ashworth (1987) refers to this as clarifying the obscure. This section of the thesis is concerned with planning and living the ethnography. Chapter Three will outline my philosophical assumptions regarding the research approach, my position in the research process and relationships with respondents; elements which Ashworth (1987) suggests should be thought through and made visible by the researcher. Chapter Four goes on to describe the practicalities of conducting the research including a discussion of participant observation, data collection and analysis. Through the interrogation of the social world the student experience is revealed as the findings of the research. Chapters Five through to Eight are a presentation of each of the findings.

Chapter Three.

Planning the Ethnography.

Research approach

Introduction

This Chapter clarifies the philosophical assumptions that underpin the method within this research. As Koch points out it is important that these assumptions are consistent with the researcher's view and alludes to the philosophical framework, the fundamental assumptions and characteristics of a human science perspective (Koch 1995). The selection of method is based on the researcher's philosophical beliefs about the inquiry; and therefore it is important to acknowledge that my own personal beliefs will affect the way in which the research is designed, undertaken, analyzed and reported (Woods. 1997). Furthermore, Van Manen (1990) suggests that "the method one chooses ought to maintain a certain harmony with the deep interest that makes one an educator in the first place" (p2). Establishing my personal philosophical beliefs through reflection is an important part of this study. McCormack (2001) argues that reflection is an essential component of research design (irrespective of methodology) as a means of clarifying values; motivations and in pursuing rigor in decisions and judgments during the research. Indeed McCormack (2001) acknowledges the need to develop a methodological framework which enables the researcher to focus on the process of doing research, rather than the outcome of doing a thesis. In his paper describing his personal journey towards a Doctorate he argues that completion of the written thesis was in fact secondary to the process of self discovery. Therefore, my personal reflections are included in order to clarify my thoughts, values and beliefs. These are sometimes recorded as my experiences whilst undertaking this research. This is not to say that the researcher experience is the focus of the study; as in autoethnography (Ellis

and Bochner. 2000); rather it acknowledges that my personal reflections and stance within the research does have an impact upon the research itself.

The research paradigms

According to Leininger (1998) to assume that there are no major differences between qualitative and quantitative research methods, or to accept the supremacy of one method over the other in blind conformity to tradition is questionable and, perhaps more importantly, she argues may not be in the best interests of advancing nursing knowledge. She goes on to say that "nursing has philosophical, historical and epistemological beliefs that are deeply rooted in humanistic services to human kind, and these roots can best be discovered by qualitative methods more than by quantitative, scientific ones" (Leininger 1998. p22). Eisenhart (2005) puts this succinctly when she cites the Los Angeles Times saying that arguing over which method represents the gold standard in research terms is futile, and makes no more sense than arguing about whether hammers are superior to saws, when both are required to build a house. The choice depends on whether you want to drive in a nail or cut a board. Returning to Leiningers' work, she points out that scientific knowledge has previously yielded only limited substantive knowledge concerning the nature of nursing; whereas, qualitative methods are revealing the broadest conceptualisations of understanding human groups because the goal of qualitative research is to document and interpret as fully as possible the totality of whatever is being studied and is uncovering covert, subtle and subjective realities and truths about individuals. Ashworth (1987) takes this argument further by suggesting that researchers must first question "what it is that is to be quantified, and whether it is the stuff of which numbers are made" (p5). He goes on to argue that qualitative methods become the preferred methods in the human sciences because social life is not understandable in terms of the joint effect of a large number of discrete causal variables.

Researchers may adopt either a separatist or a combination position in relation to research paradigms (Leininger 1998). The separatist (or clean) position is described by Leininger as one where the researcher does not want to contaminate or dilute either qualitative or quantitative approaches by using elements from the other paradigm. Researchers adopting a separatist position believe that the approaches must be kept separate in order for the research goals to be met. Whereas some researchers will want to adopt a combination or appeasement-like position as Leininger terms it. She suggests that individuals tend to take up silent positions within their research. However, her use of the appeasement like position implies that some researchers will opt for a combination of approaches in order to satisfy both qualitative and quantitative researchers without really considering which approach(es) best suit the research question. Jinks (1997) would refute Leininger's position because (according to Jinks) whilst traditionally the two paradigms have been separated, inclusion of both approaches may provide richer and deeper insights into appropriate studies.

Therefore when considering my approach to this research traditional positivistic scientific approaches were rejected at an early stage. Firstly, the construct under investigation is complex and poorly understood; resulting in a lack of validated instruments or outcome measures that could be used to test or validate prior assumptions.

Secondly, the number of student nurses willing to be involved was anticipated to be small; together with this the students may have different experiences and this subsequently affects the nature of the sample. Therefore, it would be difficult to make meaningful claims of significance or generalisability regarding the findings, if indeed such claims were philosophically important. The search for universal laws is downplayed in favour of detailed accounts of the concrete experience of life within a particular culture (Hammersley and Atkinson 1995). Finally, as Clarke (1995) suggests; the environment plays an important part in research arguing that behavior can only be studied and understood in the context where it

occurs. Therefore, student nurses should be studied in the context in which they work. Woods (1997) suggests that quantitative methods such as surveys and experiments attempt to control for the influence of extraneous variables on the phenomenon being studied, thus negating their influence on the data. Therefore, rather than create an artificial research environment it is important to study student nurses engaging in the everyday activities associated with being a student nurse.

In his Doctoral thesis Johnson (1993) contends that in order to overcome the criticisms (largely from positivist social scientists) that ethnographies are little more than 'mere journalism', researchers have invested energies into developing sophisticated procedures in order to demonstrate how interpretations are derived. He intimates a notion which is developed much later by Savage (2006) when she suggests that qualitative research can not and more importantly should not be judged using criteria traditionally employed by positivist researchers. Savage argues that there is a danger in trying to stretch qualitative enquiry to meet the criteria developed for other types of research which may be considered to be more scientific, or objective. Therefore, the conclusion drawn is that quantitative approaches are inappropriate for this study. A qualitative approach is assumed in order to uncover the realities and truths of the student experience which fits with my beliefs and values and is appropriate with respect to the research aims.

Ethnography

Three British ethnographers: Allen (2004), Johnson (1993) and Holland (1993) provide an overview of the history of ethnography and its' use in nursing research. All three describe the roots of ethnography as being in social anthropology, originally involving the study of so called 'primitive' communities. Evans-Pritchard (1962) an early social anthropologist, argued for three phases or levels of abstraction. Firstly, understanding the overt

features of a culture and translating them into terms of his own culture. Secondly, analysis is used to disclose the latent underlying form of a society or culture and thirdly, comparing the structures revealed through the social analysis (Evans-Pritchard 1962). Evans-Pritchard's comments would seem to indicate that researchers of the time studied a culture viewed as separate and distinct from that of the researcher.

Later, influential sociologists from the Chicago School used quantitative analysis of survey data to develop grand theory of urban life in America (Johnson 1993). The researcher's view of the culture under study was one of studying 'the other'; a community to which the researcher does not 'belong'. However, the research could be said to have been conducted 'closer to home'. More recently, Kendall and Wickham (2001) assert that cultural studies include the study of cultures as 'the other' and the study of the culture of ourselves. Indeed they consider cultural studies as a sort of "anthropology of home" (p6). They go on to contend that the details of the everyday: describing the appearances, details, systems and their uses is the best way to study the culture of the everyday.

Within the UK a number of nurses have used ethnographic methods to explore different dimensions of healthcare practice, for example, nurse-patient interactions on a ward (Savage 1995), participation of patients with spinal cord injury in rehabilitation (Pellat 2003), birth experiences of women in Pakistan (Chesney 2001). However, perhaps with the exception of Spouse it seems that ethnographers have largely avoided using the approach to study student nurses since the work of Holland (1993) and Johnson (1993).

The notion of culture is central to ethnography. According to Helman (1994)

> "culture is a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people…to some extent, culture can be seen as an inherited 'lens', through which the individual perceives and understands the world that he inhabits and learns how to live within it" (Helman 1994. p3).

Baillie (1995) suggests a critical assumption within ethnography is that any human group which is together for a period of time will develop a culture. According to Aamodt (1982) ethnography seeks to describe a particular culture and it involves the systematic collection, description and analysis of data to examine behaviour within the culture. She goes on to say that students in a school of nursing can be seen as a community of members who share "cultural rules for human activity in culturally specific scenes. The story of their lives is ethnography" (Aamodt 1982. p210). This point is clarified further by Aamodt who reminds researchers that whilst "culture is shared among informants, it is not totally shared (nor totally unique) among members of a group" (p217). A view supported by Laugharne (1995) who explains that there may be "a shared language which is unique to the group, they may have similar beliefs and in this sense the group may be seen as a culture, however, ethnography cannot reveal common meanings where there are none" (Laugharne 1995. p53). Therefore the cultural world may contain elements which the students share and other elements which each student experiences as an individual. Both views being equally important to this study since both views may shed light on answering the research questions.

Cultural behaviour is generated by learning and following the cultural rules (Holland 1999). Within nursing the students have to learn the explicit and the implicit cultural rules of the qualified staff, but as this thesis demonstrates, they do so largely as outsiders or onlookers on the culture and community of the qualified staff. The students exist in a bi-cultural world consisting of the University and clinical practice; what Melia terms as segments. The students are onlookers to the culture of the qualified staff as they have a largely nomadic existence. Whilst in clinical practice the students move from placement to placement every six to eight weeks trying to fit in so that learning can take place (Neary 2000, Earnshaw 1995, Spouse 2001 and Nolan 1998). Other work also outlines this notion of the student as an onlooker or outsider to the community and culture of the qualified staff: Cope,

Cuthbertson and Stoddard (2000) and Ousey and Johnson (2006), for example. Cope at al demonstrate that the qualified staff either grant or withhold acceptance of student nurses into the culture; acceptance having little to do with proficiency but being concerned with social acceptance (Cope et al 2000). Whereas Ousey and Johnson discuss a 'them and us' situation between qualified and student nurses; the students being excluded from the culture of the qualified staff because they do not necessarily share the same language or undertake the same duties. None the less, students still want to fit in and get through their placement successfully without asking too many questions (Ousey and Johnson 2006). Therefore, the students form a community and culture of their own.

Mulhall (1997) points out there are two important premises concerning nursing research and the case for questioning the natural science approach. Firstly,

> "an epistemological and methodological concern that the social world of nursing cannot be investigated through this paradigm. Secondly, that the scientific hegemony operating in Western societies conceals the societal nature of the exercise, making the claim that this way of knowing produces the truth rather than a truth" (Mulhall 1997. p971).

She goes on to say that ethnographers assume that people create their own worlds, and therefore, ethnographers (and the accounts which they produce) are one version of reality. Therefore this thesis presents one version of reality, that which is interpreted by the researcher but which seeks to explain the experience of the students under study. Like Holland (1999), I see the fact that I have a personal history as a nurse together with my relationship to the students as a strength to uncovering that truth.

Savage (2006) argues that the strength of ethnographic research is that it gives voice to individual experience. She asserts that this is a recent move amongst ethnographers in an attempt to gain the perspective of numerous and differently positioned individuals and to ensure that all voices are heard. Traditional approaches to ethnography maintained a distance between

observer and observed, in order to maintain a sense of objectivity; with the resulting account being seen as a true reflection of reality (Borbasi, Jackson and Wilkes 2005). Indeed, Savage (2006) suggests that a number of different types of ethnography have emerged in recent years "largely differentiated by the epistemology (theory of knowledge) and ontology (theory of being) that inevitably inform an ethnographers approach" (p386). In an earlier paper Savage (2000) relates this development in terms of new and old views of culture. Old views of culture being concerned with the identification of collective understandings of research participants, whereas a new understanding of culture suggest a greater emphasis on the activities and explanations of participants and the power base amongst participants. In terms of authority, Savage (2000) suggests that because of the developments in the ethnographic movement, the ethnographer is said to no longer provide the most legitimate or only account. This is supported by Denzin and Lincoln (2000) who assert that the researcher is unable to make claims to objectivity because the researcher is not neutral. This is because it must be acknowledged that knowledge generated by an ethnographic approach is strongly shaped by the nature of the relationship between the researcher and the researched. New ethnographic approaches therefore attempt to restructure the research process itself in ways that promote views of those who are often hidden, silent and marginalized. This research uses the students' words and experiences in order to portray the kind of 'story' which Johnson is referring to (1995), using an emic perspective to enhance the student voice. Ethnography places a high priority on gaining the emic or insider's view of a particular group or community (Savage 2006). It is an insider's view in the sense that the researcher and the researched share part of the same cultural world: that of the University.

Savage (2000a) also comments that

> " it is also important to draw attention to the silences in what people say, that they may speak more, for example about the atypical and less about what is assumed to be shared knowledge; there is therefore a need to

> acknowledge the different emphases and modulations, indeed the spoken and the unspoken 'voices' of a single speaker." (Savage 2000a. p1495)

In other words the researcher must learn to recognise these subtle inferences of intonation and silence and learn to read between the lines in order to uncover the assumptions behind the shared knowledge.

The concept of strangeness with regard to this research.

In this case the aim is to study a community of student nurses who are known to me. The roles of teacher and researcher co-exist. As teacher to the students; I am inextricably linked to them, I participate in and facilitate their learning. We are convened by the timetable on a regular basis throughout each module of the curriculum throughout the entire three years of the pre registration programme. The research environment therefore, is natural and not contrived. Furthermore, a relationship has already been established with the students under investigation. My position in the research process ensures that people do go about their business as usual. I withdraw from cultural immersion at the end of each day in order to intellectualise what I have learned; put it into perspective and so be able to write about it convincingly as Peacock (1986) suggests.

However, although immersed in the world of student nurses I cannot view experiences from their perspective. I do not experience their world as a student nurse; I am not one of them. Although I do have my own past experiences as a student nurse on which to draw. Therefore ethnography is used as a broad approach to this inquiry. Indeed Hammersley and Atkinson warn researchers against feeling "at home" and suggest that even where the researcher is studying a familiar group or setting, the participant observer is required to treat things as "anthropologically strange" in an effort to make explicit presuppositions taken for granted as a culture member. A critical, analytical perspective is required (Hammersley and Atkinson 1995).

However the notion of strangeness is not straightforward, for example, Knoblauch (2005) a sociological ethnographer suggests that when researching within one's own culture the problem of ethnocentricity presents itself in a different way. He suggests that the problem of strangeness is less pertinent, in other words 'the other' is to be constructed differently. Knoblauch refers to what he terms an 'ethnographical travesty' in popular ethnography of disguising one's own culture as if it were a foreign world. Similarly, Baillie (1995) suggests that for nurse ethnographers in particular, the research setting will never be totally unfamiliar. Indeed VanMaanen (1988) argues that in order to undertake an ethnography the researcher requires " at a minimum some understanding of the language, concepts, categories, practices, rules, beliefs and so forth, used by the members of the written about group" (p13). In other words, having such prior knowledge is a prerequisite and strengthens the ethnographic process. We come to the research with some prior knowledge, what Holland (1993) refers to as a position of assumed knowledge. When researching within a familiar society or culture Knoblauch argues that the researcher may lack the contextual knowledge of specific situations, but typically knows of these situations and disposes of methods to handle new situations; hence the need to control and take account of such knowledge through reflexivity (Knoblauch 2005). This would seem to support the use of the kind of model proposed by Ashworth (1987), and utilized in this research since the model enables the prior knowledge to be made explicit, and its influence on the research process managed.

Research design

Hammersley and Atkinson suggest that in order to understand peoples' behaviour we must use an approach that gives us access to the meanings that guide that behaviour. In qualitative studies the researcher is usually clearly evident and has to establish a relationship to the participants (Lathlean 1996. Peacock 1986). In some cases the researcher intervenes in order to change a

system whilst participating in the research context: action research (Moch and Gates 2000); whilst in other methods such as autoethnography the researcher is the focus of the research (Ellis and Bochner 2000). The relationship between the researcher and the participants is central to this research; a relationship is established with the participants.

According to Brewer (2000) "ethnography is not one particular method of data collection but a style of research that is distinguished by its objectives; which are to understand the social meanings and activities of people in a given setting" (p11). The value of ethnography as an approach to research is that it exploits the capacity that any social actor possesses for learning new cultures and the objectivity to which this process gives rise (Hammersley and Atkinson 1995. p9). They go on to say that language is important to ethnography in that language demonstrates the meaning that individuals subscribe to at any given point in history. The meanings are fluid and ever changing and are reflected by the language we use in our narrative. Three key characteristics unique to ethnographic research are a focus on culture; cultural immersion and reflexivity (Streubert Speziale and Rinaldi Carpenter 2003). This research seeks to make the implicit cultural knowledge of the students explicit; the focus therefore is on the students and their experience of peer learning. As a researcher, in order to reveal such implicit knowledge cultural immersion is a prerequisite. In order to make sense of the cultural group under study, Ashworth (1987) argues that the researcher is not a passive recorder of the talk, but an active understander; thus making the relationship between the researcher and the researched central to the research process. Making sense of the cultural world under study also involves interpretation on the part of the researcher.

VanMaanen (1988) is more emphatic in his assertion regarding interpretation:

> "A culture is expressed (or constituted) only by the actions and words of its members and must be interpreted by, not given to a fieldworker. To portray culture requires the fieldworker to hear, to see, and, most important, to write of what was presumably witnessed, and understood during a stay in the field" (p3).

VanMaanen's comments would seem to imply that interpretation is inevitable; the decisions required of the researcher relate to what to tell and how to tell it. He presents three options regarding this dilemma: realist, impressionist and confessional tales (VanMaanen 1988). Within realist tales he warns researchers not to fall into the trap of passing off observations and interpretations as the native's point of view, or vice versa, "the so called 'dictated text' of ethnographic ill repute, in which the native's point of view is passed off as the fieldworker's interpretation" (p137). A realist tale, according to VanMaanen (1988) is one where the author is invisible in the final text; the author narrates the tale as an authentic cultural representation conveyed through the text and are characterized by closely edited quotations which suggest that the views expressed are 'straight form the horse's mouth' (p49). He explains that exponents of this approach believe that by removing the observer (the "I") enhances the authority of the narrator and so allays audience concerns regarding subjectivity. Finally, he suggests that such tales do not reveal what the respondents make of it all and are often "flat, dry and unbearably dull" (p48). Therefore, to a certain extent this ethnography is a realist tale, since it includes the students' words; however, here the commonalities end, because within this thesis the researcher is clearly evident.

However, as Lecompte and Preissle (1994) point out, not all of what participants know about their culture is carried consciously and furthermore ethnographers are faced with a dilemma of revealing cultural knowledge of groups under study whilst preserving its meaning to those within the culture. According to Denzin and Lincoln (2000) qualitative inquiry locates participants in their natural world which means that the researcher must use interpretive practices in order to understand and bring meaning to the experience of the participants. Within ethnographic approaches, Brewer (2000) argues that "interpretation involves attaching meaning and significance to the analysis, explaining the patterns, categories and

descriptive units and the relationships that exist between them" (p190). Whereas Crotty (2003) suggests that the interpretivist approach looks for

> "culturally derived and historically situated interpretations of the social life world. A positivist approach would follow the methods of the natural sciences, and by way of allegedly value-free, detached observation, seek to identify universal features of humanhood, society and history that offer explanation and hence control and predictability" (p67).

It seems to me that taking an interpretive stance within the ethnographic approach is appropriate for this research. Like Crotty, I acknowledge that my interpretations are not value free since they are informed by my previous experience; however, it is equally important that the research is not prejudiced by those experiences. Ashworth (1987) suggests a model which indicates a way of practicing qualitative research that includes the testing of the adequacy of descriptions. This research makes use of Ashworth's model to test the validity of descriptions.

Student nurses do not exist in a vacuum; that is to say, they exist in a world of relationships: relationships with fellow students, teachers, patients and so on. As an educator and a researcher it seems inevitable that part of this study should include some examination of the relationship between the students and the researcher. Although this seems natural and somewhat obvious to me, rarely do academics study the realities of interactions with their students (Alvesson 2003). Within Higher Education qualitative approaches to research involve the researcher in getting 'close' to the meanings, ideas, discursive and social practices. The researcher begins at a distance and moves closer and closer to the lived realities of others (Alvesson 2003). Bjornsdottir (2001) argues that coercive language is often adopted in research which potentially distorts or silences respondents and therefore researchers need to be aware of people's location and social and cultural backgrounds in the recording and reporting of the research. She goes on to say that researchers must try to make clear the motivations for our projects and also state our own location and our influence on the research process.

A further interpretation of ethnography is offered by VanMaanen (1988) in impressionist ethnography. Impressionist ethnography is described as a form of ethnography comprising of a series of remembered events in which the author participant chooses to reconstruct only those events perceived as especially notable or reportable as impressionist tales. According to VanMaanen (1988) these tales are affected by the researcher's participation in the research context because the researcher is herself affected by this experience. The focus of the ethnography is the researcher's subjective impression of the research scene, based on her engagement with that scene. Furthermore, it is the relating and recreating of the experience which allows the researcher to communicate with the audience. In terms of impressionist ethnography, it could be argued that engagement in the scene is sometimes by proxy. Students relate stories from their lives in clinical practice that they feel are important; I in turn interpret these in line with my own research aims and personal philosophy. I do not engage in the scene in practice settings; although this is less true in the classroom. To a certain extent I am undertaking impressionist ethnography by default, in that I sift through all the stories told by the students and reconstruct only those I feel are notable or reportable. For me this seems almost inevitable; I interpret what the students are telling me. However, I must constantly ask myself whether what I am reporting is real or whether I am looking for what I want to find. Ashworth (1999) argues that the researcher must set aside her own assumptions, in order to register the student's own point of view. Whereas Ellis and Bochner (2000) suggest that the researcher's personal experience is crucially important in how it illuminates the culture under study. Ellis and Bochner (2000) term this notion of using personal experience as reflexive ethnography. Reflexive ethnography ranges "along a continuum from starting research from one's own experience to ethnographies where the researcher's experience is actually studied along with other participants, to confessional tales where the researcher's experience of doing the study become the focus of the investigation" (Ellis and Bochner. 2000. p740).

Alvesson (2003) outlines a further ethnographic approach which he terms "self ethnography"; this is described as a study and a text in which the researcher describes a cultural setting to which she has 'natural access'; and is an active participant. The researcher then uses the experiences, knowledge and access to empirical material for research purposes. He goes on to argue that observing participant is a better label for this kind of study as the researcher is not a professional stranger; rather the participation comes first and is complemented with observation in a research focused sense. This description reflects the approach I have adopted. I participate as both teacher and researcher with the students; I observe their journey to becoming nurses over a period of three years. Our collective experiences are used as data which are interpreted; sifted through and important instances are presented. If something revealing is observed, it is recorded in field notes or is audio taped. These events are considered and interpreted and then presented back to the students if more clarification or deeper understanding is required. This process is repeated several times, each time, aiming to achieve a closer understanding of peer learning for these students. I do not set out to observe students on certain days, rather the teacher as research participant 'waits and watches' until empirical material reveals itself; activating the researcher to come to the fore. The students were asked to verify the content of the transcribed tapes or field notes; enhancing the validity of the study. However, it is important to point out that students were not providing interpretation or assigning meaning to the transcriptions. Within this study, interpretation rests wholly with the researcher.

Insider, Outsider or a different view?

Allen (2004) explains the insider / outsider dialectic with advocates of the insider view asserting that only close immersion in the field of study produces an authentic account; whereas those adopting an outsider position maintain the lack of affiliation with respondents leads to an account free from

potential bias. However, Savage (2000b) presents another perspective which moves beyond the insider/outsider stance. Savage describes her attempts to 'stand in the shoes of others' during participant observation. In order to access embodied practitioner knowledge Savage participated in the nurses' bodily practices; in so doing, the differences between the researcher and the researched became evident to the researcher. Savage suggests that being aware of the differences or 'otherness' helped the researcher to make aspects of the practices more explicit. However in an earlier account Savage (1995) appears to realise that she lacks competency as a nurse and therefore fully sharing in an experience may not be possible. Therefore participation in the field may need to be carefully considered; a point which is developed further in Chapter Four.

Johnson (2004) raises concerns that "given the possibility of coercion, too many of us study our own students for reasons that can only be explained by excessive convenience". As an educator, I am with particular groups of students throughout their journey to being a nurse; we are inextricably linked. If as Bjornsdottir (2001) suggests research needs to be part of everyday nursing practice; then it seems appropriate to transfer this notion to my work as an educator and study a group of students who is known to me because they form a part of my everyday practice, and are not simply convenient. Lofland and Lofland (1995) suggest that there are both benefits and difficulties associated with staying at home to research in your own nest. For example: if the researcher wants to conduct the research in an open and honest manner then rules regarding making their intentions known to the research participants; gaining their co operation; seeking formal permission to conduct the research are all required, the same rules which an outsider is required to follow. However, they go on to point out that the clear benefit to being an insider is that the researcher already knows the "cast of characters" (Lofland and Lofland 1995. p37).

Knowing the cast of characters may enable the researcher to have a greater understanding of the culture being studied because there is an established intimacy between the researcher and the respondents; an intimacy which is said to promote both the telling and the judging of truth (Bonner and Tolhurst 2002). This notion of trust is interesting since it needs to be developed whether the researcher adopts an insider or outsider stance. Watson (1996) takes this argument further by suggesting that ethnography inevitably involves the study of *self* as well as *the other* and when the teacher studies his own students these two elements are more closely intertwined than in more normal ethnographic situations where researchers can more readily 'distance' themselves from those around them and from ongoing events. Indeed Watson is of the opinion that those adopting an outsider perspective (or studying a group of unfamiliar students) use the notion of being an ethnographic stranger to their advantage by constantly reminding themselves to 'stand back' in order to see more clearly (or objectively). He goes on to say:

> "If one is as little a stranger as a teacher must inevitably be in their own classroom, one faces a greater problem than normal of being able to retain the degree of control which is vital if any ethnographer is not to completely go native and hence lose any capacity to see events from the perspective of the investigator as well as from that of a member" (Watson 1996. p449).

In the study of his own management students Watson outlines the dual role of undertaking research on familiar students of both teacher and researcher. As investigator he is able to 'force the pace' of the research and more importantly, because of his relationship with the students could make their norms, values, priorities and lay theories of the learning community more visible and audible. He does not see this as a form of coercion, rather it is an acknowledgement of the dual role. He goes on to comment that as researcher his interventions in the classroom were also of a more substantive nature: "these experiments were 'classes' as well as research events. I was the teacher in those classrooms. As teacher, I was attempting to change the thinking and understanding of these students as much as I was trying to make

sense of the ways in which they think and behave" (Watson 1996). Therefore it seems that great skill is required in order to fulfil Watson's concept of the dual role of researcher and teacher. Baillie (1995) would refute Watson's view, arguing that ethnographers refrain from any attempt to control or manipulate the situation, but will enter the world of the group and study it 'as it is'. This is perhaps a somewhat naive view; unless the researcher is adopting a covert position from which to conduct the research, the possibility for manipulation must be acknowledged. Baillie's position would also seem to prevent researchers from studying students who are known to them; being at odds with Watson's position on the dual role. Therefore, it could be said that Watson is both brave and honest to acknowledge his position with regard to the manipulation of his students as their teacher whilst also taking on a research role. Perhaps Watson is merely presenting the reality of researching whilst the teaching is taking place. However, it is clearly important for ethnographers; particularly within nursing to acknowledge their impact on the research process (Chesney 2000, 2001, Pellat 2003). As a lecturer, like Watson, I hope to influence the thinking and practice of the students I teach, but as a researcher I should be mindful of my impact on the research process, something which I will return to in Chapter Nine.

It seems that the relationship between students and teachers may often be seen as unequal and therefore open to manipulation in the research context. This is what Johnson is referring to when he talks about the idea of coercion although Johnson himself acknowledges that it would be quite wrong to avoid research on those who might be seen as vulnerable; particularly when such groups (or individuals) may stand to benefit the most (Johnson 2004). However Gillespie (2002) demonstrates that it is possible to build a type of connected relationship which is egalitarian and liberating for both student and teacher. In this type of connected relationship between student and teacher the egalitarian nature of the relationship arises from an equality as people and notably, that this personal equality co exists with an inequality of knowledge

and skills (Gillespie 2002). Gillespie goes on to encourage teachers to consider the balance of power within the student teacher relationship, particularly the teachers' use of their knowledge within the relationship, their willingness to be known as a person, and their predominant role as these factors influence the nature of the relationship. In other words, the teachers' way of being and way of teaching is crucial to the nature of the student teacher relationship. I would add the teachers' way of researching to this equation.

Elements previously described as being characteristics of effective teachers may also be applicable to being an effective ethnographic researcher: being genuine and present as a person, a point which is supported by Borbasi et al (2005). It is the relationship and way of being with the research participants which is important and which can overcome problems associated with perceived differences and inequality of status. This means that researchers have to develop effective relationships with research participants. Where this is done, it is possible for the participants to have their say, even if this means saying what the researcher does not want to hear. For example, Pellatt (2003) explains that by establishing a rapport with participants, they in turn were open, honest and uninhibited by her as a nurse researcher. Some participants felt able to criticise nurses, such was their relationship with her as a researcher. Eraut is more forthright in his suggestion that " researchers have to be able to develop relationships which empower their respondents to be brutally honest about what they think of the researcher's suggestions, and to give them the opportunity for a second, more considered response" (Eraut 2000. p121.). From my own perspective, conducting research on this group of students has meant having to listen to views which I had not previously considered; views which challenged my own ideas about what it means to be a student nurse, and which in turn have enabled me to develop as a researcher and teacher. At times this has not been an easy journey as this thesis will demonstrate.

Research participants

According to Peacock (1986) in any community of people there are bound to be differences of opinion and behaviour. He goes on to say that using a truly random sample, ensures these differences are represented in the data. However, it should be acknowledged that ethnography can employ a few key informants rather than a representative sample. Furthermore Peacock (1986) suggests that although a few key informants are capable of providing adequate information about a culture; this is dependent upon two factors. Firstly, choosing good informants and secondly, asking things they know about (Peacock 1986). In this case the researcher and informants are linked, the sample is purposive; chosen because a relationship is already established. Some students within the group became key informants, being able to clearly articulate their views and provided rich data; similarly some students rarely made comments and therefore feature less within the research. In all cases the students agreed to the use of their own words within the research. They also wanted to be able to identify their own comments and agreed to the use of their first names within the reporting of the findings, as opposed to a coding system alone to identify respondents. Whilst I am aware of who said what response, no other person would be able to identify the research participants; anonymity is assured.

Uncovering tacit knowledge

In order to make tacit knowledge explicit Eraut (2000) argues that either the knower learns to tell or that the researcher tells and seeks respondent verification. However, he acknowledges that awareness and representation have a bearing on this problem. When researchers talk about making tacit knowledge explicit they often imply that this means presenting it as a set of propositions; like the findings from a piece of research. However it is important to consider the nature of tacit knowledge; for example: in the case of my research peer learning may involve tacit knowledge which to date has

not been investigated enough for it to be clear whether it is possible to communicate this kind of knowledge. Furthermore, Eraut urges the researcher to think about whether it is an attribute of the knower which some can communicate and others can not; or is it an attribute of the knowledge itself. He goes on to outline two approaches to knowledge elicitation: to facilitate the telling or to elucidate sufficient information to infer the nature of the knowledge being discussed; both require the researcher to construct an account as it is best practice to offer that account to the respondent for verification.

Implicit learning is difficult to detect without prolonged observation and interestingly Eraut (2000) suggests that reactive learning and some deliberation are unlikely to be consciously recalled unless there was an unusually dramatic outcome. However he offers no explanation as to why this is the case. He goes on to say that respondents are unaccustomed to talking about their learning and may find it difficult to respond to a request to do so. If they do, they are more likely to refer to formal learning than informal learning because informal learning is perceived as part of their work. The interviewer needs to find an appropriate way to home in on problem solving at work in order to make it easier for individuals to discuss events which are taken for granted. Eraut argues that the ability to tell is linked to people's prior experiences of talking about what they know and talking more explicitly about knowledge is enhanced by a climate of regular mutual consultation where the consulted are encouraged to describe what they know. Secondly a mentoring or training relationship may facilitate telling as explanations are expected and thirdly; informal relationships which lead to work related discussions of information where more provisional or riskier comments might be made. These three aspects of facilitating telling have a direct bearing on this thesis since I actively encourage the kind of dialogue described by Eraut, although this is a feature of the curriculum and not specifically the research. As researcher I have also developed the kind of relationship with the respondents that makes telling seem like part of every

day life. The comments from Eraut also provide some justification for educational research to be conducted by educators within their own institutions with respondents who are known to the researcher.

Eraut (2000) also remarks that another approach depends on the researcher being able to suggest types of knowledge which might be in use in a particular situation and ask the respondent to confirm, modify or deny their suggestions. An empowering relationship is necessary if respondents are to be brutally honest about what they think about the researchers' suggestions. Not only do researchers require a repertoire of types of knowledge and knowledge use but must also develop situationally located styles of interviewing and reflexivity and awareness that there will always be multiple representations of knowledge embedded in any complex situation (Eraut 2000).

Similarly, Leininger (1998) discusses the idea that the researcher needs to build a relationship with the co researchers which affords her back stage access. She explains that the front stage has many protective facades which those who are being researched can erect; for example, behaviour which tests the researchers' motives and goals. The key, according to Leininger is getting back stage where the real world can be found. She argues that the researcher will know when the back stage is reached because the quality and quantity of the data are both rich and meaningful and it is back stage where the researcher is able to check and recheck that the data are accurate. Leininger points out that usually the observation comes first and is followed by participation. Importantly the researcher takes on an active learning role as informants instruct the researcher about the situation or topic under discussion and she goes on to say that letting go to learn from others is crucial in qualitative research (Leininger 1998).

Conclusions

This Chapter has established the philosophical values that underpin the chosen method(s) for this research. There are two main aspects, firstly an ethnographic approach is adopted to uncover the students' perceptions of peer learning and I as the researcher act as interpreter of that experience to provide insight and ascribe meaning. The relationship between the students and myself is important because it is seen as assisting rather than hindering the research process. The researcher adopts the position outlined by Alvesson (2003) watching and waiting; when something interesting happens the researcher is activated and comes to the fore. Secondly, the researcher takes on the dual role as suggested by Watson (1996) of teacher and researcher; the research is conducted whilst the teaching is in progress. The method uses Ashworth's research framework in order to ensure that the fore understandings are acknowledged and do not lead the research away from the student perspective. Having established the method the following Chapter describes in more detail how the research was conducted.

Chapter Four

Living the ethnography.

Method: Participant observation

Introduction

This Chapter is concerned with the reality of undertaking the research, it describes the method along with the process of gaining ethical approval for the study and how informed consent of participants was gained and maintained. Having decided the overall approach as being based on an ethnographic, and essentially observational method it is pertinent to establish how the observation occurred in both classroom and practice settings. Participant observation is discussed together with some examples of my experiences in the field which illustrate the reality, and conflict of data collection. A summary of data collection is also presented in table form. Three diagrams are presented which demonstrate the emergence of the themes of peer learning as they became visible within the data together with data analysis.

Participant observation

Bonner and Tolhurst (2002) expound various perspectives on the relationship between researcher and participants. Participant observation allows researchers to observe actions and interactions, together with their antecedent and consequent conditions. They explain that the researcher may take on the research from two perspectives: insider and outsider. Insider researchers are complete members of the group under study whilst outsiders are strangers to the field setting (Bonner and Tolhurst 2002). Benefits of being an insider researcher are said to include having a greater understanding of the culture being studied and having an established intimacy between the researcher and participants which promotes both the telling and the judging of truth. Bonner clarifies this further by adding:

> "Being an insider made me theoretically sensitive. I was accepted as one of the group and I did not have to establish a rapport with the participants, although I needed to establish my researcher role whilst ensuring that the participants did not view this research as threatening to them. Trust through knowledge of our existing relationship, developed more quickly than if I had been a total stranger" (Bonner and Tolhurst 2002. p9).

Ellis and Bochner (2000) also explain the notion of what they term as "complete member researchers" whereby the researcher explores groups of which they are already a member. This is similar to my own situation in the research context of this study. The group is comfortable with me, and I with them; however, prior to undertaking this study research played no part in our relationship therefore to some extent both insider and outsider stances are adopted during research. Whilst I assume several roles for the group I do not consider myself to be a member of the group, although we share a cultural world within the academic setting I acknowledge that our perspectives of that world may be different.

Bonner and Tolhurst (2002) offer some strategies to minimize the effect of being an insider which focus on being reflexive and undertaking critical analysis of one's own assumptions and actions in relation to data collection and analysis. However, Alvesson (2003) offers a word of warning when researching from within as an insider, and suggests aspiring to describe the complex reality of long term participant observation is always difficult to transcribe in research texts. Indeed, he argues that "only a small portion of all that which has been said by the interviewees and observed, usually during several weeks or months can appear in a publication or even fully considered in analysis" (p173).

Brewer (2000) points out that there are often inconsistencies and contradictions in the accounts of respondents which need careful exploration as it is the researcher who, through ethnography, interprets the events. However, he goes on to say that there is no single interpretive truth. Brewer (2000) argues that "there are multiple interpretations in the field that need to be captured in the ethnographer's representation of the polophony of voices,

but people are sometimes wrong in the truth they hold or try to conceal the truth they hold by saying something else" (p126).

Preparing to undertake participant observation in the field: ethical dilemmas

Johnson (1997) suggests that even though many researchers may feel that the approach of participant observation is intuitively right, it is important to identify in a rational and honest manner the practical and theoretical advantages to the approach. He argues

> "there are several technical advantages which include being very close to the data, being able to follow up leads and hunches, being able to validate emerging theory continuously within the context in which it most relevant and to experience the social world of informants in a way that an interviewer in an office or other setting cannot. The theoretical advantages include the opportunity to construct an account of phenomena in the terms of the persons involved directly, rather than those of researchers' journal articles or case reports" (Johnson 1997. p29).

Like Johnson, to a certain extent participant observation feels right for this study; but more importantly as a method it sits well with the aims of the research and with my philosophical stance regarding the research participants. It is also important to be cognisant of Keyser-Jones' view that participant observation is not without risk:

> "As qualitative investigators, many of us are engaged in research that is risky and challenging. We must not be reluctant to investigate these matters, because these are the problems that most need our attention. Furthermore, although there might be a certain amount of risk, these research projects often provide the greatest reward" (Keyser-Jones 2003. p127).

Observational methods are particularly useful in ethnographic research enabling the researcher to capture the whole social setting in which people function, by recording the context in which they work (Mulhall 2003). Observation allows the researcher to ascertain whether what people say they do and what they do in reality tally (Mulhall 2003). Indeed, Mulhall goes on

to argue that both accounts are equally valid and present different perspectives on the data.

Participant observation in this case is concerned with the two areas where student nurses learn: namely the worlds of theory and practice. Conducting research in the clinical setting is not without its problems and ethnographic researchers are encouraged to think a bit first before embarking on observation in settings where the findings might be controversial (Punch 1994). Therefore, during the preparation for undertaking observation in clinical practice it was important to consider what might be observed. Since it is documented that one of the mechanisms by which student nurses learn is trial and error, it was important to consider how to react to any such errors. When observing how student nurses learn from each other, it is possible that observations would include seeing students learning the wrong thing from each other which might afford me an ethical dilemma. Punch (1994) suggests that such ethical dilemmas are difficult to anticipate because they are bound to the specific context in which they arise. However, it seemed appropriate to consider what ethical dilemmas I might face and in so doing reveal my perspectives (perhaps my fore understandings) on these issues.

This research is about student nurses and entering their life world in order to gain a better understanding. Much of the peer learning may be about how to cut corners in clinical practice. Students may be showing each other what Melia (1987) refers to as “the real way”. The dilemma faced here has several facets: I have to consider my research; will I report what I have observed as a researcher? Or will I correct what I have observed because I am also a Registered and accountable Nurse; and as a lecturer I have a responsibility to teach? There is also the possibility that I am encultured to the world of hospitals and health care; the routines and practices may look so familiar to me that I may not recognise them as improper (Goodwin, Pope, Mort and Smith 2003. Mulhall 2003). Indeed Knoblauch (2005), Pellat (2003) and Holland (1993) all point out that the researcher will have come to the

research with esoteric knowledge, and to a certain extent the research setting will be somewhat familiar. Goodwin et al (2003) go on to discuss multiple roles of researcher, nurse and in my case; educator; and relates her experiences of undertaking participant observation in a health care setting which was familiar to her. Goodwin acknowledges that she found she was "bargaining with herself" about when and what to record as field notes.

Field (1991) suggests that researchers who are also nurses will base their judgments on their own standards of practice. Therefore it seems inevitable that there will be a sliding scale in terms of my judgment and possible interventions. It will be important that I document these incidents carefully and explain decisions taken at the time. Field (1991) also acknowledges that nurse researchers are placed in situations of moral dilemmas which non nurses are not; once the nurse has identified a concern her two (or more) roles are in conflict. Interestingly Kuzel, Woolf, Engel, Gilchrist, Frankel, LaVeist and Vincent (2003) comment that not all mistakes are of concern. They contend that only those that cause or have the potential to cause harm are important and conversely, not all harm stems from errors. Indeed, Kuzel et al go on to say that some errors matter more to patients than to health professionals. This raises further areas for me to consider: As a researcher are errors or improper learning that may occur the same issues as those which matter to me as a nurse or as a lecturer? Field notes may provide a useful place in which to focus on this issue. Goodwin et al concludes that it is impossible not to base your actions on your own standards of practice. As nurse researchers we find it difficult to relinquish our nursing roots. Furthermore Goodwin suggests that as a researcher she would consider her position before acting, whereas as a nurse she would simply act. This calculating Goodwin found to be unsettling. Indeed she states that the question of ethical conduct became conflated with professional responsibility and personal morality. For Goodwin, her field notes (which she refers to as a

diary) provided her with a private space where she could deliberate on what to do with sensitive information.

Similarly, Seed (1991) relates her experiences of observing student nurses in the clinical setting where she chose to be a participant observer whilst undertaking her Doctoral study. However, sometimes the students would get the work done before she arrived in order to avoid being observed. Seed describes examples whereby she was tested by the students to see if she would reveal when they ate toast that was meant for patients. However, she does not go on to say whether or how she resolved such conflicts. Interestingly, Seed acknowledges that she often used unscheduled encounters with students for her research and in so doing played several roles for the students, providing a sounding board for them and making them feel that someone had a genuine interest in them (Seed 1991).

On the subject of researching in settings where controversial findings may be generated Keyser-Jones (2003) stresses the importance of establishing ground rules prior to commencing data collection. Keyser-Jones would speak to key people in order to provide full explanations of the purpose of the study and to discuss mechanisms for the staff to instigate if they had any concerns about the research, or what the researchers would do if a serious problem was observed. In my case there are qualified nurses in the clinical situation who are responsible and accountable for their actions and for the patients (and students) within their care.

Participant observation in the clinical setting

Due to the unpredictability of observational work it may be difficult to ensure that all participants are informed and therefore able to consent (or not) to the research. Indeed, Johnson (2004) argues that to gain consent from everyone in the research field is almost impossible. The field of observation is a busy social setting and may contain observations of student nurses from other wards or departments; therefore it was necessary to think carefully about whether or not continue to collect data together with the impact associated

with continuing to collect data. Moore and Savage (2002) add to this by suggesting a more flexible approach to gaining informed consent in the field, they argue constant seeking of permission to undertake participant observation may result in loss of rapport. Gaining informed consent should be viewed as an ongoing process where the researcher uses tactical decision making and negotiation.

The aim of the research is to observe student nurses in clinical practice for evidence of peer learning, specifically what the students are learning from each other and how they are learning from each other. Traditionally there is a continuum between complete observer and complete participant in observational studies. Covert observation does not fit well with my personal philosophy and is inappropriate given my relationship with the students. Whilst I wanted to observe the students I did not want to interfere with what they did or how they did it; this would not fit with the research aims and would make the research something else; namely action research.

Mulhall (2003) suggests that researchers often worry about the Hawthorne Effect (when the behaviour of those being researched is altered because of the presence of a researcher) but that this concern is over emphasised. Throughout the course of the direct observation of the students there was only one incident where the Hawthorne effect may have been present at Site 1 ward 2 where a student and a mentor conducted a dressing together towards the end of the morning shift. Later the student told me that the undertaking of the dressing was purely for my benefit and would not usually have taken place. (The incident was recorded in the field notes which are presented in Chapter Eight.) Once the initial stages are over, most professionals will carry on as normal. Acting as a complete participant may prevent natural exchanges between students, and would involve having to perform nursing work alongside the students. Eventually I decided against this kind of participation because I was concerned that I may be more tempted to teach than to observe. Therefore I decided to conduct my observations in the clinical setting as a researcher acting as observer who undertakes intermittent

observation together with conducting ethnographic conversations. The observations were guided by the fore understandings and used data collected in both the academic and clinical settings. The students in the base group were allocated to five sites within three NHS Trusts across the region. I observed students in each of the Trusts whilst in clinical practice. Whilst all students agreed to be observed in clinical practice, due to geographical and time constraints, not all students were observed in clinical practice. Observations were conducted across a variety of acute settings in order to gain as broad an overview of the practice situation as possible.

Casey (2004) encourages researchers to consider the best way of collecting the data in terms of the observational position, time or event sampling, the duration of observation sessions and methods of data collection. The fore understandings provided the observational tools; in the sense that they provided a framework for what and who to observe. However, this is not to suggest that the observations were structured. Using Ashworth's framework the fore understandings were revised and developed as the data were collected and analysis commenced. In terms of observational positioning in clinical practice I adopted a mobile approach roaming around the ward or unit in order to observe student nurse interaction. It was necessary to be within earshot of conversations and dialogue between students but I did not feel it necessary to venture behind the screens to observe their clinical practice with patients; since this would be clearly outside the parameters of the study. The duration of each data collection period varied in clinical practice but typically, I tried to ensure that I was present for the start of the shift and stayed until either I felt I had seen important elements which required reflection and deeper deliberation or until the concentration required to undertake such focused observation rendered me exhausted, or as Ashworth (1987) suggests until new insight gets thin. Data were recorded using field notes in clinical practice. Students were observed in six different clinical settings in the second and third years of the programme, clinical areas included intensive care and high dependency wards, general surgical and

vascular ward, and rehabilitation or medical wards. Approximately thirty hours was spent in observation within the clinical setting.

Participant observation in the classroom

Here my role is less contrived in that I am in the setting where the students are most used to seeing me. Students were observed for evidence of peer learning in the everyday activities of being in a base group. Like Watson (1996) I adopted a dual role of teacher and researcher and used Alvesson's (2003) notions of watching and waiting until something interesting happened activating the researcher to come to the fore. This observer position seemed to work well in that allowed me to adopt both roles. However, I soon discovered different methods of recording events are necessary. Being an observing participant who is teaching during the research process makes taking detailed notes whilst the situation is unfolding extremely difficult. This early excerpt from my reflexive field notes illustrates this point:

> *"This was a situation which arose "out of sync", they weren't supposed to be using this session as a debriefing process, but they did. I wasn't prepared. The discussion was very intense and I found it impossible to take notes while it was taking place. I tried desperately to remember what was said after the event and recorded these thoughts straight away, but I don't think I've captured the feeling of what was said. This has raised an issue about constantly being with the group whom I am studying. The research never stops and at times it is difficult to see where my teaching role ends and my research role starts. Nothing I have read deliberates on this concept; it seems to me that as an educator researching my own students this is a unique conflict which requires further consideration." [Field notes.]*

Hence data were collected using single word entries in field notes, words which I would deliberate on after the lesson had finished; and I relied on an audio tape recorder which I could switch on as and when required without stopping the natural flow of the session. (The students gave their permission for recordings to be made. All recordings were stored by the researcher for the duration of the study in a locked drawer in a locked room within the

university and all recordings were destroyed at the end of the study.) In some lessons no recordings were made, whilst other lessons required constant recording and were particularly fruitful in terms of rich data. Therefore it is almost impossible to quantify the number of hours spent in observation within the academic setting, suffice to say that typically I met with the group every week while they were in University. Johnson (1995) supports this approach to data collection, arguing that it is acceptable to paraphrase from field notes in this way, providing the meaning remains the same and that the source of the data is acknowledged.

Ethical approval

According to Doyal (2004) recent years have seen increasing concern about the ethical conduct of student projects within health and social care education, however the report points out that research for PhD theses demands the creation of new knowledge and as such there is no difference between this kind of research and ordinary professional research in health and social care. Therefore ethical approval is required to conduct research which involves humans. In this case the research is conducted in both academic and clinical settings on students who are both enrolled on a programme of education within a University and who are also engaged in clinical practice within NHS Trusts. In order to undertake research with these students ethical approval is necessary from both the University ethics committee and the Central Office for Research Ethics Committees (COREC). Ethical approval was sought and granted from both bodies. Whilst this process delayed my entry into the field (within clinical practice) as my attendance at the local research ethics committee meeting was required, it proved to be a valuable experience.

Being cognisant of Johnson's (2004) views concerning the coercion of students into participating in research, and in order to adhere to principles of informed consent, I decided to appoint a third party to elicit the student participation in the research. A colleague with no vested interest in the

research but who was known to the students discussed with them their participation in the research. She revisited the students (at my request) each semester to ask if they wished to continue with the research or wanted to withdraw. This approach served two purposes; firstly, the students had an opportunity to discuss the research with someone other than myself. Speaking to another lecturer may have been easier, particularly if the students wanted to withdraw. Secondly, the students were given good opportunities to opt out of the research. As Moore and Savage (2002) point out, protracted involvement in the daily life of a community under study may result in those in the research field forgetting that they are research subjects and therefore participants may need reminding of their position in terms of informed consent. By appointing a colleague to talk to the students about their involvement in the research I hoped that this element of forgetfulness would be overcome. Actually none of the students withdrew from the study, although later I discuss some of the mechanisms the students used to separate what could be used for research purposes.

Whilst I wanted to access the world of 'back stage', to use Leiningers' term (1998), I also felt that it was important that there were clear boundaries drawn when the research stopped. Both the students and myself as the researcher required some time off stage. Therefore, I decided that I would not accompany the students to coffee or meal breaks whilst engaged in participant observation throughout the programme in both University and clinical practice, affording both parties some time off, and privacy. From my own experiences during my study it seems that it is often difficult to discern when the teaching ends and the research starts. Indeed as far as the students are concerned, whilst you are visible on stage you become fair game, and are available to them in whatever capacity is required. In this sense the researcher requires great stamina to adopt all the roles required by the students at any one time whilst also being the one who pushes the research forwards.

Consent to participate

Due to the nature of the relationship between the researcher and the informants it is important to ensure that students provide informed consent to participate or withdraw. Cormack (1984) reminds us that nurse educators often use student nurses as the subjects for research study and that when research is conducted with their own students, often the students feel they have no option but to co-operate. This is an important ethical consideration, which I struggled with for some time, particularly as like Reid (1991) and Moch and Gates (2000) I wanted the participants to feel like co researchers. In order for the students to decide whether to participate in the study they require information. However this raises a conflict. I do not wish to release so much information (particularly about my tentative theories) that the students alter their behaviour; on the other hand, students need some information on which to base their decision. The students need to know when I am the researcher, when I am the facilitator and when I assume any other role; however, these roles co exist and do not occur in isolation. This idea of role conflict is debated later in Chapter Nine when the reality of data collection is discussed. Moch and Gates (2000) explore this notion in detail and raise questions regarding telling participants about the progress of the research. In particular they also question what the participants thought about the researcher; was she seen as researcher, nurse or friend. Moch and Gates (2000) believe that research participants are collaborators in research; jointly contributing to the evolution of knowledge. However, they acknowledge that true collaboration is difficult to achieve when the researcher has power over how the research is conducted and how the findings are presented. This point is illustrated with an example from their own research in which women participants were asked by the researcher to tell her whether or not she had captured the essence of their experiences of having breast cancer; the women almost always agreed. The researcher reflects: “maybe I have captured the essence, or maybe they don’t feel comfortable disagreeing with me”. This raises questions about participants comfort in questioning the researcher.

Ashworth and Lucas (2000) also explore this notion of introducing the research to the informants and argue that the research has to be formulated somehow in the researcher's mind, and the research informants have to be told that the research is about something. In other words, there is a necessary presupposition concerning the starting point of the research. Both parties must begin with some kind of shared notion regarding what the research is about. Furthermore, Ashworth and Lucas (2000) suggest that to put this shared notion aside would render the conversation as directionless.

Therefore, I decided to tell the students about my interest in peer learning and about the aims of the research. However, initially the fore understandings were not shared with the students in case these coloured their actions and responses during the research. (As the work progressed the fore understandings were shared with the students, together with the revision of some of my ideas.) The students were assured that participation within the research was entirely voluntary and students could withdraw from the research at any time. It was important to share the nature of the research in terms of my direct observation. This required careful explanation of my dual role of teacher and researcher in the classroom followed by direct observation within the practice setting. Students were assured that non participation would not impact on our relationship, rather I would not report my observations of them. Students were asked to sign a consent form prior to commencing the research. Following the Local Ethics Committee recommendation, a further consent form was required prior to commencing direct observation in the clinical setting.

Recording observations: the role of field notes and interviews

It is suggested that how we present ourselves in the field will be largely governed by our disciplinary interests and ourselves as people; field notes will be affected by the researcher's personal and professional world view (Mulhall 2003). It seems that ethnographers have to strike a balance between writing and being immersed in the culture. As I discovered it is more

difficult to write whilst observing in great detail within the academic setting since facilitating the students' learning takes place at the same time. In the academic setting field notes were written up at the end of each teaching session, with a more considered period of writing at the end of each day. However, the clinical setting afforded more opportunities to record in situ.

Mulhall (2003) provides a personal schema for recording field notes which includes physical descriptions of the people, environment, dialogue and daily life. I found that making rough sketches of the ward layout to be useful in enabling me to keep track of where the students were and what they were doing within various parts of the ward. These can be seen in the data extracts in Chapter Eight. However, writing field notes which are overly descriptive is suggested as being time consuming and not particularly effective (Spradley 1980). I found that analysis began as soon as I started to write field notes as I began formulating questions; moving from the description (what is going on?) to ask questions of the data (What does this mean? What is the significance of this?). For me, this affirmed Ashworth's notion that in reality the data collection and analysis are artificially divided.

Documenting decision making is also evident within my field notes, this provides an audit trail for readers to follow and also an aide memoir for me after the event. In addition, my reflexive thoughts were documented within the field notes in an attempt to record how I have affected the direction and focus of the data collection. In this way field notes were useful for recording notes or words regarding what was taking place, but also became where my analysis would begin. I found myself writing questions in my field notes for future consideration or things which I wanted the students to clarify; a process which Holland refers to as surface analysis (1993).

Ethnographic interviewing has the specific aim of describing the cultural knowledge of the informant, whereas phenomenological interviewing is concerned with uncovering knowledge related to specific phenomena (Sorrell and Redmond 1995). Sorrell and Redmond go on to say that ethnographic

interviews are like a series of informal conversations through which the researcher is trying to discover the meanings in a culture. I think that the term 'ethnographic conversation' reflects more closely the nature of how the data is collected, and therefore I prefer to use this term as opposed to interviews , which suggests a more formal and premeditated meeting with the students. Sorrell and Redmond provide a useful outline of what they refer to as a hermeneutic phenomenological approach to the use of interviews; arguing that this approach is concerned with interpreting concealed meanings; meanings which are embedded within a culture and which are manifested in shared language, practices and practical knowledge about common day-to-day experiences (Sorrell and Redmond 1995). For them the purpose of the interview is not to generate theory but to understand shared meanings by drawing from the respondent "a vivid picture of the lived experience, complete with the richness of detail and context that shaped the experience" (p1120). The researcher uses active careful listening in an attempt to gain insight into the experience; subsequently this active listening shapes the interviewers interpretation of what is happening during the interview (Sorrell and Redmond 1995). The result of this phenomenological approach to interviewing is that whilst the interviewer shapes the interview there is an element of reciprocity where the interviewer is also shaped by the process. This kind of cathartic approach outlined by Sorrell and Redmond describes how I feel about this research process. The students' narratives are important to me personally and to the research process. We participate in the conversation together.

The reality of data collection in clinical practice

In terms of data collection maintaining a neutral stance may lead to shallow, convention-guided and ultimately not very honest responses. However, closeness to the research participants does not necessarily guarantee honesty (Alvesson 2003). Olesen and Whittaker (1968) outline the creation of what is termed "the shared and liveable world" (p25) where a common culture is

built around the marginal identity of the researcher and where mutually understandable and meaningful roles are created. Whether or not the students told the truth was of little concern to Olesen and Whittaker as they believed in a notion of intersubjectivity, where the students presented multiple realities and chose what to share with the researchers. The students remained in control of what was presented. In the study Olesen and Whittaker suggest that students developed clear norms of what was on stage (and therefore visible to the research gaze) and what was off stage: "There were appropriate areas where faculty could observe and make notes…some (students) adopted the policy of revealing as little as possible, others worked out ingenious tactics for interpreting the appropriate portrayal of self" (Olesen and Whittaker 1968. p164).

From my own experiences I can identify with the view of Olesen and Whittaker. For example, although all the students had given their consent to take part in my research and were prepared to be observed during their three year programme there were some occasions where the students had discussions over lunch or away from the research setting. On one occasion one of the students told me about a conversation which had taken place at lunchtime where another student from the group shared her story about witnessing a cardiac arrest; a story which she had clearly decided not to share with the group as a whole, or to me as a researcher. The story was very similar to the one shared by one of her peers in class and which the group seemed to find very powerful. This student had clear ideas about what she was willing to share; and more importantly, was in control over what she shared (within the research gaze). From my own experience students are generally not easy to coerce into divulging information which they want to keep private.

Indeed students may have more control over what happens during the course of the research than Johnson suggests. For example, in her three year relationship with a group of students during their three year training for general registration, Seed describes how when she turned up to conduct

participant observation within the clinical setting the students would ensure that the work was already done, prior to her arrival, in order to avoid being observed.

Chesney (2001) debates the view presented by Hammersley and Atkinson (1995) whereby the researcher constructs a research identity as part of the fieldwork and she acknowledges that little guidance is provided concerning how these identities should be established, shaped or reproduced. Chesney goes on to say that she found it uncomfortable to construct a persona believing that her female co-research participants would see through her disguise. I would argue the research persona is unnecessary and impossible to maintain when studying your own students. As an educator who is researching my own students it is important for me to develop relationships with the students which are reciprocal. I often use my own experiences (as a student nurse, qualified nurse and as a teacher) to illustrate my teaching and believe that this is an important way of establishing credibility, trust and a good working relationship. After all I cannot expect my students to open up and talk to me if I am not prepared to do the same. There may be an element of self disclosure, openness and honesty required in order to undertake research (on students who are known to you) and this may be uncomfortable for some researchers to maintain during the research process. Indeed this may be one reason why educators avoid researching their own students (Roberts 2007).

Whilst it is clearly important to develop open and honest relationships with research participants it is equally important to stress that just as a therapeutic nurse-patient relationship is not necessarily based on the concept of friendship, neither should the research relationship. Chesney acknowledges that during the research process she became part of the lives of the women she observed and that perhaps because of her approach, the women came to see their relationship not from within a hierarchical power base, but a relationship of “a dynamic intermingling of culture, sometimes clashing, sometimes merging” (Chesney 2001. p132). Olesen and Whittaker (1968)

also address the idea of closeness within the research relationship suggesting that the relationship is one of "we-ness" rather than friendship (p25). They argue that seeing the students frequently and knowing them well enabled them as researchers to have access to the students' more elusive feelings about change in themselves and their classmates as well as better chances for learning about their hidden strategies for passing through the school. They go on to say that "by existing together through time, researchers and actors develop a sense of 'we-ness' or an intersubjectivity which presupposes the existence of a shared world" (Olesen and Whittaker 1968. p25). Indeed they caution against friendship in the research process suggesting that friendship may mean that the study is biased, data may be obtained under false pretenses and the interactions of friendship inhibit the research process (Olesen and Whittaker 1968). This seems a crucial consideration. Student nurses do not exist in a vacuum; that is to say, they exist in a world of relationships: relationships with fellow students, teachers, patients and so on. Although I am linked with my students and we exist in the world together, I do not experience the world as a student nurse. Our relationship is connected but different to one of friendship.

Data collection and analysis

The following table (Table 2) provides a summary of data collection by location, time spent in each area, methods used and types of data collected.

Location	Time	Method	Types of data
Classroom	22 days per academic year spent with the students	Observing participant (after Alvesson (2003): watching and waiting. Dual role of teacher and researcher (after Watson (1996) Foreunderstandings used to guide	Audio taped ethnographic conversations with and between students. Field notes: observational data; single word entries with surface

		observations.	analysis and preliminary reflexivity; followed by a further analysis and reflection.
Clinical practice	6 clinical settings Approx 30 hours. (Intensive care and high dependency wards, general surgical and vascular surgery wards and rehabilitation or medical wards) years 2 and 3 of the programme.	Observer undertaking intermittent observations using mobile positioning. Within earshot of conversations.	Audio taped ethnographic conversations with and between students. Field notes: observational data, analytical notes with surface analysis and preliminary reflexivity; followed by a further analysis and reflection.

Ashworth (1987) suggests that whilst it is useful to distinguish between research interaction and data analysis, the divide is actually artificial. He refers to research interaction as the interview encounter which takes place between the researcher and the participant under observation; whereas data analysis refers to the process of reflection on the research interaction. The data analysis is not reliant on the data having been recorded in some way (Ashworth 1987). He goes on to argue that the distinction between these two activities is artificial because analysis and interaction should be intermingled. Indeed the interrogation of the social world should be viewed as including the three stages of the research process in miniature; interaction is informed by previous analysis and itself entails a test of some aspects of that analysis.

However, Holland (1993) argues that whilst the data collection is being carried out the researcher undertakes what she terms a 'surface analysis' of the cultural scene. Here provisional themes are developed which may be considered more fully away from the research setting. During the data collection for this research I found that I agreed with Holland's ideas and began to comment on the data. For example, in Chapter Eight field notes are presented which demonstrate how some themes emerged during data collection. At Site 1 ward 2, the data shows the emergence of students converging together and seeking each other out which was also seen at Site 4 ward 1. Similarly, at site 4 ward 1, the ideas of proleptic instruction, coaching and legitmisation of the staff nurse role are apparent.

The work of Wertz (1983) is used by Ashworth to outline the attitude of the interpreter in approaching the data, together with some skills which are required by the researcher in order to come to insightful interpretations. I too have used the original work by Wertz and here provide some examples from the research and in so doing demonstrate my attitude in approaching the data. Essentially Wertz uses thematic analysis to assign meaning to the data. However, I conducted this deeper analysis after each session of data collection had finished. The research environment was noisy, fast paced with too much going on for me to focus on the meaning behind the data. Dingwall (1977) outlines this situation well and describes how some ethnographers make excessive visits to the toilet for note taking to take place, developing 'ethnographers' bladder'. However, I found myself in the opposite situation, not wanting to leave the field for fear that I might miss something crucially important to the study. I developed an ability to hang on to my urine for the entire shift: 'ethnographers' retention of urine' perhaps?

Initially Wertz (1983) requires the researcher to achieve empathic immersion in the world of description. This is explained as being where the researcher uses the description as a point of access from which to make the subject's living of situations his own. In order for this to happen, Wertz argues that as

researchers we cannot be spectators but must experience the joys and pains of our subjects in full detail and in our very depths if we are to faithfully know them. For example, returning to the situation earlier outlined where I was not ready for my researcher role to come to the fore; the students had been discussing good and bad experiences in clinical practice, Helen shared a situation she had experienced in her first clinical placement where she witnessed a man having cardiac resuscitation:

> *"it all happened so quickly, yet at the same time everything was in slow motion; a bit surreal…..I didn't do anything, I just watched…I don't know how I feel about it all. The man died".*

When Helen was describing this situation the pauses between her words were long and both myself and the group were captivated by her explanation of the situation she found herself in. In order to uphold Wertz' stance it was necessary for me to place myself in Helens' position and to feel her sense of being lost in a world where everyone else seems to intuitively grasp what is taking place. Whilst I did not find this a difficult stance to adopt, at times it was tough to listen to the students' descriptions.

Secondly, Wertz suggests that the researcher must not pass over the details of the description as if they were already understood; instead he must make room for the description and give it time, a concept he calls slowing down and dwelling. Slowing down and dwelling allows the description to secrete its sense. To use Helen's story again as an example it was important to allow Helen the time and space to relate her tale but also for me to give her description proper consideration. The situation held great significance for the student and for her peers and it was important for me not to brush over her description of what must have been a terrifying ordeal. Slowing down and dwelling enabled me to achieve a full sense of the impact of the situation.

Thirdly, Wertz contends that when we stop to dwell and linger with something, its significance becomes magnified or amplified. Even things which at first seem unimportant and mundane are transcended by the researcher to become a big deal (Wertz 1983).

Fourthly, rather than staying immersed in the description, the researcher should abstain from continued absorption and take a step back to consider what this particular way of living the situation is about: suspension of belief and employment of intense interest. The researcher breaks his initial fusion with the subject and readies himself to reflect and think interestedly about where his subject is, how he got there, what it means to be there (Wertz 1983). Here Helens' text is interpreted, I use my own experiences, my fore understandings and literature to interpret and lead me to Wertz' final stance of turning from objects to their meanings. Wertz acknowledges that these final two requirements are closely linked and the researcher turns his attention from the facts to their meanings. The facts are that Helen witnessed cardiac resuscitation; but the meaning of the event is far more significant and tells the researcher considerably more about what it means to be a student nurse in this situation. However, it is important to note that the student may not necessarily be able to articulate the meaning. It is the responsibility of the researcher to unearth the situation as experienced, as behaved or more generally, as meant by the subject (Wertz 1983). Wertz' process is employed as each new piece of information becomes apparent. The initial stage of empathic immersement takes place as the description unfolds, but in order to slow down and dwell and complete the final stages of the process requires time and I found that I needed to conduct this off stage and out of the research gaze. Only when the meaning had been established and verified by the students could I begin to bring out the themes from the research findings.

Just as it is necessary to be empathically immersed in the description, as and when it occurs, it is also important to become immersed in the totality of the data. Crotty (2003) refers to this as "understanding the whole through grasping its parts; and comprehending the meaning of the parts through divining the whole" (p92). This entails several readings of the data in order to become fully conversant with it, according to Hammersley and Atkinson (1995) the data are used to think with. The data includes the transcripts of audio taped classroom and clinical practice observations, field notes and

personal thoughts in the form of reactions to the data and reflection on the data. Data is organized and reorganized seeking relationships, patterns and themes, together with contradictions. Leininger (1998) explains this as bringing together components or fragments of ideas or experiences, which are often meaningless when viewed alone. She stresses that much creative thought and analytical ability is needed to literally 'put the pieces together' so that a theme or synthesis of behaviour is formulated that is congruent to the people being studied. She goes on to say that whilst the themes should be verified by the people under study the total gestalt or coherence of ideas rests with the analyst (Leininger 1998). During this process it is important to retain a critical stance to the data; termed by Thorne, Reimer Kirkham and O'Flynn-Magee (2004) as remaining "skeptical of the immediately apparent" (p11) in order to ensure that subsequent data collection challenges initial ideas. They go on to point out that it is the researcher who drives the interpretation.

After each period of observation field notes and audio tape recordings were transcribed verbatim. The transcribed notes were then shared with the students for verification in terms of accuracy of what was recorded and meaning attached to what was said. The interpretations are those of the researcher not the students. Following transcription of the data and verification by the students the data was read and re read several times. Ashworth (1987) refers to this attempting to notice the way various parts of the lifeworld are linked: seeing relationships. The material which is the focus of the work is then seen in relation to the participants' normal course of life, and by doing so the researcher uses an existential baseline. The data is searched for recurring themes and Ashworth asserts that here researchers should pay attention to continuities and discontinuities of the members' lifeworld. He suggests that in particular the meanings of different places, roles and identities, groups etc should be unpicked. In order to do this the researcher requires an interrogating opacity and must adopt the hermeneutics of suspicion. Finally, concepts and models can be applied to enhance

interpretation which will enable a coherence of description to be developed (Ashworth 1987).

In order to do this I began by reading and re-reading the data several times. Several copies of the data were made and transferring each individual comment or string of related phrases which I deemed important or significant were selected and labelled and transferred to post cards. Brewer (2000) refers to this process as "breaking the data down into bits that relate together as classes that comprise concepts" (p115). To a certain extent I found this quite a reductionist way to treat the data; and I felt that sometimes I was losing sight of the data as a whole. Each phrase or set of data was identifiable to a respondent through a series of numbers, shapes and / or colours that I scribbled in the corner of each post card. For example, Helen's comments were identified by a red circle and Lisa's by a blue triangle and so on. Each respondent was allocated a letter which was followed by a number to indicate the order of the string of phrases. Sometimes an additional letter was used to indicate groups of related phrases. An example can be found in Appendix Four, example two. This enabled me to physically move the data around into common ideas and trace it back to its original place in the transcript. In this way I could keep track of who said what. Each segment of text (common ideas, words or phrases as expressed by the participants, incorporating largely their terminology) was grouped under emerging headings or overarching themes. As analysis progressed the sub-themes emerged which were altered to achieve best fit. This system worked well for some verbatim transcripts and paraphrased field notes of conversations. However, when playing the audio tape back in order to transcribe what was said some individuals could not be identified as during class discussion or on the ward some voices could not be attributed to individuals due to speed of the conversation, background noise or poor quality sound recording. Therefore the unidentified voices or field note comments were numbered. Eventually through further examination, reflection and sorting deeper analysis was achieved resulting in an end product of overarching themes with identified sub-themes which

together constituted the overarching theme. This is represented by the three diagrams demonstrating the emerging themes and sub-themes.

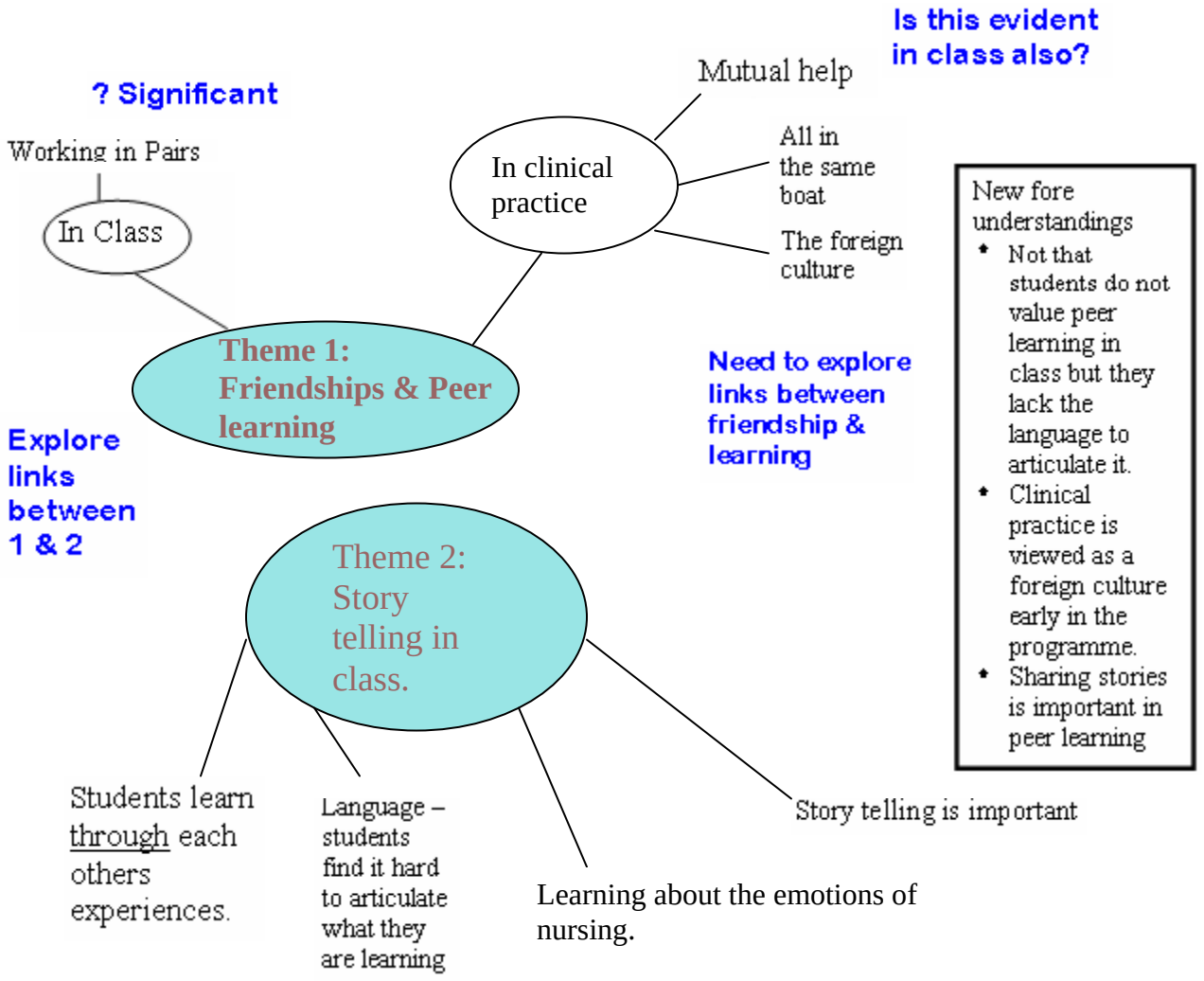
Initially, after six months of data collection and analysis, two clear themes were discernable: friendships and story telling in class. These themes were arrived at as the data contained many similar words indicating friendship and the presence of story telling. However, the links between these two areas were unclear at this stage and required further observation and conversations with the students. Arriving at these two initial themes was an important breakthrough and the time taken to arrive at these themes should not be underestimated.

Diagram One

EMERGENT THEMES AFTER 6 MONTHS DATA COLLECTION

Fore Understandings:

- In terms of learning in clinical practice student nurses learn from each other, using mechanisms which have not been fully explored & are poorly understood.
- Students value peer learning in the clinical setting.
- Dialogue plays an important part in promoting peer learning in clinical practice.
- In terms of learning outside the clinical domain, students do not value learning from each other in small groups in the same way as they value peer learning in practice.



New fore understandings

- Not that students do not value peer learning in class but they lack the language to articulate it.
- Clinical practice is viewed as a foreign culture early in the programme.
- Sharing stories is important in peer learning

The diagram shows the flow between the fore understandings with which the work was approached; what the interrogation of the social world revealed at that time and the development of new fore understandings as a result. In other words, the diagram represents the research process as Ashworth would have the researcher practice it. However, although some sub themes were apparent it was important not to restrict the data collection to the initial two themes; doing so would mean not being open to allowing further data to come to the fore. Thorne et al (2004) argue that the "mechanics of interpretation depends far less on coding, sorting and organizing than they do on the processes of intellectual inquiry" (Thorne et al 2004. p13). They go on to suggest that researchers should consider a range of possibilities before drawing interpretive conclusions. The range of possibilities I considered is indicated by the questions and comments indicated on the diagram. I was constantly asking myself, "What does this mean? What is the significance of this?"

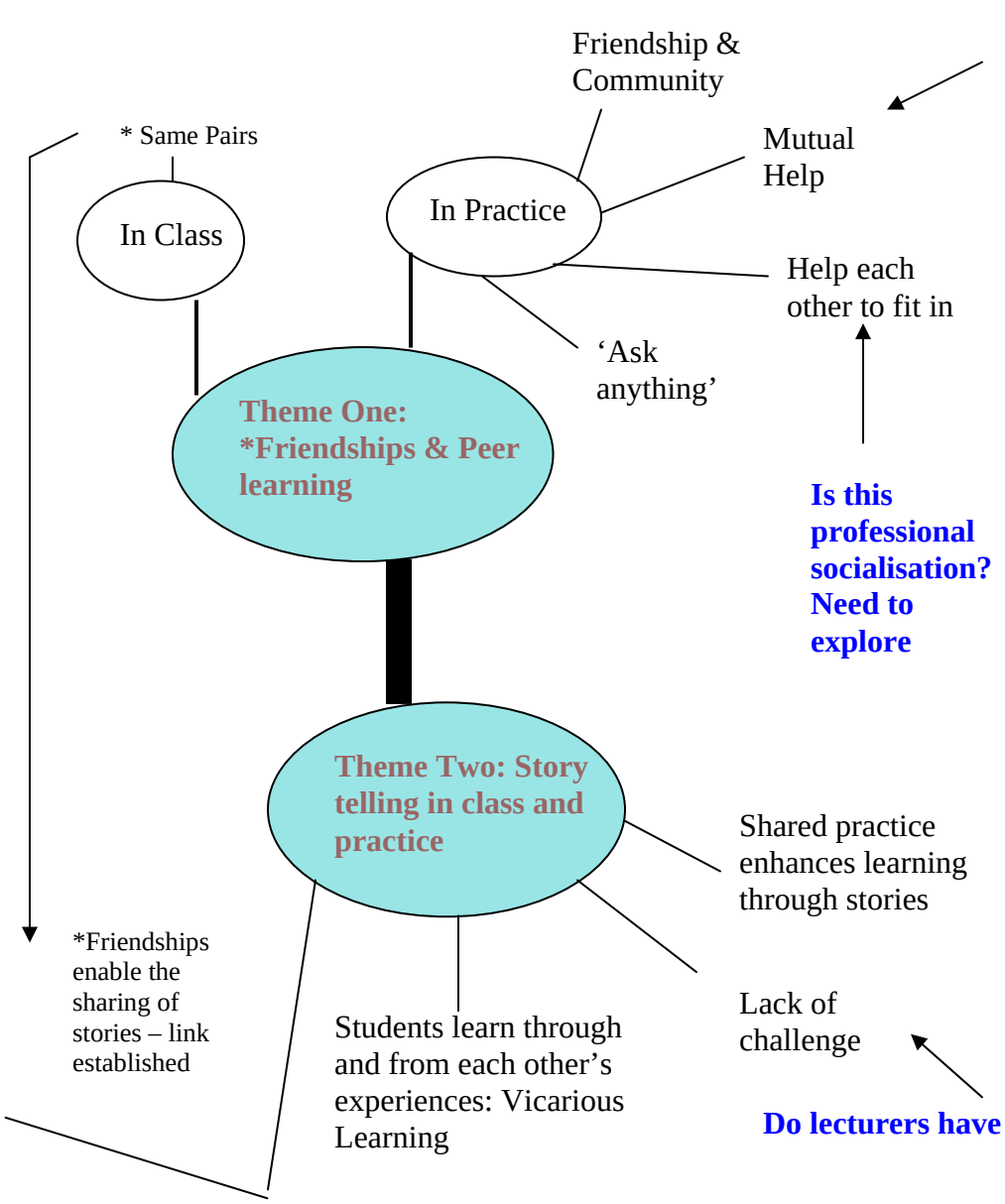
Through further interrogation of the social world the themes became elaborated upon; fleshed out with increasing detail. Hence after twelve months of data collection and analysis links were established between themes and new themes and sub themes which appeared through the data collection were added. Here the themes highlighted are friendships, which has been developed to include the sub themes of friendship and the community of students, ask anything, mutual help, helping each other to fit in and friendships in class. The second theme is story telling; which includes the sub themes of the importance of shared practice, vicarious learning and emotional labour. Diagram two demonstrates this development in the same diagrammatic form as diagram one.

Diagram Two

Themes & sub themes after twelve months data collection

Fore Understandings:

- In terms of learning in clinical practice student nurses learn from each other, using mechanisms which have not been fully explored & are poorly understood.
- Students value peer learning in both academic & clinical settings
- Students find it hard to articulate the value of the learning
- Dialogue is an important part of peer learning mainly through sharing experiences (stories).
- Students see clinical practice like a foreign culture.



New fore understandings:

- Story telling in clinical practice takes place after the work is finished & away from the ward.
- Shared clinical practice enhances peer learning in class
- Students exist on the edge of the community of practice of qualified staff.
- Dialogue is superficial – no challenge
- Observed practice is assumed to be correct – no challenge
- Peer learning involves teaching clinical skills to fellow students
- Vicarious learning experience is effective.

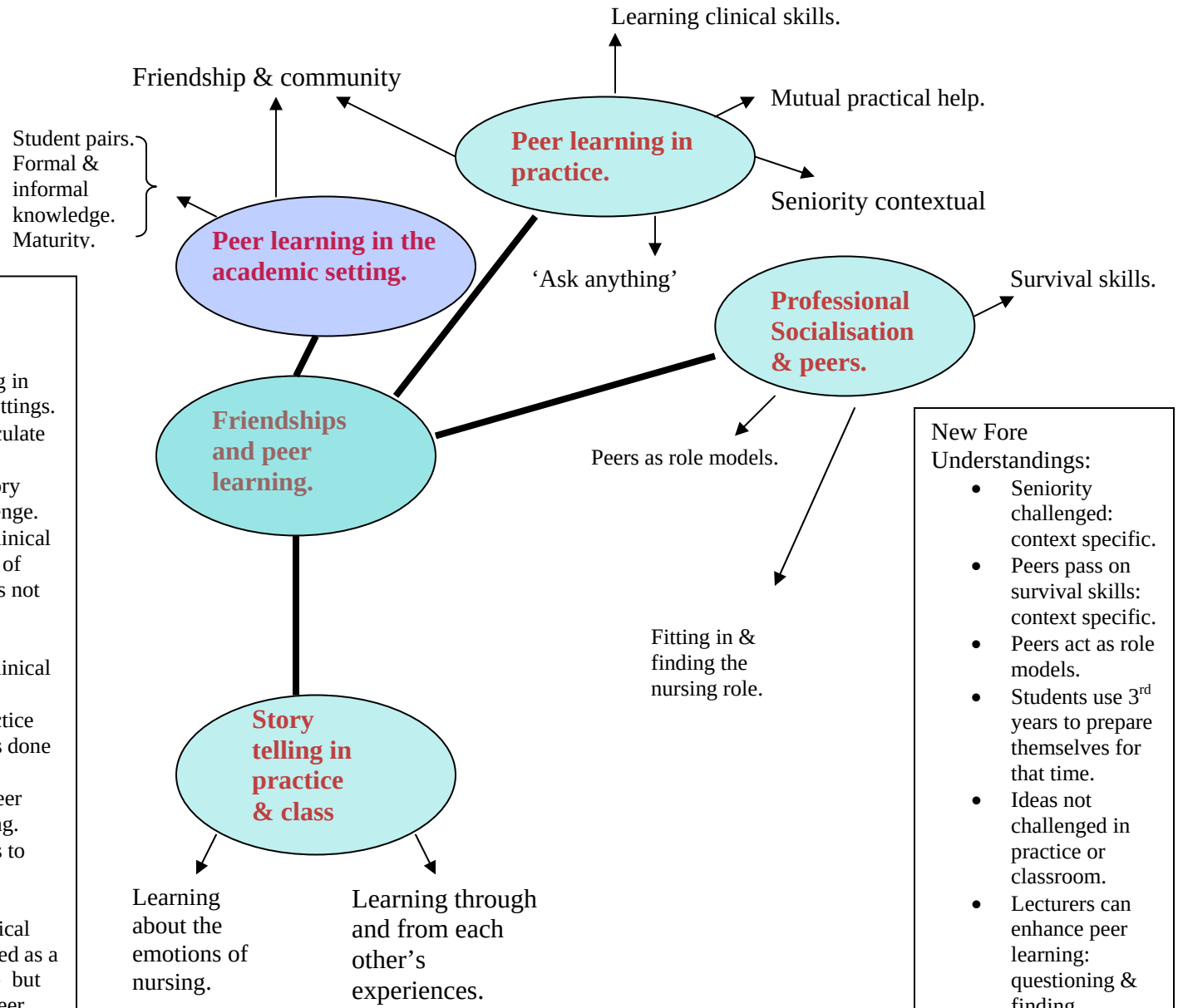
Again the diagram shows the revision and development of the fore understandings as a result of the data collection and analysis. After twelve months of data collection whilst the initial two themes remained; it became clear that this initial frame of reference was inadequate for the new ideas that were being developed through the research. Therefore the sub themes indicated in diagram two were developed to reflect the growing complexity and detail within the data. However, questions remain which require further investigation in order to provide greater clarity and indicate the continuing focus of the data collection; all the time ensuring that it is the student experience which is interpreted, as opposed to looking for what the researcher wants to find. According to Thorne et al (2004), the researcher moves in and out of the detail of the data and is "guided to focus on, and engage in, the intellectual processes that are the cornerstone of qualitative data analysis. Like the taste of a good wine, qualitative data analysis is best understood in the doing; it is inherently experiential rather than technical" (p14). Indeed I can identify with this and found the process of data analysis to be somewhat intuitive in nature. Whilst the intellectual inquiry is time consuming; for me it was crucial and part of the immersion in the cultural world of the students under study. Being close to the data was just as important as being close to the students; the data was indeed used to think and enabled me to construct the interpretations. These diagrams helped me to bring together ideas and patterns of ideas into logical and coherent themes which directly reflected the student experience.

A further example of the process of data analysis is provided in Appendix Four examples one and two which show how sub themes were revealed in the raw data.

Finally, after eighteen months of data collection and analysis diagram three demonstrates the final themes and sub themes. No new themes emerged as saturation was reached. The final fore understandings are developed and detail concerning the how peer learning takes place was evident.

Diagram Three.

Themes & sub themes after eighteen months data collection.



Fore Understandings:

- New insights emerging into processes of peer learning.
- Students value peer learning in both clinical & academic settings.
- Students find it hard to articulate the nature of that learning.
- Dialogue is important in story telling but there is no challenge.
- Students teach each other clinical skills – an important aspect of peer learning, but practice is not challenged.
- Students form their own community of students in clinical practice.
- Story telling in clinical practice takes place after the work is done and away from the ward.
- Shared practice enhances peer learning through story telling.
- Peer learning helps students to learn about the emotions of nursing.
- Need for friendships in clinical practice should not be viewed as a marker of lack of maturity - but as an essential element of peer learning.

New Fore Understandings:

- Seniority challenged: context specific.
- Peers pass on survival skills: context specific.
- Peers act as role models.
- Students use 3rd years to prepare themselves for that time.
- Ideas not challenged in practice or classroom.
- Lecturers can enhance peer learning: questioning & finding meaning.

Four main themes emerged from the data: Friendships and peer learning, the importance of story telling and peer learning, the processes of peer learning in clinical practice and the role of peer in professional socialization. In addition, there was a further emerging area of findings form which tentative conclusions can be drawn: the process of peer learning in the academic setting. Together the themes demonstrate the experience of peer learning for the students under study. Each theme is presented as a Chapter in its own right together with sub themes discerned from the data with appropriate discussion.

Before proceeding with the findings and discussion of the research it is perhaps pertinent to reiterate the stance with which this work is approached. The findings presented here are pertaining to the students I have studied. This might seem a somewhat obvious thing to say, but I am keen to point out that I am not suggesting that peer learning for all student nurses will appear in a similar fashion. The findings here merely seek to unearth peer learning as it was for the students in the study and shed some insight into their world. However, I should also point out that the students are representative of students across the cohort as a whole in terms of age, gender, previous experience and qualifications and social background. Indeed this group is also representative of other cohorts within the School of Nursing and possibly beyond.

Chapter Five

The student experience of peer learning is revealed.

THEME ONE: Friendships and Peer Learning

The students demonstrated a bond, a sense of cohesion; particularly when they were in clinical practice. Friendship amongst peers takes on a greater importance in clinical practice than in the academic setting. The findings indicate clear links between friendship and learning.

The findings relating to the importance of friendships became apparent early on in the research process. (Diagram One represents this development within the first six months of data collection. Page 141.) Gradually through interrogation of the social world, the theme became more detailed and insights emerged which were drawn together to form important sub themes. The data in relation to friendships and peer learning reveals five key sub themes. The findings relating to each sub theme is presented followed by discussion. Whilst each sub theme is discussed individually, together they form the overarching theme of friendship and peer learning. The data demonstrates the importance of the friendships to learning; without the friendships, the learning could not take place.

The findings from the direct observation undertaken in clinical practice reveal an 'ask anything' culture, where students were all seen as possessing knowledge and no students were perceived as holding the monopoly of knowledge in clinical practice (**sub theme 1**). Students seem to have a reciprocal arrangement of helping each other and this partly links to this idea that the students experience a sense of family and community together (**sub theme 2**). I observed students asking each other for help, particularly when qualified nurses with whom they were supposed to be working, were busy elsewhere. Students were seen as a valuable resource, particularly when mentorship failed. (**sub theme 3**). When the students were unsure of what to

do, or appeared to be alone, they would actively seek out another student and converge together (**sub theme 4**).

Sub Theme 1: The 'ask anything' culture

The data reveals how the learners use the community of students as a resource for answering questions. The students appear to ask each other because they know that peers will provide a simple answer and will not make them feel silly for asking the question. It appears that students may feel vulnerable when entering clinical practice and so use fellow students rather than approach the qualified staff. This questioning of peers is seen as a natural thing to do and is clearly reciprocal in nature. Other students appear to have a tacit understanding of what it feels like to enter clinical practice. Examples of the 'ask anything' culture are offered by Lisa:

> *"During or after report I would ask simple things like What did that actually mean?, I would ask another student so I didn't sound stupid…in the first year you're feeling vulnerable but you soon realize that it's OK to ask another student" [Audio transcript from classroom data H1a].*

> *"When we're in clinical practice we form a support network and we learn from each other's experiences, provide each other with resource information and emotional support" [Audio transcript from classroom data Su3o].*

The students fear appearing foolish in front of the qualified staff and so ask each other questions in order to preserve face:

> *"We ask each other advice on many occasions, mostly if you are new to a ward and don't want to bother your mentor, you'll ask another student like …what time do the dinners come round? How does this obs machine work?" [Field notes from clinical practice. M2b]*

> This comment is also interesting in that it links to the idea of seniority (Discussed in Chapter Seven).

Similarly, another student outlines the reciprocal nature of the 'ask anything' culture:

"Other students are a favourable option for gaining or consolidating your knowledge…you know, you can ask them anything…something five times a day and not feel stupid, as undoubtedly they will have done or will do the same thing to you" [Field notes N1d].

Sub theme 2: Friendship and community

The students clearly expressed the importance of friendships both within clinical practice and in university. The developing friendships were important because they facilitated learning particularly within clinical practice. It appears that it is the friendship between the students which enables the asking of questions in clinical practice (even five times a day). The students spoke of the notion of being in the same boat and clearly felt that there was a common bond between them. These comments highlight this idea.

"When you begin university you are told about all the support available to you, but the most important support network is never mentioned: fellow students. No one can empathise with you like another student can" [Audio transcript from classroom data. Obtained in the second year of the programme.E1]

"I believe every member of the health care team has much to offer in the way of experience, knowledge and facts. But only other students have that 'there and then' feeling of what it is like to be in training, whilst trying to fit in to the team and get along with the rest of the staff. It is therefore invaluable to me personally to have the opportunity to work alongside other students". [Audio transcript from clinical practice. Third year.N2b]

In the first year of the programme the students were allocated to general medical or surgical wards. Without exception they were all placed on wards with other students, sometimes the other students were those from their own base group, sometimes the other students were from different base groups within their intake, some were from different intakes on the same programme or were undertaking a different programme of nurse education. On some wards there could be as many as six students whose placements at least partly overlapped. The students developed friendships which bound them together

as a community of students. Asking each other is seen as a natural thing to do, and students readily accept the reciprocal nature of asking questions. Fellow students are seen as approachable, available and alike. They stick together in the face of a new and frightening culture, all feeling like outsiders to the community of practice of the rest of the ward staff. The following excerpts from the field notes illustrate this:

> *"I have found the company of fellow students whilst on clinical placement to be very reassuring. A new placement (whether it is my first or last) is always daunting. Students tend to stick together and swap experiences and anecdotes". [Field notes from clinical practice. Second year. Su2g]*

> *"On my first placement I felt like a fish out of water, I was in a completely unfamiliar environment, in a town I had never been to before, surrounded by people whose roles I didn't understand, and most worryingly of all; patients. However, there was another first year on this placement and I think we found each other's support invaluable. To have someone else there who knew exactly how you felt was a great help. It was this mutual support on this placement that formed the basis of our friendship and how we learned from each other." [Field notes from clinical practice. First year.Cl2]*

This previous comment indicates that friendships and learning are linked. The learners create their own community of students to promote the idea that they are not alone. The students emphasize the importance ascribed to developing the friendships, particularly when they are in the unfamiliar environment of clinical practice.

> *"During my training I have had many pleasant experiences with other students, my first interaction with other students in practice was on a general medical ward. I was extremely nervous and scared because I'd never worked in a hospital environment before. This was the placement where I made two of my now closest friends. My first placement wasn't what I expected it to be. I felt very disheartened with the whole experience, little did I know that it would be this experience that would bring us together. Who would have thought that from something bad, friendships would flourish?" [Audio transcript from clinical practice at the end of the second year, but the student is talking about her first year experiences. D1]*

I observed the students converging together in clinical practice and commented on this within the field notes.

> *"Where mentorship is effective, the students and mentors are together and work together, but here like on the last ward (where I undertook observation) the mentorship system is less effective in that the students are working mostly alone (without their mentor). The students migrate towards each other, almost out of necessity." [Excerpt from field notes. Observing students in the third year of the programme. Site 1 ward 2.]*

Friendships were also evident within the classroom as students adopted the same positions within the group for almost every session, choosing to sit next to the same fellow students on a regular basis. Pairings of students soon became apparent. Students tended to sit with peers of a similar age and gender. The two male students always sat and worked together. Andy and John commented that they did this because

> *"I feel more comfortable and I associate with him out of University*" and "*our conversation is different when not in female company". [Transcript from classroom data. Third year.]*

Some pairings were dependent on students who traveled together. Students allocated to the same NHS Trust also tended to remain in pairs. Initially, this might seem like an unimportant observation, but it is this taken for granted behaviour that needs to be unpicked in order to better understand the student world. The students clearly felt comfortable working with certain individuals from the group: their friends. This is evidenced by the following comments:

> *"The girl I sit next to is the first person I spoke to when I started this course, we have formed a good friendship and have similar ways of thinking."*
> *"I have found that like minded students tend to stick together (in class)". [Field notes from classroom data. Third year. M 13.]*

Similarly another student comments:

> *"At uni I have learned a lot of information form other students…shared experiences and feel very comfortable and at ease with my base group members." [Field notes from classroom discussion. Second year. B7.]*

Again the link between friendship, support and learning is evident:

"This camaraderie is one of the reasons I love returning to uni after being in placement. Uni is the place where I feel safe in the knowledge that everybody is working together for one aim and we'll all get there, come 'hell or high water'. I wouldn't be able to complete the course without the support and help from my peers." [Field notes from classroom discussion. Second year. Su2f.]

During the period of data collection I observed that students tended to sit together in the classroom in pairs and developed friendships in each dyad. The pairs remained constant throughout the programme. Whilst pairs were particularly evident, there were times when students sat and worked in three's or alone, for example when there was an odd number of students present. Students in this study tended to develop friendships (and sit alongside) students who they saw as being similar to themselves. They tended to be of similar age and social circumstances. The following comment demonstrates this notion of being similar:

"We share the same ideas and have similar ways of thinking…we swap experiences and anecdotes". [Field notes from classroom data. Ba.]

Similarly, the following observation recorded in field notes highlights this point:

"Paula and Natalie are both in their mid twenties, both have a child and waited to enter nurse education until their child(dren) were considered to be at the right age; both had previous experience as health care support workers and they sat and worked together at every single group session throughout the programme." [Field notes. Classroom.]

Friendships enhance the learning process in the academic environment:

"Like minded students tend to stick together during the PBL process. Because we are friends, each pair takes their piece of work away and organises how they are going to tackle it. Some people telephone each other, some meet at their homes and others come in to University on their reading days". [Field notes from classroom data. Su1b.]

It seems that the students need to find other students in class who they see as being like themselves. In the world of clinical practice the 'them and us' situation described by Ousey and Johnson (2006) prevails and so all students converge together to form a community. However, in the classroom, it

appears to be more important to find someone to work with who shares the same ideas.

Sub theme 3: Mutual practical help

The community of students was also used to provide each other with mutual practical help. The data demonstrates how students stick together to support each other and provide each other with mutual practical help. The following comments illustrate this point:

> *"You are all in the same boat; this instantly gives you a sort of 'protective feel' towards each other…no one wants to see one of their fellow students struggle and you want to offer help, if it is needed, to the best of your ability". [N1c.]*

> *"the first couple of weeks on the ward we all went in two's, it gave us confidence to do the care. The students all work together". [H3b.]*

> *"It's the other students that will come into your bay and help you…with the beds and stuff…often no one else will even realize that you are struggling on your own. [1R11a.]*

An example of practical help is outlined by a situation where two students were asked to perform last offices. Neither student had ever done this before. I asked one of the students what happened, she said that the two of them supported each other and "*got each other through it*". Together they found and followed the policy and procedures as best they could. The student went on to say, "*I don't know how I would have got through it without her* (the other student)". However, it also highlights the practical help that students provide each other with in a clinical setting.

The students feel a need to be fluent, efficient and competent and will help each other in order to get their allocated jobs done in an acceptable time frame. When the students are unsure of how to proceed, they will ask each other for advice in order not to appear silly in front of the other staff on the ward. They use the community of students to get organised and get things done. For example:

"When I was a second year a third year asked me how to do a basic leg dressing and then a fellow second year who had never written in a patients' notes before, asked me what I thought she should be writing". [M2c.]

The field notes recorded in clinical practice support the nature of practical help:

"The students work together, they help each other to wash their allocated patients (turning them over to wash their back); if they need help to move patients or make beds, they ask each other and help each other. They do not approach the qualified staff for this kind of help. Shortly before lunch there appeared to be an unwritten rule that everything in terms of patient hygiene must be complete and there was a flurry of activity between the students to ensure that everything was done." [Field notes site 3. Third year.]

Conversations with students continued as the students progressed into their second year of the programme. Here the students tended to have clinical practice placements with very few other students. The students went to community settings to work with Health Visitors and District Nurses and some students were placed in acute areas such as Accident and Emergency, Intensive Care or High Dependency Units. Here the students clearly felt that there had been a shift in emphasis in that the qualified staffs' expectations were different. Students in the second year are expected to be much more independent. Some students found it advantageous to be the only learner to be placed in a particular department. For example, being a lone student in Accident and Emergency, one student comments:

"I really like being the only student, it means I get to do more. If anything happens, you can always be there instead of having to ask; or you wouldn't be refused because another student had beaten you to it" [Field notes. Second year. IN1a].

In some placements the students might be allocated to the same unit or ward but did not always work together. Lisa, illustrates the impact of this well:

"I was in theatres and I was the only student up there who wanted to do scrubs (the others wanted to do anaesthetics) we were all learning

completely different things…so when we did see each other we had nothing to talk about…no common learning experiences. There was one degree student doing the same as me but we didn't have a lot in common…nursing–wise Yes, but academic-wise, nothing. But she did help me with some stuff on reflection which was useful…she gave me some good ideas, like about my assignment." [Audio transcript from classroom data. Second year. H2d.]

Here Lisa is expressing the importance of having someone else around who is perceived to be in the same boat. Lisa demonstrates the different perceptions of students undertaking different programmes; the degree student, whilst she is a fellow learner, is not seen as being in the same boat. In addition to this Lisa is suggesting that it is difficult to use the community of students when there are no (perceived) shared learning experiences. Of course the students may have been learning similar principles but a different set of skills. The fact that Lisa perceives that she and her fellow student were learning different things because they were in different departments is important. The students do not seem to be able to make the connections between different departments or wards in terms of the common ground of learning to be a nurse. This view of having no learning in common is also interesting in that it is clearly different to the view expressed in the general medical and surgical wards of earlier placements. In the general medical and surgical wards all students were seen as having expertise in some way and all could be used in terms of peer learning, but here (in theatre) the situation appears to be different. For the adult branch students the second year is a time when they branch out into various (medical) specialties in terms of the allocated placements. The community of students becomes less evident and students become more independent.

One student commented that the placements themselves have an impact on how peers are used to learn:

"I have experienced four very different placements: endoscopy, surgical wards, community and theatre. I believe that these different learning environments, along with my developing knowledge of the nursing role within these environments, has influenced that way in which I have learned from other students." [Cl1.]

In the second year a number of students expressed the desire to become more independent within the clinical area. However, this was tempered by the similar desire expressed by the staff that the students should be able to complete certain tasks. Jo illustrates this point particularly well:

> *"Well being in my second year…and they keep reminding you, you know that you're in your second year…I feel you're doing a lot more for yourself; well…I mean I am capable of doing it, so it doesn't really bother me that there's no other students around. You know being able to do observations by myself…when I first came on here, they were like…well you're a second year student now so you should be able to do the observations by yourself; but they expect you to know it." [Audio transcript from clinical practice. Second year. Site 2, ward 1. J4b]*

Not having the community of students readily at hand in the clinical placements during the second year meant that some students became more independent out of necessity. The students are still reticent about asking questions in front of the qualified staff, especially the questions which might make them look silly. The absence of a fellow learner forces the student into independent action, particularly when the staff expectations increase. The students feel a great pressure to become proficient; the pressure is applied by themselves and from the staff around them. During the second year the data from my research demonstrates that students still exist on the edge of the community of practice although, the need for the safety net of a similar community of students is less strong. The students appear to have developed sufficiently enough to not need the support which the friendships provided in the early placements. The placements were different in their nature and the requirement for mutual practical help had lessened and the kind of help required had changed. For example, this comment is from a student in the second year on a community placement:

> *"Interaction with other students here is very different to that on the wards, I would only come into contact with others (meaning students) at the start of the day and at lunch. Learning from each other was largely based around sharing information about spoke placements and who to contact to organize visits." [C7.]*

One of the main differences noted between peer learning in clinical practice and peer learning in the classroom was the lack of mutual practical help and absence of passing on survival skills. However it seems that students create the environment for mutual practical help themselves in clinical practice, but do not appear to require practical help in the same way within the academic setting. The mutual practical help barely extended beyond sharing of journal papers. Students were happy to share the papers but did not seem to want to find out how their peers found the papers, the paper itself was sufficient. The nature of this superficial help is highlighted by the following excerpt:

> *"Whilst compiling information for assignments it is surprising how students talk in the library. I have struck up conversations with people that I have only known by sight. I think we draw comfort from each other in our quest for knowledge and are all striving to reach our goals. We help each other to find good, appropriate pieces of work and recommend books to each other." [Transcript from classroom data. Third year. Su2e.]*

I asked the students whether anyone had given them any hints and tips about surviving university life, as with many aspects of articulating informal knowledge they found it hard to say what they were learning from each other. There appeared to be few hints and tips relating to university life. One skill which the students did identify as learning through peers was that of referencing in their academic work. They would ask each other to check that references had been cited correctly.

Sub theme 4: Seeking out another student

The students seek each other out in order to find a way into the every day workings of the ward:

> *"You find other students, so that you can get into the whole nursing team on the ward."[Audio transcript from clinical placement .Second year. Site 1 ward 2. M2g]*

Some students described how lost they felt when entering the clinical area for the first time. They often needed someone to get them started as they found

beginning difficult. The following narrative concerns how one student helped a fellow learner; the student was towards the end of her first placement and here she describes a situation where she helped a Cadet nurse who said she felt lost:

> *"She told me that she (the Cadet) had lost her mentor and didn't know what to do. We consequently spent the whole afternoon in the sluice. She claimed that the one problem she was encountering was that she wasn't sure what to do if she ever found herself on her own; she felt she lacked the knowledge to know where to begin, although she desperately wanted to prove that she could attempt to do something by herself. I introduced her to the patients' care plans. I told her that if she was ever at a loss, to read through the care plans and get the basic gist of their illness and then go and talk to the patient themselves as they are almost always a fountain of knowledge concerning their own ailments." More importantly, the student went on to say "where you are in your training holds no significance since you are often able to offer guidance to a student who is further on than yourself, just as much as you can gain from someone who is less experienced. It depends more on the individual experiences you have as a student and not on the amount of time you've been training." [Field notes. Site 3.N2d]*

The following comment is from the same student in the second year of the programme as she discusses how she learns:

> *"I find you often have the theoretical knowledge but lack the skill or confidence to apply it to the scenario in front of you and provide care for your patient…so you have to seek guidance or advice from some one rather than from a book. The guidance sometimes comes in the form of your mentor, a health care assistant or another student and there are times when one is more suitable and appropriate than the other." [Field notes from classroom. Second year. N1a.]*

Interestingly, mutual practical help was much more evident in the clinical setting than in the classroom. Friendships became evident within the base groups early on in the programme as individuals soon started to take up the same seating patterns week after week, tending to sit with the same people on a regular basis. Sometimes the friendships developed as a result of traveling in together in order to cut costs.

Discussion

Much has been written about the importance of social relationships to learning amongst children (Slavin 1996, Parr and Townsend 2002). Azmitia (1998) explains that very little is known about the products of friendships in terms of cognitive gain although it seems that amongst children, peers are able to influence knowledge acquisition and revision. Slavin suggests that students will help one another to learn because they care about one another and therefore want one another to succeed. It seems that this research confirms the idea that social relationships and caring about fellow students is evident amongst this group of student nurses, indeed one student specifically mentions the notion of students having a protective feel towards each other. Whilst some interactions between students may be important for the lesson in which they take place, Parr and Townsend (2002) argue that there are also friendship associations that are prominent and enduring. The findings from this thesis would seem to confirm that these enduring relationships are formed and valued by these student nurses. One student uses the closest to indicate the importance of the friendships. The data shows that the students found the friendships to be important not only in a supportive capacity, but also in terms of contributing to learning. The friendships help the students to ask questions in clinical practice and contribute to the work of the ward. Friends also sat and worked together in the classroom.

Additionally Eraut et al (2003) have produced some early tentative findings from an ongoing study which demonstrate that social relationships are an important factor in informal learning. However, the underlying assumption is that the relationships mainly refer to those between junior and senior colleagues in three different professions (nursing, engineering and accounting). The findings within this thesis would seem to refute this notion, because for these students, hierarchy takes on a different meaning and seniority in the traditionally accepted sense is less important than the particular experiences the student has encountered, together with the

contextual knowledge of specific clinical settings. Social relationships are an important support mechanism for the student nurses in this study in terms of learning to be a nurse. In a study amongst children Kutnik and Kington (2005) demonstrate that common social experiences between friends sets a basis for shared understanding, and they suggest that this is the basis for cognitive development. In their study friends were shown to share experiences and provided each other with help. It is this shared activity which is purported to lead to increased problem solving ability and cognitive gain (Kutnik and Kington 2005). It appears that friendships continue to be important in helping adults to learn. Being in the clinical placement together provides the individuals with the shared activity to which Kutnik and Kington refer.

Many other students spoke of "*being in this together*" [Su3n]. Whilst at face value this notion of togetherness, or being in the same boat seems obvious, since they are a group of students undertaking a course together; it is only after slowing down and dwelling with the data that the importance of the students' comments becomes clear. However, this appears to be more significant than merely a group of people who are all undertaking the same programme of education (and could therefore be said to form a culture). They are on the same journey (towards qualified nurse status) and as Baillie (1995) implies it could be argued that any group which is together over a period of time will develop a culture. However, the manner in which the students described their friendships suggests that they are highly valued and an important part of the culture of the students. Fellow students are important in terms of getting each other through the course. The students clearly aligned themselves with each other; their bonds of friendship were tacit but real.

It is interesting that one student clearly describes the concepts outlined by Campbell et al (1994) in fact she uses many of the same words and phrases found in Campbell's work. Campbell demonstrates how emotional support is seen as binding together to encourage and protect one another; this is referred to a sense of family. Furthermore, by being in the same boat as others the

students in Campbell's study felt understood by their peers in a way that no one else could possibly understand; and felt safe in confiding in their peers; concepts with which these findings concur. However, the Canadian study does not make any links between friendships and learning. The work clearly makes claims concerning emotional support and the value that the students placed on this. Findings here would seem to move Campbell's original ideas forward and demonstrate how the friendship and the learning are linked. The friendships are crucial to the learning. What is interesting is that the students' perceptions of *who* is in their boat is liable to change. For example, Lisa's comments clearly demonstrate that there are times when students are allocated to specific areas; often with few other students, and therefore there are limited opportunities for shared experiences. The lack of shared experiences accentuates the students' feeling of being alone and makes it difficult for the learners to integrate what the other is learning into their own practice.

According to Eraut et al (2004) both parties must feel comfortable with asking questions of each other which might seem silly or trivial to an experienced practitioner. Newcomers realise the importance of this 'ask anything' culture and prefer to ask questions of those with a similar level of experience. Eraut argues that access to peers who are only a little more senior needs to be made easy for students. However, it seems that the students themselves are able to find fellow students who have a marginally greater contextual knowledge of that particular placement and who know the ropes. Friendship amongst peers takes on a greater importance in clinical practice than in the academic setting. The concept of being in the same boat and the need for friendships may be accentuated by the students' existence on the edge of the community of practice. When entering clinical practice they feel like outsiders and this is evidenced by their comments relating to early clinical placements within the data.

It is already known that student nurses need the help of mentors to help them be assimilated into the ward team, some authors suggest that learning cannot

take place until the students feel that they belong (Neary 2000, Campbell et al 1994, Earnshaw 1995, Spouse 2001). Nolan (1998) describes an Australian interpretive study where analysis revealed three main categories to the student nurse experience: I don't belong, doing and practicing and transitions in thinking. The study explored how student nurses thought, acted and reflected on their clinical experiences. Six second year students, who were known to the researcher, were interviewed for one hour at the end of a nursing shift, for six days. Using only a small number of students and exploring their perceptions in the second year of the course alone makes inferences from the findings difficult. A longitudinal study with the same sample may have yielded a more comprehensive understanding of the development of the respondents' thinking. However, interestingly Nolan does highlight the importance of belonging for the students in the study arguing that as students spent time on a clinical placement so they felt more accepted by staff and clients, only when students felt accepted could learning take place. Nolan's work mirrors other work which highlights the needs of students to fit in. Cope, Cuthbertson and Stoddart (2000) suggest that becoming proficient is as much to do with joining a culture of practitioners as it is of becoming technically skilled in some fashion. In their study a distinction is made between social acceptance (which may be granted before competence has been demonstrated) and professional acceptance. They argue that professional acceptance requires a basic familiarity with the context of the placement and acceptance by the professionals. Students demonstrate competence because of increased confidence brought about by social inclusion by the professionals within the group (Cope et al 2000). Although it is not clear whether the joining of the culture is a conscious activity on the part of the learners or whether this occurs by accident. This study suggests that student nurses may not be full members of the culture of clinical practice and need peer friendships to form their own culture. They see themselves as outsiders as expressed by their comments. They join together in order to improve their psychomotor skills and learn from each other. Mastering the

skills is perhaps seen as an implicit mechanism of the students being accepted into the culture of the qualified staff.

Cope et al (2000) also confirm the notion of students feeling like outsiders to the culture of the qualified staff. They argue that the novice status of the students amplifies their feelings of vulnerability. The study interviewed newly qualified staff nurses about their experiences as students; together with a further sample of students who were about to qualify. Each group experienced a different curriculum of education. One of the striking aspects of the results was the similarity of the responses of each group as they described their placements. Some respondents did not feel that they had been accepted as legitimate members of the community. However, more data is presented (or was available) concerning one of the groups of respondents which has the effect of making the responses appear more significant. The study was also conducted retrospectively for the group who were newly qualified, but Cope et al do not explore the impact of potentially flawed memory on the findings.

More recently, Ousey and Johnson (2006) suggest in their discussion paper that the culture of the ward (and the language used within the culture) can exclude or marginalize the student group, creating what they refer to as a 'them and us' situation. Hence, they argue, it is important for the students to learn clinical skills and understand the ward routine. The students want to fit in without asking too many questions (Ousey and Johnson 2006). However, it is important to be cognizant of the fact that that paper is not reporting a research study and the 'them and us' situation may not be the student perspective. However, this thesis does demonstrate links between the notion purported by Ousey and Johnson. Therefore, I am suggesting that the students converge together because of the 'them and us' situation that they find themselves in, and form an 'ask anything' culture in order to learn the cultural rules in the safety of those who they perceive as being similar to themselves.

Wenger (1998) also sheds some light on to the notion of how students might fit in to a community of practice. In order to become full participants within the community (and therefore learn) the student is separated from fellow classmates and have to get enough attention and create enough relationships with busy “old timers”. In order to access the community the learner must take part in meaningful peripheral participation. The participation must be meaningful in the sense that there must be mutual engagement with other members; to their actions and the negotiation of the enterprise and to the repertoire in use. Wenger goes on to explain that in order to be on an inbound trajectory, newcomers must be granted enough legitimacy to be treated as potential members. This may be problematic for student nurses since their existence is somewhat nomadic and placements may not be long enough for the student to participate in the meaningful way which Wenger outlines. Because students exist mainly on the edge of the community of practice, and because the opportunities for working with mentors are few and far between (Earnshaw 1995, Lloyd-Jones 2001, Andrews and Chilton 2000), the students learn to rely on each other in order to learn. Furthermore, the evidence leads to the suggestion that it is the friendship which makes this learning possible. Therefore there may be implications for nurse education, based on this finding, in that we may need to be far more flexible in enabling students to go to early practice placements with those who they consider to be their friends. This will help the students to promote peer learning, in that at least one friendship is already established prior to entering the clinical area; the student automatically belongs to the community of students. Furthermore, as educators, we should not perceive the need for friendships as a marker of lack of maturity, but rather as an essential element of peer learning.

Parr and Townsend (2002) point out friendships in the classroom are based on similarities between peers, both in personal characteristics, such as attitudes, values, activities and personality. They present a paper in which they explore the dynamics and processes of peer group influences in learning settings form a social constructivist perspective. They suggest that examples

from classroom instruction are used to illustrate their points, however, actually no hard data is presented. The paper reviews one hundred and twelve articles to arrive at the claims. Parr and Townsend reviewed literature relating to primary school children and suggested that gender, age, ethnicity and socioeconomic status were important factors in choosing friends. Furthermore, they suggest that motivation and academic performance at school are affected by friendship among peers. Within the classroom I observed that students tended to develop friendships with students of a similar age. Students who tended to develop friendships also subsequently worked well together on an element of problem based learning. Some students tended to produce work of a consistently high standard, whether this was because of their friendship or motivation and commitment to the course, or academic ability is unclear. But it is clear that certain students liked to work with certain other students who they saw as their friends. However, what is interesting is that the friendships were not seen as important to the survival of the classroom setting, whereas friendships were crucial to getting through the different cultural world of clinical practice. Even though the students had skills to learn within the academic context (essay writing, presentation skills etc) the mutual practical help was much less evident. This may not be surprising given the stance within many Higher Education institutions on the concept of collaboration and plagiarism; but even in work which was not assessed; there did not seem to be any evidence of the 'ask anything' culture or mutual help.

The students in this study particularly value friendships which they develop in the early clinical placements. The students view the clinical area as a foreign culture and use each other to form a community. Ousey and Johnson (2006) suggest students are largely outsiders whilst in clinical practice as they strive to understand the cultural patterns of their various placements. This notion of not belonging is accentuated by the fact that the students are often unable to understand the language of the culture; and so become marginalized. Findings form this thesis move Ousey and Johnsons'

suggestion forward and demonstrate this feeling of being outsiders. The formation of a community is evident as the students appear to be drawn together, especially when mentorship fails. Fellow peers are seen as approachable, in the same boat and therefore alike. In order not to appear foolish by asking questions of the community of practice of the qualified nurses the students use each other as resources. It is the friendships which make this ask anything culture possible. The friendships are seen as crucial to survival in the different cultural world of clinical practice. The friendships also extend to the provision of mutual practical help.

As the students progress into the second year they rely less on the safety net of fellow students and become more independent. However, it should be acknowledged that in some instances the manner in which the curriculum is organised often means that students are alone or with few other students when on clinical placements in the second year. There may also be a different perception of the learning that takes place in the (medical) specialties placements, although why this might be so, is unclear. Although the students are clearly developing they still exist on the edge of the community of practice and continue to be reticent about asking questions of the qualified staff. The nature of the mutual practical help gained from fellow students was different to that within the wards.

Within the academic setting whilst the development of friendships is evident, they lack the significance and bonds made by students in clinical practice. Although the students have new skills to master within the academic context, the world of the classroom does not require the same demands in terms of mutual practical help. Students of a similar age tended to work together and form friendships within the classroom.

Links to fore understandings

One of the surprising emergent themes from studying my own students was the importance placed on friendship. Whilst my fore understandings reveal that I believed students valued peer learning in clinical practice, I had no thoughts concerning friendship as being important in order to learn. However, one might expect student nurses to care about each other since caring could be argued as the very essence of the professional role to which they aspire. The students in this study demonstrated the importance of social relationships particularly amongst their peers and especially in clinical practice. The students provided each other with a sounding board for ideas, a shoulder to cry on when things got tough, support to get through the course and mutual practical help. Prior to undertaking this research I had not considered the impact of friendships on clinical learning. It is now my belief that during early clinical placements students rely heavily on a community of fellow students; a new fore understanding has evolved. It is the friendships developed in these early placement encounters which enable the students to use each other in order to learn. Indeed we may need to be more flexible in enabling students to go to early practice placements with those who they consider to be their friends in order to facilitate an increased understanding of the practice encounter by maximizing the peer learning which takes place.

Chapter Six

The importance of story telling and peer learning

Introduction

Story telling as a theme emerged early in the data collection as Diagram one (Chapter 4. Page 141.) demonstrates, however as data collection and analysis progressed it became clear that the friendships and the story telling are linked (Diagram 2 Chapter 4. Page 143.)

Story telling and sharing experiences is revealed as an important mechanism of peer learning. Story telling within the findings refers to students discussing their practice experiences with each other. They are story telling in the sense of narrating their own experience. The data reveals story telling to be taking place in both clinical practice and the academic environment. However, it appears that story telling in clinical practice is more opportunistic in nature whereas there is an expectation within the classroom setting that students will share their experiences with group members. Students use the stories from their peers to discuss difficult situations and also to confirm that they are all doing similar things (and therefore developing in similar ways); both of which are seen as important by the students. It appears that the friendships also make the sharing of stories easier because the students use their community to feel safe. The sub themes within the data highlight how story telling takes place in both classroom and clinical settings.

The data within this Chapter highlights four main sub themes: **sub theme 1**: story telling in practice; **sub theme 2**: story telling in class; **sub theme 3**: the role of the lecturer and finally, **sub theme 4**: story telling and shared practice.

Sub theme 1: Story telling in clinical practice

During the direct observation within the clinical setting whilst I observed students working together I saw no evidence of story telling in clinical practice. However, it is clear that students utilized story telling because they revealed this during conversations. The students revealed that they often

shared their practice experiences at lunch time or over coffee in the staff dining room. The following example is typical of what the students said and also serves to highlight the importance of friendships once again:

> *"I found strength from my fellow students to carry on and during particularly bad days we would wait expectantly for lunchtime to come so that we could share our experiences, analyse them and make each other feel better about them". [Field notes from clinical practice. Second year. Site 1 ward 2. E4.]*

This example from that data is interesting in that it leads me to make the following three interpretations on the importance of story telling in clinical practice. The first interpretation relates to the fact that the students clearly want to have this conversation away from the ward. This may be due to the expectation of the staff that discussions of this nature do not contribute to the work of the ward or there may be an implicit understanding between the students that this kind of conversation should happen away from the ward. This leads me to a second interpretation; the student clearly wants to feel better about her experiences and looks to her peers to provide this support. The student perceives that the support is linked to learning through the analysis that takes place. Finally, the student is suggesting that through the sharing of experiences it is possible to learn. The students learn from sharing their own stories in addition to hearing the shared stories of others.

There appears to be a link between the sharing of the experience, the provision of support and learning how to be a nurse. All three aspects appear to be important for the students as this comment from Lisa demonstrates:

> *"As a mature student you have more life experiences, and have a lot more on your plate to deal with while studying…there's an impact not only on yourself but on your family if you are a mature student; younger students really only have themselves and their study to worry about. I'm not sure if it's life experiences which changes the way you learn but I think you are more open to learn from your colleagues. It's about attitude when it comes to learning from your peers. When I talk to other mature students we are more likely to talk about nursing issues that we have come across or seen. I can remember talking to Wendy and Jo about issues that had got up my nose or had upset me in some way. I can remember in my first year speaking to Jo about a nurse who I believed was crap and treated her*

patients badly, I remember saying that I hoped twenty years of nursing would not make me react in the same way. I think we used each other as a sounding board a lot of the time". [Transcript from classroom discussion. Third year, final semester.]

Similarly another student comments:

"We would tell each other about the experiences we had encountered, about clinical areas we had visited and people we had met and how to go about doing things".[Field notes from clinical practice. Site 3.DB 13]

Another student also highlights the importance of making each other feel better in clinical practice. Interestingly, this student is also on placement within the operating theatre and is clearly often a lone student. Here the student also mentions the need to feel that you are doing the right things; implying that this is an important aspect for students:

"I am currently on placement in theatre and very rarely see never mind speak to other students. When this does occur we tend to swap experiences but not really in any great detail, I think just enough to reassure ourselves and each other that we are getting on and developing our skills and knowledge and sometimes that we feel the same about situations that have caused us stress". [Field notes from classroom. Second year discussion.C9]

One student also offered a suggestion as to the benefit of sharing stories with peers as opposed to others:

"The majority of mentors and qualified nurses are approachable and do seem to want to help and inform you but the problem arises when maybe they have been so long out of training that they have forgotten what being a student is like and are also maybe ill informed about what we are supposed to know at our academic level. In a situation such as this they may overload you with information, or not give you enough, whereas conversing with another student about your experiences can help to put things back into perspective." [N2a.]

Sub theme 2: Story telling in class

Story telling in class, or the sharing of clinical experiences appears to be important for the students and many of the incidents shared appear to have a great impact on the students. For example, one student commented: "*I enjoy listening to people's experiences, they seem to stay with me in my mind*", [N1a.] which suggests that when experiences are shared they remain in the memory. Story telling within the academic environment is formal as it is convened by the timetable, whereas, story telling is more opportunistic in nature within clinical practice. The findings relating to story telling in class highlight the difficulties the students initially had in sharing their stories, the students tended to focus on issues where there had been some degree of personal conflict. During one of the feedback from practice sessions the students started to have their discussions and each student I asked to nominate a subject matter chose a nursing theme, some chose very specific events from their previous practice environment.

One student nominated "*Good and bad experiences in practice*" as the subject for discussion. For one student in particular it was as if the flood gates had opened and she began to relate her experiences of being a first year student on her first placement. Jess told the group about how she wanted to learn so much but was often ignored by her mentor, she said that she asked loads of questions and was told time and time again:

> *"I don't want you to worry about that now, I don't want to bog you down with that*". *The student told the group, "But I wanted to be bogged down, I was desperate for her to explain….. you know, to tell me stuff…..…but she just wouldn't. I just feel like I was insignificant*". *[Transcript from audio taped classroom data. First Year. H]*

This was obviously important for the student to tell this story and it seemed to have a powerful effect on the group. This was evidenced within the field notes:

> *"There was a long silent pause after Jess finished. The group appeared to identify with the helplessness of her position. Many of the students were visibly emotionally moved by the frustration in her story. It seemed that*

the group recognized that this had been difficult but important for Jess to talk about." [Field notes. Year one.]

Another student commented on how she "*really felt for*" Jess, and wanted to be able to help. This is similar to the notions expressed in Chapter 5 concerning the 'protective feel' the students extend to each other. As a more mature student nurse who had previously worked in a healthcare environment Angie offered some suggestions of phrases to use to prompt the mentor into action next time the students went into practice.

After this first story from Jess, Helen went on to describe the first time she witnessed cardiac resuscitation:

"it all happened so quickly, yet at the same time everything was in slow motion; a bit surreal…..I didn't do anything, I just watched…I don't know how I feel about it all. The man died". [Transcript from audio taped classroom data. First Year.C]

When Helen was describing this situation the pauses between her words were long and both myself and the group were captivated by her explanation of the situation she found herself in. The following field notes from Helen's story highlight this:

"Helen told the group about witnessing a cardiac resuscitation attempt; she had not seen this before and provided a vivid explanation of how everything appeared in slow motion. The group appeared to really understand her perspective, it was as if they could feel her sense of watching the events unfold yet feeling powerless to help. But I am unsure if they have learned from Helen's story." [Field notes. First year.]

Having slowed down to dwell and linger over the data I was intrigued by the discussion, sensing it had been important, but was unsure whether the group had perceived Jess and Helen's story as a learning opportunity. The next time I met with the group I told them how I thought the previous session had been an important one and asked whether they had used the session to learn from each other. They seemed to nod in agreement that the session had indeed been important. I asked them to try and tell me what they had learned, one student said that she was determined not to let herself get into that situation,

she had been empowered by what Jess had related. She couldn't say anymore about what she had learned. None of the other students could say what they had learned, but they did say that this kind of discussion was beneficial and that as a group we should do it again:

"Jo: 'well it was really emotional and I've really learned from it.'
Lots of nods in agreement from the group at this comment from Jo.

Paula: 'I think I would have felt exactly the same as Helen, it was helpful to hear her experience.' [Field notes. First year.]

This seems to be an important point, the session had clearly been important and one where the students felt that they had learned; but the nature of the learning was unclear and difficult for them to express.

Similarly, other students confirm the importance of hearing other students' experiences in class in order to learn:

"Whilst at university I have learned a lot from my fellow students, you get a different perspective on things…I still talk to a group of mental health students and love to hear what they have done in clinical practice an in university, after all, they will become fellow professionals one day and are another good source of information" [Su1d.]

"We discuss our experiences on placement a lot...you know ask each other how we dealt with various experiences." [Natalie year 2 Field notes.]

"Jo: 'From hearing the other's experiences I remember thinking to myself, What would I do in that situation? Would I have acted differently or the same?'"

The sharing of experiences was also important in that it provided the students with the reassurance that they were all progressing at similar rates as this excerpt demonstrates:

"The most important part of sharing my experiences with fellow students is so that I know that I'm having similar experiences to everyone else…to check if we were all the same point or level. If we learned something different from everyone else we would come back and say, 'this was really good or bad for me' and someone would always say something reassuring". [Lisa. Third year.]

Pairs of older students would use their knowledge and skills gained from their life experiences to enhance their nursing knowledge. This was particularly evident during story telling when mature students seemed to be able to make links between their nursing experiences to what they had done before in their lives. For example, Angie comments how as one of the students who was a mature single parent with previous experience as a health care assistant, she already knew about being assertive and how to stand up for herself:

> *"As an auxiliary before; I know a lot of that stuff, there were a couple of times where I wasn't nasty or anything like that, but I stood up for myself…You know I remembered Jess' story from the first year and I thought, Right, I'm not going to get stuck like that". [Transcript from classroom data.]*

Whereas another student identified how she used her life experience:

> *"As a more mature student I can help the younger ones with grammar for the assignments and of course communication skills; you take things that have happened to you before (starting the course) and this helps you in all sorts of ways with your nursing". [Transcript from classroom data. Su3k.]*

This second example from the data is also supported by a theme identified in a previous study by Chesser-Smyth (2005). Chesser-Smyth used a phenomenological approach with twelve students to discover the lived experiences of the students on their first clinical placement. It is suggested that mature students strived for interpersonal and communication skills to be recognised as a distinct advantage to their nursing. It seems that the above comment (from a mature student) infers that her effective communication skills are linked to her maturity. However, from Chesser-Smyth's study it seems that this may be linked to the self awareness of the student and correlations between self awareness and maturity offered by her study are tenuous and not clearly articulated.

Sub theme 3: The Role of the Lecturer

The data provides some evidence that the students can be helped to provide richer descriptions within their stories, but also reveals that they need help to develop the stories into learning opportunities. Rather than allowing the students to continue to simply accept the sharing of experiences as an end in itself and in order to promote the learning opportunities within the sharing of experiences; I realised that if the students either could not, or would not question each other, I would need to provide the challenge. The students are helped to see the relevance of what they are describing and are pushed into thinking about their experiences with a greater purpose.

From my perspective, examples include questions such as: "Can you tell me more about that; how did that make you feel; are there elements of other situations which might be useful here?"

However, when I asked the students if they could recall my questions which had really made them think, their responses included:

> *Helen: "All the time, because we have to find the answers ourselves, as you make us."*
>
> *Jo: "Always getting us to think about what we have said and not leave it with one sentence but you make us provide more detail, more information."*
>
> *Lisa: "Most of your questions make us have to think."*
>
> *Natalie: "When you gave us a scenario of a man in A&E who was asking for his wife, but we knew she had died; you asked us what we would say to him." [Transcript form audio taped classroom data. Third year.]*

However, these responses were not those I had anticipated. Perhaps this supports the view that students find it difficult to discuss what and how they learn. On the other hand, the responses may demonstrate the differences between teacher and students ideas about the how learning takes place.

The role of the lecturer within the UK context in influencing students' clinical practice remains unclear. Whilst Jinks (1997) and Fitzpatrick, While

and Roberts (1996) assert that educators within the academic setting are influential in the development of student nurses; it seems that differences remain concerning the perceptions of how and why educators are influential. This thesis highlights a difference in perceptions concerning how learning is influenced; the lecturer feeling that the discussion and careful, probing questioning is significant; whereas the students are unsure of its' value. More research is required in order to fully explore the concept of the influence of academic educators on the clinical practice of student nurses.

Sub theme 4: Story telling and shared practice

One of the most interesting findings relating to sharing experiences within the academic context was the link between shared practice and story telling. There are two types of shared practice. Firstly the students appear to benefit when they have been on the same ward or unit and are able to share their contextual knowledge of the ward, together with their imagination to enhance the vicarious learning experience. An example of the benefits of shared practice in relation to peer learning through sharing of experiences is provided by the following excerpt from the field notes:

> *"I think it helps because both parties have got the experience of the situation; you both know the staff and patients involved (Wendy)."*
>
> *Jess: "Yes, that's it…because you (Looking at Wendy) are another student that's in my place, in my boat".*
>
> *Angie: "You see I can't picture their ward, whereas when we talk together (pointing at another student who has been on the same placement), it's like 'Did you see that?, What was going on there?" [Transcript audio taped data. Second year.]*

Secondly, when two (or more) students have taken part in a specific clinical practice, the vicarious learning is enhanced from the other's experience of that practice.

For example:

"I catheterised a lady on my last placement. I was so nervous I was shaking like a leaf. The thing I found most difficult was trying to inflate the balloon whilst ensuring the catheter tip remained in the bladder and not in the urethra; I felt like I needed four hands!"

"Oh, definitely, Yes, and that bit when you're trying to get the water into the balloon and you're trying to make sure that you don't pull the catheter out, I can really identify with that…it's really tricky". [Excerpt from transcribed audio tape from classroom data. Second year.Su3m]

During this discussion the two students are using their hands to illustrate the movements that are taking place with the syringe to inflate the balloon and the not pulling on the catheter. They are both using their memory and imagination to develop a mental picture of what the other person experienced. This was evident as at times during the description they both closed their eyes as if they were reliving the event again in the classroom.

Discussion

Story telling and learning from narrative appears to be an evolving concept within the literature and is suggested as a means through which learning can take place. Through listening to the stories (and experiences) of others, students learn vicariously (Nehls 1995, Fox 2003, Bowles 1995, Northedge 2003). The literature surrounding story telling and using experience in order to learn is of particular interest to me. One of the features of the curriculum in which the students are engaged is termed feedback from practice where following clinical placements the students are given the opportunity to share their experiences in the classroom. The findings from the research demonstrate the importance of story telling not only within the classroom but also in clinical practice. The findings regarding story telling also reinforce the earlier ideas concerning friendships. It appears that the friendships also make the sharing of stories easier because the students use their community to feel safe.

The interpretations become apparent through slowing down, dwelling with the data and allowing the amplification of what is important to come to the fore. The examples regarding story telling in clinical practice are important in that they provide new insight into the notion of learning and working and would seem to add weight to previous assertions that students view learning and patient care as two quite separate activities (Cahill 1996, Melia 1987) and that the clinical area is centered around practice rather than education (Hewson and Wildman 1996). However, rather than the qualified staff teaching when the work is finished, it appears that the students themselves feel the need to separate the learning from the working; the learning happens when the nursing work has finished. The fact that the students left the ward in order to have the conversation seems to be an important point and implies that the ward environment does not seem to foster this kind of learning; or that the students prefer to be alone. The students' examples also show that together the learners share experiences and make each other feel better about them. This leads me to a second interpretation; the students clearly want to feel better about their experiences and looks to their peers to provide this support. One student in particular perceives that the support is linked to learning. The student refers to the conversation as sharing experiences and analyzing them; it is not possible to say whether analysis did indeed take place, or whether the conversation was just talking things through. It could be argued that the students were simply engaging in collusion in order to protect each other and provide support. This notion of collusion is explored further in the next Chapter when the nature of peer learning processes is discussed. Finally, the student is suggesting that through the sharing of experiences it is possible to learn. The students learn from sharing their own stories in addition to hearing the shared stories of others.

The students tend to imply that there are two types of stories which are discussed in the clinical setting; firstly the students talk about what they have been doing in order to provide reassurance that they are all doing similar things and developing along parallel lines. Secondly, the students discuss the

difficult times. The subject matter of these shared experiences could be said to be concerned with emotional labour (Smith 1992), in that whilst the practice is unfolding personal emotions are set aside or suppressed in order to appear confident, in control and professional (Smith 1992). However, the stories outlined in this research show that student nurses often struggle to come to terms with these emotional elements of learning to be a nurse. The two examples shared by Jess and Helen are typical of what the students chose to share within the classroom. As Smith points out when students are exposed to circumstances which are tremendously difficult, the students will either choose to leave or develop styles and strategies to protect their emotions. I believe that through the sharing of stories from clinical practice students are creating the styles and strategies to which Smith is referring. Hearing another's story from practice enables the student to be exposed to each other's feelings and associated ways of coping.

The story telling can be formal: convened by the curriculum; or informal, occurring in an opportunistic manner. Perhaps the students were learning through thinking as described by Smythe (2004). The feedback from practice sessions (when stories are shared) required discussion rather than note taking. Smythe explains that students are often too busy note taking in lectures whereas in small groups there is less pressure to do this, and students are enabled to think. Perhaps this kind of discussion liberates the students in their thinking? Azmitia (1998) suggests that such personal contemplation (whether conscious or unconscious) is necessary for cognitive growth and the construction of knowledge.

Story telling and sharing stories is said to help students locate nursing experiences and apply these to nursing practice (Smith and Gray 2001) and may be a form of vicarious learning. Furthermore, in terms of work based learning novices may lack the vocabulary to talk about what is observed and require careful guidance until they have learned to talk and read about practice as old timers (Spouse 2001). It seems to me that there was a general consensus that these tales were important and that the students learned.

However, the students could not find the language to articulate this learning. It seems that this situation mirrors work based learning in terms of being able to talk about the learning that has taken place. Indeed, Eraut (2000) cautions researchers by saying that often respondents are unaccustomed to talking about learning and may find it difficult to respond to a request to do so. The learning which takes place is taken for granted. However, it is difficult to say with any certainty whether the students are unable to communicate the knowledge because it is knowledge which is not, or cannot be communicated; or whether there is a deficit in the attributes of the knower. If the learning is attributable to the assets of the knower then this would imply that ability to learn through story telling should increase as the students progresses through the course, however, there is no evidence within the data to suggest that this is the case.

Thompson (2003) points out that language is more than simply the ability to use words to get across a particular message. He asserts that language is much deeper than this and refers to a complex array of interlocking relationships in its own right, in that meaning arises from the way in which particular language forms are combined and interact with one another. Furthermore, language forms the basis of communication and social interaction. Earlier when discussing sharing of experiences in the clinical setting, the student seemed to imply that she would wait expectantly for the opportunity to share her experiences with her peer. There was no sense that this sharing of experiences was difficult, although the inference is that the sharing was emotional whereas, the sharing of stories within the classroom appeared to be difficult for the students. The students were in control of what they shared within the class and some may have been uneasy with the self disclosure required.

Much of the literature concerning how students learn from discussions or discourse within groups asserts that there is an element of challenge and support within the dialogue. However, direct observation of the students in the academic setting revealed no evidence of the students challenging each

others ideas. The students listened intently and would add their own thoughts to the discussion, but this was not framed in terms of challenge. The students passively accepted the experience as it was shared and accepted it as an account.

Pfund, Dawson, Francis and Rees (2004) and Arbon (2004) demonstrate the crucial role of educators in helping students to examine their feelings and together the whole situation. Indeed Arbon suggests that by modifying teaching and learning approaches and developing the ability of nurses to use what he terms reminiscence will help students to find meaning and learn from their experiences. He goes on to say that often this can create dilemmas for those involved as past events may be difficult and traumatic but that this is acquired over time. However he provides no details concerning how educators might support learning in this way. Restructuring the practice setting is implied; but findings from this study would suggest that it is not only the practice setting but educator perceptions of the value of story telling in experiential learning which requires a cultural shift. Similarly, Northedge (2003) is of the opinion that the lecturer is crucial in helping the students to make sense of their experiences. It is through the asking of questions and introducing new elements to the discussion that the lecturer helps the students to frame and generate meaning. Interestingly, Spouse (1998) indicates that a mediator is necessary in order to help students translate their knowledge. Spouse is of the opinion that in clinical practice the role of translator is taken on by qualified staff acting as mentors. During the clinical activity Spouse asserts that student and qualified nurse work together to undertake legitimate peripheral activity. Simultaneously with the activity the student is verbally guided through the whole process; a term which Spouse refers to as proleptic instruction. Learning is structured by being encouraged to think aloud whilst engaging in tasks which are beyond the students' perceived level of skill. In other words, Spouse is making use of Vygotsky's zone of proximal development. Stone (1998) contends that "prolepsis is a special kind of conversational implicature in which the necessary context is specified after

the utterance rather than before it" and is said to involve "the construction of new understandings of a speaker's intended meaning" (Stone 1998. p160). He goes on to argue that where there is mutual trust there is an increased likelihood that the listener will adopt the speaker's perspective as his own. Spouse presents her argument based on her research of student learning in clinical practice and contends that "regular opportunities to review the boundaries of knowledge allow student and supervisor to identify new developmental activities and opportunities to acquire professional knowledge" (Spouse 1998. p264). However it is debatable whether this is realistic for two reasons: firstly, opportunities for such regular contact for working together and subsequently discussing practice may be few and far between and secondly, the supervisor of student practice will be a different person in each placement and developments in six to eight weeks may be small. Perhaps a supervisor who can view developments over the entire programme would be better placed to act in this capacity. The data from my research reveals that this role of translator can also be adopted by the lecturer to promote learning about clinical practice. I contend that this is made possible through the development of mutual trust.

Laurillard (1993) asserts that peer learning entails a two way conversational process but warns that whilst discussion is an excellent partial method of learning there is a need for it to be complemented by something else if students are not to flounder in mutually progressive ignorance. Peer learning was being effective as a vehicle to encourage students to share their stories, but the learning was fairly superficial as the students were content to leave the descriptions of the events as the end point of the learning. The data shows that the lecturer can intervene to promote deeper learning and sense making. The students are helped to see the relevance of what they are describing and are pushed into thinking about their experiences with a greater purpose; although the students are necessarily able to articulate when they have been pushed into thinking in a more meaningful way.

By combining the ideas of proleptic instruction with Northedge's notions of the lecturer as a person who acts as a specialist speaker of the discourse, it is possible to encourage the students to think more deeply about the experiences which are shared in class. The students are encouraged to think aloud and talk through the clinical experience; I make them slow down and clarify points which I think are significant. I ask questions which make the students think about their preconceived ideas and how these have affected their practice, thus helping the students to add the theory to their experience. As Fox (2003) asserts, this adds dissonance to the learners' psyche in order to create a teachable moment. However, this can only be undertaken when the teacher has a connected relationship with the students and has created an environment where the students feel safe and are encouraged and nurtured to explore. Together teacher and student uncover the meanings of the practice encounter and make sense of what took place. However, as the findings demonstrate there may be a difference between what the lecturer thinks is contributing to the learning and the student perception.

Cope et al (2000) suggest that within clinical practice much expertise is directed to dealing with the contextually bound demands of the situation which cannot be accounted for context independent technical-rational models of learning. They go on to say that the key for developing practical skills sits wholly within the clinical setting, only in the clinical setting can students learn to interpret situations and to deal with them effectively. However, I would question this notion. The data reveals that students are able to interpret the meaning of the practice encounter within the classroom. In fact there may be benefits for doing so. Horrocks (1998) employs Heideggerian principles to assert that theoretical knowledge is grounded in practical knowledge. Furthermore, Horrocks contends, it is consideration of practice which generates theory, it is impossible to generate theory without consideration of practice. However, he acknowledges that the relationship between theory and practice has been mistakenly inverted as today theoretical knowledge is viewed as most important. However he makes no comment regarding where

such consideration should take place. Whilst he asserts that theoretical knowledge is viewed as most important, I assume that he is implying that this is the view of educators. However, students seem to remain fixated with the mastery of psychomotor skills, rather than acquiring theoretical knowledge. Therefore, I am suggesting that rather than seeing the classroom as a separate entity where theory sits; a shift is required where the classroom is seen as an extension of practice where consideration takes place. As Nehls (1995) suggests the classroom becomes a forum where fundamental philosophies of narrative pedagogy are uncovered for both teachers and learners.

When students returned from the same clinical placement, the experiences were not necessarily common to both students but the students used their knowledge of the clinical area, and in some cases knowledge of the patients and staff, to their advantage. Having an underlying appreciation of the ward in question is influential in helping the students to make sense of the experience. Other students who have not shared in the practice area cannot engage in the same way. Whilst we know that learning is contextual it seems little attention has been paid to the impact this has on learning; particularly when students are expected to transfer learning from practice to learning in class. Students at a number of different points on the journey towards registration as qualified nurses enter a practice placement together. As a group, what they learn there is contextually bound and is relevant to that particular setting. However, because the notion of linear, chronological progression prevails it is assumed that what the students learn is dependant on where they are on the journey to qualification. In other words, it is assumed that first year students will learn something different to third year student nurses. This study demonstrates that by being in the same clinical environment and being given an opportunity to share experiences together enhances the peer learning. Peers are more able to picture the scene and use their imagination, memory and contextual knowledge to help them to learn form each others' experiences within that setting. Therefore in order to promote learning which is relevant to students; based on clinical practice, it is

recommended that students who have experienced the same practice placement should be brought together with the explicit aim of promoting peer learning from the practice experience. According to Boud et al (2001) reciprocal peer learning emphasises students simultaneously learning and contributing to other student's learning. Such communication is based on mutual experience and so they are better able to make contributions. This would seem to add weight to the idea that students who have been on the same placement, and therefore may have some mutual experience on which to draw, should be brought together with the specific aim of promoting peer learning from practice.

Summary and links to fore understandings

The research demonstrates that for these students story telling is important in terms of promoting peer learning. Within clinical practice story telling takes place away from the clinical setting, after the nursing work has finished. Evidence shows that it is the student's choice to separate patient care and learning and mirrors similar earlier findings from Melia (1987) and Cahill (1996). It is clear that questions remain concerning the reasons why students feel the need to leave the ward environment to enable this kind of discussion. Whilst it is beyond the scope of this inquiry it would be interesting to investigate whether the students feel that this kind of discussion is possible within the clinical setting. Story telling in clinical practice is seen as a valuable peer support mechanism and reinforces the importance of friendships in peer learning.

The students in this study found story telling in class problematical and emotional and often found it difficult to articulate what they had learned. However, they clearly felt that sharing experiences through story telling was important and worthwhile. The students learned through each other's experiences, this challenges the primacy of first hand experience. The lecturer can help the students to unravel the meaning behind the experience through

questioning and being an expert speaker of the discourse. Although proleptic instruction has previously only been considered within the practice domain it is clear from the findings that it is possible for the lecturer to use proleptic instruction in the classroom to help the students to learn clinical practice. The lecturer helps the students to consider practice in order to generate theory and thus it is suggested that practice can be learned in the classroom. In particular peer learning is enhanced when students have been party to the same clinical placement. The students in this study who had shared clinical placements were able to use their contextual knowledge, imagination and memory to make their peer learning seem more real and relevant. Other students who had not been in the same clinical placement could not engage in the shared experiences in the same way.

The findings from the research relate to all four of the fore understandings with which this study was approached. The work has shed light on the importance of story telling for this group of students. Students appear to value the sharing of experiences in both clinical and academic settings, although they find it hard to articulate what they have learned. The knowledge gained through story telling is seen as informal and part of the process of learning to be a nurse. It is not considered in the same light as learning a clinical skill such as giving an injection. Dialogue is important to the sharing of practice encounters but the students in this study seemed to accept the stories as an end in themselves. In other words, the stories can remain simply as interesting tales, rather than being used for peer learning. I now have a better understanding of my role in helping the students to make sense of their clinical experiences and see my role as crucial in this respect. The fact that the students do not provide the challenge within the classroom may not be particularly important in terms of peer learning but it may be important in developing critical thinking skills. However, what is of concern is whether this lack of challenge continues when the students qualify and are accountable for their practice and responsible for the practice of others.

Chapter Seven

Processes of Peer Learning in clinical practice

Introduction.

One of the aims of the research is to discover more about the processes used by the students while engaging in peer learning. I was interested to find out specifically what the students were learning from one another within the practice setting and furthermore, to discover the value ascribed to this learning. These data suggest within clinical practice the student experience of peer learning takes on great importance. The data demonstrates once again how the community of students is accessed as a resource for learning. Each of the processes of peer learning in clinical practice is presented as a sub theme. The sub themes became evident after eighteen months of data collection and are highlighted in the in the third diagram in Chapter Four (Page 145). It was at this point that the specific nature of the processes became clearer as the detail of what the students were doing emerged. Each process of peer learning appears to be equally important to the students.

This Chapter outlines four key processes from the data relating to the processes of peer learning in clinical practice: Confirming what you already know (**sub theme 1**); Student becomes teacher (**sub theme 2**); seniority often referred to who had been on the ward marginally longer, rather than who had progressed most along the three years of the programme; furthermore, seniority in terms of how long a student had been on the course appeared to be unimportant. (**sub theme 3**) and finally, confidence as evidence of learning (**sub theme 4**).

Sub theme 1: Confirming what you already know

The data shows an important aspect to the types of questions the students ask each other. The students perceived that they already knew the answer to their own question, but what they really required was simply confirmation of that supposition; for example, one student comments:

"other students are often a favourable option for gaining or consolidating your knowledge. This is more often the case when you already have a fair idea concerning a subject and just require confirmation… it's probably more your confidence rather than your actual knowledge that is lacking".[Transcribed audio taped data from clinical practice. Third year. Site 3. N1d.]

Similarly, another student supports this idea of confirmation by adding that learning from other students is about "*confirming with each other that we're doing the right things*" [Ea.]. However, it could be argued that rather than confirmation of knowledge and best practice taking place; in fact the students were engaging in a form of collusion whereby practice or knowledge is superficially agreed with. The students here clearly wanted someone to tell them they were "on the right lines", and were not really expecting a fellow student to say otherwise. Perhaps, this need to protect each other means that there are unwritten rules about not challenging a fellow students' knowledge or practice. The students would frame their questions of each other in a way which elicited the response they were expecting, and the fellow student obliged. I never observed students disagreeing with each other's practice.

This framing of questions may be examples of tentative theorizing; the student has formulated what she thinks is a reasonable explanation and requires confirmation from another student. The student lacks the confidence in her own knowledge or ability to proceed without confirmation. Once again, rather then show her lack of confidence to the qualified staff, the student relies on peers for support.

Sub theme 2: Student becomes teacher

The students used each other as teaching resources, particularly when there was an absence of qualified staff:

"I felt that I helped the first years' on my ward, but you feel that you should do more. It's like on my last placement, I was asking a third year, but here the first years' are asking me; so that they can learn from you. It was expected in a way…I mean, they never came out and said it (meaning the qualified staff),…you know…Can you take such a person with you?…it

just seems obvious…I was even teaching junior Doctors things they didn't know". [Transcribed audio taped data . Second year. Site 2 ward 1. IS3b]

Indeed in some cases it appeared that the students were used by the qualified staff as teachers to other students as this comment illustrates.

"As a first year I was a bit overlooked, not in a nasty way, but if there were any clinical skills to perform, the staff would pass these on to some students who they knew to be confident. One student took me under her wing and would take me with her to do clinical tasks and explain them to me whilst performing them." [Field notes from clinical practice. First year. Site 4, ward 1. E6]

What is particularly interesting is the nature of the specific practices which the students observed. Indeed, dressings emerged as a key skill which the students relied on each other to learn. During an observation period with Helen in the third year of the programme, she worked with a first year Degree student; the first year commented about how Helen taught her to do wound dressings:

"She talks me through it and tells me what to do…well, she tells me what I need to get, what order to do it…she's really good" [Field notes from clinical practice. Site 4. Ward 1.C17b]

This appears to be an example of peer learning which uses proleptic instruction. The student is saying that Helen verbally coaches her through the clinical skill. The skill itself is seen as important and legitimate peripheral activity which contributes to the over all work of the ward.

One example from the data highlights the link between confirming what is already known, reciprocal learning and observation. Angie Comments:

"I would watch a student do a dressing, then the student would watch me. We'd come out of the cubicle and the student would confirm that she would do it the same as me".

I asked Angie if she would ever correct another students' technique, to which she said:

'If she asks my advice I would tell them; or I would wait until after they had finished and ask them why they did it a certain way'.

Again I asked for some clarification and added 'but that discussion would happen afterwards?'

Angie 'Yes, it would be embarrassing to the patient if you questioned it at the time…it gives the patient the chance to worry about what you are doing'. [Transcribed audio taped classroom data. Second year.]

The importance of clinical skills is also outlined in this final example. The account also demonstrates how the learners use the community of students once again and reinforces the idea that all students are perceived as being knowledgeable. Furthermore, seniority in terms of chronological progression is unimportant:

Lisa: "In the first year we had a naso-gastric, but on my ward there was a third year who had never come across it and didn't know how to clamp them off or what to do, so I was showing him. He was OK with it- but I was like 'WOW!', a second year showing a third year how to do something; he just said that in his three years he'd never come across one, didn't know how to flush them…so I showed him what to do." [Transcribed audio taped classroom data. Second year.]

Lisa's example illustrates how the students rely on each other for demonstrations of clinical skills; however, it is also clear from her story that students are satisfied with being shown how. There does not appear to be any rationale offered behind why you might need to clamp a naso-gastric tube, or when you might decide to let it drain. The students in the study appear to be preoccupied with being able to perform clinical skills, such as dressings or passing naso-gastric tubes.

Not all students engaged in teaching and learning with or from peers. The following student expressed this minority view:

"As far as clinical experience is concerned I have never been shown how to do a procedure by another student. I have found that students won't volunteer practical clinical experience but will act as though they don't know how to do it….a mentor will sometimes take two of us (students) to see a procedure, if she asks one of us to do something, I feel intimidated when I make a mistake and don't feel confident in doing procedures with a

student audience". [Transcribed audio taped data from clinical practice. Third year. B2]

However, later the same student went on to say:

"I have never shown another student a clinical procedure by myself and would not feel happy about doing this, as I feel I'm not confident in my experience to do so…but I have shared information with other students about care planning, documentation and computer care planning". [Transcribed audio taped data from clinical practice. B4]

This is an interesting point because it seems to emphasize the difference in perception concerning the teaching and learning of clinical skills. This student clearly sees clinical skills to be rooted in the psychomotor domain and does not acknowledge what she terms 'the sharing of information' as teaching. It is as if the skills associated with care planning are not seen as important or indeed as a skill at all. I would say that the student is engaging in teaching others about care planning, but she clearly does not perceive this to be the case.

It seems that teaching other students can be beneficial for both parties. Here this second year students highlights the mutual benefit:

"She asked about the BP/TPR chart which I subsequently described and introduced her to. I found this really useful because it made me re-examine how I had been introduced to the chart on the ward and the way in which it had been explained to me. Describing to another student the basics of blood pressure and pulse, and also the importance of respiratory obs made me more aware of how important it is to get a sound initial grasp of a subject before feeling able to embark on attempting to understand it further. I was satisfied that I had helped her gain a basic level of understanding without over facing her with too much information she wouldn't have been able to put into any context. In turn it made me re-revise my own basic knowledge of a nursing intervention that we can sometimes fall into the trap of doing on auto-pilot and so it was an experience that was equally valuable to me." [Field notes from clinical practice. Second year. Site 2. Ward 3. N2e.]

This leads me to conclude that Wenger's (1998) premise concerning how nursing practice is passed down in an oral tradition from one generation to the next is correct. However, this data in particular, would seem to imply that

student nurses are also replicating practice as they take on a reciprocal teaching role. Here the student clearly suggests that she introduces the observation chart to her peer in exactly the same way it was introduced to her.

Sub theme 3: Seniority in clinical practice

Traditionally within nurse education seniority amongst student nurses tends to be viewed in terms of first, second and third year students. Students progress through each year in a chronological, linear fashion.

Here the data reveals a view of seniority in clinical placement which suggests that length of time served on the programme is less important than contextual knowledge of the ward in question. For example, one student said:

> *"If a student has already been on the ward for a couple of weeks, they usually impart important information such as, is the Sister scary or approachable; which mentor is the most student friendly and which HCA is the most knowledgeable and motherly". [Field notes from clinical practice. Second year. Site 3. Su2h.]*

Students appear to be more concerned with what the peer knows and has experienced before, rather than which year she is in on the course:

> *"I have both learnt from students and taught other students clinical skills and procedures whilst on placement…if I have confidence in a fellow student I will ask them". [Field notes from clinical practice. Third year. M2f]*

> *"Whilst on placement the main advantage is that you mix with students from first to third year. Receiving advice and support and assisting other students is equally important. After all, we are all in this together". [Field notes from clinical practice. Su3n]*

The assessment strategy within clinical practice reinforces this notion as the students have to be assessed as competent in a range of clinical skills before they can progress from the common foundation programme (at the end of the first year) into their chosen branch of nursing (in the second and final year). However, findings here suggest that seniority may also be viewed as contextual and applying to each clinical setting:

"A fellow student asked me to show her the ropes, she was a second year and I was a first year; but I had been on that ward for three weeks before she arrived. This was her first time on a respiratory ward. Later that day she asked me how to increase someone's oxygen". [Field notes from clinical practice. First year. Site 3.M]

Later the same student went on to comment on how members of qualified staff might also use students' contextual knowledge:

"I remember on one occasion a ward manager asked me if I would show a new student the ropes, I was a first year and she was a second year; I was a little embarrassed for her really." [M2e.]

Usually there is a constant supply of students who rotate through their clinical placements. I observed the students deliberately targeting other students who had been on the ward slightly longer in order to ask questions. Other students who had been on the ward for some time are seen as knowing the ropes, and having the important contextual knowledge which the students required. These entries from the field notes describe the feelings of the students towards the idea of seniority:

"where you are in your training holds no significance since you are often able to offer guidance to a student who is further on than yourself, just as much as you can gain from someone who is less experienced. It depends more on the individual experiences you have as a student and not on the amount of time you've been training." [Field notes from classroom data. Second year. N2c]

Lisa goes on to elaborate:

"Also if you think within this room, we've all been to so many different placements; something that Angie might know, I have no clue about and some things I might know, she may not." [*Transcribed audio tape from classroom data. Second year.]*

The comment is from a mature student who was twenty seven when she started the course. This comment was captured towards the end of the second year and she is talking about her learning experiences with other students:

"On my second placement in the first year I was with another student who I knew and was friends with, but there were also third year students on this placement and my relationship with them was quite different. We would have conversations about what I could expect from the rest of the

course, we would compare how the course was affecting our home life and how we were coping with the lack of money…I respected and valued the third years and wanted to learn from their experiences. But on my third placement (at the start of the second year) I was on the community. A first year joined us half way through the placement and I found myself in a similar role to that of the third year I just mentioned. The first year wanted to know about my experiences on the course and on the placement, what she could expect to learn, the assignments…she was really young and wanted to know who was best to work with and who would let you have a go at things." [Second year. Classroom data. C7&8.]

The comment shows how as a mature student she can recognise the changes in her role. She intimates that the younger student lacks confidence and uses the mature student to help her learn survival skills because the older student is seen as confident and knows the ropes.

Sub theme 4: The importance of confidence to peer learning

Confidence emerged from the data as an important element in terms of peer learning. The friendships developed in clinical practice enable the students to work together and learn from each other. The learners use the community of students to boost their confidence levels. Proleptic instruction and coaching each other helps the students to achieve increased confidence in their ability. The students would often work in pairs and would deliberately target fellow students who had been on the ward slightly longer than themselves. For example, Angie stresses the importance of paired activity in clinical practice:

"on the ward we all went in two's, it gave us all confidence to do the care. The students all work together here. We are well motivated and know what we are doing by now". [Transcribed audio taped data from classroom. Second year.]

The increased self confidence allowed the students access to more clinical skills and so they were able to do more and engage in legitimate peripheral activity. In turn, being able to do more was seen by the students as evidence that they were learning. Thus confidence is central to learning. By adopting the front of confidence, qualified staff acting as mentors would allow the

student to undertake the dressing, or give the care. For example one student comments:

> *"I do not like to be supervised too closely when undertaking basic nursing skills. I feel that the nursing staff on the wards tend to get a feel for what your capabilities are within a short space of time; generally, because I'm confident I'm left to get on with it and find that as time goes on and they get to know you more, you are given more difficult and more interesting things to do. My mentor knows that I have been carrying out basic skills for some time now and tries to spend time with me doing more advanced things." [Field notes from clinical practice. Second year. Mature student with previous health care experience. Site 3. M12.]*

The students clearly expressed that self confidence was crucial in clinical practice and increased self confidence was seen as evidence of learning. However, they acknowledged that *"no one can measure it…but I can feel it…I know I'm learning, my confidence is growing all the time" (Jess).* It is also interesting to note that the students made a direct link between increased confidence and learning, and assumed that what they were learning was inherently correct. Some comments which highlight the importance of increased self confidence to learning include:

> *"I am more confident in speaking to others; one to one, or in a group I have gained more knowledge and nursing skills as a result of my increased confidence." [Lisa. Third year.]*

> *"I am much more confident now and more aware of my abilities." [Paula. Third year.]*

Confidence was also important in terms of relationships with other disciplines. The findings imply that other disciplines make judgments about the students' ability based on their projected self confidence. For example, one student comments:

> *"I found that Doctors are more tolerant when you know a bit more, when you're a first year, some Doctors aren't willing; you don't get a say; but once you've been seen on a few wards and they know your face, they trust what you say more, they listen more to what you have to say. You might even do a ward round by yourself and receive instructions, they trust you more." [Field notes from clinical practice. Second year. Site 1, ward 1.IS2b.]*

One student implied that others (including patients) are able to recognize this confidence, as this data highlights:

"Medical students want to see what you're doing, they say 'let me just watch you do that again' or doing dressings and the patients will say 'Oh, let her do it, she knows what she's doing'…sometimes the patients prefer it when it's a student because they know you." [Field notes from clinical practice. Second year. Site 1, ward 1. IR4a.]

The students appeared to need to feel confident that they were progressing along parallel lines with other students. It was important to them to feel that they were learning the same things: Andy comments:

"Are people experiencing similar things to myself in practice or is it an individual experience…I want to ensure that what I'm doing is right." [Transcript from field notes.]

When he uses the phrase "I want to ensure that what I'm doing is right", what he means is that there is a need to know that what he is doing is the same as everyone else.

The data also demonstrates how students feel they have the theoretical knowledge but lack the confidence to proceed without checking with someone else first. The comment is from a student in the second year of the programme as she discusses how she learns:

"I find you often have the theoretical knowledge but lack the skill or confidence to apply it to the scenario in front of you and provide care for your patient…so you have to seek guidance or advice from some one rather than from a book. The guidance sometimes comes in the form of your mentor, a health care assistant or another student and there are times when one is more suitable and appropriate than the other." [Field notes from classroom. Second year. N1a.]

Discussion

It is thought that attitudes, skills and behaviours acquired within the clinical setting are more profound and lasting than those acquired within the University setting (Smith and Stephens 2001). Cope et al (2000) contend that students undergo a cognitive apprenticeship in clinical practice where the

qualified staff use strategies of modeling, coaching, scaffolding, articulation, reflection and exploration, in order to help students to learn. Knowledge is contextual as it arises from the placement. Cope et al (2000) and Taylor (2000) assert that clinical learning in particular is not linear but cyclical. Taylor suggests that not only is learning context or task specific, but it is also an ongoing process of sense making in which new items are incorporated into broad patterns and in which there is ongoing, normative and cultural shaping and re-shaping of what is learned (Taylor 2000).

Sense making could also take place through the use of internal speech. Vygotsky (1978) explains that during childhood when children find that they are unable to solve a problem for themselves, they turn to an adult and verbally describe the method that they cannot carry out alone. Later, as the child develops, this speech is turned inward; instead of appealing to the adult, the child appeals to herself and so language takes on an intrapersonal function. Gradually the child begins to guide her self in developing a method of behaviour; organizing their own behaviour according to social norms. Vygotsky terms this as the internalization of social speech. It is possible to apply Vygotsky's principles to the data from this research in order to explain how the students might be making use of this internal voice. When the students are saying that they think they already know the answer to their own problem, perhaps they are making use of the intrapersonal function of speech. Perhaps the thinking is going back over what they have seen or done before, but the student requires the confidence boost of verbalizing this speech to another before proceeding. The framing of the question also enables the student to use the language of the nurse. The use of language is a sign to the peer that the student is developing towards being a nurse. Vygotsky (1978) asserts "the acquisition of language can provide a paradigm for the entire problem of the relation between learning and development. Language arises initially as a means of communication between the child and the people in the environment; only subsequently, upon conversion to internal speech, does it come to organize the child's thought" (Vygotsky 1978. p89).

Demonstration and observation is an important aspect of professional learning, student nurses are expected to observe, rehearse and practice. However, the literature assumes that students will be observing the practice of qualified nurses, and will rehearse and practice under their guidance. This seems to be a reasonable notion, but previous work reveals that the concept of mentorship, from the students' perspective may have more to do with the provision of emotional support and socialisation than as a specific learning tool. However this may not necessarily detract from the value which students place upon mentors. A small scale study carried out in Wales by Andrews and Chilton (2000) suggests that a large proportion of the student nurses' learning takes place outside of the mentor/mentee domain and it is not solely the mentor who is responsible for the students' learning. Students learn from all they interact with and are influenced by the learning environment as a whole, rather than specific individuals. Neary (2000) concluded that Mentors also saw provision of educational support as secondary to psychological support. Interestingly, assessors saw themselves as giving educational support in the form of teaching, monitoring and assessing but not as working with students. Neary questions how the teaching took place if assessors did not work with students. Staff acting as supervisors within the study did not see themselves as teachers, role models or facilitators. Chapter Eight goes on to demonstrate how the students in the study often worked alone or under the guidance of unqualified staff.

The findings from this thesis highlight the role of peers who have more contextual knowledge. Not only are they able to pass on survival skills but also more experienced peers who have been on ward slightly longer are able to help their less experienced counterparts by structuring tasks such as undertaking a dressing; coaching them through the process and helping them to learn.

The findings also show that the students want to appear competent and confident in front of the patient. As Davis (1975) points out during the journey from lay to professional there are times when others expect the

student to play the part of the professional and assume the role before the student feels completely identified with it or competent to carry it out. This notion of wanting to appear competent is similar to that of assuming a front as described by Olesen and Whittaker (1968). Students adopt a front in order to fool the instructor and each other. For example, “after determining what the instructor wanted, the students tried to assume the appearance of the identity, which was not necessarily an integrated part of the self, although they expected the faculty to believe that it was” (Olesen and Whittaker 1968. p 173). What I am suggesting is that the students can also adopt a front of confidence in order to see themselves as nurses. Within the social culture of clinical practice the ability to undertake a dressing in a fluent and confident manner is seen as important. It is a performance skill which the students strive to learn. A point which is supported by Chesser-Smyth (2005) who suggests that increased confidence is linked to motivation and learning that is intrinsic to the socialization process in nursing. However, whilst Chesser-Smyth presents some interesting discussion on this point, no data is supplied to support this important element of student learning. This thesis begins to provide some detail as to how confidence and learning are linked.

According to Calman (2006) patients assume that technical competence of nurses is taken for granted. The research aimed to generate a grounded theory of patients’ construction of competence of nurses in a Scottish context. Twenty seven patients were interviewed in the hospital setting. The environment in which the interviews took place could be viewed as a weakness in the study since interviewing patients whilst they are still potentially in receipt of care may affect the answers they provide but this point is not considered by Calman. Patients in the study assumed that because the nurse had been employed that competence was inherent. There may be implications from the Scottish study in terms of the perceptions of patients towards the competence of student nurses. As Holland (1999) purports a “student nurse is not a nurse in practice, but through learning over a period of time is required to participate in nursing activities in order to be able to

undertake this future role" (p232). However, the findings from this research tentatively imply that patients are able to identify when students are confident and may also assume that this confidence is linked to competence. The students wanted to appear confident and saw this as evidence that they were learning. The data shows how the students sometimes felt that they had the knowledge but needed someone else to confirm their supposition before proceeding.

The dressing is significant for the student because it is seen as being a skill which they have not fully mastered. Therefore it could be said to lie within the zone of proximal development (Vygotsky 1978) because it is a higher level of potential development. The partner who is seen to already have the experience of doing the dressing, provides verbal coaching for the less experienced student. With repeated action the less experienced student gains in self confidence and begins to lead the practise. It is also interesting to note that the students made a direct link between increased confidence and learning, and assumed that what they were learning was inherently correct. Whilst my observations provide no evidence that what the students learned was wrong; I think it is interesting that they did not seem to question what they were learning. Indeed one student implies that to challenge the practice of another student in front of the patient would not be acceptable because this might arouse concerns in the patient about the students' ability.

The students in the study appear to be preoccupied with being able to perform clinical skills, such as dressings and passing naso-gastric tubes. The skills are passed on through generations of students in an oral tradition which relies heavily on Alexander's (2001) suggestion that students are developing a set of performance skills that enables them to imitate what they see happening in the workplace. Alexander asserts that childcare students adopted the practices of the qualified nurses in a largely uncritical way. Similarly, Taylor (1997) suggests that novices in particular, copy nurses with varying standards of practice, rather than solving problems for themselves. Taylor provides an account of the cognitive processes involved in carrying out nursing work. The

sample included fifteen undergraduate nursing degree students, who were viewed as novices and fifteen more experienced, qualified nurses. Taylor concludes that the novices merely wanted to perform skills in the same fluid manner as the qualified staff. Therefore, whilst not entirely new, the findings would seem to add weight to previous work. However, it is my interpretation that these oral traditions are being passed on through fellow students and not just from qualified staff as suggested in previous studies. I think this is exactly what Wenger (1998) is referring to when it is purported that newcomers become encultured into maintaining the status quo. Within Wengers' definition of the community of practice the members interact, do things together, negotiate new meanings and learn from each other; this is inherent within practice and is how practice evolves. Learning takes place almost by default. Wenger goes on to say that

> "communities of practice reproduce their membership in the same way that they came about in the first place. Those who are experienced share their competency with new generations through a version of the same process by which they develop" (p102).

However, I suggest that the students exist on the edge of the qualified nurses' community of practice and configure their own community in which practice is reproduced. Students teach other students, based on the same way in which they themselves learned. The historical continuity of practice is maintained.

As long ago as 1968, Olesen and Whittaker outlined the then new approach to nurse education within the United States by saying

> "Recently, however, diploma schools have distributed their emphasis between as mastering of the skills, as before, and an understanding of the theoretical reasoning behind the procedures. In contrast, the university school is ostensibly usually seen as stressing the theoretical bases, the *why* rather than the *how*" (Olesen and Whittaker 1968. p60).

It seems that despite the passing years mastering the skills is still seen as the epitome of nursing endeavour. Student peers pass on the *how* of nursing skills through demonstration. This is not a direct criticism of the students rather it is a reflection of the system in which they are placed in order to

learn. The students are well intentioned and are merely trying to resolve the conflict of learning and working.

Davis (1975) and Benner (1984) suggest that it is beginning students who are preoccupied with technical skills and procedures. Davis reminds us however that "although not rejected, as such, by the schools' ideology, it never the less receives a very different contextual emphasis. Rather than treating technical proficiency as the essence of the students' performance, the school places vastly more emphasis on learning 'the principles of nursing care' upon which such skills are said to be based" (Davis 1975. p121). Therefore the data reveals that these students are still preoccupied with technical proficiency, even in the final year of the programme. Being technically proficient makes them appear confident and competent and is not limited to those who are beginning their nurse education. Students have difficulty in transferring principles of care learned in one clinical context to other areas, including transferring skills learned in the classroom to the practice setting.

In a qualitative study Snelgrove (2004) administered a forty two item questionnaire to three hundred students during the common foundation period of the course. The questionnaire related to students approaches to learning. However the study is presumably limited to academic learning in isolation. There is a lack of explanation concerning whether the approaches demonstrated by the students apply to learning per se or are specific to the academic setting. The findings from this thesis would suggest that within clinical practice, surface approaches dominate. Snelgrove (2004) asserts that students are often motivated just to get through the course and adopt a surface approach to learning because it what they perceive as the demands of the course. The surface approach is certainly evident in the practice area; there is an emphasis on the students being able to contribute to the nursing work with the performance of clinical skills seen as vitally important. The students then find it hard to adapt and use a different approach within the academic setting, particularly when there are few opportunities to demonstrate understanding and knowledge within the clinical area. Higher education favours a deeper

approach to learning, but within this research nursing students seem to struggle to achieve this deeper understanding.

A further interpretation is that students do not perceive the skills associated with academic learning as important; being irrelevant to their future practice as a nurse. Whereas the skills learned in clinical practice are seen as immediately relevant and 'useable'; particularly, as Holland (2002) argues student nurses are making a significant contribution to patient care and service delivery and she goes on to suggest that students are central to patient well-being. However, it is less clear for the students how their academic learning can be transferred and used with the same 'obviousness' as psychomotor clinical skills. The academic element of learning to be a nurse is seen as a necessary encumbrance which the students have to endure. The skills of essay writing, how to access the journals in the library, where to find certain information is learned through trial and error or informal conversations with other students. As much of this learning occurred outside the classroom, I was unable to observe exactly what took place as it was beyond the scope of the inquiry and would involve being with students outside my usual allotted times, or the research areas to which the students had consented. This kind of academic learning across cohorts requires further investigation to unearth the mechanisms involved and the value placed on such learning by the students.

Spouse (2001) contends that without support from qualified staff acting as mentors, students have difficulty in refining their psychomotor skills. It is suggested that novice professionals arrive at their clinical placement equipped with relevant theoretical knowledge but have not seen it applied to practice (Spouse 2001a). The findings from sub theme 1 (confirming what you already know) concur with Spouse's view as the students clearly perceive they possess the knowledge but lack the confidence to proceed. She argues that being coached through the work by an experienced practitioner who shares their professional craft knowledge is crucial. Effective

supervision allows students to appreciate the significance of what they are doing and as a result they learn far more than just the technical aspects of care, although she acknowledges that supervision and subsequent independent practice should be educationally focused. However, as Andrews and Roberts (2003) point out, such learning depends on the ability of whoever is doing the teaching to ask the right questions. The findings in relation to the peer teaching and learning in clinical practice demonstrates how the students use each other to refine their psychomotor skills, with the emphasis being on the performance of the skill as an end in itself. The sharing of craft knowledge between students is less evident in the findings and it could be argued that this role should be the domain of the qualified staff, however, unless students work alongside the qualified staff it is difficult to see how such knowledge can be transmitted.

Within clinical practice the students seem to view each other as fellow learners who collaborate in order to learn. They appreciate that each student will have individual and unique experiences but importantly, the students do not perceive different experiences as being commensurate with hierarchy. Rather the students help each other by assuming what Forman and Cazden (1998) refer to as separate but complementary social roles. One individual adopts the role of observer and guide and provides assistance by way of proleptic instruction. The roles are swapped depending on the task at hand and who has the prior experience. The amount of time served on the programme was of little importance to the students, if during your first placement you had seen a patient with a naso-gastric tube; you were assumed to be experienced in that specific area of care and therefore had authority. The idea that the students would show each other what they knew was taken for granted and reciprocal in nature.

Nolan (1998) demonstrates the importance of confidence to clinical learning in a study of six student nurses in Australia. The suggestion is that as problems are placed within context, critical thinking can be developed. As the

students became accepted by the qualified staff into the community of practice they sought an increase in independence and wanted to be more self directed in their work. The more the students in Nolan's study participated in patient care, the more confident they became. However, it could be argued that repeated practice alone may lead to increased confidence. Nolan makes no comment regarding the quality of the students' practice. Olesen and Whittaker (1968) refer to a concept of studentmanship said to intricately involve expectations and definitions, with a front encouraged by skilled execution of a clinical practise. Each successive performance involved fewer painful deliberations, and embarrassing blunderings. "Studentmanship requires playing for an audience by processes of divining appropriateness, of choosing alternative modes of projecting and finally exerting the self (Olesen and Whittaker 1968. p183). Spouse (2001b) also makes links between confidence and ability to provide holistic nursing care. Unlike the students in this study, Spouse studied undergraduate student nurses on a four year degree programme. The academic level at which the students are studying may be a factor concerning how student nurses learn. However, it seems that confidence is an important element to clinical learning regardless of the programme (and therefore level) of education, a notion which requires further research.

Similarly, Davis (1975) asserts that during role simulation students will fashion performances before instructors, patients, staff nurses and peers which are in accord with the doctrinal practices of the school of nursing. Through repeated performance Davis suggests that the initial incongruity which the students feel (guilt, hypocrisy and role illegitimacy) diminishes. Initially the student is said to be like an actor when a "lack of conviction and quality of inauthenticity felt about his performance, will somehow communicate itself to the audience and 'give the show away'. In other words, will the audience dismiss his performance as 'mere front' or 'show' and accordingly view him as inept and untrustworthy?" (Davis 1975. p126). Perhaps in the example provided by Angie, she uses the role simulation to

convince the patient that the students are doing the right thing. To challenge the practice of a fellow student in front of the patient would demonstrate a lack of conviction and may therefore compromise her relationship with both the fellow student and more importantly, the patient. Davis goes on to say that over time the students learn that despite their own misgivings, others can and do affirm the students' trustworthiness, competence and legitimacy. In short, the student assumes the status which his performances claim him to be (Davis 1975).

Summary and links to fore understandings

This Chapter highlights four important elements within the process of peer learning in clinical practice. Students looked to their peers to support their own predetermined ideas; feeling that they already possessed the knowledge but wanted mere confirmation that they were doing the right thing. The learners used the community of students to confirm their own knowledge, lacking the self confidence to proceed alone. Tentative theories were shared and made the students feel supported when positive responses ensued. However, questions were framed in such a way that the students elicited the response they were looking for. The data shows no evidence that students challenged each others practice or ideas about practice. Before conducting the research I had considered that dialogue was an important mechanism through which students would learn from each other in clinical practice. Whilst the students use questions to support their own tentative theories, I did not observe the kind of detailed, discussion and challenge to practice which I anticipated. The dialogue was superficial, observed practice is assumed to be correct and students observe each other perhaps far more than previously thought.

Students become teachers early on in the programme and perceive the teaching of other students as inevitable and reciprocal. In particular clinical skills such as undertaking a dressing appear to be important for the student to master. There is evidence that students use scaffolding and proleptic

instruction to verbally guide each other through the legitimate peripheral activity. Previously it has been considered that it is qualified staff that help students in this way. However, the findings here suggest that peers also play an important role in teaching clinical skills. Students in this study had a need to appear confident in their clinical actions and would sometimes create a front of appearing to be confident for the benefit of the patients, qualified staff and fellow students. Appearing confident generates access to more clinical skills. Students reproduce what they are shown and can learn from anyone from within the community of students who is perceived to have previous exposure to the skill. Length of time on the programme in terms of seniority appears to be unimportant. Indeed the findings suggest that students rely on each others contextual knowledge and target those who appear to know the ropes, having been on a particular placement slightly longer than themselves. This highlights the importance of contextual knowledge and reinforces the need for friendships among the community of students.

Confidence is particularly important to these students and increased self confidence is seen as evidence of learning. Furthermore, the students assert that this kind of evidence of learning can only be felt by the student themselves, and is not amenable to measurement. This is an interesting point when it seems that all aspects of the students' progress must be amenable to measurement in terms of learning outcomes, practice based competencies and written assignments. It is now my fore understanding that students use verbal coaching the form of scaffolding and proleptic instruction to push forward the development of each others clinical skills. The skill of undertaking a dressing is initially perceived as beyond their actual development, and therefore lies within the zone of proximal development (Vygotsky 1978). Students use other, more experienced peers to help them to achieve mastery initially through observation, progressing on to using their own speech to guide their own practise. The less experienced learner then begins to lead the practise over repeated exposure to the skill. Eventually the performance is developed and fluent. However, the skill itself is seen as the end product, providing the

skill is performed with fluency of action the practice is assumed to be confident and therefore competent. Competency is assumed. Practice is not questioned.

Chapter Eight

Peer Learning and the role of student nurses in Professional Socialisation

Introduction

Whilst it was clear that the students were teaching and learning psychomotor skills in clinical practice after twelve months of data collection it became clear that this was only one element to the learning that took place. The second diagram in Chapter Four (Page 143) highlights how the theme started to become apparent as I began to notice that the students were helping each other to fit in. By the end of the data collection, the third diagram from Chapter Four (Page 145) demonstrates how the initial ideas had become more refined as the data highlighted four areas in particular where learners help fellow peers to become socialised into the profession of nursing, namely survival skills (**sub theme 1**), finding the nursing role, (**sub theme 2**) learning about the emotions of nursing (**sub theme 3**) and role modeling (**sub theme 4**). Together the sub themes demonstrate that students play an important and valued role in the professional socialisation of their peers. Previous studies have outlined the importance of qualified nurses in helping students to become socialised into the profession; however, it appears that fellow students are also influential in this role. The findings add to what is already known about professional socialisation in nursing and demonstrate both the importance of peers in this role and the mechanisms used by the students.

Sub theme 1: Survival skills

Professional socialisation is concerned with acquiring the values, attitudes, knowledge and skills of a professional group. Many of the hints and tips to which Gray (1997) alludes are unwritten rules, invisible and silent as Liaschenko (1998) puts it. Here the data sheds light onto some of the unwritten, silent rules which the students pass on to each other; in terms of

learning to be a nurse it transpired that these unwritten rules are just as important to know.

During the ethnographic conversation with the students we began discussing how the students were involved in teaching. When this conversation took place they were at the beginning of their second year on the course. The following is a verbatim transcript from the field notes which demonstrates the issue of survival skills:

> *Rachel: "Yes, it was doing dressings, tubigrips and stuff, they would just want to watch you".*
>
> *Sally: "I don't think it's just technical things; it's not like that, it's just survival skills; it's things I could cope with…you know…on a ward".*
>
> Again, I wanted to understand more about the exact nature of what they were teaching so I asked: *"Can you tell me more about these survival skills?"*
>
> *Sally: "Just like…I don't know how to describe it…you go in, in your first year, and you haven't got a clue what to do and as you gradually go on; you know that you don't start a conversation in the middle of report and things like that".*
>
> *"So is it about unwritten rules that you otherwise wouldn't learn?"*
>
> *Sally: "You might learn them but only from making mistakes; being pulled up or called about them". [Transcript from audio taped classroom data. Second year.]*

Sally finds it hard to identify what the survival skills are. This highlights the problem with which the students are faced. The rules are so subtle and obvious to those who belong to the community of practice that there is an expectation that students will somehow just know what is expected. Sally demonstrates the sometimes painful consequences of getting it wrong. Olesen and Whittaker (1968) point out that studying professional socialisation often "directs attention to commonplace matters…matters that are often defined as unimportant, but which are of greater significance than was once thought" (p4). Starting a conversation in report might seem like a fairly unimportant

thing in the great scheme of things, but clearly Sally felt that this was a significant thing which she wished someone had told her.

Survival skills were also evident during clinical observation. I saw Sally approach a student who was new to the ward, Sally told the student to ask the Staff Nurse if she could have a break. When I asked Sally why she did this, she told me that she realised from her own experiences that if students don't ask for a break; they often get forgotten about and so may not get one. Sally passed on this survival skill:

> *"Sally to first year student: 'It's nearly eleven o'clock so go and ask Staff Nurse if you can go for a break.'*
> *DR: 'Why did you tell her to ask for a break?'*
> *Sally: 'In your first year, I think you would never ask if you could go for a break, ever, 'cos you would just get told off; but in the second year you realize that sometimes, if you don't ask you're not going to get one. If you don't ask, she's not going to say." [Site 1 ward 1. Field notes.]*

Interestingly, when I observed Sally in her third and final year in clinical practice as a student, she did not pass on any survival skills to her fellow student. It later transpired that the two of them "didn't get on", which serves to reinforce the importance of friendship in fostering learning. (See Field notes for Ward 1, site 1.)

Students also used their own past experiences to draw on when telling fellow learners about survival skills. For example, when I observed Helen in her third year she used her previous experiences of witnessing a cardiac resuscitation with a student who was new to the ward and in her first year:

> *"Helen to 1st year student: 'I know that this is something you will worry about, because I did when I was a first year, so let me just show you; this is where the crash trolley lives, when it's quiet you should come over and make sure you know how it all works; I can go through it with you if you're not sure…Vomit bowls live in here (she points towards a store cupboard) and the tissues as well."*

Helen told me that she always tells fellow students to make sure they know where the crash trolley is (Crash trolley is a term used by nurses to refer to all the equipment that is used during a cardiac arrest) and vomit bowls; and to

know how it all fits together. Not only is Helen using her past experiences to inform the new student about what she should know, Helen is using the language of nurses by referring to the term 'crash trolley'. Helen is in her final year here and is already sounding like a qualified nurse. She goes on to tell me more about what she feels is important for the first year students to know:

"I would give them (the first years) a hand to transfer patients, show them how to transfer a patient on their own so they don't have to keep coming back to the nurse's station trying to find out how they should do it".

Question to Helen: *"That seems like something that's really straightforward, fundamental for a first year to know; how did you know to tell her that?"*

Helen: " Because I think having a list of all your patients that you're working with; I just find it really important to know where you're up to with them, and you can always refer to your list".

Question to Helen: *"OK, so did someone tell you about having a list?".*

Helen: "A staff nurse gave me a piece of paper and I didn't know what to do with it. I just scribbled the weight down, I didn't know any abbreviations or anything; so now I just try to help them, with abbreviations I will put something in a box, like this (Helen shows me her list with some writing on it, around some of the words she has drawn a box) if I don't understand and I'll go and find out what it means and tell that to the student. I put a line under there (She points again to the list, to words under which she has drawn a line) because I know what that is and I can explain that to the student now". [Transcript from clinical practice data. Third year. Site 4 , ward 1.]

Helen's example clearly demonstrates peer learning in action, she is telling the fellow students about aspects of nursing life which she feels are important for the student to know. It is interesting that Helen seems to infer that *the student* is somehow different to herself; that she has already assumed the role of the qualified nurse. The emphasis is still on getting the work done. Again, Helen uses the language of the qualified staff by referring to the transferring of patients. This is the phrase used to imply helping people from bed to chair, from chair to toilet and so on). Telling the student about how to transfer

patients alone helps the student to be more effective in contributing to the work of the ward and promotes the concept of the learner as worker. Olesen and Whittaker (1968) illustrate this point well when they say "the school naturally regarded students as learners, whereas some hospital staff thought of them as cheap labor. The instructors thought of the students on the wards as neophytes seeking experience, in contrast to some staff who found the students an extra burden in an already crowded and hectic work situation" (p141). Students here, nearly forty years later are still under great pressure to contribute to the work of the ward first and are aware that their role as learners is often secondary. There are also clear consequences when students object to being used as pairs of hands. This excerpt form the field notes illustrates this point:

> *"Students have to be grafters…they'll say 'I like this student, she's fantastic, such a grafter', I know of one student who refused, and said, 'I'm not an auxiliary', they all hated her". [Transcript from clinical practice data. Third year. Site 3. IS11a.]*

Sub theme 2: Fitting into the profession and finding the nursing role

Whilst observing in clinical practice using mobile positioning I made field notes concerning the movements of the students, in particular noting the activities they were undertaking and who they were working with or had discussions with. The following extracts from five of the wards where observations took place show the nursing role as experienced by the students from the study who were placed there. The field notes are from Site 1 wards 1 and 2, (both medical wards) Site 2 wards 1 and 3 (ward 1 is a High dependency unit, ward 3 is a surgical ward for vascular surgery) and Site 4 ward 1 (a medical ward).

At Site 1 wards 1 and 2 the students worked largely alone, having only occasional contact with their mentors. The students (together with the

unqualified staff) were the ones who cared for the patients' personal needs by undertaking washing, dressing and feeding. Interestingly, on both these wards (at the same site) the emphasis was on getting the work done; although as far as I was concerned learning opportunities on the early shift were plentiful; there appeared to be a complete absence of teaching and learning. The ward appeared to operate a system whereby all the patients in a bay were washed and dressed before the staff moved on to the next bay of patients where the same process was repeated. Whilst the work was being carried out the students did not ask any questions of the qualified staff. Opportunities for the students to learn from the qualified staff were minimal. The students contributed hugely to the work of the ward, following and replicating the actions of both the qualified and unqualified staff.

At site 1 ward 1 both the students were observed working in isolation from their mentor however both students were comfortable with this situation. They were confident in what they were doing. They implied that working alongside a mentor was unnecessary, because they were confident and therefore competent:

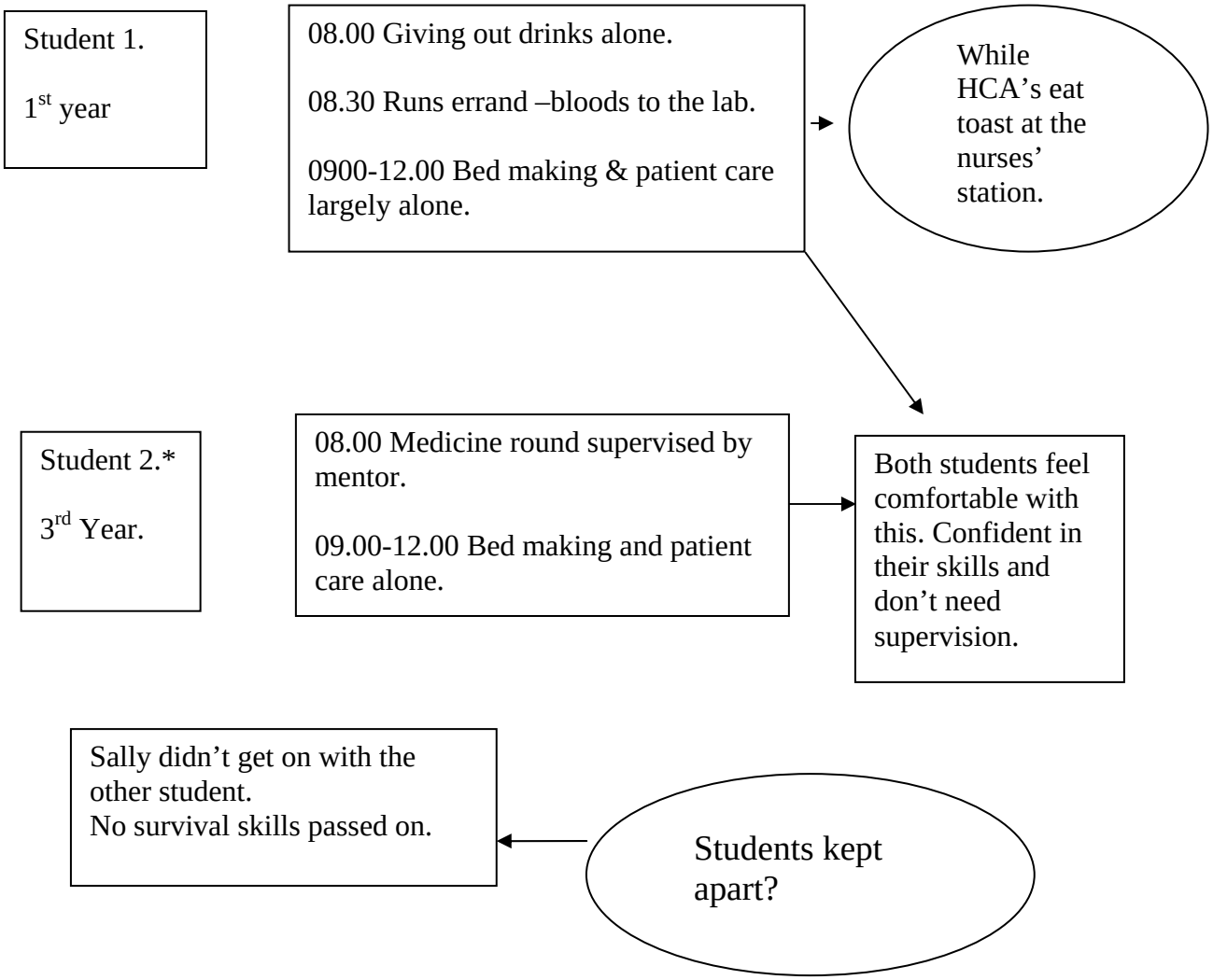
> *"Question to Sally (student 2): 'You seem to be working a lot by yourself?' Sally: 'Yes, it's fine, well I've been on here for a while now, I'm a second year and I know what I'm doing. The early's are just about getting everyone up and I'm fine doing that by myself." [Field notes Site 1 ward 1 early shift.]*

Supervision therefore, would have undermined the confidence in the students. Site 1 ward 1 was perceived by the students as a good ward because allowances were made for the students to leave the shift early and collect their children from school. The student perception of ward 1 (Site 1) as a good ward did not match my perceptions of what a 'good ward' should look like.

FIELD NOTES

Site 1 Ward 1. Early shift. (Same layout as Site 1 ward 2)

Student Roles?



Students appear to make sacrifices. A good ward is one where flexibility is allowed to cater for childcare arrangements, even if learning opportunities are ignored. Students will run errands (bloods to the lab) & see this as a good ward because Sister lets them go early to collect their children from school.

Site 1. Ward 2.
27 Beds – Medical ward
Early shift.

Staff: Qualified Nurses x 4
Health care assistants x 2
Students x 3

Std 1 = 1st year degree student
Std 2 = 2nd year diploma student
Std 3 = Lisa 3rd year student.

Layout:

Bay 1 6 beds	Bay 2 6 beds	Bay 3 6 beds	Side room 1	SR 2	SR 3

Bay 4
6 beds

Bathroom

Nurses station

Bays 1 & 4 are seen as one 'end' of the ward.
Bays 2, 3 & side rooms are the 'other end' each with its' own team of staff.

→ 2 staff nurses
2 HCA's
Std 2

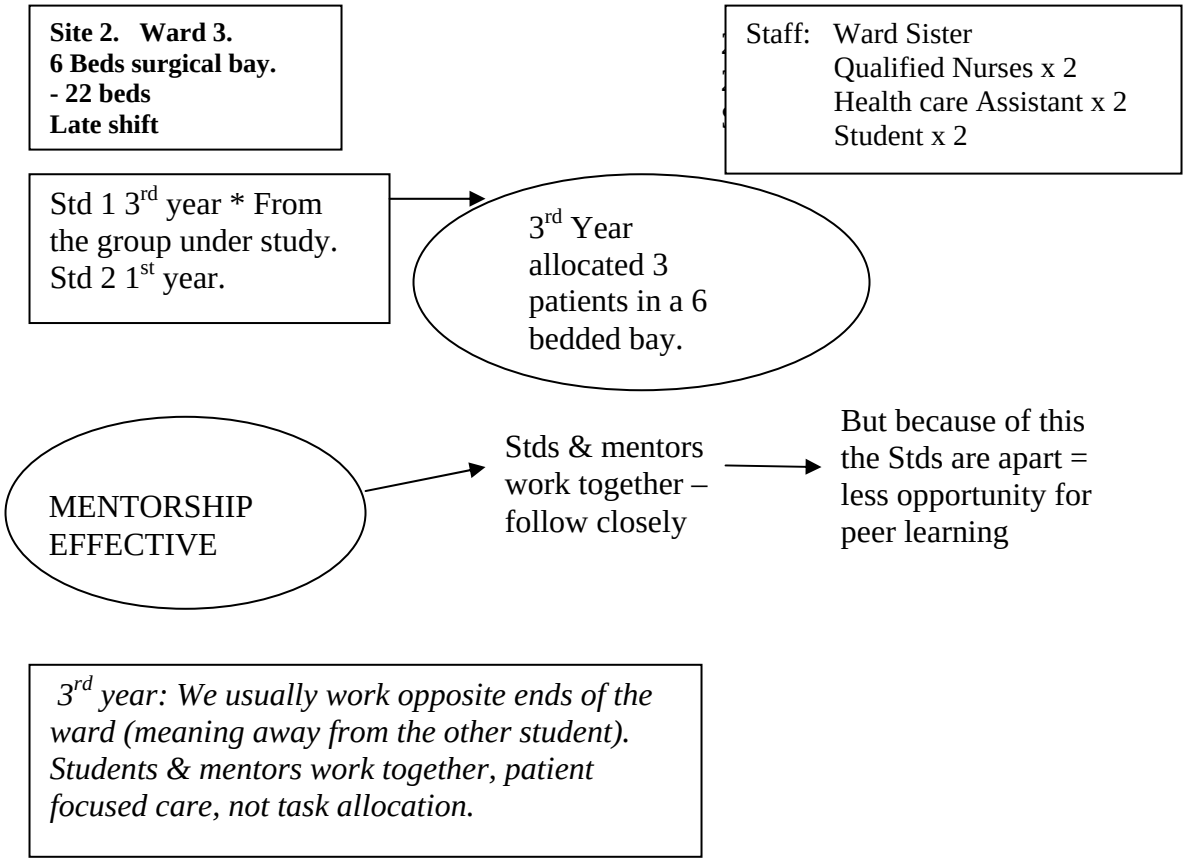
→ 2 Staff Nurses (one is ward coordinator = no patient care)
Std 1 &3

Std 2: is working with HCA, bed making & washing & dressing patients, but 2 staff nurses are working the same end of the ward. WHY? Absence of teaching & learning/ MENTORSHIP
Std 3: Works alone, washing & dressing. Catheterises a woman. The ward coordinator is the mentor for this student but no contact all shift. NO MENTORSHIP.
Std 1: Does a dressing supervised by a staff nurse; after the washing & dressing has finished. PARTIAL MENTORSHIP.

→ *"Mentor not on duty today, this always happens"*

→ Later the student tells me this was for my benefit & not normal

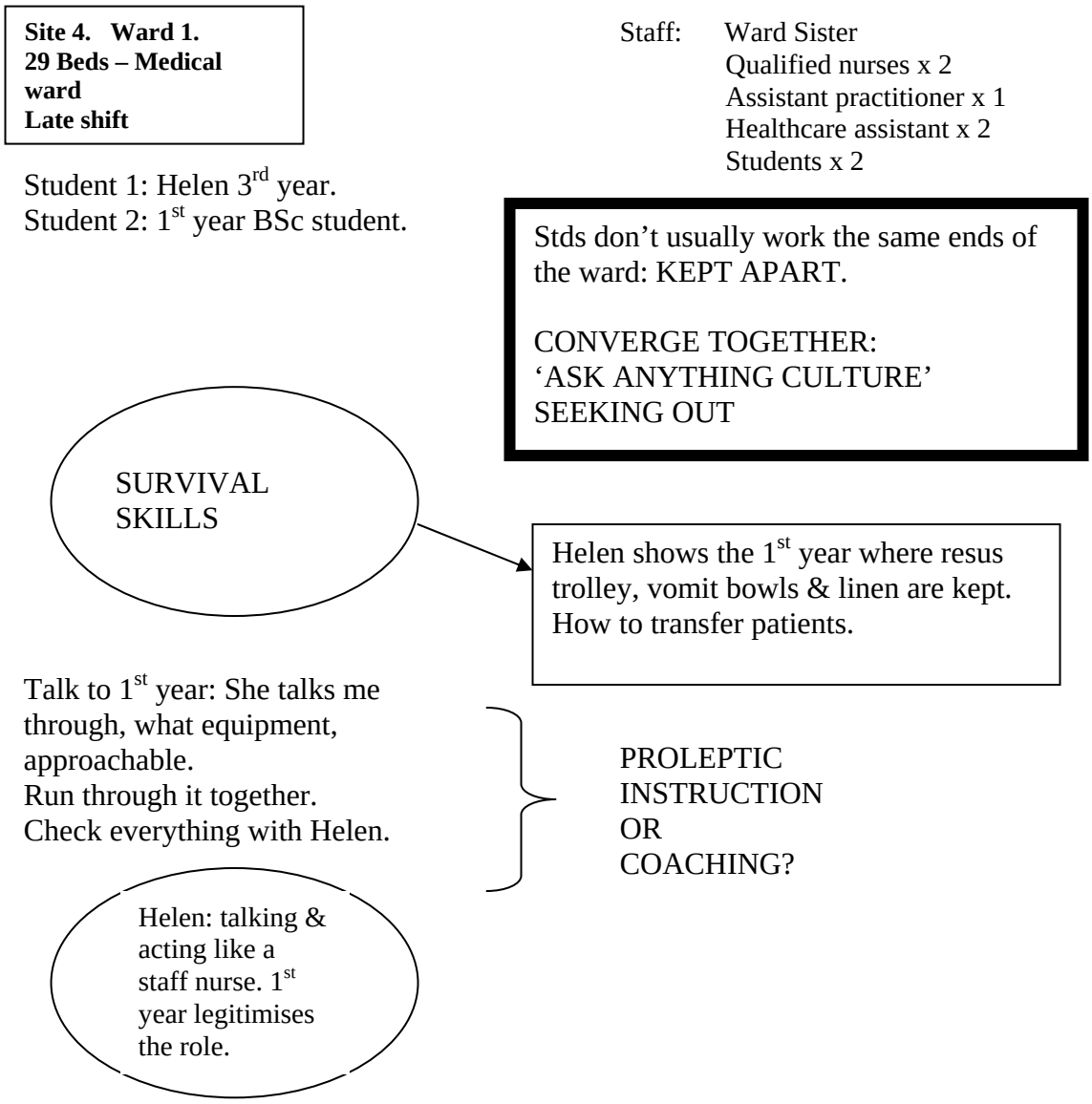
Each bay of patients washed & dressed, all the team in one bay (task allocation) & then they all move to the next bay. Emphasis on getting the work done.



At site 2 ward 3 the students worked closely with their mentors staying in close proximity to each other. The third year student was allocated patients for the shift but the mentor also worked in the same bay and so was close at hand to provide guidance should it be required. The student was encouraged to ask questions and in turn the mentor questioned the student throughout the shift. The two students on this placement were kept apart as the mentorship was effective and there appeared to be less reliance on task allocation. Interestingly, the two students took their breaks away from the ward at the same time: converged together.

At site 4 ward 1 the students also tended to work opposite ends of the ward along with their qualified nurse mentor, however, here the students converged together throughout the shift with the third year student taking on

the role of the staff nurse. Helen passed on survival skills based on her own experiences as a first year. The first year student legitimized her role.



The data demonstrates that where students work with their mentors as they did at Site 2 ward 3 and to a lesser extent at Site 4 ward 1, the students are kept apart. Indeed at Site 2 ward 3, the students worked closely with their mentors and there appeared to be little opportunity for peer learning because the students were kept apart by the effective mentoring. At site 2 ward 3, the students could be observed seeking each other out throughout the period of observation. However, at Site 1 ward 2 the students tended to work largely alone or with unqualified staff. Together the students and the health care assistants engage in washing and dressing the patients. What was particularly interesting about Site 1 ward 2 was that whilst I observed some qualified staff engaging in this kind of patient care, they did so together whilst a student worked along side a health care assistant. When I approached the student to ask why she was not working with a qualified nurse, she told me that her mentor was not on duty that day; so had been allocated to work with an HCA instead. She told me that this was a common occurrence:

> *"DR: 'Why are you working with a Health care Assistant today?'*
> *Student: 'My mentor isn't on duty today, so I've been asked to work with the HCA. This always happens, even when there are plenty of qualified staff around, it's just the way it is.' [Field notes. Site 1 ward 2.]*

The situation is similar to that explained by Spouse (2001a) where she describes a staff nurse who does not recognise the need to communicate her craft knowledge to the student. The student is deprived of the very information she has come to the clinical area to learn and so, Spouse asserts a cycle of deprivation is generated. What is interesting from the findings form this thesis is that the students themselves do not appear to recognise or perceive that they may be within such a cycle.

The students in this study demonstrate the difficulties associated with trying to fit in and the data highlights the conflicts with which the students wrestled. The learners relied heavily on the community of students to establish the reality of the nursing role according to the expectations of that particular

ward. Here the notion of being someone who knows the ropes and has been on the ward slightly longer is important as it was these students who were targeted for help. For example, one student comments:

"You find other students because that helps you get into the whole nursing team on the ward". [Field notes from clinical practice. Third year. Site 3.]

Some students found it hard to identify the nursing role. Largely as a result of not always working along side qualified nurses, the students would observe the work of unqualified health care workers (sometimes referred to as H.C.A's, or auxiliaries) and would compare what they observed to the work that they themselves were engaged in. One student states:

"It's really difficult, there's no role for you as a student, so you follow the auxiliaries. You don't know what is auxiliary and what is nursing…I keep thinking and judging myself thinking, 'am I doing auxiliary or am I doing nursing?' it's very hard to separate them". [Field notes from clinical practice. Site 2 ward 3. Third year.E11c]

It seemed that as the students progressed throughout their education they became concerned about the nature of nursing as they were practicing it. The students used each other to ensure that the clinical work was complete, tending to work with each other and unqualified staff. The students perceived little difference between what they were doing and what the unqualified staff were doing. They saw qualified staff doing different work, such as dressings, administering medications and paperwork; furthermore, my observations confirm that this is largely the case; a point supported by Ousey and Johnson (2006). Melia (1984) describes this as "students spending three years doing the work, in order to gain staff nurse status and, ipso facto, supervise the work". In other words, the students must have engaged in the work as a student, even though the skill may not be carried out as a qualified nurse, but realise that it is the qualified nurses who direct the work. The following comment describes the conflict of this situation well:

"I think it's quite difficult because you want to think right, I'm the student nurse, I need to do bed baths and stuff, but I want to work with the staff nurse; but unless I know how to do this stuff, when I'm qualified, how can

I say 'Go and do'?" [Transcript from clinical practice data. Second year. Site 4 ward 1 .IN11.]

My interpretation here is that the students acknowledge the need for the work to be done (the bed bath) but see this as a skill which is innate and does not contribute towards learning. The work of bed baths is not valued as a nursing skill because it is largely carried out by non nurses, therefore doing the work of bed bathing as a student is seen as a right of passage. Bed bathing may not be practiced once qualified but had to be mastered none the less as a student in order to delegate once qualified. Thus the students often worked together in order to get the work done. In so doing they contributed to the legitimate work of the ward and saw this as a necessary part of their development towards being qualified nurses. Student nurses hold different values for different tasks, perceiving some nursing activities as being of little value once qualified. This finding is supported in the work of Holland (1999) who highlights how students perceive a hierarchy of care to exist which has the impact of blurring the boundaries between professional nursing and skilled health care work.

Sub theme 3: Learning about the emotions of nursing.

The students clearly support each other in clinical practice and together with sharing survival skills the findings demonstrate how the students also use each other to learn about the emotions of nursing. Holland (2002) points out that student nurses play an underestimated role as care givers, one which belies their supernumerary status and she asserts that the students may not be the novices that their position on the programme might initially suggest. Two data sets are presented to demonstrate the emotional conflict which the students face. The two stories from clinical practice illustrate the nature of the support gained from peers and how the students learn about the emotions of nursing and share these with each other. The following statement was from a mature student at the end of her second placement (within the first six months

of the programme) and she describes her first morning on a male medical ward:

"There were two of us starting the placement that day, both of us new to nursing and terrified. We stood at the end of this Nightingale ward and could see the patients; all old men either sitting in bed or in a chair at the bedside. We were waiting for the Sister to finish report and to come and give us a tour of the ward and show us where everything was. We stood and looked down the ward. We looked at each other, both knowing that one man was at the far end of the ward, sitting up in bed. I could tell he was dead, and so could the other student…I just knew. He looked like he had been there for some time. As Sister came out of report she began to walk down the ward with us. As we drew closer to the man, I asked her if he was alright. She closed the curtains round the bed and came back out and told us that the man was dead." [Audio taped transcript from clinical practice. S.]

The two students were subsequently asked to perform the last offices for the man and together muddled through the process. I asked the student about the impact of the incident.

"I immediately thought that the ward staff were uncaring, all of them; because how could they not notice that a man had died? Did he die alone? I thought to myself, 'this is going to be an awful placement, if they don't care about the patients, they won't care about students either'. [Audio taped transcript from clinical practice. S.]

The second incident is from another mature student at the same point in the programme. She was telling the group about her experiences of caring for a patient on a female medical ward:

"I looked after a lady who was very old and frail; she was very thin and curled up in a fetal position in the bed. I had been told by all the staff that this lady was unable to communicate. This lady was one of my patients, I looked after her every time I was on duty, washing her, turning her…doing everything. This lady always had a student to look after her. I can manage her by myself but ask the health care assistant to help me with her back. I'm sure that she is able to recognise me, I think her facial expression changes when she sees me. On my last morning on the placement, while I'm washing her; I tell her that this is my last day and that I will be sad not to be able to come and care for her again. When I washed her hand, she squeezed me tight; she had never done that before; but it was like wow…you can communicate…you could communicate all along, but no one thought to notice. How can I leave now? Who is going to care for this

lady now when I'm off on my next placement? The student was visibly upset. " [Audio taped transcript from class. S1.]

The story provoked an emotional response from the group and from myself. Sadness was observed amongst the group but it appeared to me that there was also a sense that as students they were often in situations where they felt responsible for providing care for patients and were unsure why the qualified staff did not share their emotional response to such situations.

Smith and Gray (2001) suggest that this kind of work is emotional labour and go on to say that brushing over this kind of work as an essential skill infers that the skill does not require any development because it is so basic. The stories here show how the students are an unacknowledged source in caring for patients and also show how they work largely alone in clinical practice. The student in the second incident has made what Smith and Gray (2001) refer to as 'an invisible bond' with the patient. However, in this case the bond did not make the patient contact easier but rather made it more difficult for the student to leave the placement. Both the students demonstrate the impact of what they perceive to be uncaring attitudes by qualified staff. I asked the students if they had spoken to anyone about the incidents and both said that there "simply wasn't anyone to share it with apart from other students." However, sharing their stories helped the students as an end in itself. Other students offered similar tales in order to help the group to come to terms with the emotions of nursing. No solutions to these situations or how to manage the emotions were offered, but the students valued the sharing of the stories none the less. The concept of emotional labour applied to student nurses was the focus of Pam Smith's seminal work for her PhD thesis (1992). This important work demonstrated how students learned to labour emotionally from their influential role models who shaped the learning culture. Smith (1992) suggests that students learn to labour emotionally by suppressing their own feelings, she goes on to say that classroom sessions whilst giving students an opportunity to describe emotion work gave them little knowledge

or guidance on how to manage their feelings. However, there may be an implicit benefit in hearing the stories which expose the students to a variety of coping mechanisms and therefore, indirectly may help the students to manage their feelings.

This notion of sharing stories is the focus of Spouse's study (2003) in which she suggests that students use seminar groups to compare their own feelings with those of their peers. This is said to be important because the stories (and experiences) carry a reality which is engaging for students; enabling them to develop concepts of themselves in different roles. The story teller develops new insights based on the sense making activities of her peers and the group benefits by developing a wider understanding (Spouse 2003). It would appear that the sharing of stories; particularly those which could be said to be of the emotional labour type do in fact help the students as an end in itself. The group members were observed listening intently to the stories and they appeared to have a profound impact, as many students displayed the same emotions as the story teller. Eraut (2000) argues that knowledge is expanded, modified or transformed according to the magnitude of the situation. What I am suggesting is that that some of the stories which the students share are of a similar magnitude to the practice encounters that they themselves experience and because of this they are able to learn vicariously through each other's experiences.

It is also interesting that the students appear to be able to discuss practice in a manner which belies their so called novice status. However, both the incidents are related by mature students and therefore maturity may have an impact on how students learn; a point which requires further investigation.

Sub theme 4: Peers as role models

Many students spoke of being "*taken under the wing*" of a third year who acted as guides for the less experienced students. Acting as a guide means that the third year imparts the kind of unwritten rules which Helen's earlier examples highlight. The senior student helps the less experienced student so

that their passage through the ward is unhindered. The feeling of community amongst the students means that a protective feel is extended towards one another, the students want one another to succeed and do well on the placement. The more experienced third year students guide the less experienced students through the pitfalls of that particular ward or placement and provide some of the context specific information. They recognise what it was like to be a beginning student and have genuine empathy for the newcomers. The following example is typical of what the students told me:

> *"I will never forget the first time we met. She was so very friendly, helpful and encouraging and to be honest, I was totally in awe of her. I think on reflection it was her total positive attitude to the ward, qualified staff, students and most importantly to the patients and relatives that impressed me most. I remember thinking at the time how much I hoped I would be like her when I got to my third year. She was always prepared to share her knowledge with me; this applied to questions I had about the course as well as things that were related to the ward. Nothing was ever too much trouble and it really helped my confidence and self esteem". [Transcript form clinical practice data. Third year student. Site 3. D.]*

Similarly less experienced learners also used their conversations with the third year students to help to prepare themselves for when they would be in their final year. Helen commented that the first year degree student on her ward would ask her what it was like to be a third year: *"She would say to me, is it really scary being a third year, are you ready to qualify?"*. I asked Helen about what she told the other student in her reply; to which Helen said:

> *"I thought the first year was more scary, because I thought, I'm never gonna remember all this, but I'm getting there now. I'm feeling like I know; not everything, but enough to get by. Even though it is still scary and when I'm qualified on my first day I'll probably go to pieces." [Transcript from clinical practice data. Third year. Site 4 ward 1.]*

Another student also highlights the importance of preparing for the final year:

> *"When I was on my second placement I would ask the third year about what I could expect from the rest of the course; how it felt to be at the end and nearly qualified". [Transcript from classroom data. IS.]*

Discussion

A number of previous studies concerning professional socialisation of student nurses have provided tentative suggestions that it is not only qualified nurses who help students into the profession. Melia's (1987) seminal work reveals that students worked together to get the work done. This is what I have described earlier as providing mutual practical help. Melia also suggests that students are involved in teaching each other and she touches on the possibility that senior students may act as role models for more junior students. This research highlights role modeling as an important aspect of professional socialisation amongst student nurses. In particular the students use the third years to ask about what it will be like as a third year, in order to prepare themselves for this future role.

The role of qualified staff acting as role models for students is well documented. However, it seems that fellow students can also act in this capacity. Gray (1997) suggests that students are able to quickly establish which fellow students are keen to share their knowledge and skills. This implies that not all students act as role models. This would seem to mirror the idea that when qualified many nurses feel ill prepared to undertake their teaching role, lack confidence in their ability and have mentorship elements thrust upon them as a part of their job descriptions, rather than having a flare or desire for teaching (Andrews and Chilton 2000). Unlike other aspects of peer learning where seniority seems to be unimportant, in terms of using peers as role models it is the students who are in their third and final year who are influential. The data demonstrates how the learners use the third year students to prepare themselves for the time when they will be about to qualify as nurses.

Previous work studying student nurses on a preceding curriculum demonstrates the importance of the final year in terms of transition to qualified status (Holland 1999). During this final year Holland (1999) suggests that students are considered as being able to practice as qualified nurses by the qualified nurses because the students have passed the tests of

endurance. It appears that it is not only the qualified nurses who legitimise the students in this way, fellow students are also perceiving the third year students as competent and knowledgeable.

The question of what it was like to be a third year was almost impossible for Helen to answer (Page 225). Helen is a third year student and therefore has a tacit understanding of what it is like, but trying to communicate this to someone else was clearly difficult. As Eraut (2000) points out respondents are unaccustomed to talking about their informal knowledge. Informal knowledge is seen as part of the job, and it is difficult for individuals to speak about things which are taken for granted. Helen is approaching the point of qualification and her fellow student sees her as being nearly qualified. The less experienced nurse ratifies Helen's position as a nurse. Olesen and Whittaker (1968) describe the twin concepts of legitimation and adjudication. They assert that legitimation is the process of others sanctioning the student's claims to the role of the nurse. "Legitimation comprises a series of sanctions accorded to the student claims on the general role of nursing and it subsumes such interaction as being generally accepted or rejected as a nurse" (Olesen and Whittaker 1968. p202). In turn, Helen projects the role of the nurse by coaching the less experienced nurse through wound dressings (which are seen as the realm of the qualified nurse), facilitating the less experienced nurse's professional socialisation and being a role model.

Wilson (1999) examined the role of qualified staff acting as mentors and contends that there is a particular relationship between junior and senior students, whereby the junior students seek out the senior students for advice as and when necessary. However, Wilson tends to view this as a one way relationship and does not acknowledge a role for junior students in educating more senior peers. Like Melia, Wilson also suggests that senior students take on some elements of the qualified role by beginning to teach and delegate tasks to the junior students. However, this research suggests that there is more to the teaching of peers than this traditional hierarchical view would suggest.

The students pass on clinical skills to their peers regardless of their length of time on the programme; students teach fellow students according to what they have been exposed to. Gray (1997) demonstrates similar findings which support the notion that fellow students are seen as approachable, able to pass on hints and tips and with more time to teach, were better at explaining things. However, it should be acknowledged that these studies were mainly concerned with professional socialisation as a whole and not the specifics of peer learning.

Davis (1975) asserts that during professional socialisation students will undergo labelled recognition of incongruity where the practice of nursing as they experience it, does not match up to their initial lay images of what nursing is or should be. This is compounded by the fact that what they see as nursing on the wards, does not match with what the school upholds as the expectations of nursing practice. In some cases the images do not match up to what the expectations of the students themselves as the data highlights. Melia (1984) also describes the gulf between service and education sectors where it is education, through the school of nursing which presents the professional version of nursing. A version which represents the official aims of the three year training programme: to produce a competent registered nurse capable of independent practice and professional judgement. The managers of the service segment, on the other hand, are more concerned with getting the work done, and are far more interested in having students who are competent, but compliant (Melia 1984). It seems that students may still feel a need to be compliant as the data shows. In the situation where a student works with a Health care Assistant highlights; the student clearly accepts the situation as it is and does not challenge the status quo.

More recently, Ousey and Johnson (2006) discuss how students learn to be a ‘real nurse’. In their discussion paper they suggest that because the role of nurses is changing it is almost impossible to offer a generic definition of their role. As a result of this, they argue that students on clinical placements become confused and frustrated as to what their role is and how they should

develop their skills. This idea is supported by the findings in this thesis with the students experiencing conflict about their role. They talk of being unsure about their role as students and seem to be experiencing difficulty in reconciling what they are doing with the work that qualified staff engage in. However, this notion of role blurring is not new (Holland 1999), but the fact that this issue remains indicates that education programmes have been unsuccessful in reconciling this conflict. The findings from this research demonstrate role blurring remains an issue for these students. They clearly express the conflict of undertaking large elements of nursing care which they do not perceive as the role of the qualified nurse.

Bathing dependent patients is viewed as non technical work and associated with caring for older people (Spouse 2001). Moreover, the students in Spouse's study felt that the work was routine and that they were innately competent in the task but interestingly, they struggled throughout the programme to develop clinical skills which they saw as giving injections or medications. It seems that just as injections and medications were important for the students in Spouse's study, so dressings are significant for the students who I have studied. The bed bathing is seen as a skill which the students do not need to rehearse, not because they are innately skilled, but rather because they do not see it as part of the work of the qualified nurse. Melia (1984) suggests that the students in her study conceived of nursing work as distinct from student work, but where patient care was common to both forms of work. From my own study, I would suggest that there is qualified nurse work and health care assistant work and student work tends to focus more heavily on the latter. Direct patient care is much less evident in the work of the qualified nurse. This raises concerns for me as an educator. I wonder about the rationale of continuing to teach skills to students such as bed bathing, if they are no longer practiced by qualified staff. Persisting in teaching skills to students which are not a part of nursing seems odd, after all a carpenter who makes the window frame does not need to know how to make the glass to go inside it. If unqualified staff are doing something which is so different from

qualified nurses then the two jobs may need different methods of teaching and socialising newcomers. The fact that students do not see the work of bed bathing as a nursing role is a point I shall return to in Chapter Nine.

Summary and links to fore understandings

Interpretations from the data reveal the important role which peers play in professional socialisation. In particular peers are crucial in passing on context specific survival skills. Students help fellow learners from the community of students as they pass on the nuances of the traditions of nursing as it is practiced in each area. Students often learned survival skills through making mistakes and shared their experiences to prevent fellow learners form embarrassment. This could be vicarious learning applied to the clinical area, since the students are preventing others from making their mistakes. Students in the study used their own past experiences to inform others about what might be viewed by an outsider as insignificant or petty details. However, such detailed knowledge was vital to a smooth and unhindered placement. Again there is evidence to support the importance of friendship in enabling this type of knowledge to be shared. Being on a particular ward and knowing the ropes was more important than time served on the programme. This seems to be an important aspect of peer learning, one which the students place great value on since it helps them through the different cultural world of clinical practice. The importance of this type of peer learning from the student perspective has been hitherto underestimated. The resultant new fore understanding is that students play an important and valued role in professional socialisation of their peers.

The students often had difficulty in finding the nursing role. In clinical practice the students from the study tended to work with other students or unqualified personnel. They saw themselves as engaging in auxiliary work, as opposed to nursing work and in particular questioned the value of learning skills such as bed bathing. Often they took part in providing care which

seemed to be of little value to them as staff nurses, since staff nurses did not engage in such care; learning skills which they would not practice once qualified. A lack of distinction between the roles of nurses and health care support workers may have implications for how and what student nurses should learn.

Seniority became more important when the less experienced students wanted to know what it would be like when they reached the final year for themselves. As the third year students began their transition towards qualified status they were viewed as role models and took less experienced students under their wing. The third year students took on some of the attributes of the qualified nurse and acted as guides for the less experienced. In particular they would coach others through dressings, using proleptic instruction and used the language of the qualified staff. In turn the less experienced staff ratified them as nurses.

Conclusions drawn from the student experience of peer learning.

The study demonstrates the presence of peer learning in both academic and clinical settings amongst a group of pre registration student nurses and highlights observable differences in how peer learning is manifest in each area. The research illustrates the importance of social relationships to peer learning in both settings in the form of friendships. The students formed enduring social bonds with their peers which remained constant throughout the programme. Within the realm of clinical practice there is evidence to suggest that learners form a community of students which extends beyond the student's own immediate cohort to encompass all students, regardless of the programme being studied or the length of time served on the course. The students converge together, especially when mentorship fails, existing largely on the edge of the community of practice of the qualified staff. The students rely heavily on each other in the different cultural world of clinical practice; seeing each other as knowledgeable, approachable, alike and all being in the same boat and therefore the friendships play an important role in peer

learning as the friendships facilitate an ask anything culture. The students use each other to confirm what they already know and frame questions in order to manipulate a positive response.

The students feel under great pressure to become proficient at specific clinical skills such as wound dressings, and use each other to learn through demonstration. The students strive to appear confident in their actions and perceive increased confidence as evidence that they are learning. They would often assume a front of confidence for the benefit of other students, patients and qualified staff. The front of confidence also allowed the students access to perform and refine their skills; as the qualified staff would be more likely to allow them to undertake the procedure if they appeared confident. However, the findings demonstrate that the students relied heavily on a superficial approach to learning clinical skills, being content with showing each other *how* to accomplish the skill, rather than providing any underpinning knowledge. Fluid and speedy performance is seen as the goal of clinical practice. The clinical skills which the students are particularly concerned about are those which they see qualified nurses engage in, such as wound dressings or medicine administration; skills which the students perceive to be beyond their actual level of development, but within their potential level of development and as such lie within the zone of proximal development (Vygotsky 1978). Furthermore the observational data shows that students help each other to achieve mastery of clinical skills through verbal coaching and providing proleptic instruction through scaffolding. The students adopt interchangeable roles during the demonstration and gradually the less experienced learner begins to take over the leading role. Prior exposure to the skill inferred competence and therefore ability to demonstrate the skill to another student; even if this meant third year students being taught by first year students. Whenever demonstration took place, the practice was assumed to be correct and there was no evidence of students challenging each other's practice.

The research highlights a continued emphasis on getting the work done and students will provide each other with mutual practical help in order to accomplish the work of the ward. Students rely on peers who have been on the ward slightly longer than themselves to show them the ropes. This evidence highlights a perception of the role of seniority which is more to do with the context specific knowledge of each clinical area: knowing the ropes; than chronological progress on the course. This idea of seniority was understood by the students, but not necessarily shared by the staff who assumed that the students should have mastered certain skills according to which year they were in on the programme. The students in this study often struggled to find the nursing role in clinical practice working with each other or unqualified staff (Health Care Assistants or Auxiliaries). They participated in care which they did not see the qualified nurses undertaking such as bed bathing, washing and dressing patients. These skills were seen as a right of passage; something which they had to do as a student but may not practice as a qualified nurse and therefore were of little value.

The study also shows that peer learning in the academic setting takes place in two ways. Firstly, the students learned from each other through story telling and sharing their practice experiences. Students do engage in story telling whilst out on clinical placement, but conversations take place away from the bedside and after the work has finished. They found sharing experiences to be a powerful way of learning about clinical practice, even though it took place in the classroom away from the clinical setting. This challenges the notion of what it means to learn clinical practice and suggests that this is not solely within the clinical domain. The primacy of first hand experienced is challenged as the students learned vicariously from their peers. The students found listening to each others' practice experiences to be valuable to their learning. In particular the students shared emotionally difficult practice encounters but found it hard to articulate both the details of the story and the learning that took place as a result of hearing the story. There appears to be a benefit in hearing the story which may expose the learner to a wider variety

of clinical experiences through vicarious learning; and thereby helps the student to acquire coping mechanisms to deal with the emotions of nursing. The shared experiences can remain as interesting stories but the lecturer can play a vital role in helping the students to achieve a deeper level of understanding. The observations show that a lecturer can also make use of proleptic instruction and verbal coaching to help students to make links between different areas of clinical practice; the use of propleptic instruction is not limited to clinical practice. The findings support the ideas purported by Northedge (2003), in terms of the lecturer lending the student the discourse of the expert in order to open up the conversation. The research also shows a link between shared practice and enhanced peer learning through story telling. When the students have been on the same clinical placement they are able to use their context specific knowledge and imagination to fill in the gaps of the story. The students listened intently to the shared experiences but at no time did they challenge each other's ideas.

Finally, much of the literature which seems to provide some useful explanations of the observed behaviour in this research is rooted in childhood learning: Vygotsky (1978), Kutnik and Kington (2005), Parr and Townsend (2002), Forman and Cazden (1998) for example, are studies concerning children and adolescents. However, the research findings here clearly demonstrate an application to how student nurses engage in peer learning. It appears that how student nurses learn is similar, if the not the same as the childhood studies suggest. This leads me to believe that the way in which humans learn does not change as we get older; peer learning amongst children is mirrored in peer learning in this group of student nurses.

SECTION THREE

Reflecting with new experience on the initial approach

Ashworth (1987) considers that reflection on fore understandings is only possible after the interrogation of the social world, but that researchers must be careful to show that the description was not merely a consequence of the prejudices which were brought to the research at the start. Through the interrogation of the social world the obscure has become more coherent but descriptions have to be seen to have emerged in a research context where fore understandings were open to challenge (Ashworth. 1987). In other words it is important to ensure that I did not go looking for what I wanted to find; reflexivity is the key to remaining objective.

According to Gray (1997) regardless of the type of qualitative research it is vital that the researcher actively adopts a reflexive mode throughout the study. Without reflection the researcher would be unaware of the effect of their own decisions or actions on the meaning and content of the experience being investigated. The researchers' actions may affect the findings to the extent that they are altered. The essence of reflexivity is that the researcher is inextricably linked to the social world under study. To be neutral and detached is impossible (Gray 1997. p93). Therefore this final section of the thesis is presented as a single Chapter aiming to examine the approach taken to the research in terms of my impact on the process; and the impact of the research on me, and therefore includes self critique.

Chapter Nine

Gaining new insights

The position of the researcher has been a vital component of this study and throughout the research it has been necessary to ensure that my relationship with the students did not hinder the research process. The insights I have gained relate not only to the student experience of peer learning but also to me. According to Foster, McAllister and O'Brien (2006) a reflexive orientation is concerned with how the researcher constructs meaning in the research, rather than simply describing the participant's reality. They argue that through the process of conducting the research, the researcher subtly influences the opinions shared by respondents, the stories evoked and thus, the meaning made. According to Foster et al "a reflexive orientation seeks to make visible the beliefs and values that the researcher uses, sometimes consciously, that shape interpretations of data" (Foster et al 2006. p46). They imply that the influence of the researcher is inevitable but that what matters is that researchers are aware of how their beliefs and values have influenced the research. This point reinforces the use of Ashworth's model since it enables the researcher to make visible the preconceived ideas held prior to undertaking the research in the form of fore understandings. The model then encourages the researcher to leave these iterated ideas open to challenge throughout the research. A reflexive stance is required throughout each stage of the research process because as Foster et al suggest "without reflexivity the researchers' influence on findings may be overlooked" (p47).

Ethnography and reflexivity.

There is clearly a need to strike a balance between personal experience of the researcher and those of the participants, Foster et al argue that this is in order to ensure that personal writing is not privileged over, nor overshadows the

voices of the participants (Foster et al 2006). Coffee (1999) suggests that it is not unusual for ethnographers to separate reflective accounts gathered in the field from emotional or more personal reflexive accounts. However, Allen (2004) argues that such a separation is misleading and may even distort the meaning of field data; so she contends that reflexive accounts should be integrated into the presentation of findings. Whilst I agree with Allen up to a point, for me it seems that the process concerned occurs at two levels; much the same as Holland (1993) suggests that data analysis occurs. I found that during the data collection I would take some 'time out' to reflect and question both what I was observing and my own position with regard to the data; it was only after the data collection had finished at the end of each day and subsequently again at the end of the study, that a more considered response could be reached. Therefore during the presentation of the findings there is some evidence of preliminary reflexivity but it is here, in the final stage of Ashworths' model, that a view on the whole can be revealed. Mulhall (1997) refers to this as reflecting at both a superficial and deeper level; the superficial level, telling it like it is and the deeper level attempting to uncover the impact of the researcher's beliefs, interests, values and position on the research. This is similar to the stance taken by Chesney (2000) and her description of her reflexive approach to research. She argues that ethnographers can never capture everything from the field but as the data is "recalled, re-written, re-read, a differing perspective emerges" (p61) emphasizing the cyclical and developmental nature of reflexivity in research.

Allen (2004) suggests that uncritically adopting phenomenological approaches to ethnographic practice can lead to an excessive focus on the meaning of participation and excessive psychological introspection on the part of the researcher. Indeed, she goes so far as to say that she aims to increase the rigour with which the research process is described, rather than encourage further "navel gazing" (p22); implying that such introspection is somehow not scientific and inappropriate. However, Johnson (1997) is of the

opinion that rather than being self indulgent (providing a balance is achieved) that personal introspection demonstrates researcher integrity and awareness. Chesney (2001) supports this view by arguing that in order for "readers to accept the research as valid, they must be able to scrutinize the integrity and philosophy of the researcher so that the findings are trusted" (p128). A view which is supported by Carson and Fairburn (2002) who suggest that there is a sense in which all research is concerned with telling stories about ourselves, as researchers, and about the world; implying that both are necessary.

Allen (2004) argues that accounts such as those provided by Pellat (2003) dwell on the impact of the research on the researcher and she goes on to say that "whilst such accounts are insightful, the emphasis on psychological introspection overpowers the sociological reflexivity leading to a blurring of the relationship between the account and the execution of the research" (p15). VanMaanen (1988) describes personalized authority in terms of confessional tales. He suggests that when done well, a confessional tale is a gift to readers of a "self reflective meditation on the nature of ethnographic understanding; the reader coming away with a deeper sense of the problems posed by the enterprise itself." (p92). However he also provides a cautionary note concerning the confessional tale in unskilled hands, sucking both author and reader "into a black hole of introspection; the confessional is obsessed with method, not subject…Yet however involuted some confessional accounts may appear, the reader who wonders why the confessional writers don't do their perverse, self-centered, anxiety work in private and simply come forward with an ethnographic fact or two are, quite frankly, missing the point." (p93). Suffice to say that this thesis contains elements of both realist and confessional tale in an attempt to provide a rounded account which creates and interprets new knowledge concerning the experience of peer learning for the students under study and the research process itself.

Right form the start I believed that the researcher could not be separated from the research. Whilst this research is about revealing the experience of peer

learning from the student perspective it is also, perhaps inevitably about me. I agree with Chesney's view that "without presenting the self, a gap exists in the research, self knowledge which would otherwise hide behind an unspoken veil, therefore it is imperative to present such personal feelings and knowledge" (Chesney 2001. p129). She argues that rather than coming across as being too involved (and therefore introducing bias from over familiarity with respondents) that "acknowledging, documenting, learning from the transition from objective to involved, and then applying this information to the research findings may enhance, enrich and increase the validity of the research" (Chesney 2001. p129). Therefore, reflexivity is concerned with personal feelings, the impact of self on the research process together with the process itself. Each element is seen as equally important.

Ethnography and interpretation.

According to Kendall and Wickham (2001) representations are vital to cultural studies because they are "examples of the systematic distortion of reality that is part of the field of culture" (p161). This is a point which concerns me since I have tried to present the student experience of peer learning as I interpreted it; that is clearly not the same thing as trying to distort reality. Indeed, probably like most writers I seek to provide a balanced view. VanMaanen (1988) also asserts that an ethnography is written representation of a culture (or selected aspects of a culture) and culture is only visible through it's representations; however, he goes on to point out that such representations carry "serious intellectual and moral responsibilities, for the images of others inscribed in writing are most assuredly not neutral" (p1). My interpretations of the student experience of peer learning are the result of my previous experiences as a student, nurse, educator and so on. Like Carson and Fairburn (2002) I wanted to write in a language and style that was understandable and therefore more likely to be helpful.

Taylor (1993) suggests that understanding is achieved through constantly moving from the whole to the part and back to the whole: a hermeneutic circle. The circle however, is not an endless repetitive loop, because each time one goes round the cycle, one's appreciation of the unity of the whole, grows and matures. This view mirrors my own journey throughout this research. I constantly find myself moving conceptually in my mind from the whole, to the parts and back to the whole. Indeed engaging in the research process in this way not only reflects the approach to the study, but also to the data collection and analysis and the writing up. I can clearly identify the three interlocking and complementary activities of questioning, reading and writing; my understanding has increased with each loop of activity. The process is one of questioning, reading; perhaps more questioning and more reading and writing. I have found it useful to write in field notes as these provided a literal carte blanche, a free space in which the thoughts (the questioning) could flow. I have also found it useful to link the literature (the reading) to the questioning (the interrogation of the social world) as the study progressed; undertaking constant comparative analysis. In this way interpretations seem to be logical and have helped me to achieve a deeper understanding of peer learning and the process of the research.

Ashworth (1987) presents a model of conducting studies which reflects my own philosophical stance on the nature of people and research itself. He comments as social scientists our data is predominantly talk but the talk requires a hearer "who is by no means a passive recorder, but is an active understander of the talk; the researcher/researched relationship is, thus absolutely central to the research process" (p7). To be an 'understander' perhaps some esoteric knowledge is actually a prerequisite. Like Pellat (2003) and Holland (1993) I came to the research from a position of having some knowledge. Using Ashworth's model enables the researcher to interpret the social world and lend it coherence. Making clear the fore understandings with which the work is approached allows the researcher to make use of presuppositions in guiding the data collection and analysis. Keeping the fore

understandings constantly open to challenge and revision broadens and illuminates self understanding, and understanding of the material under study, the two going hand in hand. The fore understandings are embedded within the research. The data has been interpreted using both analytic and empathic approaches. The suspicious approach to data being analytic; seeking out obscurities and searching for hidden meaning in members' accounts whilst the empathic approach focuses on the felt understanding in order to achieve a sense of the situation members are in. Ashworth acknowledges that both approaches are necessary in interpretation in order to produce a balanced view. I would add that focusing on both the analytic and empathic approaches allows the researcher (in my case) to see the whole (student). This work has confirmed my fore understandings concerning the nature of my relationship to the students: the relationship is central to the process of my teaching and research.

Self and the research process: my impact on the research

Moss (2005) argues that situatedness is an important factor in the research process; in other words, the extent to which researchers' understandings (including the generalizations they produce) are shaped by the social context(s) in which they live and work. Moss goes on to argue our

> "interpretations are unavoidably shaped by the linguistic and cultural resources the interpreter already possesses and by the nature of the questions the interpreter brings to the text (that is, by why the text draws the interpreter's attention in the first place, and by what the interpreter takes the text to be). This does not mean that anything goes or that there are not better or worse interpretations… There is no single interpretation, but this is not an arbitary interpretation, that is independent from the original text; there is a definable degree of appropriateness" (Moss 2005. p267).

Thorne et al (2004) make this even clearer by saying that it is the researcher who drives the interpretations, "no matter how participatory and collaborative the method, it is the researcher who ultimately determines what constitutes data, which data arise to relevance, how the final conceptualizations

portraying those data will be structured, and which vehicles will be used to disseminate the findings" (p12). Therefore it is important to revisit both the fore understandings which were declared at the start of the research and my relationship to those fore understandings. Right from the start, I strongly believed that it was impossible to separate the research and my own professional experience. Indeed the fore understandings demonstrate the link between the research and my own experience, as both elements are evident:

- That in terms of learning in clinical practice, student nurses learn from each other; using mechanisms which have not been fully explored and are poorly understood. Moreover, students value peer learning in the clinical setting.
- Dialogue plays an important part in peer learning for student nurses in practice.
- In terms of learning outside the clinical domain, student nurses do not value learning from each other in small groups in the same way as they value learning in practice.
- Mechanisms such as problem based learning purport to develop learning through dialogue whereby students challenge each other. From my own experiences this is not the case; it is faculty that provides the challenge, rather than students themselves.

These fore understandings were constantly at the forefront of my mind during the process of conducting the research. Indeed, I typed them up and attached them to the inside cover of my field note book as a reminder to ensure that my prejudices were not leading me away from what the students were telling me. The whole point of undertaking research into peer learning was to answer the research questions:

- What are the students learning from each other in clinical practice and in the classroom?
- What are the mechanisms of peer learning as used by this group of students?

- Do these students value peer learning in both settings?

In other words to discover more about what, when, where, how and why it took place according to the observation of and ethnographic conversations with the students. However, due to my relationship with the students, the research was also inevitably about me as their lecturer and me as a beginning researcher. Relationships proved to be a recurring theme in the data; so it also proved to be within the research process. Without a connected relationship to the students the method would not have worked in terms of the richness of the data provided by the students. My relationship with the students afforded me backstage access to their thoughts and behaviours concerning peer learning. Indeed I would go so far as to say, it was my very relationship with the students that enabled the research to take place at all. Without the relationship and connectedness to the students, the research (for me) would have been meaningless.

Gillespie (2002) demonstrates that it is possible to build a type of connected relationship which is egalitarian and liberating for both student and teacher. In this type of connected relationship between student and teacher the egalitarian nature of the relationship arises from an equality as people and notably, that this personal equality co exists with an inequality of knowledge and skills (Gillespie 2002). Gillespie goes on to encourage teachers to consider the balance of power within the student teacher relationship, particularly the teachers' use of their knowledge within the relationship, their willingness to be known as a person, and their predominant role as these factors influence the nature of the relationship. In other words, the teachers' way of being and way of teaching is crucial to the nature of the student teacher relationship. I would add the teachers' way of researching to this equation. Elements previously described as being characteristics of effective teachers may also be applicable to being an effective ethnographic researcher: being genuine and present as a person. It is the relationship and way of being with the research participants which is important and which can overcome

problems associated with perceived differences and inequality of status. This means that researchers have to develop effective relationships with research participants. Where this is done, it is possible for the participants to "have their say", even if this means saying what the researcher does not want to hear. For example, Pellatt (2003) explains that by establishing a rapport with participants, they in turn were open, honest and uninhibited by her as a nurse researcher. Some participants felt able to criticise nurses, such was their relationship with her as a researcher. Eraut is more forthright in his suggestion that " researchers have to be able to develop relationships which empower their respondents to be brutally honest about what they think of the researcher's suggestions, and to give them the opportunity for a second, more considered response" (Eraut 2000. p121.).

From my own perspective, conducting research on students that are known to me has meant having to listen to views which I had not previously considered; views which challenged my own ideas about what it means to be a student nurse, and which in turn have enabled me to develop as a researcher. At times this has not been an easy journey. Underlying my fore understandings was a desire to show that nurse education has moved on since I was a participant in the system. I wanted the students to demonstrate deeper approaches to learning which were commensurate with the ideals of higher education. However, my fore understanding remained open to challenge.

The data shows that students still have a heavy reliance on surface approaches to learning; mastery of clinical skills remains a priority for the students. I expected to find that since nurse education had moved into higher education from the time when I had trained; and given that there have been several attempts to improve nurse education in the intervening years (Project 2000), [UKCC 1986], Fitness for Practice [UKCC 1999]), that the way in which student nurses engage with clinical learning would be different. On the one hand, I was disappointed to reveal the lack of deeper approaches to learning, but on the other hand, relieved to know that as an educator I can be

pivotal in tipping the balance in terms of promoting deeper learning through scaffolding, coaching and careful questioning.

Self and the research process: The reality of data collection

Prior to entering clinical practice I had indeed prepared myself for situations where student nurses were engaged in peer learning and were clearly learning the wrong things from each other. I had reconciled that I would employ a sliding scale of personal judgment; from intervening where practice was about to endanger a patient, to not even reporting or recording in my field notes events which I considered to be irrelevant. However, the reality of data collection in the clinical setting revealed the unique position of educators who wish to research their students in clinical practice. My position as researcher, nurse and educator was not always easy in the sense that there were occasions where one, or more of these positions were to be tested and compromised. The three positions are discussed in relation to one incident from data collection in the practice domain in order to illustrate the conflict and my personal resolutions.

Whilst I had prepared myself for incidents which may involve students I had not anticipated conflict coming from other areas. Whilst in clinical practice as a researcher, the following incident took place:

"The research period had finished and I was standing towards the exit of the ward thanking the student for allowing me to observe her shift. We were out of sight of the rest of the ward. Whilst observing on the ward I noticed that many patients (who were in side rooms) were being barrier nursed. This is a system designed to prevent cross infection from the source (in this case; the patient) to the rest of the ward community. I was discussing with the student why the patients were being barrier nursed and in particular, why the side room doors were being left open for all the patients who were assumed to require source isolation. During the morning one of the patients in a side room was becoming more and more vocal and was calling out incoherently. The student explained to me that the man had dementia and was to go home later that day. It seemed he was calling out to his daughter. At this point we were quite close to the side room and were having to talk quite loudly to hear ourselves over the man's calls. As I was about to leave we saw a qualified nurse go up to the

door of the man's room; she shouted 'Shut up Les!' and slammed the door closed. The conversation between the student and myself was halted by this remark." [Transcript from field notes taken in clinical practice.]

As an educator I felt compelled to discuss the issue of barrier nursing with the student before I left the ward. I saw this as a valuable learning and teaching opportunity. Whilst the student found our discussion useful it also reinforced her position within the ward hierarchy as she explained that she was well aware of the need for the doors to be kept closed. However, she went on to say that even if she were to go and close the doors, everyone else would only leave them open and as a student she didn't feel it was her place to challenge the practice of other, more senior staff. Having seen and heard the incident between the staff nurse and the patient who was shouted at, I also felt as an educator that I couldn't leave without discussing what we had witnessed. The student and I discussed issues such as elder abuse, dementia, communication with patients and a whole host of other things. The educator in me took precedence.

As a researcher, I recorded the event in my field notes (which allowed me to recount the detail of the incident here). Having recorded the incident, I then needed to make a decision about whether to report the incident within my work. This decision presented me with another dilemma. As a researcher I feel it is important to describe the realities of data collection within the clinical setting as it appears. After all, I have reported faithfully every other aspect of this research and the research process and in this respect this incident is no different.

Finally, the largest area of personal conflict and decision making: as a nurse, what do I do about the incident? Clearly I was, and still am, appalled by the staff nurse's behaviour. However, my primary purpose at that time was as a researcher, to observe and to report; none the less, I still have a duty as a nurse to protect patients. On the one hand, the rest of the ward community was better protected now that ironically the side room door had been closed. On the other hand I had just witnessed the abuse of a patient. I was conscious

of the fact that I had worked hard to gain the trust of the ward staff to allow me to observe students on the ward as part of my research. Future access for myself or others may be jeopardized by acting in a capacity which, in the staffs' eyes I was not there to fulfill. Costley and Gibbs (2006) suggest that research which involves work colleagues, friends or other professions raises different ethical issues. Whereas researchers usually remain emotionally detached from the research setting, work based researchers are unable to do so, because they temporarily transform their work colleagues into research subjects. As a result of this they argue that an 'ethics of care' could be invoked to safeguard the personal and moral relations to others. To a certain extent there is the same emotional attachment of researcher to the respondents. The students and I are linked, we both occupy dual roles; the respondents are also students, the researcher is also their teacher. The students still had some time to spend on the ward and I feared that she may be subject to recriminations if I were to challenge the Staff Nurse there and then. The 'ethics of care' extended to both the students who remained on the ward after I had gone (and the observation period had finished) and to the patient.

In the end I decided not to challenge the nurse directly, instead I decided to discuss my concerns with colleagues who link directly with the clinical area in question. I hope that through education practice will change. The situation still fills me with conflict and unresolved feelings. I hope that by recording the situation others will recognize the unique position of educators who wish to research within the clinical setting. Like Johnson (1997) I had thought about the times when my position as researcher would be compromised: negligent or unsafe conduct. However, as he points out a good deal of what the ethnographer sees is conduct which is not bad but which could be better. However, just as Johnson questions whether he coerced a patient into having an enema he initially refused (1997); so I am left questioning whether I allowed 'an ethic of care' towards the students to override an 'ethic of care' towards the patient.

In another paper Johnson (1997b) debates the idea of intervention in nursing research. He deplores the seemingly aimless drift for researchers towards hygienic approaches such as semi-structured interviews and questionnaires and encourages more researchers to conduct their work in clinical areas. Two views of intervention in nursing research are outlined: a positivist and qualitative perspective. Within the positivist view he explains that ideally no interventions should take place in nursing research, but where intervention is required, it should be planned. He goes on to explore the idea of non intervention in nursing research and describes what he terms the "wildebeest perspective" where observing naturalists refuse to intervene when the lion is stalking the wildebeest, because to do so would interfere with nature (p23). Relating this positivist stance to my own experience, the event occurred in a split second; there was no time to preempt what was going to happen and intervening after the event would not change what had happened. The event would have taken place regardless of whether a researcher was present or not. The qualitative perspective is described by Johnson from his own experiences where instead of direct intervention he uses an indirect approach. During his research in the clinical areas Johnson employs a long hard look of the questioning variety to question the action of a ward sister; but he too failed to intervene. Being a guest in the research field and essentially invited will always make the researcher-respondent relationship somewhat fragile. Finally he asserts that within humanistic research the relationship should be one of empowerment and raising consciousness (Johnson 1997b). It is my belief that at least here I have upheld my own standards.

Preparing future students for the world of nursing: insights concerning teaching

According to Diekelmann (1990) nurses do not teach as teachers teach because our teaching is informed by our practice of nursing. She goes on to say that we must create a pedagogy based in care and reflective language: a

dialogue attuned to the nature of nursing practice. Diekelmann asserts that as educators we do not leave nursing to go into teaching, although initially we think we do because we first take on new skills and rules of teaching promulgated by education. However, she argues that as we become more experienced and proficient in our skills, we allow our nursing practice to enter our practice of teaching. In other words our thoughts, values and beliefs as nurses form an essential part of our teaching; I would argue it also informs how we conduct research. I can certainly identify with Diekelmann's position, I found her work influential in that she focuses on teacher student relationships and the impact of this on learning. As an educator who is researching my own students it is important for me to develop relationships with the students which are reciprocal. I often use my own experiences (as a student nurse, qualified nurse and as a teacher) to illustrate my teaching and believe that this is an important way of establishing trust, credibility and establishing a good working relationship. After all I cannot expect my students to open up and talk to me if I am not prepared to do the same. There may be an element of self disclosure, openness and honesty required in order to undertake research (on students who are known to you) and this may be uncomfortable for some researchers to maintain during the research process. Indeed this may be one reason why researchers avoid studying their own students (Roberts 2007).

The experiences I choose to share with the students come from my past as a student, staff nurse, ward sister, nurse manager and lecturer and are a reflection of my beliefs about nursing. As Werner (1973) points out "I don't believe that I have to go out and demonstrate the practice of nursing in order to show students what professionalism, commitment and autonomy are all about. I am already, whether or not I realize it, and whether or not I like it, teaching these very things by my behavior in the educational setting; where I carry out my professional practice of teaching". But my role in the academic setting has to be acknowledged, like Watson who comments that as researcher his interventions in the classroom were also of a more substantive

nature: “these experiments were ‘classes’ as well as research events. I was the teacher in those classrooms. As teacher, I was attempting to change the thinking and understanding of these students as much as I was trying to make sense of the ways in which they think and behave” (Watson 1996). My experiences are shared with my students through conversations and so I am exposing them to my philosophical stance about nursing, my practice of nursing all the time. Like Watson I am trying to change the thinking of my students. I want them to see nursing as I see it, practice it as I practice. If, as Harden (2000) suggests one establishes one’s own beliefs through the experiences and opinions of another’s discourse; incorporating another’s ideas as our own and if words emanating from those in authority are not usually interpreted; rather they are accepted as truth; conducting this research it has led me to the belief that I am trying to create nurses in my own image, since it is my philosophy, my practice, my values and beliefs to which the students are exposed.

Self and the research process: the impact of the research on me

During my study of peer learning; from reviewing literature to conducting the research itself I have learned a great deal about the importance of relationships to peer learning. Through the gathering and interpretation of data, evidence has come to light which demonstrates new insights into peer learning amongst a group of pre registration student nurses. As a result I have a much clearer understanding of the mechanisms used by students during peer learning in both clinical and academic settings. I now realise that I was very much blinkered by the idea that student nurses progress along a chronological continuum; learning over a period of time. Because the curriculum is organised in chronological sections I had not stopped to fully consider the impact of this blinkered view on student learning. I had accepted the pattern of development as fact and taken it for granted that student nurses progressed in a logical, orderly manner throughout the course of the programme. However, the research has made that which was previously seen

as unimportant and commonplace to become significant and I now understand that professional development is much more complex than the linear model would suggest. The students demonstrated a much more cyclical model of development, with much more ebb and flow. There is a tendency for educators to keep students in their cohorts according to how long they have been on the programme. What is required is a much more flexible approach which helps students to use peer learning across these traditional boundaries. As educators we are being encouraged to engage in scholarship and research which underpins our teaching (Ramsden 2006). He urges academics to demonstrate an understanding of the student learning experience through knowledge of how students learn with a view to incorporating such pedagogic research into preparation of lectures (Ramsden 2006). Research in education can uniquely contribute to understanding and improving education. Conducting research on students who are a part of our everyday practice is one way to achieve this aim. The research informs my teaching as I am much clearer about mechanisms that promote peer learning in both segments of nurse education, namely practice and so called theory. However, the findings will also change my practice in terms of reconsidering the role of educators in helping students to learn from practice; since I now believe that such consideration of practice can take place in the classroom and educators can be pivotal in making learning from experience in a deeper way possible. I would also like to implement my recommendation of bringing student nurses together from across cohorts who have shared practice placements, in order to promote peer learning.

The feelings provoked through conducting the research

Undertaking ethnographic research in which the researcher is immersed in the culture under study is an emotional process. The researcher is dealing with people and all their incumbent emotions which provoke feelings in the researcher. Chesney (2000 and 2001) highlights the importance of personal investment in the research process. During her research and work with

Pakistani women Chesney acknowledges that she became part of the lives of the women she observed and that a bond developed with the women she interviewed. She comments: “I used to consider this was entirely because I am a woman, working in midwifery with a history of being a community midwife for Pakistani mothers. These factors are all important but I realise there is more” (Chesney 2000). In later work she concludes that real subject knowledge comes from knowing the people as well as the topic, but that there are many veils within the research methodology which can hide the researcher (Chesney 2001). This seems to me to be an important point; like Margaret Chesney, I am very much a part of the lives of the students’ I have studied, we share part of the same cultural world and the method I have adopted during this research has enabled me to ensure that the veil between us is lifted. Chesney (2001) points out that rather than seeing this personal involvement as a negative thing which detracts from the research process, it in fact adds a dimension of quality to the research. Personal investment and involvement in the research setting requires an element of self disclosure which some researchers might find difficult. As Lofland and Lofland (1995) point out there is the possibility that you will experience what they term as an “ethical hangover”: a persistent sense of guilt or unease over what is viewed as a betrayal of the people under study. They explain this as “the closer your emotional relationship to those persons, the more you can feel that in leaving the setting and in transforming your personal understanding of it into public knowledge; you have committed a kind of treason” (Lofland and Lofland 1995. p28). Whilst it is clearly important to develop open and honest relationships with research participants it is equally important to stress that just as a therapeutic nurse-patient relationship is not necessarily based on the concept of friendship, neither should the research relationship. Elements previously described as being characteristics of effective teachers may also be applicable to being an effective ethnographic researcher: being genuine and present as a person. It is the relationship and way of being with the research participants which is important and by developing effective relationships

problems associated with perceived differences and inequality of status can be overcome.

Some of the most significant feelings were provoked during direct observation of students in clinical practice. Since taking a post as a lecturer I have become steeped in the world of learning and teaching within principally an academic setting. My wanderings into clinical practice are (mostly) as an academic. It is a strange experience to be in clinical practice as an observer, with no active clinical role. In some respects I regret not taking on an active nursing role (like Johnson 1997), perhaps then I would have been in a better position to act when the observed practices of other nurses did not live up to my own standards. Being a researcher first, educator second and nurse third, was a difficult position to adopt; and in the incident outlined earlier where I overheard verbal abuse aimed at a patient; my nursing role was compromised in favour of maintaining research access. On the other hand, the students are not used to seeing me in clinical practice as a nurse. Working behind the screens as a nurse alongside the students would have afforded me more teaching opportunities I am sure; but may also have interfered with the research. I really wanted to see peer learning as it was (with me as an onlooker), working as a nurse would inevitably draw me into teaching and this may have changed the dynamic of the thing under study. Therefore, I adopted two different approaches to participant observation depending on whether I was in the classroom or in academic practice. Other research tends to adopt a single approach and may only follow respondents in either clinical practice or the classroom, but seldom both.

I often saw student nurses working with Health Care Assistants (HCA's) and other unqualified staff; there was even one occasion where a student worked with a HCA down one end of the ward, whilst three staff nurses worked at the opposite end of the ward. The student told me that her mentor was not on duty that day, so Sister had allocated her to work with the HCA. It was the students and the unqualified staff who cared for the patients in terms of

washing, dressing and feeding them (where necessary). This was commonplace on many of the areas where I undertook direct observation. With a few exceptions, the qualified staff tended to do the medicine round, wound dressings, paperwork and speak to relatives. I am concerned about the implications of non nurses carrying out what I consider to be skilled nursing tasks and consequently the value ascribed to these tasks by student nurses.

The responsibility of the interpreter

The study has involved bringing the testimony of the students' experiences of peer learning through my interpretations. Chesney (2001) acknowledges that this feels like a big responsibility and points out that the method by which the experiences were obtained took on huge significance, necessitating close self scrutiny. I have used the students own words as exemplars of comments that were observed or recorded in field notes, or audio tape. The students have verified the accuracy of the transcribed notes. The interpretations are mine, but based on what I hope appears as visible, logical questioning which seeks to illuminate the meaning and significance of peer learning for these students. The research process as suggested by Ashworth (1987) has proved to be a user friendly method of conducting ethnographic research. Reflection takes place at all stages of the research process, making the fore understandings known, during the interrogation of the social world; where fore understandings are revisited and revised; through to these final stage reflections. Reflection on both the process and the findings has enabled me to examine my taken for granted ideas and consider the impact of the research on my practice as an educator. I have shown how the fore understandings have been revisited and revised in light of the interrogation of the social world and iterated these throughout the study and within the diagrams describing the emergent themes from the research (Chapter Four). The research aims have been met and this work has uncovered new knowledge relating to the impact of peer learning on these students. Peer learning for these students has been demonstrated as being much more than "sitting next

to Nellie", the study has revealed the characteristics and mechanisms involved in peer learning (for these students) and found it to be an important and valuable element in the journey to becoming a nurse; thus answering the research questions.

Limitations and emerging findings for future research

This research was conducted with students from a single branch of nursing within one University. It would be interesting to replicate the work with other groups of students across different branches of nursing and in different geographical locations. Since nursing is a practice based discipline there may also be elements of the findings which relate to other practice based disciplines; particularly those in health care. Therefore further research across disciplines may add further weight to the importance of communities of students and peer learning.

The role of educators in supporting peer learning especially in relation to promoting deeper approaches to learning also requires closer scrutiny. It remains unclear whether the students' perceptions about what is important in terms of their learning is understood and / or reflected in the perceptions of their teachers. The literature suggests that students learn through discussion in groups, but there appears to be little guidance for educators concerning their role in such discussion. Parr and Townsend (2002) and Barrow, Lyte and Butterworth (2002) acknowledge that often in order to achieve collaboration amongst the students and in order to achieve a breadth and depth of learning, orchestrated discussion is required. This is consistent with my own findings which suggest that rather than the challenge coming from peers, it is the lecturer who orchestrates the discussion through scaffolding, coaching and careful questioning. Problem based learning is associated with several benefits, including the encouragement of deep (or personally meaningful and potentially transformative) learning (Greening 1998). Greening argues that usually within problem based learning there is an emphasis on contextualization of the learning scenario which provides a basis

for later transference of what is learned. Greening goes on to say that there is a relationship between teaching role and quality of learning adopted by students. In other words, deeper learning can be facilitated by appropriate scaffolding.

In addition to the four main themes there were some additional ideas beginning to emerge from the data. The findings relate to peer learning within the academic setting. These emergent sub themes are less refined and therefore suggestions regarding this aspect of peer learning are tentative and less developed. The findings suggest that there may be difference between formal and informal peer learning (**Sub theme 1**); provides insights to how the students make use of knowledge gained through peer learning in class (**Sub theme 2**) and the impact of maturity on peer learning (**Sub theme 3**).

Sub theme 1: Formal and informal learning from peers

There appeared to be differences between the value ascribed by the students to informal and formal peer learning. When students shared their experiences from clinical practice they appeared to be listening intently to each other and found the sharing of clinical experiences to be helpful. I would describe this as informal learning from peers in that what they learned from each other did not fit neatly into the learning outcomes set by the curriculum. However, where there was an expectation that the students would share knowledge through the problem-based learning process, it appeared that their behaviour, and therefore values ascribed to the more formal learning from peers was different. During the final session of the problem based learning process students present their findings generated through the learning material to each other as new formal knowledge. This sharing of knowledge can take many forms, students often opted for a formal teaching session whereby each addresses the group with their findings. Whilst sometimes the students were observed listening intently, (although this usually depended on the quality of the student as teacher) often the students were observed demonstrating non

listening behaviours. For example, students would not be looking at the presenting student, would fidget, doodle and would appear generally disinterested. There was an absence of note taking and perhaps more importantly, students did not ask each other questions. This excerpt from my field notes highlights this:

"Today I made a conscious effort to observe the students whilst they were undertaking a formal presentation of their work to each other. Each had developed a poster based on a government document, each was presenting for about ten minutes and they were undertaking formative peer assessment. The session should have generated some discussion and was meant to be (as far as I was concerned) an ideal opportunity for peer learning to take place.	
Students were all nervous and tended to read from cue cards and/ or the poster.	*Discussion was minimal. I notice that they are all nervous and were showing non verbal cues that they are finding it stressful. Shaking, dry mouth, can't get their words out.*
They listened to each other, the quality of presentations varied greatly, but they didn't take any notes. I suspect that they learn their own poster well, but not each other's.	*They don't take notes from each other. I find this surprising. Why is this? Is it because they are nervous and worried about presenting?*
	Do they see this as a learning opportunity?
	Do they value what each other are saying?
	When I teach, they write everything down, perhaps I should have asked them to do so?
	Is this because it is the first time they have been asked to present, or is this

	indicative of first year students?
I asked them why they didn't take notes from each other but they have no answer.	

However in the third year when the students undertook a presentation as part of the problem based learning sessions, the same behaviours were observed:

> *"We had a trigger presentation day today, the group shared the knowledge gained. Some of the presentations were really good; potential teachers perhaps. After three or four presentations, the group were losing interest: not listening, not looking at the presenter. No one is asking questions. Question: Why? Question: Are they learning from this?" [Field notes.]*

This indicates that the behaviour in relation to the absence of note taking was not just limited to the first year. Throughout the course the students did not take notes from each other, they did not generate discussion, or ask each other questions during the presentations. This is in stark contrast to whenever as a lecturer I addressed the group or showed them some information, they would copy it down, listen intently to what I had to say and ask pertinent questions. This behaviour was also different to the obvious and intent listening that the group displayed on hearing each other's experiences from clinical practice. However, this behaviour may be manifest in response to the process of problem-based learning rather than peer learning therefore, further work is required in order to investigate this further. Boud et al suggest that one of the reasons for this disinterested behaviour which I also observed may be due to a concern that the knowledge gained from peers is somehow flawed, that it might be a situation where the ignorant lead the unknowing (Boud et al 2001).

Harden (2000) explains that when we hear the words of authority we usually do not interpret the meaning, instead we accept it and acknowledge it as truth. The students' perception of their own formal knowledge and information is not ascribed the same value as the knowledge that they receive from the lecturer or from each other when sharing informal knowledge gained through

practice experiences. This is evident in their lack of note taking when hearing each other provide information for the group. The findings here would seem to support Hardens' assertions since the observable behaviours were present but this is a tentative suggestion at this stage.

In addition the information provided by other students is viewed as not being learned as well. The following comments demonstrate this point:

> *"Presentations are of limited use…I find I learn my piece extremely well but would be hard pressed to demonstrate a depth of knowledge of other group members' work". [Field notes from classroom data. Second year. M.]*

> *"I feel that doing PBL has made me learn and gain a deep understanding of the area allocated to me, but I can't honestly say I have learnt a lot from the areas that the other students have done. I find sitting and listening to hours of information being read out very boring and I 'switch off'". [Transcript from classroom data. Third year. B9.]*

The students are not questioning or critiquing each others' clinical practice, or the ideas on which that practice is based. The younger students seemed to lack the self confidence to challenge each others views or practical skills. They chose not to ask each other questions because as they freely admitted:

> *"we don't ask questions, so no one will ask us a question when it's our turn to present". [Excerpt from classroom field notes. Third year.]*

Another student comments:

> *"Questions are rarely asked to other students as we don't want to cause any embarrassment and would like the hours of reading out loud to end as soon as possible. [Excerpt from classroom field notes. Second year. B10.]*

In terms of classroom discussion the following data provides insight in to the students' notions of what is valuable to their learning:

> *"It's great when we have an impromptu discussion when we make a nursing diagnosis based on information about a patient. I really enjoy that, and the learning stays with me…I have learned to look at the wider picture…when we talk in base group, I enjoy listening to people's*

experiences, they seem to stay with me in my mind." [Field notes from classroom discussion. Third year. DB.]

Sub theme 2: Transferring the knowledge gained from peers in class to the practice setting

Despite the overtly disinterested behaviour displayed when students were presenting their new knowledge; the students were able to shed light on how the knowledge was in fact useful at a later date. The following excerpt from the transcribed audiotape illustrates the role of memory:

"The thing is with the trigger, we're being asked to learn such a lot and you can't take it all in but…" (Angie)

"With the whole group feeding back to you it's a lot to take in." (Wendy)

"You have all this information from everybody and you can't learn it all at that time but you go back afterwards and go over it and make use of that information, that knowledge at different times." (Angie)

"The thing is, it doesn't come back out until you actually need it, you think in the back of your mind, hang on we did that for a trigger, and so you look back and read your handouts or whatever and then you think, Ah, I've got it!. But now literally, two minutes after presentation I've forgotten what people have said." (Lisa)[Transcript from classroom data.]

This is an interesting point on several fronts, firstly Lisa is of the firm opinion that she uses memory to guide her back to some handouts provided by her fellow students. The handouts to which she is referring usually took the form of an article or two from a nursing journal, some notes which the presenting student had provided (these were not always referenced), or sometimes a reference list. However, Lisa (and her peers) had no notes of their own on which to draw (since no note taking ever took place). Whilst I as an educator question the value of the shared information, the students seem to find the information an important and useful resource.

Lisa talks about physically and mentally going over the notes and handouts provided by her peers. However, as stated earlier, I have concerns regarding

the effectiveness of physically returning to poor quality handouts; none the less, the students perceive this to be effective. Although the group seemed to be in agreement with Lisa regarding how knowledge was transferred, more evidence would be required in order substantiate this. The second interesting point amplified from the data would seem to illustrate Erauts' ideas concerning the role of memory and Hardens' view of the importance of dialogue. Whilst no discussion is taking place during the presentation of new knowledge, the students are assimilating at least some of what they hear. According to Harden (2000) one establishes one's own beliefs through the experiences and opinions of another's discourse. At the time when the students hear each other's new knowledge the knowledge is too abstract to be used; deliberation on what the student has stored in semantic memory is required and enables the student to make use of the knowledge at a later date during performance (Eraut 2000). It would be interesting to test this on the respondents at a later date once qualified. the location, activities and social relations are missing when the students listen to presentations from their peers. They have not been personally involved in creating the knowledge and therefore fail to see the usefulness or value of the knowledge, until a similar situation presents itself at a later date in the practice setting, when the knowledge can be applied. However, the knowledge cannot be applied until the learner goes back over the written information she has collected. Going back over the information is a process which occurs both mentally and physically. Mentally the learner tries to rely on memory to provide the information; when memory fails, the action may be postponed until the physical going over of information has taken place. In both cases it seems that the information itself is assumed to be correct; there is no evidence of any questioning of the information, either at the time the information is provided or later when application is required.

Sub theme 3: Peer learning: Maturity and learning

The mature students who had waited for what they perceived as the right time in their lives to start the course clearly felt that they were more highly motivated, and therefore strived to achieve a deeper understanding. The following comment was indicative of the view of the mature students:

> *"This is it for me, I am in my forties, I won't get a second chance…I've been waiting for years to do this…it's something for me, not as a Mum, not as a Wife, but for me…I've got more to lose than them (meaning the younger students) if I don't make it." [Field notes. First year. Su4o.]*

The mature students in the group were more likely to engage in exploratory talk and elaboration being more able to articulate their learning. For example, the following comment was obtained from a second year mature student as she talked about presentation of knowledge during the problem based learning process:

> *"When the presentation takes place it can be surprising to find that members who were thought not to be making an effort come up with brilliant information. This has caused tension in the group at times, but I think it's more about respecting how we all learn in different ways." [Second year. Classroom fieldnotes. Su1b.]*

Another mature student makes the following comment which shows a deeper understanding of how she learns:

> *"I feel I would personally learn more if we were tested regularly on subjects…I learned far more from my trigger on coronary heart disease as I knew I had an exam on it". [Field notes form classroom. Second year. B11.]*

In addition the students felt that they had learned some things which were going to be of little value to them once qualified, however their comments show insight into what they have learned and the manner of that learning, demonstrating a deeper approach:

> *"I've enjoyed how much I've learned, when I have to do the reading, it's good, it makes me understand…I like the ward work being hands on but you wouldn't have learned all the theories. (Angie.)*

"I don't think staff nurses know about motivation theories; people learn what they need to know in their area…become specialised…some nurses know it, others don't, some know bits". (Jess.)[Transcript from audio taped classroom data.]

The older students had different worries and needs to their younger counterparts and looked to their peers for support. Peers were particularly good at listening and providing helpful suggestions about problems associated with childcare arrangements, finding the time to study and keeping a positive outlook. This comment highlights the nature of support through friendships and the impact of maturity:

"I find that my mature years (46) can be a disadvantage in that younger students seem to assume that I know what I'm doing. Maybe I should take this as a compliment. For us older ones, communication is our forte, we can give advice on attitude and handling awkward situations; whilst their strengths (the younger one's) are that they grasp new skills quickly and know all about IT (information technology)". [Transcript from classroom data. Su3j.]

The lack of challenge concerning practice in the clinical areas appeared to be associated with not wanting to provoke concern in the patient and maintaining a front of confidence and therefore competence. However, here in the classroom there appears to be a conspiracy of mutual protection aimed at not provoking embarrassment in their fellow peers. This emerging finding is supported by Alexander (2001) who studied child care students and outlines respondent perceptions of assignments as tasks to be completed in order to gain qualification. Interestingly, all the students in Alexander's study were sixteen or seventeen years old, yet the behaviours described mirror those which I observed. Alexander comments that "all the students said that it was important that they fit in to the settings and do not stand out in any way. This even extends to being unwilling to ask questions about practices they do not understand for fear of drawing attention to themselves…students would comply with practices they found questionable". However, unfortunately, Alexander provides no observational data to substantiate this claim, and no examples are provided to illustrate which practices are blindly complied with.

According to Vygotsky (1978) in child development, along with processes of organic growth and maturation, a second line of development is clearly distinguished: the cultural growth of behaviour; based on the mastery of devises and means of cultural behaviour and thinking. Similarly, in nursing a dual transition is said to exist. Olesen and Whittaker (1968) explain that within the United States professional education takes place when the student makes the transition from adolescence to adulthood, as well as from layman to professional. They go on to say that "these years of becoming a professional are both 'developmental socialization': acquiring an adult role and self; and 'resocialization' from lay to professional. Both take place simultaneously but not necessarily smoothly or harmoniously" (Olesen and Whittaker 1968. p9). For Olesen and Whittaker acquiring the adult role is an important aspect of silent dialogue, it is an issue which at first seems unimportant but which takes on great significance. In a study of beginning students' ways of knowing, Eyres, Loustau and Ersek (1992) make a distinction between those students who were accessing nursing as an initial career choice and those for whom nursing followed a variety of life experiences, including raising a family and pursuing other occupations. They noted that students making nursing their initial career choice tended to be less than twenty-three years old.

Vygotsky (1978) asserts that there are some circumstances where students need to be evenly matched to maximize the productivity of the interaction. However it seems that the students in this study were able to choose partners who they saw as being similar to themselves; although it is unclear whether this is a conscious choice. The older students were typical of those described in other studies (Kevern and Webb 2004, Roberts 2006). Kevern and Webb (2004) explain that for mature students entering nurse education represents a significant change in their personal and social lives and they often worried about their academic ability and practical skills. They go on to state that one of the most widely shared findings from their study was the importance of

support from other mature women. The women developed significant and enduring friendships; friendships based on mutual understanding and awareness of each other's needs. The participants in their study expressed a need to feel affiliated to others in a similar position and one of the most reassuring aspects was the presence of other mature women on the course (Kevern and Webb 2004). The older students had different worries and needs to their younger counterparts and looked to their peers for support. Peers were particularly good at listening and providing helpful suggestions about problems associated with childcare arrangements, finding the time to study and keeping a positive outlook. Eyres et al comment that whilst older students are novices in some of the theoretical and scientific content of nursing, they are simultaneously more capable of dealing with the complex situations, compared to younger students.

The younger students seemed to lack the self confidence to challenge each others views or practical skills. Andrews and Chilton (2000) suggest that generally nurses do not recognise the importance of challenge as they are socialised to be compliant. It seems that compliance also extends to not causing embarrassment through asking questions. Eyres et al (1992) suggest that younger students learn in a different way to older students and tend to have a predominantly subjective framework of knowing in which multiplicity of perspectives is acceptable and where individuals maintain allegiance to what their inner voice and experience tells them is truth. They go on to say that the younger women in the study were more likely to engage in silent disagreement and avoid challenging others as this exposed their vulnerability and might jeopardise their connection to other group members. Although they do not explain how this was evident or whether the students themselves articulated this point of view. Finally, they suggest that younger women displayed prevailing patterns of received and subjective knowing whereby knowledge comes from an authority, is filed without modification and called upon for tests; or it comes from experience, with an inner intuitive voice holding one view in the face of multiple possibilities; or it is likely to be

some combination of the two (Eyres et el 1992). My own observations would concur with Eyre's findings in that the younger students were certainly more reticent about using their voice and speaking in class. The younger students were more concerned about the vulnerability involved in making their presentations to their peers. The students engaged in mutual protection by not asking each other questions; even though they all agreed that the group was supportive and helpful; challenging their friends was impossible.

Whilst there are some tentative findings concerning the impact of maturity on peer learning, it is acknowledged that the evidence is not as revealing as for the other themes. This is an area where further research would be useful, particularly to inform future teaching of mature students. It would also be interesting to see if previous healthcare experience has an impact on peer learning. Similarly, tentative links have been established between the importance of confidence to learning but this requires more focused exploration in order to be fully understood. It is unclear if the students' confidence is misplaced or whether increased confidence is in fact an indicator of learning.

Fore understandings and conclusions from the research

New fore understandings have evolved as a result of conducting the research; in some cases my initial pre conceived ideas have been confirmed but some of my ideas have been challenged and subsequently changed. The research has provided insights into the nature and value of peer learning together with the processes involved in how students learn from each other. Based on the process of undertaking this thesis my new fore understandings are as follows:

- Peer learning takes place in both clinical and academic settings and students value this learning in both arenas, although students find it hard to articulate the nature of their learning.
- Story telling is an important element of peer learning and can take place in both clinical and academic settings. Story telling in clinical

- Students exist on the edge of the community of practice and form their own community which is used as a resource to facilitate peer learning through an ‘ask anything’ culture.
- Shared practice enhances story telling, students use imagination and context knowledge to fill in the gaps of the narration.
- Peer learning through story telling helps students to learn to labour emotionally. Peers play a greater role in helping each other to labour emotionally than was previously thought.
- Peers pass on crucial survival skills which are context specific and act as role models. The role of peers in professional socialisation is greater than previously anticipated. Junior students use the third years to prepare themselves for when they will assume that role.
- Seniority in clinical practice is more to do with knowing the ropes than chronological time served on the programme. Knowledge is context specific.
- Students use peer learning to teach each other clinical skills, using demonstration, observation and coaching through proleptic instruction.
- Practice is not challenged but assumed to be correct; similarly ideas in class are also unchallenged by peers.
- There are clear links between confidence and learning. Students adopt a front of confidence and see increased confidence as evidence that they are learning.
- Friendships are vital in peer learning, the need for friendships should not be seen as a marker of lack of maturity, rather as an essential element of peer learning.
- Lecturers can enhance peer learning.

In Chapter One I established my personal location and journey to this research. This was an important part of the research process and helped me to identify my preconceived ideas regarding peer learning. The work of Ashworth (1987) enabled me to articulate these preconceived ideas as fore understandings which were subsequently used to guide the whole of the research. I concluded that the fore understandings with which the work was approached were a combination of my previous experiences as a student, qualified nurse and educator; and from reviewing the literature. The literature review in Chapter Two highlighted several gaps concerning the nature of peer learning in nurse education. In particular little was known about the mechanisms used by students in learning from each other. Furthermore, it was unclear whether the students acknowledged or valued this kind of learning. Non formal learning and in particular vicarious learning has been a neglected area of research and therefore its importance to nurse education subsequently underestimated. Whilst some tentative links had been suggested between vicarious learning and story telling; this concept was poorly understood.

Chapter Three justifies the use of an ethnographic interpretive approach in order to uncover the students' perceptions of peer learning. In particular the dual role of teacher and researcher proved to be crucial to my position within the research. The relationship between researcher and respondents was vital in that it facilitated the research process. I described how I used two approaches to participant observation throughout the research in order to gain access to the back stage life world of the students. In the classroom a position of observing participant was adopted; watching and waiting for the data to emerge activating the researcher to come to the fore. My decisions regarding not to work along side the students as a nurse is also discussed. I outlined the importance of slowing down to dwell with the data to allow the key themes to become visible as findings. The process of constant review and revision of fore understandings was explored and these are further represented in diagrammatic form in appendices one, two and three. This demonstrated how

I applied Ashworth's framework throughout the research and makes the process of thematic analysis visible.

The findings demonstrated four key themes which play an important part in peer learning for the students under study. I contend that friendships in particular are crucial to peer learning. The students developed a community to support each other in the different cultural world of clinical practice. Within the community students made enduring friendships which in turn facilitated the development of an 'ask anything' culture. Within the realm of clinical practice the students considered that they were all in the same boat, especially in early placements. However, as students went on to placements where fewer students were present, the findings show that their view of who was in their boat could change.

In Chapter Six the role of story telling in peer learning is discussed and the primacy of first hand experience in experiential learning is challenged. The friendships developed by the students were also important since the sharing of stories was made easier between friends. Here I suggested that the story telling takes place in both classroom and clinical settings; but crucially the students told their stories away from the bedside, after the work was finished. The students clearly felt the need to separate learning from working. Two types of stories were evident in the findings: firstly, those which were used as reassurance that the students were developing along parallel lines; secondly, stories related to learning to labour emotionally. I suggested that through the sharing of stories the students developed coping strategies based on each other's experiences. The students appeared to find the sharing of stories in clinical practice much easier than in the academic environment. However, in both settings the findings demonstrate an acceptance of what is said and an absence of challenge. Contrary to other studies where the students are described as challenging each others' ideas through discussion within the group; I found no evidence of this. Indeed it was the lecturer who provided the challenge. However, whilst it is my belief that the lecturer pushes the thinking of the students in a particular direction; it seemed that the students

are less clear about how this takes place. I discussed why this might be the case and asserted that the fundamental element was the relationship between teacher and students.

One of the key findings relating to story telling and peer learning was the importance of shared practice. The findings show that when students had shared the same clinical placement they were able to use their contextual knowledge, memory and imagination to fill in the gaps left by the narrator. This enhanced the ability of the students to learn from the stories. Students who had not shared in the placement could not engage in the same way.

I concluded that there are four key processes associated with peer learning in clinical practice which were presented in Chapter Seven. Students used the ask any anything culture to facilitate the asking of questions and suggested that they had already formed a potential solution to their own problem, and were simply asking the question to seek confirmation of what they already knew. Secondly, the findings establish how students teach each other specific clinical skills. I suggested that because students exist largely on the edge of the community of practice (of qualified staff), and may spend minimal time working with qualified staff and so they used each other to learn and refine the skills which were seen as the legitimate work of the qualified staff. I illustrated how the students wanted to appear confident and competent in front of each other, the qualified staff and the patients and would adopt a front of confidence in order to appear competent. There appeared to be important and hitherto under investigated links between confidence and evidence of learning. The students strived to be technically proficient in their skills. This was not limited to beginning students; but was evident in students at all stages of the programme.

A further aspect of peer learning was established as being concerned with professional socialization. In Chapter Eight the findings demonstrated how students passed on vital survival skills relating to clinical practice; used each other to find the nursing role and acted as role models. Survival skills were based on ward specific knowledge or knowing the ropes and was seen as

important information by the students. The findings demonstrate how the students targeted fellow students who had been on the ward slightly longer than themselves and therefore had begun to acquire such specific knowledge. The nature of seniority is brought into question. However, third year students were influential in helping more junior students to prepare for their time as third year students. The assertion is that there is more to do with teaching peers than the passing on of clinical skills in a traditional hierarchical manner. Students were all seen as possessing different clinical skills and were therefore all able to pass on the skills to which they had been exposed.

The research suggests a blurring of boundaries concerning the role of the student nurse. The findings indicate that students perceive qualified nurses work and health care assistant work to be different; with the role of the student being focused heavily on the latter. The students were unsure of the value of learning and undertaking skills such as bed bathing because they did not perceive this as legitimate qualified nurse work, since they did not observe qualified nurses necessarily engaging in such work.

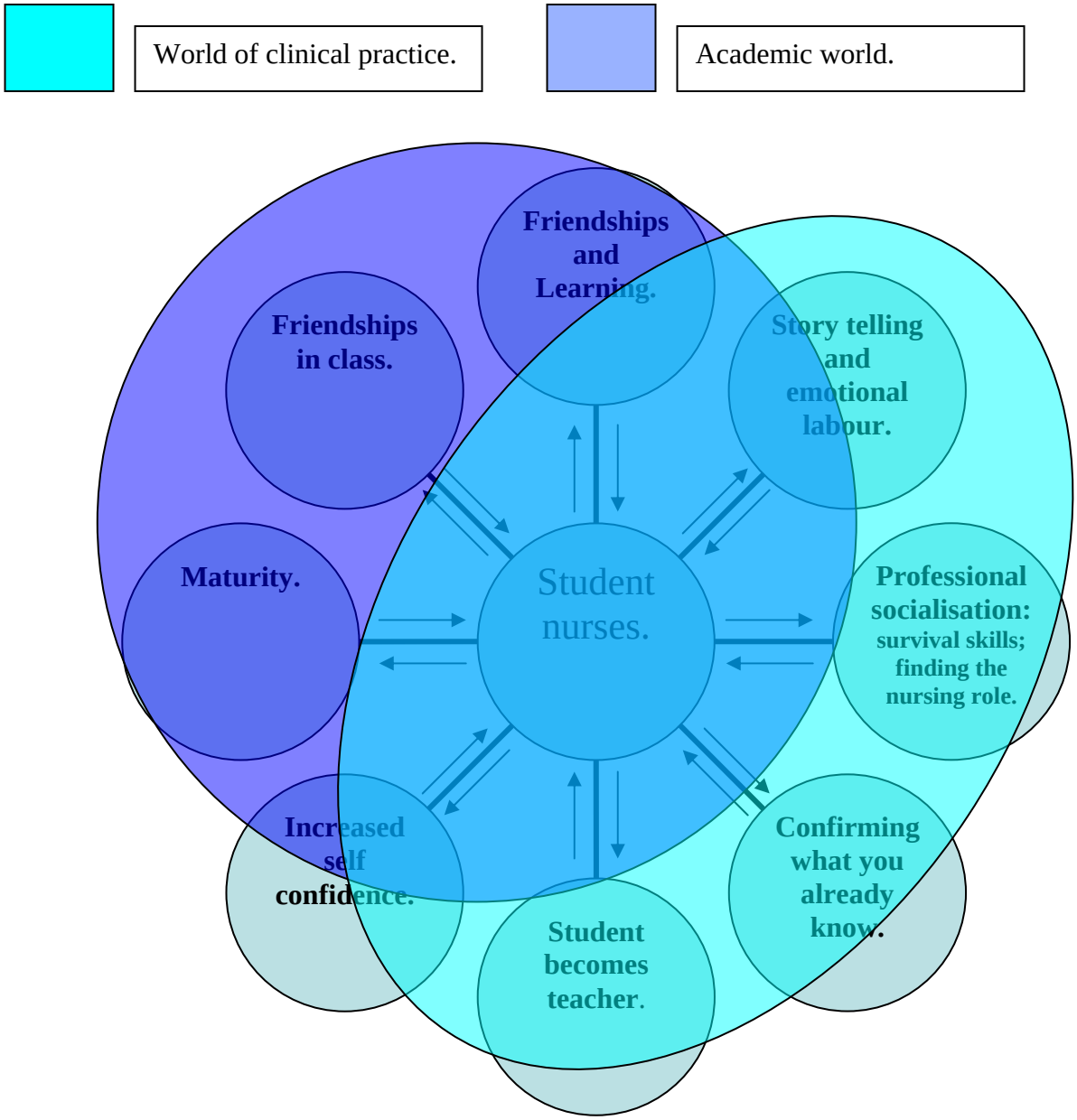
The findings reveal three emerging sub themes from the data. There appeared to be differences in the value ascribed to informal peer learning (through each other's experience) and formal peer learning (where presenting each other with formal knowledge). The findings revealed how students used information gained in the classroom whilst in clinical practice. The process appeared to be twofold: a mental process relying on memory of class discussion combined with a physical process of retrieving information when memory failed. In my opinion the information shared during student presentations was sometimes of poor quality, and students did not take notes from each other's presentations to refer back to. None the less, the students seemed to find what information they did have as valuable. I also concluded that the students are able to make use of their knowledge gained in class at a later date, when the students felt that it could be used in clinical practice.

Maturity is asserted to also be an under investigated aspect of peer learning. The findings begin to demonstrate that students in this group tended to sit and

work in pairs within the classroom setting; pairs which remained constant throughout the programme. The students chose to sit with peers whom they saw as similar to themselves. The research suggests that mature pairings acknowledged that they had different skills to their younger counterparts; being more confident in their ability to communicate and handle difficult situations. The younger students displayed vulnerability, especially regarding making a presentation to the rest of the group. In addition, the younger students wanted to ensure that they had experienced similar nursing incidents and had developed as nurses at the same pace as their peers. Mature students were more able to articulate their learning.

Together these findings highlight the importance of friendships to peer learning. The findings are expressed below as a model of peer learning in a bi-cultural world:

Model of Peer Learning in a bi-cultural world.



During the pre registration programme students move between the academic and clinical world. The only constant to this nomadic existence is their peers. The students learn from their peers in both the classroom and clinical practice. Friendships are developed through which the learning takes place. The smaller circles represent the mechanisms by which peer learning takes place. Some elements of peer learning are present within the academic or clinical world only whereas others are present in both. Students are able to use their peers for learning regardless of chronological position on the course: seniority is more to do with what you have experienced and knowing the ropes of a particular ward, than length of time served on the programme.

In Chapter Nine, the final phase of the research process was undertaken and I reflected on the initial approach. I concluded that using Ashworth's model (1987) was an appropriate and useful research mechanism within an ethnographic study. I pointed out that for me it was impossible to separate the research and my own professional experience. The method enabled me to identify and make use of my fore understandings throughout the data collection and analysis together with reflection in order to keep on track, and not move away from the student's experience. I contend that having what I considered to be a connected relationship with the students afforded me access to the back stage life world; without which the data may not have been as rich. Therefore, I suggested that there are clear links between the characteristics of effective nurse patient relationships, student teacher relationships and researcher respondent relationships.

Recommendations

The application of the findings from this thesis is of relevance to nurse education. In both settings the research has demonstrated a lack of challenge between peers. In clinical practice students converged together to observe each other undertake clinical skills. There is evidence that students help each other through the procedure using reciprocal coaching roles in order to refine their skills. In clinical practice the skill is seen as the end in itself; speedy, fluid performance is desired by both the students themselves and the qualified staff. Technical proficiency is paramount and competency is assumed. Similarly, there is a lack of challenge within the classroom when information is shared between peers. The students did not question ideas either at the time they were shared or later when the ideas were applied in practice because again, the ideas were assumed to be correct. Lack of challenge was associated with not wanting to cause each other any embarrassment. Unlike the 'ask any thing' culture indicative of practice placements, the culture is one of self and peer protection. As educators there is clearly a need for us to have a greater

understanding of these two different cultures which operate throughout the journey to becoming a nurse.

The role of story telling in peer learning also needs to be considered. Students appeared to differentiate learning and working and chose to share their stories away from the bedside, after the work was finished. Therefore as educators we need to acknowledge this and decide whether we could or should have a role in this element of learning, or whether students should continue without qualified nurse or lecturer intervention. In addition there may be implications for nurse education in that perhaps we should stop believing that learning through doing is the only means by which students can learn clinical practice. Psychomotor skills are not the only way that students can learn to be a nurse. The findings also show that story telling between peers in the academic setting can be a powerful experience but that the lecturer can help the students to use the stories in order to learn and achieve a deeper understanding. The stories are steeped in practice, they concern the stuff of practice, therefore, I contend that a shift is required which sees this as learning practice. Viewing clinical learning in this way, may help to reduce the so called theory practice gap.

Within the realm of clinical practice the findings indicated that students experience a blurring of boundaries concerning their role. If students are seeing qualified nurse work and health care assistant work as being different and the role of the student as analogous with the support worker; this has clear implications for nurse education. It raises questions regarding how the roles of health care support worker and qualified nurse should be taught. For educators of student nurses the research raises concerns regarding the value of continuing to teach students skills which they may not necessarily practice as nurses: bed bathing, taking patients to the toilet, feeding patients etc. Skills which more importantly, the students do not see as legitimate qualified nurses' work. Within clinical practice students are engaging in superficial surface approaches to learning which is at odds with the deep approach required by students in higher education. Educators need to consider

changing how students engage with learning in the clinical setting, or acknowledge that the surface approach will suffice.

Whilst it was known that learning is contextual, this research highlights that little attention seems to have been paid to the impact of this on nurse education. Based on the findings of this thesis I am suggesting that nurse educators need to be far more flexible in enabling students to go into early placements with others who they see as friends. This should not be viewed as a childish fancy, rather as an important aspect in facilitating peer learning in clinical practice. The friendship fosters learning. Shared practice is demonstrated as having an impact on peer learning through story telling. Therefore, I suggest that students who have experienced the same clinical placement are brought together with the explicit aim of peer learning vicariously through and from each other's experiences. This type of learning can take place away from the clinical setting but should be viewed as clinical learning. Learning is contextually bound and is not necessarily related to chronological length of time on the programme. This challenges the view of what seniority means amongst nursing students. Our current emphasis on separating students out into chronological linear year groups throughout nurse education programmes should be reconsidered. We need to bring student groups together in order to promote deep learning; relevant learning based on what the students are experiencing with their peers.

Therefore it can be concluded that peer learning is an important and previously under estimated facet of learning to be a nurse. The thesis has revealed new insights into the community of students and highlights the importance of relationships in peer learning. New knowledge has been established in relation to the mechanisms of peer learning in both clinical practice and classroom settings and the notion of seniority has been challenged. Students use their peers to learn practical psychomotor and survival skills. Students also learn experientially through each others'

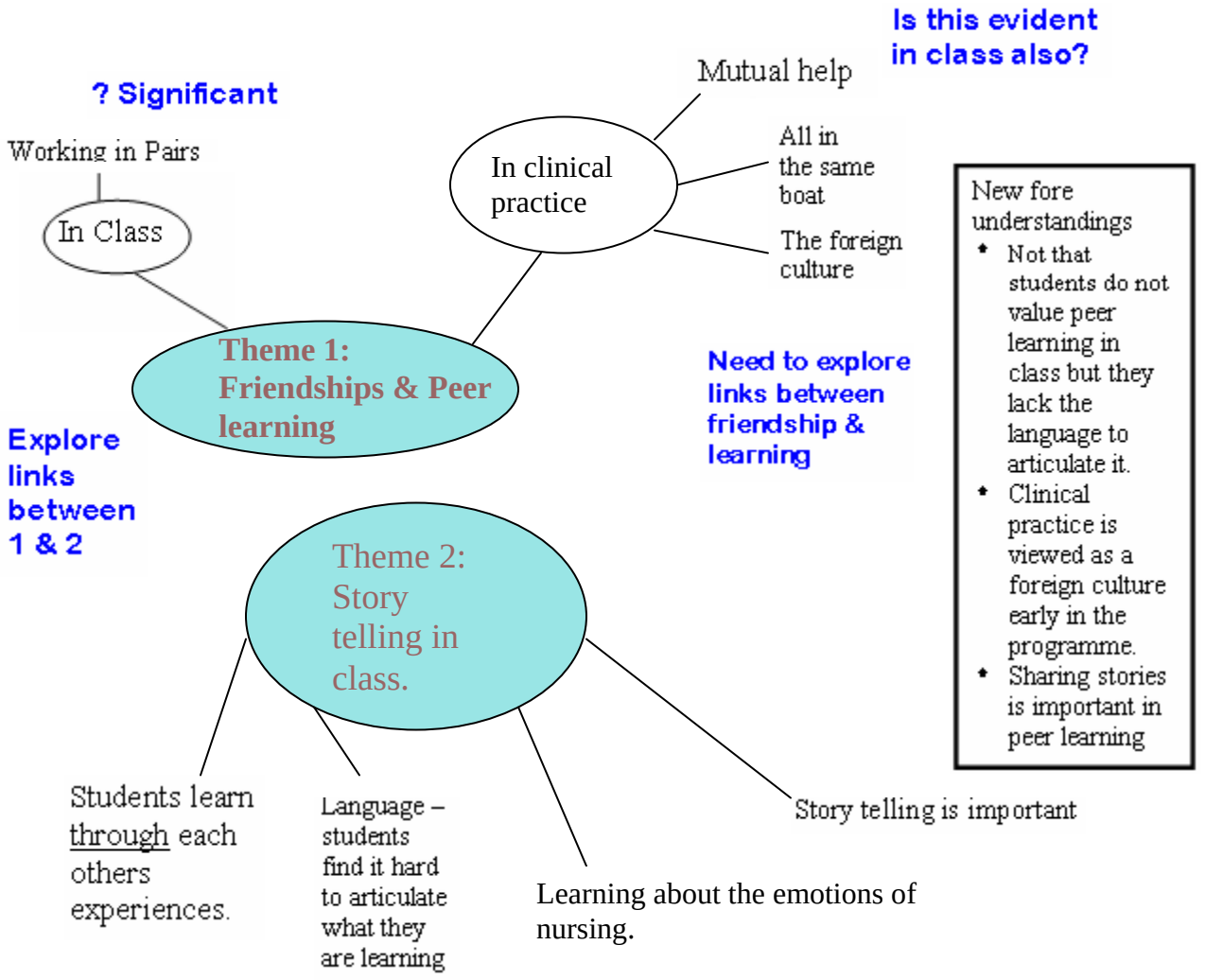
experiences by sharing stories about clinical experiences; whilst doing so, the students are learning clinical nursing. The clinical practice setting does not hold the monopoly on clinical learning. As far as the individual students are concerned their three years of pre registration education will be one of the most important periods in their lives. Those of us who have been through the experience find that it stays with us and remains a reference point for a great deal of subsequent learning. It has been an enormous privilege for me to share in the experiences of the community of students who are the subjects of this thesis and it is pleasing that through this research, their experiences will add to the body of knowledge concerning nurse education.

Appendix One: Diagram One

EMERGENT THEMES AFTER 6 MONTHS DATA COLLECTION

Fore Understandings:

- In terms of learning in clinical practice student nurses learn from each other, using mechanisms which have not been fully explored & are poorly understood.
- Students value peer learning in the clinical setting.
- Dialogue plays an important part in promoting peer learning in clinical practice.
- In terms of learning outside the clinical domain, students do not value learning from each other in small groups in the same way as they value peer learning in practice.



New fore understandings

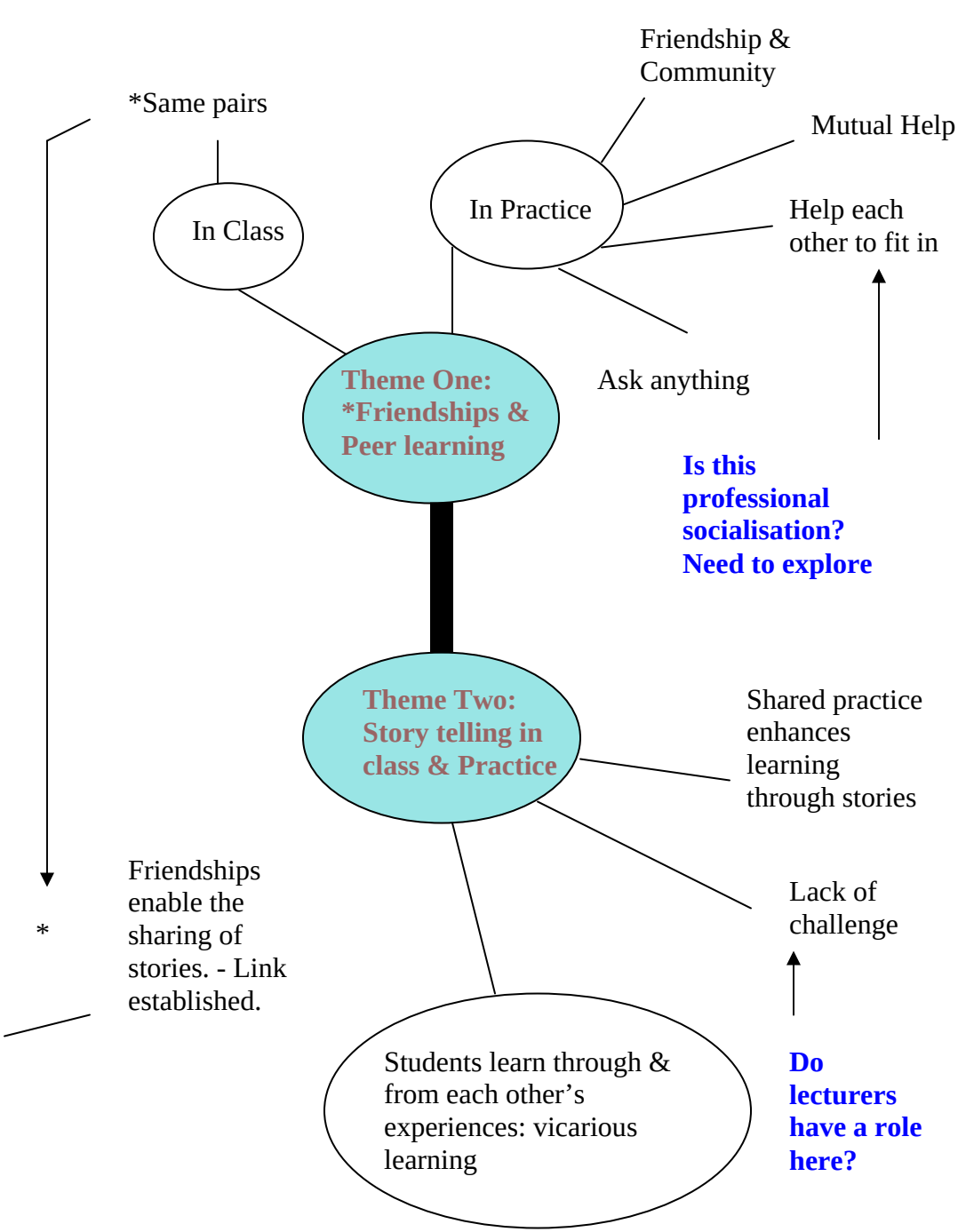
- Not that students do not value peer learning in class but they lack the language to articulate it.
- Clinical practice is viewed as a foreign culture early in the programme.
- Sharing stories is important in peer learning

Appendix Two: Diagram Two

Themes & sub themes after twelve months data collection

Fore Understandings:

- In terms of learning in clinical practice student nurses learn from each other, using mechanisms which have not been fully explored & are poorly understood.
- Students value peer learning in both academic & clinical settings
- Students find it hard to articulate the value of the learning
- Dialogue is an important part of peer learning mainly through sharing experiences (stories).
- Students see clinical practice like a foreign culture.

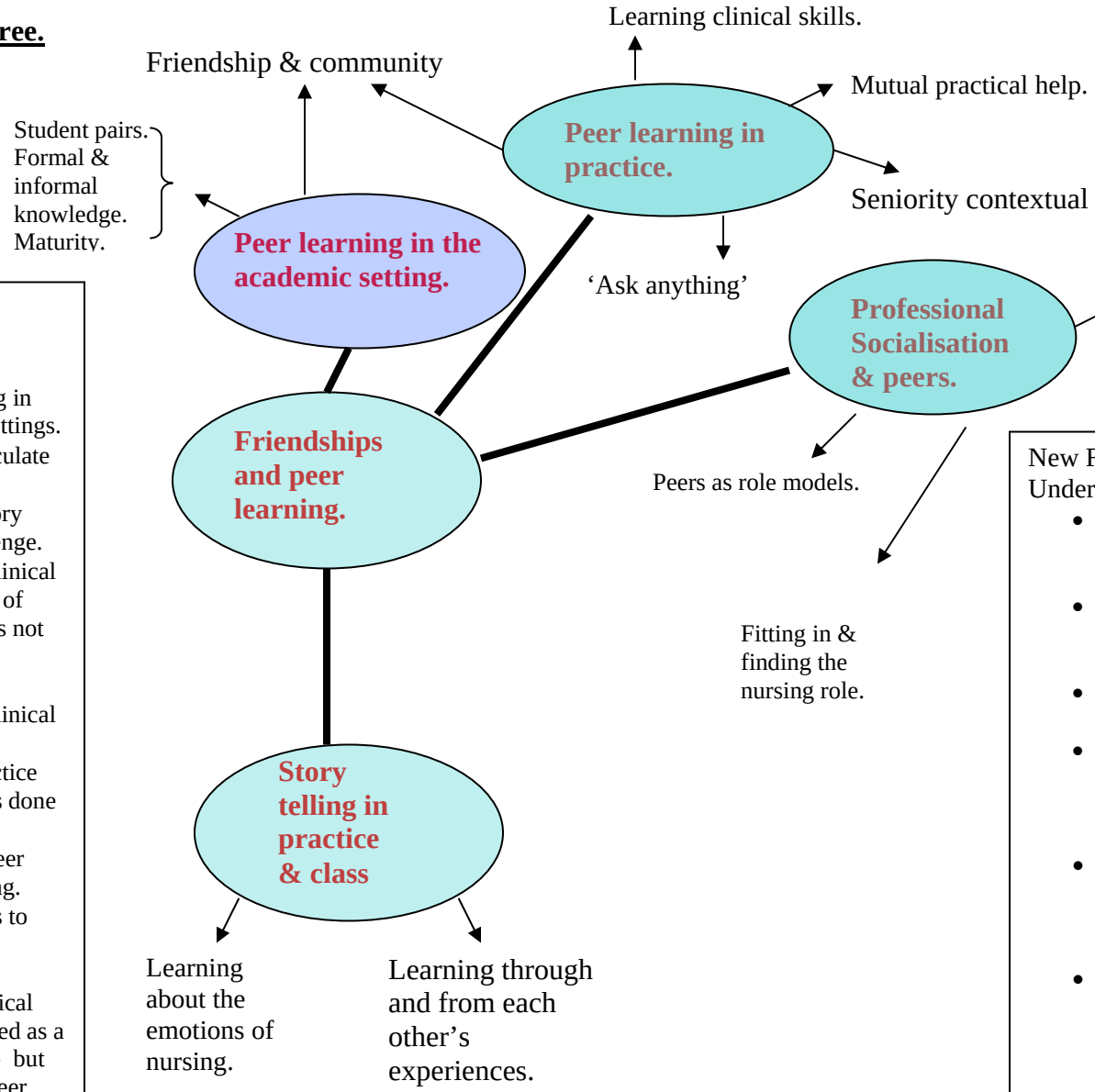


New fore understandings:

- Story telling in clinical practice takes place after the work is finished & away from the ward.
- Shared clinical practice enhances peer learning in class
- Students exist on the edge of the community of practice of qualified staff.
- Dialogue is superficial – no challenge
- Observed practice is assumed to be correct – no challenge
- Peer learning involves teaching clinical skills to fellow students
- Vicarious learning experience is effective.

Appendix Three: Diagram Three.

Themes & sub themes after eighteen months data collection.



Fore Understandings:

- New insights emerging into processes of peer learning.
- Students value peer learning in both clinical & academic settings.
- Students find it hard to articulate the nature of that learning.
- Dialogue is important in story telling but there is no challenge.
- Students teach each other clinical skills – an important aspect of peer learning, but practice is not challenged.
- Students form their own community of students in clinical practice.
- Story telling in clinical practice takes place after the work is done and away from the ward.
- Shared practice enhances peer learning through story telling.
- Peer learning helps students to learn about the emotions of nursing.
- Need for friendships in clinical practice should not be viewed as a marker of lack of maturity - but as an essential element of peer learning.

New Fore Understandings:

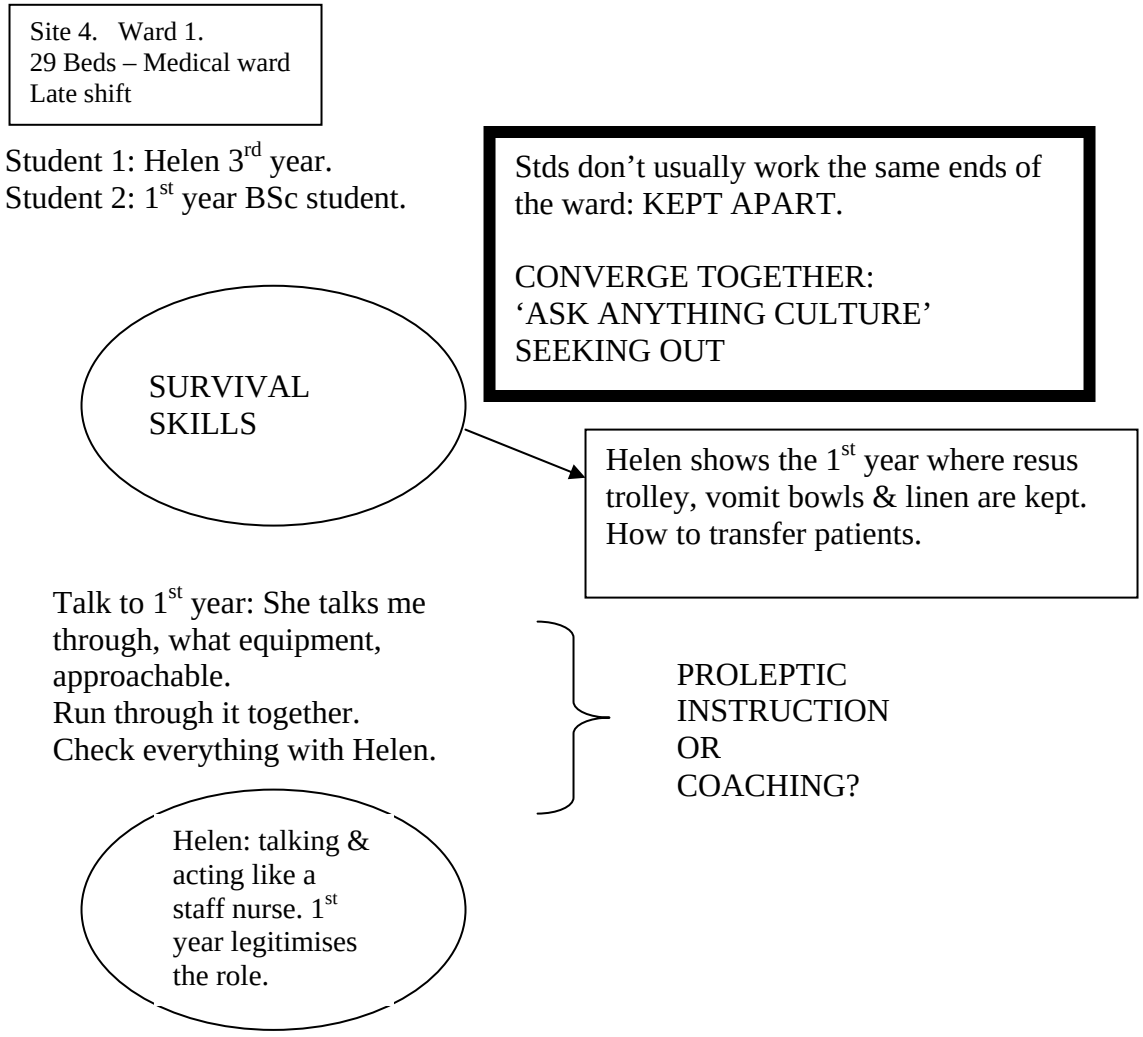
- Seniority challenged: context specific.
- Peers pass on survival skills: context specific.
- Peers act as role models.
- Students use 3rd years to prepare themselves for that time.
- Ideas not challenged in practice or classroom.
- Lecturers can enhance peer learning: questioning & finding meaning.

APPENDIX FOUR.

Examples of raw data extracts:

Example 1: Observational field notes.

Example 2: Ethnographic conversation from the field.



Example two: Ethnographic conversation site 4 ward 1.

Helen: I would give them (the 1st years) a hand to transfer patients, show them how to transfer a patient on their own so they don't have to keep coming back to the nurses station trying to find out how they should do it. C1	
DR: That seems like something that's really straightforward, fundamental for a 1st year to know; how did you know what to tell her? DR1a	
Helen: Because I think having a list of all your patients that you're working with, I just find it really important to know where you're up to with them, and you can always refer to the list. C2	
DR: OK, but did somebody say that to you at some point? DR2a	
Helen: I think so, one of the staff nurses gave me a piece of paper. C3	
DR: What happened? DR3a	
Helen: I didn't really know what to do with it, I just scribbled the weight, and didn't know any abbreviations or anything, so I try to help them- like with any abbreviations they don't understand. I would put something in a box if I don't understand and I'll go and find out what it means and tell that to the student. I put a line under there because I know what that is and I can explain that now. C4 (She shows me her list of patients with boxes and lines she has just described.	*Helen is talking like a staff nurse here. Sees the fellow student (1st year) as something different to herself.* *Is she already taking on the staff nurse role?*
DR: OK, so what other things are the other students asking you? DR4a	
Helen: Is it really scary being a 3rd year? When will you qualify? But I think the 1st year was more scary, because I thought, I'm never gonna remember all this but I'm getting there now. I'm feeling like I know, not everything, but enough to get by. Even though it is still scary and when I'm qualified on my first day I'll go to pot. C5	We are joined by the first year BSc student.
DR to BSc std: OK, so when you say she's a great teacher, can you tell me a bit more about that? DR5b	
Ist year BSc std: She talks me through it and tells me what to do. (She is referring to doing dressings) C16b	
DR to BSc Std: So she talks you through it, tell me how she does that. DR 8a	
!st year BSc std: Well she tells me what I need to get,	*Is this proleptic instruction?1st year*

what order to do it, I don't know really, she's just really good. Like if I ask her something she'd go and find out or say it if she knew. C17b	*legitimizes Helen's role as a staff nurse.*
DR to 1st Year BSc std: So you can ask her questions? DR9a	
1st year BSc Std: Yeah C18b	
DR to 1st Year BSc std: What about the other students, could you ask them questions? DR9a	
1st year BSc Std: Yeah I think so. C19b	
DR to 1st Year BSc std: And does it matter if they are 1st year's like you? DR10a	
1st year BSc Std: No, but I would ask someone who was qualified afterwards. But even though we were all in the first year we've all learned different things, been in different situations; they might have learned something I haven't. C1 10b	*What you have experienced is less important than length of time on the programme. Seniority challenged.*
DR to 1st Year BSc std: Would you teach another 1st year? DR11a	
1st year BSc Std: Yeah, I'd be happy to show someone a bed bath. C1 11b	*Teaching is reciprocal.*
DR to both students: Do you think it helps you to learn, having other students here? DR12 a	
1st year BSc Std: I think you'd feel on your own really, no I don't think you would, because you get to do loads, there's things that the students get to do, things like dressings and observations with each other. C1 12b	

Example 3: Ethnographic conversations demonstrating the importance of friendships to learning:

Student conversations demonstrating the links between friendship and learning. The data was obtained at towards the end of the second year. The first extract is from a student who was in her early twenties on starting the course (E), the second extract is from a student in her late twenties (Cl).

When you begin university you are told about all the support groups available to you during your training, however, the most important support network is never mentioned – fellow students. No one can empathise with you like another student can. E1.

During my training I have had many pleasant experiences with other students. My first interaction with other students in practice was on a general medical ward. I was extremely nervous and scared because I'd never worked in a hospital environment before. This was the placement where I made two of my now closest friends. E2.

My first placement wasn't what I expected it to be, I felt very disheartened with the whole experience. Little did I know that it would be this bad experience that would bring us all together. Who would have thought that from something bad would friendships flourish. E3.

I found strength from my fellow students to carry on and during particularly bad days we would wait expectantly for lunch time to come so that we could share our experiences, analyse them and make each other feel better about them. E4.

Another memorable interaction that I had with a fellow student was with a third year and was due to qualify; so during quiet periods she would teach me things that I didn't know. E5.

As a first year I was a bit overlooked, not in a nasty way, but if there were any clinical skills to perform the staff would pass the responsibility of these tasks on to third year students. This particular student took me under her wing and would take me with her on clinical tasks and explain them to me whilst

performing them. She also taught me about the assessment process and how to fill it in. I am so grateful to her for what she did, without her input I doubt I would have developed my skills to the standard that they are today. E6.
I love meeting new students and asking them about their experiences and where they see themselves when they complete the course. E7.
Without the experiences and interactions I have had during my training I wouldn't have made the friends I've made or be where I am today. E8

Over the past eighteen months I have experienced four very different placements in endoscopy, surgical wards, community and theatre. I believe that these different learning environments, along with my developing knowledge of the nursing role within these environments has influenced the way in which I have learned from other students. Cl1.
On my first placement I felt like a fish out of water, I was in a completely unfamiliar environment, in a town I had never been to before, surrounded by people whose roles I didn't understand and most worryingly of all patients!. However, there was also another first year student on this placement and I believe we found each other's support invaluable. Cl2.
To have someone else there who knew exactly how you felt was a great help. It was this mutual support on this placement that formed the basis of our friendship and how we learned from each other, confirming with each other that we were doing the right things, learning the same skills and figuring out how on earth to fill out all the paperwork. Cl3.
We would tell each other about the experiences we had encountered, about clinical areas we had visited and people we had met and how to go about doing the same. Cl4.
The student and I continued our relationship in a similar fashion on our second placement, where we were also on the same ward. However, here there were also second and third year students. Our relationship with them

was different, we would have conversations about what to expect from the rest of the course, how it felt to be at the end of the course and nearly qualified. We would compare how the course was effecting our home life and how we were coping with the lack of money. Cl5.

On a few occasions she was actually teaching me certain skills, not for the first time but consolidating what I had already been shown by a qualified nurse. I found she gave me confidence in my own ability. I respected and valued her knowledge and wanted to learn from her experiences. Cl6.

Appendix Five:

Student information:

Name	**Age**	**Details.**
Lisa.	25	Lisa's sister had recently completed the course. Lisa had a young child. Worked in healthcare prior to the course (nursing homes).
Helen.	27	No previous healthcare experience, had waited for the right time to start the course (children at school).
Jo.	20's	Previously worked as cabin crew for a major airline but no previous healthcare experience. Lisa and Jo developed a good friendship over the duration of the course.
Wendy.	30's	Had cared for her father during his terminal illness, but no formal healthcare experience. Wendy had two children and had waited until they were 'older' to start the course.
Paula.	Late 20's	Previous healthcare experience in an acute setting. Was seconded to do her training. Had waited until her children were older.
Natalie	Early 20's	No previous experience in healthcare. Waited until her child was older. Paula and Natalie became good friends.
Angie	Early thirties	A mature student with some years experience as a health care assistant before starting the course. Had a young son who was pre school age at the start of the course.
Jess.	18	The youngest member of the group, no previous healthcare experience.

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