The influence of international clinical placement experiences on careers of healthcare students: graduate and employer perspectives

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Abstract

The internationalisation agenda continues to be one of the key influences on the patterns of work of UK higher education institutions. In order to enhance cultural competencies for healthcare students, provisions are made by several UK universities for students to complete a clinical placement abroad, referred to as 'international clinical placement' (ICP) in this thesis. Previous studies on ICP have examined the experiences of students but research on the long-term influence of these experiences on students' careers is still scant. The research reported here represents an initial attempt to capture accounts of these influences.

This study was designed to gain a holistic understanding of the long-term influences of ICP on students' careers drawing on the multiple perspectives of healthcare graduates and employers. To the best of my knowledge, this is the first study that has gained employers' views as well as the views of graduates, when exploring the impact of ICP on employability.

Qualitative in-depth semi-structured interviews were conducted with both graduates and healthcare employers. A thematic analysis of the data identified four key themes: practice culture, communication in clinical practice, approaches to employability and career management. The attitude of participants towards the value of ICP for developing cultural competencies was largely positive but it was difficult to determine the extent to which an isolated experience such as ICP influenced their employability. The findings from this study did not suggest that ICP experiences had any greater influence than UK placements in gaining employment.

The discourse around standards and scope of clinical practices abroad was found to be the dominant feature in shaping students' careers. Whilst appreciating the differences between the clinical practice in the UK and other countries in Europe, both the employers and graduates in this study held strongly to the ethnocentric views that the standard and scope of professional practice is limited in most European countries when compared to the UK. The outcomes of this research benefit multiple stake holders including students, academics, clinical educators, professional bodies, employers, and researchers.

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List of abbreviations

AHP: Allied Health Professional

CE: Clinical Educator

CP: Clinical Placement

EBP: Evidence-based Practice

HCPC: Health and Care Professions Council

HEI: Higher Education Institution

ICP: International Clinical Placement

IDI: Intercultural Development Inventory

MSK: Musculoskeletal

MDT: Multidisciplinary Team

NHS: National Health Service

NMC: Nursing and Midwifery Council

OT: Occupational Therapist

PT: Physiotherapist

QAA: Quality Assurance Agency

SLT: Speech and Language Therapist

WCPT: World Confederation of Physical Therapy

Chapter One: Introduction

1.1 Thesis overview

The internationalisation agenda continues to be one of the key features of UK Higher Education Institutions (HEIs). Internationalisation prepares students to work in a globalised world and the intention is to enhance global dimensions for all students (Jones and Killick 2013). International and intercultural dimensions are embedded into the content of the curriculum in order to create opportunities for staff and students to experience internationalisation, both at home and abroad (Leask 2009). Internationalisation programmes enhance individual students' academic competencies, as well as social and cultural skills (Knight 2003; Middlehurst and Woodfield 2007). Healthcare students in some UK HEIs have opportunities for completing one or more of their practice placements abroad. There are a few studies that have examined the overseas clinical experiences of students, but not much attention has been given to the long-term influence of international clinical placements, referred to as ICP in this thesis. The aim of this research was to explore how ICPs influenced graduates in their professional career. Equal emphasis was given to understanding the views and perceptions of healthcare employers on employing graduates with ICP experience. This research was intended to enhance our understanding of long-term influences of ICP from multiple perspectives, including physiotherapy and nursing graduates and their employers.

A qualitative inductive approach was adopted in this research. A total of eleven UK healthcare graduates with ICP experience, and nine employers with an experience of employing UK healthcare graduates participated in the study. A semi-structured interview was the method of data collection and the data was analysed using thematic analysis. The results of this small qualitative study cannot be genaralised as it does not represent the whole population. However, some of the insights gained from this study can be utilised for healthcare curriculum development. Further, this research can benefit multiple stakeholders including students, academics, clinical educators, professional bodies, researchers, and employers.

Being aware that this thesis will be read by those who are not necessarily from the healthcare discipline, every attempt is made to explain the key terms and concepts related to the discipline. A number of resources were used in writing this thesis including books, reports, guidelines, websites, conference proceedings and journal

articles. The articles used in the literature review were retrieved from various databases to cover the wider areas of the field of education and health sciences, within both the UK and international contexts. Some of the databases used here include the British Nursing Database (BND), Allied and Complimentary Medicine (AMED), PubMed, Cumulative Index to Allied and Health Literature (CINAHL), British Education Index (BEI) and the Education Resources Information Centre (ERIC).

The term clinical placement used within this thesis refers to a clinic or a hospital in which students are given an opportunity to practice in the real world. For most healthcare students, the clinical placement experience is provided within the country of their undergraduate study. In this thesis, international clinical placement (ICP) is a relative term (depending on the student's country of undergraduate study) used to refer to clinics or hospitals abroad. For example, for all UK healthcare students, ICP refers to all the placements which are located outside the UK. Employability within this thesis refers to both gaining employment and being employed in their area of professional practice in a healthcare setting. The samples for this thesis are drawn mainly from physiotherapy and nursing who are employed in a healthcare setting as a physiotherapist or a nurse.

This chapter is divided into three parts. The first part introduces the research context. The concepts related to clinical placement and the importance of clinical supervision are discussed. This is followed by a short introduction to ICP. The second part discusses the development of research questions and the theoretical frameworks used in the study. Part three is the final part where the structure of each chapter is outlined.

1.2 Understanding clinical placement

The clinical placement constitutes a major learning component in healthcare undergraduate programmes, and forms a base for this research to compare and contrast in relation to the international setting. Clinical placements provide experiences for students to bridge the gap between theory (the knowledge gained within the university setting) and practice in the real world (where they will be working with patients) (Pront et al 2016). Clinical placement is an integral part of the undergraduate curriculum for all healthcare programmes. It is an essential component for integration of theory and practice that helps students develop skills and competencies required for professional practice (Rauk 2003; Mason and Bull 2006). In these settings, students are prepared to be competent for working in dynamic

healthcare systems that change rapidly. It is also known as practice placement, where students work with patients under the supervision of qualified professionals from the same discipline. It offers a unique opportunity for students to work in a range of settings to understand and experience care delivered within the healthcare contexts (Currens and Bithel 2000; Aiken et al 2001).

Aside from the medical and nursing disciplines, there are a number of other allied healthcare programmes such as physiotherapy, occupational therapy, social work, speech and language therapy and diagnostic radiography. Doctors, nurses and allied health professionals working in healthcare settings are referred to as healthcare professionals. In order for each of these professionals to practice in a country, they will have to be registered with their respective professional body in the country of their practice. In the UK, the Nursing and Midwifery Council (NMC) is the professional body for qualified nurses and the Health and Care Professions Council (HCPC) for all allied health professionals. For students to gain registration in the UK after they qualify, they are required to complete specified hours of clinical placement in a range of clinical areas. Students of allied health are required to successfully complete a minimum of 1000 hours of clinical placement which equates to about one third weighting of their undergraduate curriculum, as specified by standards of the education and training guidance issued by the Health and Care Professions Council, UK (HCPC 2009). Similarly, students enrolled in an undergraduate nursing programme will have to complete 2300 clinical practice hours which comprises about two thirds of their programme according to requirements of the Nursing and Midwifery Council, UK (NMC 2010).

The responsibility for organising clinical placements for students lies with individual taught programmes in a university. In the UK, most placements are with the NHS, and only recently have universities started to offer placements in private healthcare sectors. Ensuring quality of the placement for students is important as they spend a considerable amount of time in their clinical placement. However, this process is not easy as students are placed in a range of settings and maintaining standards can be very challenging (Pront et al 2016). Through careful planning of a series of structured clinical placements, the intention is to provide opportunities for students to progress steadily from a closely supervised environment to becoming autonomous practitioners (Doherty et al 2009). The nature of clinical environments is highly complex, with multiple factors influencing students' learning (Orland-Barak and Wilhelem 2005). A number of pedagogical and andragogical principles are used to

explain the learning in a clinical environment. For example, many adults prefer to learn by ‘doing’ and engaging in self-directed activities (Knowles 1984) as that promotes deeper learning through problem based learning (Gravett 2004; Dolman’s et al 2016) and critical thinking (Gambrill and Gibbs 2009; Morrall and Goodman 2013) which contributes towards becoming independent learners.

1.3 Clinical supervision and its importance

Clinical supervision for students in a clinical setting guides students to develop skills and competencies for professional practice. Educators play key roles in students’ learning in the clinical placements and, importantly, are the gatekeepers to monitor the learning quality and the maintenance of professional standards. In practice, and in the relevant literature, these educators may be referred to by many names, the main ones including ‘preceptors’, ‘mentors’, ‘clinical educators’, ‘clinical tutors’, and ‘clinical supervisors’ (Gleeson 2008). Within this thesis an educator in the clinical field will be referred to as ‘Clinical Educator (CE)’. In practice, CEs have a dual role of supporting students’ learning in addition to their primary role of delivering care to patients. In the healthcare sector, there continues to be a lack of clarity regarding their role and recognition as CEs. There are a significant number of research publications which explore the role of clinical educators and their influence on student learning (Shakespeare and Webb 2008; Myall et al 2008; Ousey 2009; White 2010). The success of practice placements depends upon the collaboration between academics, students and clinical educators (NMC 2015).

The need for structured training for clinical educators for physiotherapists in the UK was felt in 1992 when the allied health courses moved towards an undergraduate honours degree programme (Cross 1992). Prior to this, students were offered a diploma award within a polytechnic institution, and the role of clinical educators was not well defined. The students followed a clinician to observe them treating patients and some of them provided hands-on experiential learning for students; they were neither involved in structured teaching, nor were they a part of the assessment team. At the time, those responsibilities were with the academic staff. The shift to a university graduate course necessitated the introduction of training for clinicians and universities started to offer courses for clinical educators that broadly encompassed teaching and learning. In order to upgrade themselves from supervisors to educators, it was important for the therapists to consider how students learn, ways of facilitating student learning and the methods of assessing students in the clinical setting (Cross 1994). It was only a decade later, in 2002, that the framework for clinical educators in

Physiotherapy was introduced in the UK (CSP Curriculum Framework, 2002). It provided detailed guidelines that included the development of a learning contract with students and introduced assessment tools in supporting and assessing students' learning. The Nursing and Midwifery Council introduced an equivalent framework much later in 2008 (NMC 2010). In relation to this, there is always an active partnership between universities and clinical education sites, with the intention to provide the best learning experience for students within their clinical placements.

CEs must possess certain skill sets which are different to the ones acquired by clinical staff. Andrews et al (2006) found that CEs are often ill prepared, which impacted on student learning. There are concerns about a lack of preparation of educators supporting clinical placements (Health Workforce Australia 2010; Hakim et al 2014) and, these created a need for universities to design programmes for clinical educators to equip them with the necessary knowledge and skills to supervise students. One such programme is the clinical supervisor support programme for healthcare professionals in Australia. In 2012, as part of a doctoral study on nurses, the effectiveness of the one-day programme was evaluated by considering input from 199 participants. The programme received overwhelmingly positive responses from participants and further funding was approved for the next three years; by 2015, about two thousand participants across various healthcare disciplines had completed this programme (Russell 2016). Despite such successes and increasing recognition, such introductory programmes can only serve to provide overviews of the roles and responsibilities but do not adequately address the important issues related to the application of skills and knowledge in practice.

Based on a survey conducted by Chang et al (2013) on the perceptions of clinical preceptors' role in a paediatric acute care setting in one of the organisations in Ontorio, Canada. The participants' of the study indicated the need for improving their existing clinical education programme. Based on the participants suggestions, the same group with a few additional members designed two level programmes which they opened for all educators from the same organisation One at an introductory level for novice educators and another at an advanced level for experienced educators Gueorguieva et al (2016). The introductory level was offered to professionals from the same discipline, mainly nursing, and the workshop covered the basic concept of clinical education, as well as the overview of roles and responsibilities of educators within the discipline. This programme was mainly based around the use of case scenarios, role-play, and videos to facilitate group discussions. For the advanced

level, educators from different healthcare disciplines were invited to participate and the workshop included discussion of advanced concepts in teaching and learning, the importance of modeling, and the use of coaching and reflective questioning. Networking opportunities were provided and involved experienced facilitators sharing their clinical teaching experiences. Both the programmes were found to be very successful and were positively evaluated. However, such programmes are only beneficial if organisations provide timely support and recognition to educators. For a better student experience, there should be innovative ways of training educators. Gueorguieva et al (2016) argued that for such programmes to be successful, there should be an effective working partnership between universities and hospitals.

In order to have an understanding of 'good supervision' for students in a clinical setting, Pront et al (2016) conducted a literature review. They reviewed papers mainly from nursing and allied health. The papers were drawn from a number of countries including the UK. Using a thematic analysis, they synthesised their results from a total of 81 papers under four main themes which included - *to partner*, *to nurture*, *to enable*, and *to facilitate meaning in learning*. Partnering involves the learning relationship between students and clinical educator to set objectives for their learning; communication was key to this partnership, where both educator and student entered into an understanding of the process of giving and receiving feedback, whereby it need not be always 'soft' or 'gentle' but could be 'tough' (p. 488). Nurturing effectively highlighted the importance of induction of a student into the community of practice. Certain behavioral aspects such as anxiety and fear, if managed well, can create trust and respecting a student as an individual learner can also enhance student learning and improve personal attributes, thus increasing a sense of belongingness (Levett-Jones and Lathlean 2008; Edgecombe and Bowden 2009; Rodger et al 2011). Considering students as future colleagues helps in building mutual respect, which is an important attribute to have within clinical education.

Despite the willingness to provide the best possible clinical experiences, not all therapists are able to support students on placements due to various reasons such as shortage of staff, limited level of skills and knowledge in education, high workloads without any financial gain (Steele-Smith and Armstrong 2001) and weak mentorship programmes (Kinchin et al 2008). Supervising students in a clinical setting is often viewed as an additional responsibility for clinicians (Pront et al 2016). Prioritising workloads with the dual responsibility of providing quality care for patients, and better education for students has always been a challenge for clinical educators (Chang et

al 2013; Panzavecchia and Pearce 2014), thus compromising on either the provision of effective healthcare or adequate supervision. Through facilitation and feedback, clinical educators encourage students to engage in reflective practice, critical thinking and problem solving, all of which enable students to be autonomous practitioners (Pront et al 2016). Kinchin et al (2008) argue that the inability to think critically creates a negative impact on the careers of students and further warn that it compromises the quality of care they provide to their patients.

1.4 Conceptualising ICP

International mobility of students for clinical placement offers opportunities for students to study in healthcare settings overseas, in order to gain insights into different professional practices and cultures (Adomat 1997). Understanding societal injustices and inequities is important to students as they work in highly complex and dynamic healthcare environments (Petit dit Dariel 2009). Further, it is claimed that ICP experience enhances patient care and prepares students to work in a diverse environment (Kent-Wilkinson 2015). Traveling abroad to gain experiential learning is not a new concept as undergraduate medical students in the UK have been traveling abroad for some of their clinical placements. Similarly, the UK medical colleges offer placements for medical students for students from abroad. For example, Imperial college London offer six weeks of elective placement for foreign students. It has been over a decade since this has expanded to other healthcare undergraduate students in disciplines like nursing and physiotherapy. ERASMUS is a European funding body that promotes and funds a number of projects, including participation of healthcare students in clinical electives across Europe, in order to create a mobile workforce that can meet healthcare needs (European Commission 2009, ERASMSUS 2015).

1.5 Development of research questions

The impetus for this study has stemmed out of my own experiences of initiating and managing an international students' exchange programme whilst working in a UK University as a senior lecturer in physiotherapy. As a part of this exchange programme, every year two or three undergraduate physiotherapy students had an opportunity to undertake clinical placements in Italy for a period of three months funded by ERASMUS. Some of the students, having completed about one-third of their clinical placements abroad, were unsure of how the skills and competencies gained abroad would be acceptable to their educators in the UK clinical placements. Later, upon graduation, a few of them were concerned as they were unsure if their

ICP experiences would be acceptable to their prospective employers. The job market at the time was very competitive and they were unaware of their own positions in relation to their classmates, who had done all their placements in the UK. Following their graduation, all the graduates of physiotherapy including the two who were on ICP gained employment within the first three months. This suggested to me that there were many questions which could be answered regarding the employability of the two graduates, such as how they would have used their ICP experiences in gaining employment, how their employers would have perceived their experiences, what future plans the graduates had and many more relating to the contributions of ICP in shaping their careers. These questions were important to me as I was instrumental in developing the partnership for students' exchange with one of the European universities and these questions would have given the department of physiotherapy where I was employed at the time further direction on improvement and/or expansion of such provision. This study was undertaken to gain insights into the long-term influences of ICP from two different perspectives, first from the graduates who were on an ICP whilst they were students and second, from the healthcare employers, using the following research questions:

1. How do graduates of healthcare describe their ICP experiences relative to their UK placement experiences?

2. How do graduates of healthcare envisage the influences of their ICP experiences for their professional career?

3. How do employers of healthcare graduates perceive the link between ICP and employability?

1.6 Theoretical frameworks

The ways in which each individual learns in a clinical environment depend not only on how a placement is structured but also on the way the individual interacts with the environment. This inter-relationship between structure and individual agency is explained by Clouder (2003) using Bourdieu's concept of social constructionist theory (Bourdieu 1993 cited in Clouder 2003:213). Social constructionist theory emphasises professional socialisation, which is a process of induction into the culture of a profession based on individual experiences. Further, Burr (2003) argues that the experiences of an individual are unique and that they bring their own interpretations in order to construct knowledge, which is supported by Greveson and Spencer (2005)

who in a simplistic way consider learning in a clinical environment as an individual process. Every individual interacts with the world differently, thus creating their own meanings and perceptions of events (Parahoo 2006). In order to capture these experiences, it was important to consider an approach that reflected subjectivity within a social context to answer the first question on how students on ICP critically reflect upon and conceptualise their experience.

The second research question on how an individual envisages their ICP experiences in relation to their career prospects particularly in gaining first and subsequent employment utilised a number of concepts. For example, the concept of employability was understood using the employability model proposed by Pool and Sewell (2007) where the authors identified the fundamental elements of employability. Those included developmental learning for a career; work and wider-life experience; knowledge, understanding, and skills related to the discipline; generic skill; and emotional intelligence. They proposed that if opportunities are provided to link these essential elements together through reflective practice it would be possible to further develop self-efficacy, self-esteem, and self-confidence, which they believe are crucial components of employability. Similarly, Bridgestock (2009) proposed a conceptual model of a graduate attribute for employability. The concept of employability included the acquisition of self-management and career building skills in both generic and discipline-specific areas. In addition to these concepts, this thesis also has taken into account Bourdieu's (1987) notions of 'forms of capital', where mobility of an individual is seen as affording opportunities for social capital (professional networking) and cultural capital (language, intercultural and diverse) to lead to economic capital (employment opportunities) (Bourdieu 1987, cited in King et al 2010). These concepts together aided investigation of the second research question on students' career trajectory and employability. There is very limited research on how individual graduates gradually develop and utilise their experience gained abroad in gaining their first employment and/or subsequent employments. The intricate details of phenomena involved in understanding the processes of employability, necessitated consideration of a suitable research methodology and methods.

The third and final research question aimed to understand how employers perceived the link between ICP and employability. A number of initiatives of Higher Education Institutions (HEIs) in the UK have considered using employers in curriculum development and other pedagogical activities. Higher Education Academy (HEA n.d) provide resources and training to university staff members and offer suggestions on

engaging employers for aiding students' transition into the labour market to enhance graduate employability. Employers' views and perceptions are clearly identified in the literature as the missing link with regards to student mobility (Brooks and Waters 2009; King et al 2010). This is of a particular importance in the healthcare setting as clinical placement is mandatory and is important to gain an understanding of how employers perceive applications of graduates if they have had their placement experience in a different healthcare context to the workplace. Understanding employers' views and perceptions to an adequate depth was considered important for HEIs in order to improve curriculum review and development and to enhance graduate employability. There was a need for a methodological approach and methods that could explore these factors to a passable extent.

1.7 Structure of the thesis

Chapter 2 consults and critically reviews the published literature related to ICP that is relevant to the research questions established for this thesis. The chapter is divided into three major parts: first, the nature of work placements for students in healthcare, referred to as clinical placements; second, clinical placements in international contexts; and finally, a review of literature in relation to graduate employability.

Chapter 3 is concerned with the methodologies and methods used in the study. The purpose of this chapter is to critically reflect on various methodologies and methods available for a researcher, and the reasons for the chosen method. The ontological and epistemological position of the researcher is clarified within this chapter. The chapter critically examines the methods used for data collection and the related ethical considerations. The scoping study undertaken prior to the main study is also discussed in the chapter.

Chapter 4 presents the results of the data collected from the graduates for this thesis. The main codes and themes identified from the data will be presented in the chapter.

Chapter 5 presents the results of the data collected from the employers for this thesis. The main codes and themes identified from the data will be presented in the chapter.

Chapter 6 discusses the analysis in relation to the current literature and practice. The main aim of this chapter is to consider the practical implications and the long-term influences of ICP from both graduates and employer perspectives.

Chapter 7 is the last chapter and summarises the findings of this research. It makes recommendations for practice and identifies opportunities for further research.

Chapter Two: Literature Review

2.1 Introduction

This chapter reviews the literature related to both student mobility and clinical placements. The section begins with a discussion on conceptualisations of clinical placements both in the UK and abroad, followed by an exploration of factors identified in the literature as enablers and barriers to students' mobility for placements. A major part of this review is focused on the experiences of students on placements abroad. The final part of this review is related to employability. It examines the definitions and frameworks related to employability. The review offers an approach to understanding the nature of and complexities involved in ICP with a brief discussion on the approaches to graduate employability. Due to the new and emergent nature of international placements, there is a scarcity of research reported in the areas related to healthcare. Hence, the literature review presented draws on other interdisciplinary areas including nursing, medicine, and dentistry as some of the principles are applicable across all healthcare disciplines.

2.2 Clinical placement

2.2.1 A learning environment

Multiple research studies have demonstrated that clinical placements have an impact on the personal and professional development of students that continues to influence them after they graduate to a path of life-long and life-wide learning (Doherty et al 2009; Edgecombe and Bowden 2009; Knight Bridge 2014). Learning in a clinical environment is experiential in nature and is embedded in the undergraduate healthcare curriculum, which is meant to have both immediate and long-term value for learners (Knight Bridge 2014). Learning in the clinical setting is profoundly different from classroom learning. Moving from a university environment, with an established learners' community, to clinical practice, where a student is placed with a group of qualified clinicians is often challenging and daunting for students. Some studies have highlighted that students do not have a sense of belongingness and often feel socially isolated while they are on their clinical placement (Orland- Barak and Wilhelem 2005; Christiansen and Bell 2010).

Levett-Jones and Lathlean (2008) explored the relationship between belongingness and learning in clinical environments. They described 'belongingness' as acceptance of an individual by a particular group, the individual feeling connected to the group and aligning their own personal and professional values with those in the group. In the present curriculum in both nursing and allied health sciences, every student undergo clinical training in a range of placement areas within a short period of time. The students move from one placement to another every five or six weeks, leaving very little time to build the sense of belongingness.

A number of studies have been undertaken to understand personal development in clinical contexts. Clinical placement promotes autonomy, the development of self-confidence, problem-solving skills, patience and tolerance (Anderson and Kiger 2008; Doherty et al 2009; Boniface et al 2012; Knight Bridge 2014) and particularly these are important in new and emerging areas of practice (Cooper and Raine 2009). However, none of the studies followed their students to find how they further developed these personal attributes and applied and nurtured them in their future practice after they qualified. Students lacked context-specific critical reflection, and it could be argued that, with the rapidly changing and highly dynamic healthcare sector, roles do evolve and professionals need to grow beyond these simple attributes and competencies by engaging in deep critical reflection and careful consideration of the context in which they engage (Kinsella 2001; Gambrill and Gibbs 2009; Knight Bridge 2014)

There are opportunities for inter-professional peer learning within healthcare to understand the perceptions of students and educators. Students who have had opportunities to work with students from other disciplines valued opportunities to understand professional boundaries and the importance of team work (Hilton and Morris 2001; Ponzer et al 2004; Rudland and Mires 2005). Roberts (2009) and Christiansen and Bell (2010) explored the effects of peer learning on nursing students and found that they were drawn to each other in order to combat social isolation. However, it could be argued that this could sometimes have a negative impact on students' experience. Learning as students, working in an interdisciplinary group, often provides no clear understanding of individual responsibilities towards caring for patients, and sometimes students feel hesitant to disagree with their peers. This highlights that community and practice are not always compatible with each other (Cox 2005).

A study completed by Ladyshewsky et al (1998) showed that students performed better in clinical placements through cooperative learning if they were placed with their peers. Benefits of peer working and learning in an academic setting are well established. Academic researchers such as Currens and Bithel (2003) and Moore et al (2003) advocated collaborative learning with peers and their research was shown to enhance the development of certain skills and knowledge which otherwise could not have been achieved alone. This is further supported by studies undertaken by Michelle et al (1993) and Bruffee (1993). Currens and Bithel (2003) found that shared learning among clinical educators and students improved patient care. The study carried out by van der Hem-Stokroos et al (2003) found that the quality of education through ongoing feedback is key to student learning which in turn impacts on the quality of patient care.

Creating opportunities for peer sharing and learning is easier in an academic setting but is always a challenge in clinical placements. A number of research projects have looked into peer learning in clinical settings (Nemshick et al 1996; Holland 1997; Moore et al 2003; Stiller et al 2004). These studies examined various models of student and supervisor ratio - one to one, two to one and three to one. They found that both students and educators preferred a three to one model over one to one. This was later followed by a survey done by Kell and Owen (2008) to explore the students' perspectives on educator and student ratio. Students on four-week block practice clearly indicated that if more than one educator were involved in teaching and assessments, then this would disadvantage students and might deter their adoption of a deep approach to learning. This is because students feared failure if there were more educators involved in their training and assessment. However, the results of this study need to be carefully considered as the survey included only students' perspectives and not educators'. In addition, this was only the opinion of students and it was not a more objective reflection of their experience.

A similar type of study completed by Copley and Nelson (2012) explored the perceived benefits and challenges of multiple mentoring models and the study highlighted that multiple mentoring can provide opportunities for part-time and less experienced staff members to take part in mentoring where students can learn from a wider variety of case loads. However, they also acknowledged that it is a bigger challenge for students to manage both their time and the expectations of multiple staff members. Although the results of this study highlighted some of the good practice, it would still be beneficial to exercise a degree of caution when allocating placements

to students, especially during their first few clinical placements, where the student is still getting to grips with the ideas of clinical placement and the supervision process.

2.2.2 Quality of clinical placement

The term ‘quality’ in healthcare is multi-faceted with diverse dimensions, such as care with low cost, fairness in care with an overall aim to improve the services of an organisation (Ennis and Harrington 2001; Donabedian 2005; Kelly et al 2006). Measuring quality of healthcare has always been a challenge. In the UK, quality of healthcare is measured using indicators such as the clinical service quality measure, or care hours per patients per day (National Quality Board 2016). These frameworks are performance indicators for multiple stakeholders. The criteria are centered on patient experience, patient satisfaction, fair access, effective care and the number of patients seen per day. These directives give very little attention to the impact of student placements and therefore, these indicators do not adequately measure the students’ roles in the quality measurement. Neely (2011) perceives such measures as a means of control and argues that the individual’s focus will be to manage the measure, and not the performance. These, in turn, may affect student performance, as students on placement become a part of the workforce. Here, the question arises as to whether students on placement make a negative or positive impact on the quality of care provided.

Students on placement are often seen as an additional burden on clinical educators, and this might have a negative impact specifically on the costing aspect of the performance index (Huddleston 1999). Dillon et al (2003) in their study found that clinicians with additional responsibility for supervising students were more productive when compared to clinicians without a supervisory role. This was based on the number of patients seen per day, and the amount of time each clinician spent on patients. A study done by Ladyshewsky et al (1998) showed that time spent by clinical educators on students did not affect overall patient care as students were able to share patient loads and, further, teaching students helped CEs to keep their own knowledge up to date.

In the UK, the quality of clinical placement for students within healthcare is assessed by the Quality Assurance Agency for Higher Education (QAA). The quality of clinical education is influenced by factors related to the placement and supervision process. One of the important factors is related to the provision of supervision available for students in the clinical setting, and as discussed above, there are diverging views in

the literature, and in practice, on the best model for supervision. The QAA also assesses the number of students on each placement.

The other significant factor assessed by the QAA is the teaching and learning strategies used by clinical educators. There are opportunities in the clinical setting for students to apply evidence-based practice and/or critically analyse the evidence for the effectiveness of treatment. Numerous studies highlight the importance of integrating evidence-based practice into clinical practice which has also shown the capacity to improve the quality of care (Finkel et al 2003; McGinty and Anderson 2008; Melnyk et al 2014). However, there are practical obstacles to students sharing and engaging in evidence-based practice in clinical settings. The barriers to such practice include the lack of time, lack of appropriate resources like easy access to journals, exposure to all types of clinical settings and also that many clinical educators themselves are not advocates of evidence-based practice (Green and Ruff 2005; Titler 2009; Melnyk et al 2012).

In order to combat these problems, Melnyk et al (2014) strongly suggest that organisations provide clarity through staff training on evidence-based practice. Students are likely to benefit if their clinical educators value and apply evidence-based practice. They also recommend creating a culture within the organisation that promotes such practices, and that job descriptions be reconsidered to align with evidence-based competencies. Despite its advantages, it is challenging to find placements that can follow multi-model supervision as well as effective supervision in the UK. This may be due to a variety of reasons. Firstly, not all clinical areas have opportunities to accommodate more than one student, for example, in a community setting where patients receive treatment in their own homes, it may be difficult to accommodate more than one student. Secondly, the time required for supervision and the fair allocation of work needs to be considered. A literature review on student mentorship by Pollard et al (2006) highlighted the difficulties of taking up clinical educators' roles in nursing due to high workloads and the shortage of staff in some clinical specialties. This was supported by a study by Mallik and McGowan (2007) on five different healthcare professions which also highlighted inadequate clinical educators' training, and a lack of recognition of educators as a formal role within health sectors.

2.3 International Clinical Placement (ICP)

2.3.1 Understanding student mobility

Within the existing literature there are a few terms used to describe students' international travel for the purposes of study. The United Nations (1998) conceptualised mobility of people as either short or long-term migrants. The distinction between the two is based on the number of days spent in a country other than that of his or her usual residence. If someone moves for more than three months but less than a year, then they are referred to as a short-term migrant. To be classified as long-term, a migrant should spend at least one year in another country. Most studies of ICP show that the duration of placement ranges between four weeks to three months and very rarely goes up to a year, with six to eight weeks being the most desired (Kent-Wilkinson et al 2015). However, when referring to students who study abroad, this terminology has evolved and is referred to as 'mobility' and not 'migration'. The term 'migration' has been used in very few studies, where students chose to study a full time programme for a period longer than a year (King and Shuttleworth 1995). The mobility of students, on the other hand, is often understood in the literature as short term movement of students to another country as a part of their degree (Findlay et al 2010).

In the past two decades, internationalisation has driven growth within the UK higher education sector. The term internationalisation is frequently used with globalisation. To distinguish between the two, globalisation refers to external drivers such as economic, social, cultural and political relationships driven by human migration, whereas internationalisation is the response to accommodate globalisation within an institution (Naidoo 2006; Bennett and Kane 2011). Globalisation has a profound effect on internationalisation. This has implications for policy makers, academics, managers, administrators, and students (DeVita and Case 2003 Kehm and Teichler 2007). In the published literature, internationalisation lacks a universal definition. A widely used definition of internationalisation is provided by Knight (2003:1) as the

…process of integrating an international, intercultural or global dimension into the purpose, functions or delivery of post-secondary education.

This definition is reflective of cultural diversity within the global context and the emphasis is on embedding the aspects of internationalisation within curricula (DeWit 2011). As a concept, internationalisation is a multidimensional process with diverse

interpretations. As a practice, internationalisation which was both emergent and transient (Bolsmann and Miller 2008) started to become core and called for deeper engagement at both individual and institution level to prepare students adequately to work in a globalised world (Brandenburg and de Wit 2011). As early as 2003, an institution-wide initiative to internationalise every programme of the institution was evident in one of the UK universities (Jones and Killick 2007 cited in Jones and Killick 2013) and within a decade, a substantial amount of work was done to reflect IoC at the modular level (Jones and Killick 2013).

The majority of healthcare students tend to undertake short term mobility rather than studying full degree programme abroad and the students on clinical placement tend to go for up to an average of 8 weeks (Go International 2016). The number of UK students going abroad for studies through ERASMUS has increased by 50% since 2007 and more than half of the students who go abroad chose to study in another European country, however there is deep concern about the impact of UK's proposed withdrawal from the European Union on students' mobility in the future (International Higher Education in Facts and Figures 2016).

King et al (2010) argue that the way in which UK universities manage the internationalisation process for the next decade is crucial to their potential success. The internationalisation activities within HEIs vary from institution to institution depending on the resources available, their mission and strategy. For example, universities such as Warwick and University College London have expanded their internationalisation drive which has resulted in increased international student numbers and transnational education activities (Fielden 2011). Koutsantoni (2006) has provided a detailed categorisation of internationalisation activities for both home and international students. International student exchange is one of the ways of internationalising home students either for academic or clinical modules (Leask 2009).

Organising an international clinical exchange for students is distinct from setting up an academic exchange. In an academic exchange, the exercise of mapping the modules has to be carefully considered as the curriculum are set and run differently in different countries. Organising an ICP for students can prove comparatively easier than dealing with academic modules, but is still challenging in terms of time commitments, resources to train clinical supervisors, link lecturing, organisational barriers, language and cultural differences (Goldberg and Brancato 1998). Despite these challenges, research studies demonstrate that there are several benefits to

HEIs' reputation and to the individuals with both the types of exchange (Greatrex-White 2008; Milne and Cowie 2013). With the growing interest in student mobility, it is important to understand the factors involved in the decision-making process for all the stakeholders. The drivers and the barriers for ICP are thus discussed below.

2.3.2 Enablers of ICP

The rationale and motives of higher education institutions (HEIs) for providing clinical placements abroad are wide ranging. At an institutional level, HEIs benefit from collaboration with foreign institutes and healthcare providers to gain a local competitive advantage, build reputation both at home and abroad and develop research collaborations (Leask 2009; UK Government 2013). At an individual level, participation in a placement abroad provides opportunities not only for developing the required academic knowledge and clinical skills but also personal attributes, intercultural awareness, and opportunities to network and improve interpersonal skills such as confidence, adaptation and communication (Peiying et al 2012). Research on international mobility within the context of the UK's HEIs is still nascent, including on the courses related to healthcare. A search for published literature on ICP for healthcare students using databases relating to healthcare yielded more than fifty articles. The studies were largely based in Australia and Europe followed by North America. The studies were mainly in the field of nursing with most studies focusing on undergraduate student experiences. Research on ICP within the context of healthcare education can be traced back to the 1980s mainly from the US (Button et al 2005). Within the UK and Australian context, ICP is a recent phenomenon, particularly with allied health disciplines when compared to nursing.

Examining drivers of student mobility in the existing literature forms a firm base to plan institutional arrangements and facilitate student participation. There are a number of studies that have identified the reasons to travel given by healthcare students. Most higher education students who express an interest in undertaking a placement abroad are those with prior experiences of overseas travel (Owen et al 2013; Kent-Wilkinson et al 2015). In contrast, Callister and Cox (2006) found that only six out of the twenty nursing students who went on ICP had previous international travel experience. Although not a highly significant factor, it is still one the influencing factors for student mobility. The presence of family and friends abroad strongly influences student decisions of moving abroad (Burgess et al 2014). Family background plays an important role in student mobility and this was highlighted in a study by Brooks and Waters (2011), who found that students who travelled abroad

as children, either for a holiday or due to their parent's work were more likely to travel abroad for study. Further, students who had an international background, for example, if a parent is either born abroad or is a non-national, were more likely to take part in student mobility (Burgess et al 2104). Another significant factor influencing the mobility of students was the educational background of their parents, and particularly the mother's educational and professional background had an influence on the decision and was found to be one of the stronger drivers for international mobility (King and Ruiz-Gelices 2003; Messer and Wolter 2005; Findlay et al 2010; Brooks and Waters 2011). Further, students' travel is also influenced by the presence of 'Champions of Cause' in their own universities (Kinsella et al 2008:85). A champion is a university staff member who has a passion for internationalisation, supports students, and has the ability to network at all levels - including university, faculty, and individual levels - both in their own and other universities.

The availability of funding that covers living costs and flight charges were found to be one of the important factors for most students (Brooks and Waters 2011). A study by Kinsella et al (2008) highlighted that students appreciated bursaries available for study abroad. Although only small amounts of money that covered a part of an airfare were awarded, it encouraged students to consider traveling abroad for clinical placement. Often, the rest of the expenses had to be covered either through support from their families or borrowing money from elsewhere. Socio-economic background was found to be one of the barriers to international travel (Go International 2016). Findlay et al (2006), basing their study in a UK university, found that students on study abroad programmes were not represented proportionately, as most of them were from privileged, middle-class families. In Europe, Eurostudent, co-funded by Erasmus+ reports on the socio-economic background of students and barriers to international mobility (Eurostudent VI – 2016-2018).

A few studies have identified future employment opportunities as one of the drivers of student mobility. Travelling with the hope that student mobility experience would lead to better future opportunities to work abroad is found to be one of the crucial aspects to consider in the success of student mobility, as it greatly contributes to the willingness of students to participate (Bohman and Berglin 2014). Brooks and Waters (2009) found that international mobility would bring students a better position in an organisation rather than gaining initial employability, as well as a better degree classification. The study found that students were able to get a better degree if they

were a part of an exchange programme at another university. In contrast, Findlay et al (2006) found that these factors were not the major enablers when compared to other factors like gaining cultural experience and competencies. There is an understanding that graduates with international experience have better employment opportunities on their return and this area is under-researched and needs further exploration. In addition, it is also important to explore if students who go abroad are mainly those who are academically strong, with the willingness to achieve higher. However, it is difficult to determine and assess this factor with ICP due to the discrete nature of placements. It may be reasonable to suggest that students who go abroad are mainly those who are academically strong, with the willingness to achieve further. But this needs further exploration in future studies.

To create a global workforce, and for healthcare professionals to move across borders for work, it is important not only to have an understanding of a range of diseases but also those conditions that are rare and endemic. Holmes et al (2012), interviewed medical students who went to Latin America from the USA, and found that one of the interviewee's reasons for travelling abroad was to learn about diseases such as rubella, tuberculosis, and leprosy, which are rare in the USA, but are considered endemic in Latin America. The interviewee described that such diseases are very rarely encountered in the USA. Even though seemingly important, this aspect was not explicitly described in any other studies.

Two other important issues raised in the same study which were not common and yet significant for healthcare students were those that relate to the cost of care and the use of technology. The participants expressed that their international travel from the USA to other, lower income group countries was a way for them to learn about low-cost care. Acquiring the skills and knowledge to be able to work with limited resources and financial constraints can be considered a vital aspect of healthcare, particularly with current global financial conditions. The other reason for choosing underdeveloped countries as a destination is in order to gain experience of and the ability to work with limited technological resources that compare and contrast with the healthcare systems in the US (Holmes et al 2012). In contrast, in a Canadian study, Kinsella et al (2008) found that students who wished to travel for their ICP preferred countries with technological advances, in the hope of witnessing better care and communication.

Most studies on ICP found that, females tended to take up the option of international studies more frequently when compared to males. This was evident in a number of

studies consulted for this review. For example, various studies done on ICP showed that female students outnumbered male students by a large margin. For example Kelleher et al (2016) from a total of 25 nursing students, 24 were female students; Gower et al (2016) 49 females and 3 male nursing students; Haro et al (2014) had 17 female occupational therapy students out of 20; Kent-Wilkinson et al (2015) out of 131 respondents of nursing students for a survey 118 were female students. Female students consistently outnumbered male participants and the reason for this could be that, in healthcare, particularly nursing, occupational therapy, and physiotherapy have traditionally been female-favoured professions and a recent review of studies by Koch et al (2015) found that male nursing professionals perceived having lesser positive clinical experience when compared to female professionals.

The processes involved with deciding to travel abroad are not simple and depend on a variety of other circumstances and institutional arrangements, including geographical location, family background, future aspirations and the financial support available for mobility. Within healthcare, it also depends on the discipline of the study, for example, some professions like medicine and nursing present wider scope of practice covering all specialities within a hospital when compared to physiotherapy or occupational therapy. In Physiotherapy, for instance, the main areas of work are still Musculoskeletal, Neurology Cardiorespiratory or Paediatrics although the scope of practice with the last two decades has been expanding.

2.3.3 Barriers to ICP

In order to enhance student participation in ICP, it is important for their institutions to understand and address the issues related to the barriers that prevent student participation. A study by Owen et al (2013) found that students who had progressed further into their studies were comparatively less likely to travel abroad. They further found that students who held degrees acquired previously, and also mature students showed the least interest in mobility. One might speculate about the factors at different stages in life, which conspire against international travel such as a settled lifestyle, marriage, children, other financial commitments like part-time jobs, having a mortgage. The spoken and written language in the community abroad is also one of the major decision factors for students considering mobility options. Studies have found that students from English speaking countries mainly chose to travel to Anglophonic countries, in order to minimise the language barrier. Students from non-English speaking countries too preferred travelling to English speaking countries to improve their language proficiency and this was one of the perceived benefits of

study abroad (Kent-Wilkinson et al 2015). However, it is questionable whether it is practically possible for a student to spend time on learning a new language within the short period of time during their clinical placement. Study by Attrill et al (2016) found that international students in Australia who spoke English as an additional language and new to Western culture had poor performance in clinical placement, thus stressing the importance of being proficient in language.

Kumwenda et al (2014) found that students traveling from countries such as the UK, USA, Australia and New Zealand who wished to travel in pursuit of serving underprivileged patients preferred countries like Zambia and Tanzania where most people spoke English. It is important to consider the aspect of language, as this can impose a greater limitation on the choices of destination. Furthermore, King and Ruiz-Gelices (2003) argue that language can have a 'double influence' and could act both as enabler and barrier to student mobility which can be substantiated by examining the trends of mobility of ERASMUS students. In this case, the number of students traveling from the UK to other European countries (where language is seen as a barrier, due to the other European languages that are spoken in different parts of Europe), was much lower when compared to students who travelled to the UK (in which language acted as a driver of mobility, as English is still considered as a preferred language) (ERASMUS 2014).

Countries like the UK, Australia, and the USA were found to be the most preferred choices for students around the globe to gain experience in clinical placement (Goodman et al 2008). Although the reasons for choosing these countries were not clear in any of the studies, it could be because of the belief that the standard of education is better in such countries when compared to other developing countries and Rivza and Teichler (2007) referred to this as vertical mobility. However, after examining the data on students' mobility for ICP, it appears that this preference is changing and that there is more of an outward mobility of students from developed to underdeveloped countries (Kumwenda et al 2014). This could also be due to the fact that students from developed countries, like the UK, have a wider choice of placements, and it is comparatively easier to organise clinical placement in these countries.

The shortage of clinical placements for students in the UK and Australia is well documented, with students being encouraged to travel to other countries for placements. This might explain why most of the students in the published studies are from host institutions based either in the UK and/or Australia. There are challenges

to organising placements for students who wish to do their clinical placement in the UK, Australia, or the USA. This could be due to lengthier processes to obtain police clearance and occupational health checks. Students should also obtain malpractice insurance, international certifications covering minimum language proficiency, mandatory training in skills such as basic life support and manual handling prior to starting the placements. Additionally, there is an acute shortage of placements and not all placements accept students from abroad. So, arranging clinical placements is time and resource-intensive hence requiring a good planning.

In contrast, these checks are not mandatory in countries such as India and Taiwan, and it is also easier to arrange placements with individual hospitals as a number of multi-speciality hospitals are either missionary or private. This is in addition to the living costs being comparatively lower in these countries and studies have shown that cost is the biggest barrier for students traveling abroad for studies (Kumwenda et al 2014). There are not many students on exchange programmes who go on clinical placements to the US, UK, Canada or Australia. Even students from these four countries tend to go to those countries which are also affordable and easier for universities and/or individuals to organise placements. This might also explain the reasons for most studies on ICP being done on students from the UK or Australia.

HEIs play a major role in organising student mobility and the role of HEIs is highly varied across the globe. Enough attention has not been given in the literature to the role of HEIs in fostering student mobility. Fielden (2011) found that adequate support and encouragement from HEIs can enhance student mobility, and he further argues that the lack of adequate information for students on the benefits of studying abroad can become a major barrier for student mobility. Inadequate information on the available funding streams and difficulties in accessing those funds are also seen as barriers to mobility. Another key barrier is a lack of understanding of credit recognition and transfer, and this is further compounded by delayed graduation (Vossensteyn et al. 2010).

A systematic review by Brown et al. (2016) on healthcare students’ decisions about going abroad identified a total of 10 studies that included five surveys and five qualitative studies. They found that students across professional group regardless of geographical location are similar in terms of decision making. Proficiency in host language was found to be one of the major deciding factors, where students preferred destinations without a language barrier. The studies in the review reported that students who are early in their programme are much more interested in study abroad

and having appropriate information about the host countries and institutions was found to be motivating factors. Standage and Randall (2014) found that students who went from the UK to India for their clinical placement were able to reflect on patients' rights and cultural practices critically. Throughout their placement, they observed the poor care of patients with limited access to healthcare, particularly in rural areas much more than urban which made them realise the value of their healthcare system, in this case, the National Health Service of the UK.

2.4 Experiences of students

Research exploring the experiences of ICP has found that there are many benefits of gaining clinical experience abroad. It improves self-awareness, increases professional competency, provides opportunities to demonstrate social responsibility, and prepares for future employment (Kent-Wilkinson et al. 2015). Figlewicz and Williams (2005) highlighted the gap in existing literature on the experiences of international mobility of students within the HEI setting and, particularly, on the experiences of students in ICP (Grant and McKenna 2003). Since 2005, a number of empirical studies have been conducted exploring the experiences of students in ICP and some of them include, Grant & McKenna (2003), Callister and Cox (2006), Greatrex-White (2008), Green et al (2009), Keogh and Russel-Roberts (2009), Chipcase et al (2012), Morgan et al (2012), Peiying et al (2012) and Charles et al (2014). The summaries of these studies are presented in the table in appendix 28.

In general, the studies reported that the ICP experience had positive impacts on students. It was evident that ICP experiences provided students with opportunities for both personal and professional growth. Some aspects of personal growth as described by participants were: opportunities to experience a new culture, improved communication skills including both verbal and non-verbal, the ability to face challenges which were new and unexpected, the fostering of friendships and understanding of self through the process of continuous reflection. Professional development was mainly through enhanced cultural awareness that led to the understanding of context-specific healthcare issues, development of cultural competence for better care of patients, understanding of the relationship between the socio-political status of a country and its impact on healthcare, and appreciating the importance of communication in healthcare. A number of participants in these studies expressed that the ICP provided a life-long memorable experience.

Grant and McKenna (2003) explored the experiences of nursing undergraduate students from one of the Australian universities who went to the USA, China, Hong Kong, Malaysia, and Northern Ireland. The students reported that it was an opportunity to understand the differences in nursing practices through adaptation. Callister and Cox (2006) while examining the journals of nursing students from a large private Western university, who had their placements in Argentina, Guatemala, and Jordan found that students expressed their ICP experiences 'opened their hearts and minds' (Callister and Cox 2006; p 97). Similarly, Greatrex- White (2008), while examining the diary accounts of nursing students from the UK who undertook an ICP, found that participants abroad felt 'foreignness' (p 532), a detachment from all that is familiar and from the host community, which the author argues was the students' way to adapt to a new culture.

Morgan (2012) highlighted some of the risks experienced by students during their time abroad on clinical placement, especially in a developing country. Some of the risks experienced by the participants included physical risks, like food poisoning; safety concerns, e.g., robbery, that they had to be careful about; as well as political instability. Some students also faced housing issues and poor facilities. Furthermore, they faced 'otherness', e.g. a student from the UK on a placement in a developing country felt that the people did not want to be influenced by English culture. Instead, they expected the student to dress and behave in a way that fitted the local culture. The study clearly highlighted that there are associated stress factors that a student will have to deal with when they are not in a familiar environment. It could be argued that such stress can be managed well if pre-departure information and timely support are provided by the university regarding the available facilities.

Learning to cope in a new environment and fostering friendships to combat home sickness were reported in the study undertaken by Green et al. (2009) on UK nursing students who were on clinical placement in Sweden, for a period ranging from 5 to 20 weeks placement. The study also highlighted that students, while on placement abroad, struggled to balance and prioritise between university assignments and clinical workload. In the view of the author, this is an important factor to be considered by the curriculum developers within the university, especially if a department encourages students to consider ICP. There must be flexible options in the curricula to allow time for students to adapt to new cultures. However, there are practical difficulties to consider in incorporating these flexible options as almost all healthcare courses are highly intensive and academically very demanding. This is particularly

true in the UK as healthcare degree programmes are three years in duration while most other countries, including Australia, offer a similar curriculum in four years. For UK students, this could be seen as one of the barriers for students considering ICP.

Most studies highlight that ICP provides opportunities to learn about a new healthcare system. Nursing students from Germany on an ICP in Finland engaged in comparing and contrasting the two healthcare systems, through which they critically evaluated the German healthcare system (Keogh and Russel-Roberts 2009). Developing cultural sensitivity and interactions are important for students in order to provide effective healthcare and the process of developing these were researched by Peiying et al. (2012). A total of seventeen students of Physiotherapy, Occupational Therapy and Speech and Language Therapy from an Australian university who had completed their four weeks of ICP in Australia, China and India were interviewed. The study found that initially the students were unfamiliar with the culture and grappled with concepts of the supremacy of their professional practice and the students were 'inclined to think ethnocentrically' as a result (p. 65). They believed that the approach at home was far superior and as they progressed they gradually moved to an 'ethno-relative' position and started to become less judgmental. As they began to understand and respect the host culture, they started to recognise and appreciate differences in healthcare.

The alternate ways of providing effective supervision are explored by Chipcase et al (2012) at an Australian university. Eight students from different disciplines of healthcare had a placement in Vietnam for a period of five weeks. They were accompanied by two of their lecturers, who were from a different discipline to that of the students. This was a unique arrangement as the normal practice is to provide educators from the same discipline. Students of medicine, physiotherapy, occupational therapy, and speech pathology were interviewed on their return to account for the supervisory process and the quality of facilitation that they had received. The researchers found that students highly valued the interprofessional supervisory arrangements and the study concluded that imposing limitations on the supervision process enhanced reflective practice and critical thinking. This resonates with the findings of an earlier study by Laitinen-Vaaananen et al (2007), which found that structured and highly supportive supervision in clinical placements can limit student ability to engage in self-directed learning.

To summarise, the studies referred to above show that ICPs can provide diverse experiences for students. Some of the key skills developed on an ICP include

communication skills (both verbal and non-verbal), ability to face new challenges, adapting to new situations, appreciating cultural differences, professional networking, awareness of global health issues, and differences in clinical practice between home placement and abroad. This implies that there are benefits of taking part in an ICP both professionally and personally (Morgan 2012).

Equally, the studies have demonstrated that there are difficulties and challenges such as financial hardship, isolation, personal safety, language barriers, home sickness and lack of support from clinical link lecturers. These challenges and difficulties sometimes become a barrier to students going on ICPs and some of these are highlighted in the recent report jointly produced by Council of Deans of Health and Universities UK International (2017). These findings are true even with non-healthcare students and are reflected in the literature review completed by King et al (2010). There has been increased outward mobility of UK students from 2007 to 2014 according to the statistics produced by Universities UK International and published as the report *Gone International: mobility works* (2016).

In order to promote student recruitment to an ICP, HEIs need to take measures to minimise the barriers referred to above (Morgan 2012). Many of the studies lack methodological details or rigour. This demonstrates that more research is needed in the area of ICPs with a sound methodology that can benefit researchers, students, and academics. Further, with the exception of Callister and Cox (2006), no other studies explored the long-term impact of an ICP. All the above studies have explored the immediate experiences of students and Tuckett and Crompton (2014) warrants that further research is needed as the long term benefits of ICP, particularly for their employability and long term career, is not clear from any of the studies.

2.5 The concept of employability

Employability is considered during curriculum design and delivery and it is common for HEIs to highlight their students' employment success in their marketing content (Mason et al 2009). Graduate employability benefits all stakeholders in the higher education sector including HEIs, students, graduates, and employers. This further contributes to the economic competitiveness of nations and education sectors in a global market (Cranmer 2006). The term 'employability' has been conceptualised in a number of ways and lacks a universally accepted definition. The widely used definition of employability is provided by Yorke (2006:1) and defines employability as

> *...A set of achievements – skills, understandings and personal attributes – that makes graduates more likely to gain employment and be successful in their chosen occupations, which benefits themselves, the workforce, the community and the economy*.

While this definition includes many useful concepts, the term ‘successful’ is too generic and open to interpretations, whether this means remaining in employment at a particular level or moving to a higher position are not clearly defined . Harvey (2003), while analysing the term ‘employability’, posits that the term ‘employ’ has less significance when compared to the term ‘ability’. Distinguishing these terms, the emphasis is to develop critical and reflective skills to empower a learner to obtain an employment (Gibbs 2010). For the purposes of this study, the working definition of employability will include students after graduation gaining their first and then subsequent employment both in the UK and abroad and/or to remain or progress in an employment.

A number of researchers have provided frameworks for employability. These include Harvey and Green (1994), who encompassed core skills such as the willingness to learn, team work and flexibility. Similarly, Knight and Yorke (2003) produced a model for employability that covered personal attributes like understanding, skills, efficacy and meta-cognition. Pool and Sewell (2007) developed a model that conceptualised employability as reflecting and evaluating attributes like learning, work experience, knowledge, skills, emotional intelligence and self-confidence. After analysing these terms, it is felt that these models, although developed mainly for business graduates, are applicable for healthcare graduates.

A widely used framework for employability within the UK healthcare sector has been developed by Asset Skills (2007) and is known as ‘The Employability Skills Matrix for Health’. The matrix provides a good description of employability skills required at different levels and is used by employers to draw up job descriptions for recruitment. It is also a useful guide for employees both to remain in employment and for career progression. Further, this acts as a guide for individuals seeking employment within the healthcare sector. The matrix has been reviewed regularly to improve the processes of employability with a review in 2013. The review included important pointers like personal skills, qualities, values, attributes and behaviour one should possess to work within the healthcare sector.

Very few studies have examined the early experiences of graduates (Holmes 2013) and these studies on employability often examines absolute or key graduate skills

using one of the above frameworks (Tomlinson 2007). However, criticising skills-based frameworks as too narrow, Holmes (2013) suggests moving the focus beyond skills to recognise the complexities associated with employability. This view is similar to Gibbs (2010) and Lowden et al (2011) whose view is that long-term impact of any learning experience could be understood through a deeper level of engagement with the individuals and particularly employability can be best understood from the perspectives of former students (graduates), employers and academics. Knight and Yorke (2003) point out that the onus lies with the students/graduates to clearly articulate their learning experiences for employers in order for the employers to value those experiences. Further, they argue that it is the responsibility of the individual educators within the HEI to make this explicit to their learners.

Following on from the above discussion, the concept of employability used within this study is wider than the ability of graduates in getting their first job on completion of a course. It is seen as a long-term process that involves students developing desirable attributes and experiences for their lifelong professional career and personal development. The individual approach towards employability varies widely (Tomlinson 2017) and the term ‘employability’ in this study refers to an ability to gain an employment (first or subsequent) and/or if already in employment, to sustain and grow in the future, thus encompassing both the elements of employability and employment. This is because, with the ongoing financial constraints within the UK healthcare sector, it is becoming highly competitive to successfully obtain a job (employability) and if employed, to sustain and/or progress to a higher level.

Equally, it is not clear from the literature how ICP is developing graduate skills related to employability, although there is anecdotal evidence to show that they are linked to each other (King et al 2010, Holmes 2013). Not much attention in research is given to exploring how students, after their graduation, use their experiences to gain employment and further have any opportunities to utilise the skills learnt abroad in their employment. Not much has been discussed within the research about involving employers in the arrangements for ICPs. It is also not clear from any of the discussions within the published sources how universities involve potential employers while strategising on internationalisation agendas. Further, the changing attitudes and perceptions of employers regarding ICP are the missing links in research. As internationalisation and graduate employability are becoming central interests of universities, it is important to involve all the stake holders, particularly the potential employers as little is known about how employers are involved and become aware of

the changing practices within the HEIs, in this case growing ICP arrangements. Hence, it is critical to collect and examine the views of healthcare employers around the issues related to ICP and graduate employability.

2.6 Summary

There is a growing body of interesting research considering clinical placement experiences of students and graduate employability as separate bodies of literature. These two distinct aspects which are highly interconnected within healthcare need to be examined within a single research. This research study examines the experiences of ICP and compares those experiences to clinical placements at home. Further, the study explores the influences of ICP experiences on the employability of healthcare graduates.

Chapter Three: Research Methodology

3.1 Introduction

Within this chapter, using a qualitative approach, the underpinning philosophies associated with this study are discussed. The ontological and epistemological positions are clarified, as well as the methodology considered for this study and, the reasons for the choice made for the methodological approach is discussed. The chapter also critically examines the methods used for the data collection and considers ethical issues. Wherever appropriate, the reasons for adopting the methodological approach and have been justified and attempts have been made to support that justification by drawing on the existing literature and further backed up by the scoping study.

3.2 Research paradigm

Before embarking on the methodological approaches, it was important to clarify the ontological (nature and the belief about reality) and epistemological positions (nature of knowledge) by examining the research paradigms as they had considerable implications for both methodology and methods adopted in this study (Murray and Lawrence 2000; Crossan 2003; Denscombe 2010). It is crucial for a researcher to demonstrate the understanding of different approaches and their underlying philosophies to gain a holistic view of their research (Crotty 1998; Finlay 2006, Finlay 2011). Epistemologically, the position of the researcher is important as this will depend on their role in the knowledge production (Robson 2011) and the research process (Cohen et al. 2007).

Historically, healthcare professions including physiotherapy have focused on the biomedical model of evidence-based practice for patient care (Wiart and Burwash 2007), where most research done in the discipline is conducted through either randomised controlled trials or quasi-experimental designs. My professional background as a physiotherapist, trained in the early 1990s and working as a clinical practitioner for a decade was highly influenced by the quantitative approach, where I believed that the outcome of research has to be objectively measured and should largely be generalisable. I was involved in a number of multi-centric projects engaging patients with neurological conditions. In most of these projects, I worked within a

bigger team mainly with neurologists, nurses, and pharmacists where the outcomes were mostly focused on the effect size of an intervention based on statistical measurements. Very little consideration was given to the clinical significance of a study as opposed to its statistical significance. How these interventions impact the quality of life for the individual patients were not the major focus of such studies (Polgar and Thomas 2013). In the UK, nursing and occupational therapy were among the first few healthcare professions who moved beyond objective measurements as they focused their research on psychosocial factors related to patient care (Nicholls 2009). Other healthcare professionals including physiotherapists, radiographers, and speech and language therapists started to change their views as a result of a change in the national policy to provide holistic patient-centered care (DH 2010).

I began to understand the importance of the subjective approach in research while working with occupational therapists, who often had the focus of capturing patients' experiences through qualitative research. In 2005, I started to engage in qualitative research when I moved from a hospital setting to a university setting as a lecturer. My own experiences of moving from India to the UK, managing work-life balance with a dual role of being a lecturer and a student, the journey that I underwent varied depending on circumstances, and situations. My personal and professional experiences made me realise that there is more than one way of researching the world, which fundamental in justifying the methodological approach is considered for the study (Creswell 2014).

Positivism and interpretivism, the two dominant approaches are discussed and their suitability in this study is examined. The ontological premise within the positivist approach believes the existence of single objective reality (Schwandt 2000; Clarke 2005; Punch 2014). Based on August Comte's ideologies, the social phenomenon is studied using a scientific method through empirical research which is observable and measurable using quantitative research methods. Epistemologically, researchers remain outside the research, striving for an objective measurement from an outsider perspective. The interpretive paradigm adheres to an ontology where reality can be understood through subjective experiences, and their interpretation of social reality is co-constructed by the researcher and the researched (Gracia and Quek 1997; Morrison 2000). Within this approach, the proximity between the researcher and the researched is maximised (Cohen et al. 2007). The interaction between the researcher and participants is vital in an interpretive approach (Nicholls 2009). In positivism, a deductive approach is used to test a hypothesis mainly utilising quantitative research methods such as experimental and non-experimental designs, but interpretivism is

biased towards qualitative research and analysed using an inductive approach in constructing knowledge (Crotty 1998; Denzin and Lincoln 2008). It is possible to predict, generalise and control the outcome using a positivist approach, whereas, in an interpretative approach, new meaning can be generated with illuminating ideas, which can be utilised in understanding a phenomenon (Usher 1996).

The discussions in the literature review highlighted that the context of clinical placement abroad is distinct from the one that the students are generally used to, particularly concerning language and culture, and the field of enquiry is still nascent. It was imperative to think beyond positivism as the quantitative approach would have limited application in this study for the following reasons: first, perceiving both international clinical placement and employability as independent variables to find cause-effect relationships would limit our understanding of the processes (Cohen et al. 2000). Second, an approach that captures complexities associated with ICP and employability had to be considered to answer all of the research questions with a different set of participants. Third, the research was not intended to objectively measure the rate of employment, instead explore the processes which the graduates employed in their career and the employers' attitudes towards international clinical placement. Hence, the experience of the individual participant is central to this research, where the research participants are well represented in producing knowledge (Cohen et al. 2007). Fourth, this research is based on a social context, which cannot be independent of individual experiences (Parahoo 2006; Creswell 2014). In this study, it was important to take into account the personal experiences, views, conceptions, and beliefs of different participants. The experiences of each of the participants differed and are unique to the individual (Finlay 2011). As such an inductive, interpretative, qualitative approach that looks beyond positivism is appropriate in an exploratory study such as this (Kumar 2011). Therefore a qualitative approach was adopted where personal accounts of participants would give rise to new knowledge rather than testing the theories objectively as in a positivist approach (Parahoo 2006; Darlaston-Jones 2007). The qualitative approach allows the research questions to be addressed to an adequate depth to understand the complexities involved in understanding the researched topic.

The qualitative studies are often criticised for its inability to generalise the research outcomes (Flyvbjerg 2006), and this is due to the small number of participants where the outcomes are applicable in a specific context (Newby 2014). The intention of this study is not to generalise the findings but to enhance our understanding of how an

isolated experience such as ICP, which is non-routine for UK healthcare students, might be influential in their career.

3.3 Methodological considerations

This research aimed to explore the experiences of international clinical placement of healthcare students and its influence on their careers. To collect and analyse data from participants' perspectives, all of whom had lived this experience, required close interaction with these participants. Having decided on the qualitative approach, I adopted the methodology that enabled me to adequately address all my research questions in a specific context (Fraenkel and Wallen 2009; Punch 2014). A number of methodological frameworks are available for qualitative researchers, such as - ethnography, grounded theory and phenomenology (Lichtman 2007; Cresswell 2014). All the three approaches are widely used in educational research to address questions in a real-life context (Thomas 2009). These approaches are used to gain a deeper understanding of various contexts in terms of culture, language and practice (Punch 2014; Standage and Randall 2014). These approaches allow a greater degree of interaction between participants and the researcher (Morrison 2007). In all these approaches, the researchers assume active role in co-constructing the meaning with their participants (Lichtman 2007; Finlay 2011; Charmaz 2014). Due to their similarities, as a novice researcher, I carefully analysed the suitability of all three methodologies for my study, as it was crucial to adopt the most appropriate methodology that could guide me throughout the study.

The approaches vary widely in terms of their origin, philosophical underpinnings, and the types of research questions that they attempt to answer (Parahoo 2006; Cresswell 2007; Starks and Trinidad 2007; Peim 2009; Thomas 2009; Gelling 2011). Ethnography has its origins in anthropology and can be traced back to Malinowski's work in 1914 and is primarily used to study cultural behaviour. Grounded theory was first explained by Glasser and Strauss in 1967 to generate a theory that is grounded in the data through symbolic interactionism. Phenomenology emerged from a philosophy largely influenced by the work of Edmund Husserl and Martin Heidegger in the early twentieth century, which seek to understand lived experiences (Finlay 2011; Cresswell 2014).

In comparison to phenomenology and grounded theory, the emphasis in ethnography is the study of practices, interactions, beliefs and orientation of individuals within a social context (Punch 2014; Creswell 2014). Ethnographic studies mainly involve

participants observation in naturalistic settings, and often a researcher takes an active role as a participant to observe a phenomenon and uses interviewing as an adjunct method to gain additional information (Atkinson and Hammersley 2007; Robson 2011). Ethnography was not deemed suitable for this study as the focus was on individual experiences of graduates and employers rather than the context of ICP or the NHS where the participants studied or worked. Regarding methods, it was neither within the scope of the study nor practically feasible to observe the participants in their placements abroad and in their workplace to study the phenomenon.

Grounded theory is one of the popular qualitative educational research approaches. In this approach, a researcher conceptualises the data by constant comparison and continually seeks additional information from the participants when gaps in the data emerge, which in turn helps in developing a new explanation and theory (Willig 2008). The theory is inductively drawn from the data without a hypothesis, and the intention is to develop theories as the study progresses (Corbin and Strauss 2008). The grounded theory is applicable in real world contexts and was developed to bring about theories which are neither simple nor grand. The 'middle range' theories are developed to apply in day to day educational practices (Oktay 2012). Grounded theory is considered a dynamic process that brings shared meanings as a result of interaction with others (Robbins et al. 2006 cited in Okety 2012). Morse et al. (2009) argue that data processing is one of the most crucial elements in grounded theory. The method of data analysis and the constant comparison is the key to developing new concepts and the data collection and data analysis happen simultaneously until the data saturation is reached (Oktey 2012) and could be complex for a researcher new to Grounded Theory (Kell 2007; Gelling 2011).

A wide range of literature is available on both student mobility and employability which helped in identifying the gaps in research and forming focused research questions whereas the philosophical stance of the grounded theory approach is that it starts with a broader aim and this gradually evolves into research questions during the data collection and analysis in a multistage process (Thomas 2009). When compared to grounded theory, phenomenology suited better as I was interested in the outcomes of an experience, ICP, for this study and the insights were best gained by those experienced.

3.3.1 Phenomenology

Phenomenology is suitable in those areas where there is little prior knowledge and focuses on examining lived experiences (Newby 2014). It is widely used in the field of healthcare and education which are firmly grounded in professional practice (Giorgi 2008). As discussed in the literature review, the link between the experiences of international clinical placement and employability exists, and this research intended to bring these processes to the surface using phenomenological perspectives (Finlay 2011). Some of the distinctive features of phenomenological research suited this study, particularly the collection of data from those individuals who have experienced the specific phenomenon of ICP, where all of the graduate participants in the study had ICP experiences as well as going through the employment process. Furthermore, phenomenology advocates the use of additional data collection techniques to gain a broader understanding of the phenomena (Finlay 2011; Creswell 2014). In this study, additional data was collected from the healthcare employers who had experience of recruiting healthcare graduates in the UK.

Adopting a phenomenological perspective in this study allowed broader and flexible ways of researching this topic. Experiences that are not necessarily connected in time, such as ICP experiences, employment processes, and future aspirations, to link together to create a general and meaningful description of the long-term influence of ICP. Further, the experiences, views and attitudes of individual participants made the data much richer. Many graduate participants in this study, following the interview, expressed that the process of being interviewed had deepened their reflections on their ICP experiences and that it was enjoyable speaking about their past experiences as students. Further, Finlay (2011) acknowledges that a phenomenological approach could be transformative and inspiring and it opens new opportunities for both the researcher and participants. Phenomenology is a philosophy rooted in the 20th century that seeks to understand the subjective experiences of individuals. Phenomenology as a philosophy is mainly divided into descriptive and interpretative, and the next two sections will discuss each of them in detail and the discussion continues with the adopted methodological approach for this study.

Descriptive Phenomenology

The German mathematician, Edmund Husserl (1859-1938) known as the founder of phenomenology believed in a careful examination of a person's everyday experience and proposed descriptive phenomenology. He believed in enquiry that focused on

conscious subjective experience, and advocated setting aside preconceived ideas through bracketing (Finlay 2011). Bracketing enables researchers to be open to understanding the phenomena being studied. Through careful observation of salient features of a phenomenon, and with series of reductions, Husserl believed in understanding the ‘essence' of phenomena (Smith et al. 2009).

In a descriptive phenomenological analysis, researchers need to look beyond what is already known, and Husserl advocated for researchers to disregard any prior knowledge through bracketing. The research intended to collect and analyse data from participants' perspectives while ensuring that the interpretation of their findings was not influenced by preconceived ideas (Robson 2011). Bracketing is a crucial in descriptive phenomenological studies as it gives the researcher opportunity to engage and critically reflect on the aspects which are familiar, and to view the world in a different perspective (Giorgi 1985). Bracketing as a concept, although accepted, is debatable, and researchers like Sokolowski (2000) argue that there is no clarity on how bracketing is possible within any phenomenological research, particularly when the study is grounded in professional practice.

In recognising the practical difficulties associated with bracketing, Dahlberg (2006) introduces an alternate term ‘bridling’ to cover the wider aspects of bracketing and explains ‘bridling’ as the,

“…restraining of one’s pre-understanding in the form of personal beliefs, theories, and other assumptions that otherwise would mislead the understanding of the meaning and thus limit the researching openness” (Dahlberg 2003 cited from Dahlberg 2006:16).

Interpretative Phenomenology

While Husserl believed in the epistemological theory of knowledge, his student Martin Heidegger (1889-1976) adopted the ontological stance - the science of being. Heidegger believed in being in the world rather than knowing the world (Reiners 2012). For Heidegger, Husserl's work was abstract and theoretical and questioned the possibility of creating knowledge without the interpretative stance (Finaly 2008). In his early work ‘Being and Time’ in 1927/62, he described human beings as ‘Dasein’ (being in the world), and that requires reflexive awareness. Heidegger viewed ‘being alone' as ‘being without others' This ‘being' was interlinked to ‘time' which is an ever-present horizon with no fixed existence, we are always ‘becoming' – we live in our anticipations (Finlay 2011). Heidegger believed that language and understanding are

inseparable, and personal awareness was intrinsic to phenomenological research, where it was impossible to negate our experiences related to the phenomenon under study. Heideggar mainly differed from Husserl regarding bracketing. Heidegger believed in moving beyond the description of experience and rejected the idea of bracketing with the introduction of hermeneutics, the theory of interpretation (Smith et al. 2009). Hermeneutics is a Greek word for 'to make it clear or to interpret' (Pietkiewicz and Smith 2014). Heidegger believed that it is practically not possible to mask any prior knowledge as he viewed prior experiences and assumptions of the researcher as essential in understanding a phenomenon. Heidegger believed in shared knowledge and sharing experiences between the participant and the researcher (Reiners 2012). The fundamental principle of interpretative phenomenology is to understand phenomena from an 'emic' rather than 'etic' perspective (Huberman and Miles 2002).

Phenomenology as qualitative research is popular as it allows to examine the lived experiences of individuals. Contemporary phenomenological methodological approaches have expanded the original concepts as introduced by Husserl and Heidegger. As the context from one discipline varies from another, it is neccessary for the researcher to develop disciplinary attitude (Smith et al. 2009).

Both descriptive and hermeneutic phenomenological approaches are widely used in educational research. However, the main problem that they face is to translate the phenomenological concepts into methods to demonstrate rigour. Having become accustomed to highly defined study designs like randomised controlled trial or conducting systematic reviews, the flexibility offered by phenomenology was overwhelming. The philosophical framework utilised in phenomenological study vary widely, the boundaries between different phenomenological approaches are blurred as they overlap with each other. For example, descriptive-hermeneutic approaches are closely connected to lifeworld approaches. Similarly, the interpretative phenomenological approach is deeply rooted in hermeneutic phenomenology (Finlay 2011).

Giorgi (2008) examining six doctoral dissertations that adopted descriptive phenomenology, found that the researchers had difficulties in employing bracketing, phenomenological reduction, and imaginative variation. It was also challenging to validate and generalise their results.

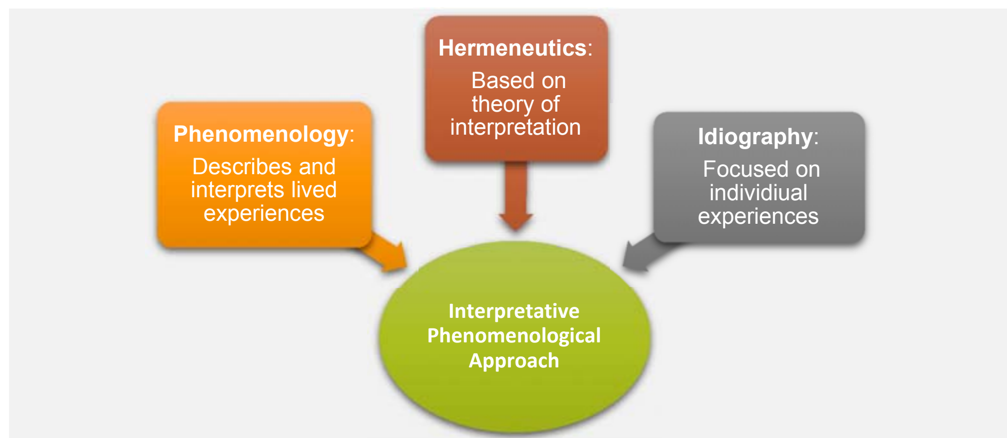
A few phenomenological researchers have proposed the steps both for descriptive and interpretative phenomenology. Gill (2014) elaborates on different methodologies advocated by phenomenological researchers and draws them from various disciplines. For, e.g., Sander's phenomenology was drawn from organisational studies, Giorgi's from descriptive phenomenology and Smith's from interpretative phenomenology from the field of psychology, van Manen's hermeneutic from pedagogy, and Benner's interpretive phenomenology from nursing practice. However, this does not imply that one has to choose the methodology from the above list based on their discipline but adopt any of the phenomenological framework based on the philosophical belief and the research questions.

Interpretative Phenomenological Approach (IPA)

IPA is a qualitative phenomenological approach that explores participants' lived experience and systematically examines the significance of major life experiences. IPA as a methodological framework was first proposed in 1996 by Jonathan A Smith in the field of psychology. IPA is a qualitative approach, where the phenomenon is understood through the lived experience. There is a greater emphasis on personal experience, focus on individual experiences through ideography and interpretation of meanings through hermeneutics. The framework was initially designed for psychological research and the popularity of this approach grew rapidly. Since then, this methodological framework has been evolving and expanding to other fields including health sciences and educational research (Holloway and Wheeler 2010; Lichtman 2011).

The theoretical foundations of IPA are based on three philosophical approaches as shown in figure 1.

Figure 1: Theoretical Foundations of IPA adapted from Smith et al (2009)



IPA is phenomenological as it is about the study of shared and lived experiences. IPA has foundations drawn both from descriptive and interpretative phenomenology. In phenomenological research, the distinction between descriptive and interpretative approaches is not clear and researchers like Dahlberg (2006) and Finlay (2011) suggest finding a middle ground. Vagle (2010) refers to this as 'descriptive-interpretative dualism' (pg. 398). This dualism is adopted in various research methods as proposed by van Manen (in hermeneutic phenomenological approach) and Smith et al. (in IPA) (Gill 2014).

In IPA, the researcher first carefully considers the descriptions provided by the individuals and later moves towards interpreting them to answer a particular research question. Although the process of reflection and bracketing, proposed by Husserl, is adopted within the initial stages of analysis by stepping back from the taken-for granted world (Shinebourne 2011), interpretation proposed by Heidegger is considered central to IPA research. IPA also considers the importance of individual perspective from Merleau-Ponty's work and the individual's relationship within the social context as viewed by Satre (1956). In this research, the participant's experiences were unique on different phases of their journey from ICP to employability, thus allowing greater flexibility for me as a researcher to uncover certain areas to a greater depth.

Hermeneutics is concerned with the way participants make sense of their experience by determining the intention and meaning of the experience (Moustakas 1994). "The very term "description" already implies that what is described has been phenomenally

encountered and *interpreted* “as” something.” (Churchill, 2014:5 as cited in Eatough and Smith 2017). The researcher further tries to make sense of a participant’s experiences with multiple levels of interpretation during the analysis (Shinebourne 2011). The researcher assumes a dynamic role in trying to get closer to have a clear understanding of the participant's experiences, first during the interview stage and then later during the analysis stage, thus creating layers of interpretation. IPA draws the work from Heidegger (1962), Gadamer (1990) Schleiermacher (1998), for providing the processes for interpreting the text. Within educational research, studies have explored experiences of students in clinical placement or graduate employability. The present study was unique in the way that it considered the dual dimension of international clinical placement and employability within a single study. As they are not automatically linked, an approach beyond the narrative experiences of students was considered.

In a phenomenological study, participants are encouraged to engage in reflection of their own experiences to make sense of the world and the researcher further interprets their reflection during the data analysis (Smith et al. 2009; Newby 2014). To expand on this, as a researcher, the intention is to understand how and why the phenomenon is occurring both during interview and data analysis (Eatough and Smith 2017). This deeper circle of interpretation is referred to as ‘double hermeneutics’ (Smith et al. 2009 pg.35) where the researcher is making sense of what is being said through interpretative engagement with the data. Eatough and Smith (2017) suggest examining the data dynamically in a non-linear and iterative manner where the researcher during the analysis moves in a cyclical process between the parts and the whole of the text in a hermeneutic circle.

Idiography is about examining the individual case to understand how a particular experience is for a person within a context (Smith et al. 2009). IPA suggests considering a purposefully chosen smaller and homogeneous sample so that the researcher can combine these individual cases to find shared meanings (Eatough and Smith 2017). The present study had a relatively homogenous set of samples; graduates with ICP experience and employed and employers with the experiences of recruiting students with ICP experiences in the UK. One to one semi-structured interview was conducted and each participant's interview was analysed separately to maintain ideographic focus.

The methodological framework adopted in this study

The concept for this study is mainly drawn from Heidegger's work of interpretation, which is rooted in hermeneutic epistemology to extend the text beyond description (Lindseth and Norberg 2004; Kinsella 2006; Smith et al. 2009; Finlay 2011; Patton 2014). As discussed in the literature review, very little is known about the long-term influences on employability of international clinical placements. The study intended to gain insight into the individual experiences of students on ICP and the influence of these as they progressed in their professional lives as graduates as well as employer views on ICP. This was to be achieved by both sets of participants, providing detailed and rich descriptions through the narration of their experiences, and reflecting on and interpreting their events, which could be very illuminating (Larkin and Thompson 2012). Reflection on the lived experience and interpretation of these experiences to provide meaning are the two most important factors to understand an interpretative phenomenological study (Finlay 2011).

IPA framework allows the researcher to examine and connect systematically a range of experiences which are separated in time but linked with a common meaning (Smith et al. 2009). As this study is based on the range of participants' experiences such as ICP, making job applications, and attending their job interviews, these individual components are separated in time. Similarly, the employer's views and perceptions on ICP would be based on their understanding of ICP, their personal experiences of involving in shortlisting, interviewing, recruiting and line managing graduates with ICP experiences.

The researcher's dynamic role in interpreting the experience while retaining the participant's voice further attracted me to this methodology. I particularly liked the way phenomenology, hermeneutics and ideography are fitted systematically together in one research. The meaningful way in which they connect phenomenology with hermeneutics by stating "without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen." (Smith et al., 2009: 37).

Criticizing Smith et al.'s IPA approach van Manen (2017) argues that the attitude adopted by IPA researchers are more psychological than phenomenological. He further points out that encouraging participants to make sense of their own experience is more of a psychological approach than phenomenological. Despite these criticisms, for a novice qualitative researcher, it was felt that the guidance offered by Smith et al.

was helpful in understanding the theoretical underpinnings and practical guidance on conducting a phenomenological study. Further, in all the articles written on IPA, the authors make it clear that IPA is a phenomenological psychological approach and has recently been adopted in other areas of study (Smith and Osborne 2008, Smith et al. 2009, Larkin and Thomas 2012, Eatough and Smith 2017).

Herbert Spielgelberg, an American phenomenologist identifies mainly five commonalities of phenomenological methodologies. These are i) a shared foundation of phenomenological philosophy ii) an explicit interest in meaning of individuals' experiences iii) attempting to grasp the point of view of the experiences iv) homogenous sampling and v) thematic analysis that necessitate creativity and imagination (Spielgelberg as cited in Gill 2014 pg 128), which I believe are achieved in this study.

Deviating from the traditional IPA approach

Due to pragmatic reasons, I have deviated from the traditional IPA approach, particularly in adopting some of the methods suggested in IPA research. IPA researchers strongly argue for homogenous samples with one group of participants. It was important to include an additional set of participants (employers of healthcare graduates) and reasons for including them is discussed in the next section. Having two distinct groups of participants with different levels of experiences, I faced a lot of challenges while analysing the data and writing up. However, it was then decided to keep these two groups discrete to analyse and present the results separately (in chapter 4 and 5). These results are discussed both in discussion and conclusion chapters (chapter 6 and 7).

Various books and articles written on IPA by Jonathan Alan Smith, Michael Larkin, Paul Flowers, Mike Osborne, Virgina Eatough, Igor Pietkiewicz, Andrew Thompson, Linda Finlay, Pnina Shinebourne Michael Gill and Gina Reiners were extremely helpful in gaining a deeper understanding of the methodological framework and approaches to conduct IPA research. Attempts were made to remain as close as possible to IPA framework throughout the study.

The following section covers the details of the scoping study and the implications that it had on the main study. The second part of this chapter considers different aspects related to the main study, including sampling strategy, interviewing techniques, and ethical approval including amendments made during the research, data analysis, quality issues, and reflexivity.

3.4 Methods: The scoping study

With a passion for internationalisation and particular interest in international student mobility, I decided to undertake my research study in that area. As a healthcare professional and the coordinator of a student exchange programme, my exposure to student mobility grew by joining the special interest groups and attending seminars and conferences on ERASMUS. A number of studies explored students' experiences either when they were abroad, or soon after their return. Most studies focused on the short-term influence of student mobility, and not much attention was given to the long-term impact of their international experiences. Given the uncertainty around the influence and implications of international clinical placement, it was important to explore how the knowledge and skills gained abroad would be used in the various stages of graduates' professional careers. Since the literature on the topic is scant and nascent, before embarking on my main study, a preliminary scoping study was conducted that formed a basis for the main research. Such scoping studies are necessary to enhance clarity particularly in those areas where the concepts are emerging and new (Davis et al. 2009). Scoping studies not only broaden the ideas (Arksey and O'Malley 2005), they also form preliminary data (van Teijilingen and Hundley 2001). Most studies on international mobility included students as participants. Within this study, it was decided to include those individuals who had international clinical experience since those who had experienced the phenomenon would provide useful feedback on both research processes and the research instrument. Since the main focus of the research was to develop an understanding of the long-term influence of international clinical placement on employability, the decision was taken to include both final year students who would be preparing for their employment and recent graduates with international clinical placement experiences who were employed in a healthcare setting. The following single broad research question was framed for the scoping study:

RQ: How do students and graduates of healthcare utilise their ICP experience for employability?

Ethical approval was sought from the School of Education, Oxford Brookes University in 2013, where this study was based, and with the intention of conducting individual interviews and consultations with students and graduates who had completed their international clinical placement. The application made towards seeking ethical clearance from the School is attached as Appendix 1. The students and graduates

were contacted through the clinical coordinators from both nursing and physiotherapy departments (Appendix 2).

Following the initial email to the six students who had recently returned from their international clinical placement, two nursing students responded and expressed their inability to take part due to their high academic demand. It was understandable as both the students were sitting their final semester exams, but said that they would be happy to participate in the research after their graduation. The other students did not respond to the email. Three out of six graduates (two from physiotherapy and one from nursing) who had recently gained employment within the NHS consented to take part in the study. The participant information form and consent forms were sent (Appendices 3, 4 and 5). As the participants were employed in various parts of the UK, Skype was chosen for convenience to conduct the interviews. A semi-structured one to one interview was conducted using the interview guide and this initial interview guide (Appendix 6) was prepared using a set of questions that broadly covered the research questions (Silverman 2013). As one of the participants had a poor internet connection, a part of the interview had to be continued by telephone. All the interviews were audio recorded using a digital recorder. The interviews on skype were smoother and much more relaxed than the telephonic call, particularly since it was important to try and re-create the face to face interview atmosphere while interviewing. Each of the interviews lasted for about an hour and the students were happy to be contacted again for any additional information or to take part in the main study. While transcribing the interviews, the clarity of the recording on Skype proved to be considerably better than the telephone call. An additional participant was recruited for the study who went abroad for less than a week on an observational clinical placement abroad and the participant herself expressed that the experience was too limited to have any noticeable effect on her. Some of the key aspects which emerged from the scoping study had implications for the main study, particularly with regards to sampling and interview guide.

The participants shared their experiences of international clinical placement and how they consolidated their learning and applied this later to their other academic and clinical modules. All three participants valued their international clinical experience and acknowledged that they had a great learning experience. All three of them reported that they highlighted their ICP experience in their personal statement. Two participants thought that their employers valued their international experience. However, one participant reported that, she initially feared that her application for

employment would not be considered favorably by the employers as she had two of the four core placements abroad.

Furthermore, there is a dearth of literature on employers' views of international mobility or long-term influence of student's mobility on their careers (King et al. 2010). One of the most significant contributions of this scoping study was to augment the topic to explore career aspirations of healthcare graduates with international clinical experience and the views of employers on ICP. The employers of healthcare graduates were added as participants in the main study. The scoping study was illuminative and instrumental in focusing the research on linking both international clinical placement and graduate employability in one research study. Besides, it was felt best to consider students who had completed at least one clinical placement of at least four weeks abroad on a clinical placement for the main study rather than just a few days on observation placement without hands-on experience.

Following the interview, the participants were asked to comment on the research questions and the participants felt that some of the interview questions developed for the scoping study were too broad or needed further clarity. In light of their comments changes were made to the interview guide for the main study. The changes were done in rearrangement and reframing some of the questions which they felt was either too narrow/broad or confusing. The changes applied to the interview guide along with the justification is attached as an Appendix 7.

3.5 Methods: The main study

A number of changes were made to the initial research proposal to include aspects of employability for seeking ethical approval for the main study. Firstly, it was decided to recruit only healthcare graduates and students were dropped from the proposal. Secondly, the employers of healthcare graduates were considered for the study as the additional set of participants. Thirdly, the research question was revised, and expanded from one to three questions. Fourthly, the interview guide of graduates was modified. Finally, a new interview guide for the employers was prepared and piloted. The ethical approval for the main study was applied and it was granted in November 2014 (Appendix 8).

3.5.1 Revising research questions

The research question for the main study was revised and it was deemed appropriate to examine the research topics through three research questions instead of one broad

question. The first question was to understand graduates ICP experience and the second question followed on from the first to gain an in-depth understanding of the journey of their career following ICP to employability. The third question was related to the employers to gain their views about ICP and employability through their experience of recruiting or working with graduates who had ICP experiences. The following are the three research questions:

1. How do graduates of healthcare describe their ICP experiences relative to their UK placement experiences?

2. How do graduates of healthcare envisage the influences of their ICP experiences for their professional career?

3. How do employers of healthcare graduates perceive the link between ICP and employability?

3.5.1 Sampling techniques

In an IPA study, there is no prescribed number of participants and typically ranges between 5 and 25 individuals, although Smith et al. (2009) and Eatough and Smith (2017), argue for a small sample size, even suggesting an in-depth single case study. The homogeneous sample size is recommended as opposed to a large sample size would not allow an idiographic study that allows sufficient in-depth engagement with each participant. Smith and Osborne (2008) and Finlay (2011) suggest that the number of participants should be dependent on size and scope of the study, the richness of individual cases, research questions, access, availability and willingness of participants to participate. A total of eleven graduates and nine employers were recruited for this study.

Selection of research participants begins with identifying individuals with relevant experience related to the research. It is recommended to have purposive sampling who have similar experiences, as it is important to take the accounts of individuals who can share their experiences on a phenomenon of interest (Smith and Osborn 2007, Creswell 2014). The participants for this study were drawn from two healthcare disciplines, nursing and physiotherapy, with two discrete groups, graduates and employers.

In line with IPA, the individuals with ICP experiences were recruited for the study. All the participants had graduated and were employed in their own disciplines. They were

deemed best to answer the first two research questions. To answer the third research question, healthcare managers who had experience of employing UK health graduates were recruited. The recruitment strategy used in this study deviated from the traditional IPA. IPA studies typically use one set of homogeneous sample as opposed to two different sets of the participants. As explained earlier, it was deemed suitable to recruit employers of healthcare into this study in addition to graduates. The profile of each of the participants is given in the next section (Table 1G and 2E).

Sample 1: Graduates

For this study, it was decided to use purposive convenience sampling and the participants had to be ones who could share their international clinical placement experiences and how this experience affected them later in their career. The initial plan was also to include both students and graduates of healthcare who held experiences of international clinical placement. Since the research focused on gaining insights into the process of internationalisation and employability, graduates who experienced the process were deemed to be suitable for the study. Graduates of healthcare from a UK university, who had been on an international clinical placement as undergraduate students were considered as participants to gain accounts of ICP experience and how they used these experiences in utilising the competencies and skills acquired through an international clinical placement further in their studies and employment.

The research began choosing one particular university that offered international clinical placements for undergraduate students of physiotherapy and nursing. At the time, there was a provision through the university for ten nursing students to take part in an international clinical programme every year in Netherlands, Hungary, Spain, and Pennsylvania, although not all the places were utilised fully despite having ERASMUS funding. Similarly, every year, two students from physiotherapy were offered ICP in Italy during the third year of their programme, which was funded by ERASMUS. In addition to this, there was a requirement for all students of physiotherapy during the first year of their programme to complete an elective placement for four to six weeks during their summer term. The students had to arrange their placements on their own and there was no restriction on the specialty area or the country. Some students utilised this opportunity and completed their placement in some of the Scandinavian countries. The duration of the placements ranged between 6 to 12 weeks, which was long enough for the students to gain broader learning experiences (Callister and Cox 2006).

This university was chosen as I thought that it would be easier for me to access graduates through the alumni office. Before the data collection, I was employed in the same university as a senior lecturer and was familiar with the placement pattern. I was aware that the students who went abroad for their clinical placement were not many but represented a diverse group. For the recruitment of participants, the head of physiotherapy and nursing departments had to forward a list of graduates who were on international clinical placement to the alumni office of the university, who on my behalf sent the introductory email to the potential participants (Appendix 9). The identified potential participants were sent the participant information sheet (Appendix 11) and the consent form (Appendix 12). Those who consented were asked to review the participant information sheet and to complete the consent form. There were opportunities for the participants to clarify any questions they had and they were told that they are not obliged to answer, and if they wished not to answer any of the questions, they were free to express this. However, it was kept in mind that the participants could have some reservations in expressing their views and could become emotional, however, the interviewer possessed skills which could manage an individual in such situations.

The response rate was very low and despite follow up, only two out of the many responded and consented to take part. International placement being a recent phenomenon and with only a small number of students taking part, it was very challenging to contact and recruit participants for the study. The university lecturers, former colleagues who were involved in organising international clinical placements, were further requested to assist in identifying and contacting some of the potential participants (Appendix 10). A total of eleven participants from both physiotherapy and nursing graduates who met the essential criteria were recruited for the study through snowball sampling. Ten of the eleven graduates were alumni of one university in England and only one participant was from a university in Scotland. All the eleven graduates had their placement abroad while they were students, of which ten were employed for three months or more either in the UK or abroad. Participants' ages ranged from 23 years to 30 years with eight female and three male graduates. Four of the eleven graduates were from the European Economic Area (EEA) and completed their undergraduate studies in the UK University.

Graduate participants' ICP experience profile

Eleven graduates, who had completed their ICP while they were healthcare undergraduate students in UK universities were interviewed via Skype using the

interview guide (Appendix 13). The interviews were audio recorded with a digital recorder. At the time of the interview, eight out of the eleven participants were living independently from their family and were located in different parts of the world with most of them working within the discipline of their undergraduate studies, either as a physiotherapist or a nurse. Two participants had recently enrolled in a higher degree in Physiotherapy and one participant was a holidaymaker in Australia. Their work experience ranged from 'just employed' to a maximum of two years. An overview of the demographic data is presented below in Table 1G.

Table 1G: Graduate participants' ICP experience profile

ID	Gender	Profession	Place of ICP	Year of study	Duration of ICP	Placement areas
G1	F	Physiotherapist	Italy	3rd year	12 weeks	ICU, Neurosciences, Paediatrics and Geriatrics
G2	F	Nurse	Belgium	3rd year	14 weeks	Operation theatre
G3	F	Physiotherapist	Norway	1st year	6 weeks	Sports and Musculoskeletal
G4	F	Physiotherapist	Italy	3rd year	12 weeks	Geriatrics, Paediatrics and ICU
G5	F	Physiotherapist	Italy	3rd year	12 weeks	ICU, Neurosciences, Paediatrics and Geriatrics
G6	M	Physiotherapist	Norway	1st year	6 weeks	Musculoskeletal Outpatient
G7	M	Physiotherapist	Norway	1st year	8 weeks	Sports Clinic
G8	M	Physiotherapist	Norway	1st year	6 weeks	Paediatrics and Musculoskeletal Outpatient
G9	F	Physiotherapist	Italy	3rd year	14 weeks	Thoracic Surgery, ITU, Neurology
G10	F	Nurse	Sweden	2nd year	12 weeks	Cardiology and Urology
G11	F	Nurse	Sweden	2nd year	12 weeks	Vascular and Oncology

Sample 2: Employers

This study also explored the experiences of employers of healthcare graduates regarding employing candidates with international clinical experience. The intention

was to explore their perceptions of international clinical placement and employability. The National Health Service is the largest employer of healthcare graduates in the UK, and hence it was decided to use a sample from the regional NHS Trust where the university was based. This particular Trust was preferred as it was one of the largest trusts with many potential employers, which also meant it was easier to obtain the diverse sample that was desired for the study, additionally there was also ease of access due to being based in the same region at the time. Ethical approval was granted by the University and further approval was required from the Research and Development Unit of the healthcare Trust. Due to personal circumstances, prior to data collection, I relocated to the Middle-East. Considering the practical difficulties, I felt that it would no longer be possible to recruit employers from the Trust that I was hoping to, and had to consider alternative options. After deliberations with the supervisors of this study, I decided to recruit ex-employees of National Health Service Trusts or the UK private healthcare sectors who were working in academic institutions or hospitals in the United Arab Emirates and who had experience of recruiting healthcare graduates in the UK. The ethical approval for this amendment was granted in November 2015 (Appendix 14). A few potential participants were initially identified through my professional network and contacted via email with attached participant information sheet and consent form (Appendices 15 and 16). Two who consented for the study helped me to recruit three more and through their network, four more participants were recruited for this study. Since they were approached as ex-UK employees, and outside their current workplace, further permission from their current employers was not required. A total of ten participants consented for the study, but nine interviews were completed using the interview guide (Appendix 17) as one of the participants could not take part in the interview due to a change in her busy schedules.

<u>Employer participants' employment profile:</u>

A total of nine employers were interviewed one on one by the researcher at their workplace. The employers' work experience in the UK ranged between 3 and 20 years and all of them had experiences of recruiting healthcare graduates to the NHS. At the time of the interview, all the employers were based in the UAE with experience in the region between one to three years. An overview of the demographical data of the employers is presented in Table 2E.

Table 2E: Employer participants' employment profile

ID	Gender	Profession	Current designation	UAE experience	UK experience
E1	F	Nurse	Lecturer, Nursing	1.5 years	22 Years NHS
E2	F	Physiotherapy	Manager of Rehabilitation	3 years	18 years British Army
E3	F	Physiotherapy	Therapy Manager	1.5 years	8 years NHS
E4	M	Physiotherapy	Therapy Manager	1 year	8 years NHS
E5	F	Nurse	Clinical resource nurse	2 years	10 years NHS
E6	F	Occupational Therapy	Rehabilitation Therapy Manager	3 years	3 years private and 3 years NHS
E7	F	Nurse	Clinical resources nurse	2 years	8 years NHS
E8	F	Nurse	Unit Manager	1.5 years	20 years NHS
E9	M	Physiotherapy	Senior Physiotherapist	1 year	12 years NHS

3.5.2 Data collection techniques

Studies using a phenomenological approach use iterative research processes that advocate to collect, analyse and compare data (Creswell 2014). The phenomenological methodology offers several methods of data collection such as interviewing, documentary analysis, observations and focus group meetings (Lester 1999; Thomas 2009; Newby 2014). One of the main and best methods employed in IPA is to interview participants where detailed accounts of a phenomenon can be collected. There are opportunities for the researcher to delve into further questions to gain deeper and richer data (Smith and Osborne 2007; Smith et al. 2009).

A few studies exploring the experiences of students on ICP have mainly used interviews and reflective journals. For example, Grant and McKenna (2003); Greatrex-White (2008); Peiying et al. (2012) used student diaries or journals as the primary method of data collection. Since the nature of this research was to obtain retrospective accounts of the students' experience that occurred over a period (one to three years – from the international clinical placement to employability) and to gain insight into their future aspirations, for the data collection, it was decided to use semi-structured interviews. The possibility of analysing journals was an option to triangulate the data and gain additional insight into a phenomenon. However, none of the participants of this study maintained diaries to record their placement experience, as this was not a requirement from the university for their ICP.

In-depth, one to one, semi-structured interviews are considered extremely useful in IPA, where the students' interpretations of experience are subjective and particularly relevant when asked to reflect on different aspects of their experience (Smith and Osborne 2008, Pietkiewicz and Smith 2014, Eatough and Smith 2017). Facilitating the interview is a very important aspect of the phenomenological study and was considered carefully within this study. It is crucial to focus completely on the participants' experiences rather than sharing the researcher's personal views or experience which could influence participants' thinking to introduce bias into the study. The outcomes of a phenomenological study are highly dependent on the ability of the participants to reflect on and communicate their experiences (Smith et al. 2009). This aspect was not a barrier to communication and reflective practice is an integral part of all healthcare curricula and professional practice facilitated in engaging with the participants to obtain the required information to an adequate depth.

To understand the phenomenon, the researcher has to be familiar with the context and this was a lesser issue within this research. IPA suggest researcher to think from two different ways. First, from the participant's perspectives to gain a deeper understanding of the phenomenon and then probe for more information which the participants would not have thought themselves (Eatough and Smith 2017). Working as a senior lecturer and as an international lead in a university was an advantage, as it provided a clear understanding of the participants' pathway from international clinical placements to employment. I was also very well aware of their positions in relation to each of these situations in most of my participants. Collegial discussions and reading relevant documents prior to engaging with the participants' enhanced understanding of the research context. There were a few instances where the ward settings in a hospital abroad and/or employment processes in some organisations were unfamiliar to me. This necessitated asking participants to give a brief description of the context either before or during the interview to have a clear understanding of the context in which the participants experienced the phenomenon.

Being familiar with international clinical placements and having taken a pro-active role in managing ICP, some of my own beliefs and assumptions were influenced by my experiences of initiating and facilitating student exchanges. Since this could impede bringing fresh perspectives into the study, I engaged reflexively to restrain my ideas to gain a better understanding through my participants during the interview process.

As the interview process progressed from one participant to another, I realised the importance of this reflexive action. Having a background knowledge of the context aided in engaging with the participants. On the other hand, having never done a placement abroad while I was a student and with no experience of recruiting graduates into the UK healthcare system, I keenly listened to all participants' experiences, and some of their narratives were illuminative, continually challenging my understanding about the international clinical placements. Further, as a person, I like interacting, listening to others and seeing the world from different perspectives and these characteristics are, I believe, desirable for a phenomenological researcher.

Within a phenomenological study, there is no prescribed number of questions one should ask in the interview. It is recommended to use questions that are open and, in order to gain depth, the researcher uses probes. Within this study, a semi-structured interview was conducted using the interview guide developed from the scoping study. The topics were identified before commencing the data collection and the questions were broad and flexible, wherein there were opportunities for probing when required, to understand the phenomenon to an adequate depth and answer the research questions (Cohen et al. 2007; Finlay 2011). There was a total of nine questions for the graduates and six questions for the employers. If there was a point where further details were required, care was taken not to interrupt the participants during the interview, and the points that required further probing were noted down and dealt with at the end of the interview. According to Cresswell (2009), the length of the interview depends on the type of context and phenomenon that is being examined.

The interviewer should feel satisfied that they have got enough depth into the phenomenon and the interview usually continues until the interviewee thinks that they have shared all their relevant experiences. Within this study, the length of the interviews ranged from 50 minutes to two hours for graduates and 40 to 60 minutes for employers. The graduate interviews were longer as they involved two sections that aimed to answer the first two research questions, one being related to their experiences of clinical placement abroad and the other one associated with their employability. The average time for the interview was one hour and twenty minutes. Seven of the twelve interviews were completed on the same day in one sitting without a need to return. Only four of the twelve interviews had to be divided into sessions on two different days. One of the participants had limited time on the first interview day, so it was decided to continue and complete the interview on the next day. Two participants (who were part of the scoping study), were re-interviewed to gain further depth on a few aspects of their learning in the clinical placement and the process of

employability. This was required due to the focus of the study changing from the scoping study to the main study. The fourth participant during the first interview had a successful job interview and was still waiting to start employment. The participant expressed her willingness for a follow-up call after three months, but despite several attempts, the participant did not respond to the email or Skype calls, the second interview did not take place. The information gathered from this participant was used as the only unanswered aspect was regarding the participant’s use of ICP experience in her current workplace.

The first section of the interview explored the experiences of graduates while they were on their international clinical placement. The questions used were broad, where the participants were asked to explain their placement experiences while they were abroad as per the interview guide (Appendix 13). The second part of the interview was related to the way the graduates called upon their international experiences during their other academic modules and other clinical placements after they returned from their ICP. The third part was about their employability, employment, and future aspirations. The intention was to understand how their international clinical placement experience continued to influence them in their careers and how it shaped their future aspirations. The interviews proceeded in an order as shown in Figure 2.

Figure 2: Chain of graduate interview events

The Skype calls worked very well in most of the interviews. There were not many interruptions in the network, and although for a few of the interviews, the line got a bit weaker when making video calls, necessitating a switch to audio only. All the calls were audio recorded using a digital recorder. Recording of interviews is one of the essential features of phenomenological studies. The participant's experience will have to be captured in their own words and no important nuances will be missed (Smith and Osborne 2007, Finlay 2011). None of the participants in the study had any objections to recording the interviews.

Verbatim transcription of participant’s account helps in the process of analysis and for the writing up (Finlay 2011; Larkin and Thomas 2012). Transcribing the interviews

was very time consuming. The intention was to use a transcriber to transcribe the interviews and this was arranged with the transcriber according to the University policy on transcription. When sample data for the interview was sent, the two different transcribers expressed their concern as some parts of audio lacked clarity and as a result of having no understanding of the background and terminologies, I found many pauses and mistakes on the sample transcript. The quality of the transcriptions was not satisfactory, and correcting the errors took an enormous amount of time as many of the terminologies were misspelt. After the first five interviews, it became clear that the microphone of the digital recorder had to be placed in a particular position with the laptop's speaker to enhance the quality. It emerged that it would be easier for the transcriptions to be completed by the researcher rather than checking for accuracy as the latter still meant spending time listening to the tape repeatedly to correct the sample transcript. Having completed the interviews and with the help of field notes, it was easier for me to complete the transcription on my own. Although it was extremely time consuming and exhausting, there were benefits as listening to the tapes over and over helped in familiarisation with the data. Various methods of transcribing faster using speech to text options were tried but were not helpful.

Like the graduates, all employers were sent the participant information sheet (Appendix 15) and the consent forms were completed (Appendix 16). Opportunities were given for participants to clarify any questions they had before the interview. The participants recruited for the study were interviewed face to face using the interview guide at a mutually agreed time and place. Most preferred the interviews in their workplace and during their break or after work. All the interviews took place in the participants' workplace in a meeting or treatment room. There were no disturbances or distractions during any of the interviews.

The interview explored the employers' views of employing graduates with international clinical placement experience and the factors that they considered while making decisions for recruiting graduates. The interview questions (Appendix 17) obtained their insight into how a graduate should highlight their international clinical experience while applying for jobs and how this was explored during the interview stage. The other questions were related to how and to what extent the graduates are supported while working with them. The interview also explored their perceptions of international clinical placement and employability. On average, each of these interviews lasted for about 40 minutes, which was shorter than the graduate interviews. The interviews were audio recorded. Following the interview, transcriptions were completed by an external transcriber. Two different transcribers

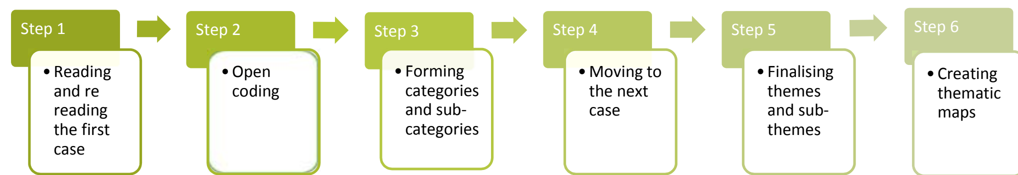
were used to speed up the transcription process. Since the quality of the audio with face to face interviews was much clearer, checking for accuracy was easier than the Skype interview. All the transcriptions were ready on the Nvivo before the analysis process.

3.5.3 Data analysis

Thematic analysis is the broad framework used in most phenomenological studies. Although there is no best prescribed way of analysing IPA, the analysis framework suggested by Smith et al. (2009) and later expounded by Larkin and Thompson (2012), Pietkiewicz and Smith (2014) was used to guide the analysis of this thesis. The guidelines provided by the IPA researchers aided in working logically upwards to connect findings from the description of individual cases to make more general claims by generating themes. The writing up and reporting is through the themes which are embedded in participants' experiences (Finlay 2011). Eatough and Smith (2017) encourage researchers to be creative and flexible in their approach to understand the phenomenon.

The steps used in analysing the interviews in this study are discussed below and the graphical representation is presented in fig 3. The steps involved in analysing the data was found to be similar to the thematic analysis by Braun and Clarke (2006). The thematic analysis include six phases - familiarising with the data, generating initial codes, searching for themes, reviewing themes, naming themes and producing the report (Braun and Clarke 2006). However, there is a greater emphasis in IPA on analysing the whole text of an individual before moving to the next and iteratively to move between part and the whole (Smith et al 2009). By doing so, it was possible to recognise the value that placements hold, both at home and abroad for each of the participants, and only then was it possible to gain a broader understanding of the long-term influences of providing work experience abroad for students.

Figure 3 : Steps used in data analysis



The data organising tool Nvivo 10 was used and being new to the software, the basic feature of Nvivo were used. Two separate projects were opened on Nvivo, one for graduates and the other for employers. All transcripts were transferred to Nvivo. Nvivo was helpful in this research in organising and navigating within and between cases during analysis and write up. By the final submission, the software was upgraded to Nvivo 12 with a few additional features.

Within the IPA framework, there is no particular order to choose the first case for analysis. All graduate interviews were analysed before moving to employer interviews. The first case for both sets of participants was randomly selected with no particular order of preference. The steps involved in data analysis for both sets of participants (graduates and employers) were very similar.

Step 1: Reading and rereading of the text (First case)

The purpose of this step is to get familiar with the data. The first case drawn for the analysis was a physiotherapy graduate who had her ICP experience during the final year in Italy (G1). Having visited the clinical site, conducted the interview and transcribing and hearing the audio recording many times, I became familiar with the data. Although interpretative approach does not agree with the bracketing, it is vital to understand the data from the participant's perspective by focusing on the sense and meanings they make about their experiences (Smith et al. 2009). The transcript was read many times both on hard copy and on the Nvivo while simultaneously listening to the audio recording.

Step 2: Open coding

The purpose here is to understand participant's (G1's) view and her perspectives. Detailed coding of the full transcript was done with a total of 68 codes on Nvivo. The initial open coding was done for the whole transcript (recognised as nodes on Nvivo).

The highlighting feature of Nvivo is excellent as the accompanying text of each code can be viewed was extremely helpful during the analysis and the write-up. It was easier to extract the participant's descriptive phrase/s related to a code.

Step 3: Forming categories and sub-categories (Classification of nodes into a child and parent node on Nvivo)

The codes were carefully considered along with the descriptive texts, and those that shared similar characteristics were grouped together. This particular step was found to be easier with this study. Fig 3c represents the graphic representation of the whole text of a single participant into different parts. The Nvivo feature of hierarchical category creation was opened and the open codes were classified as either child or parent node. This process helped in the analytical ordering of codes through forming categories and sub-categories with the participant's description of words and the researcher's interpretation (Smith et al. 2009; Braun and Clarke 2006). This process involved moving iteratively between the whole and parts and back again in a hermeneutic circle.

Step 4: Analysing the next case (coding other transcripts)

A similar process of step 1 to 3 was followed for the rest of the transcripts. Having completed the analysis of G1, it felt easier to analyse other graduates who were on placement in Italy during the final year of their undergraduate study (G4, G5, G10). The next few transcripts were also of physiotherapy graduates who were on placement in Norway during the first year of their undergraduate study (G3, G6, G7, and G8). Finally, the three nursing graduate interviews were analysed, first the two who were on ICP in Sweden (G9, G11) followed by the last transcript of the graduate who had her ICP in Belgium (G2). The coding of each transcript was done separately for each case. These codes were added into the parent or child node of the first case.

Step 5: Generation of themes (Looking for patterns across the cases)

The child and the parent nodes created by adding the codes of all participants were re-examined and the participant's descriptive statements were rechecked against each of these nodes. The classification of nodes made it easier to view the patterns across the cases by aggregating the child and the parent nodes. The final refinement of sub-themes and themes was made. This was a highly iterative process, where a significant amount of time was spent on making sense of the whole data and interpreting how each of the sub themes and categories related to each other. At this

point, it was easier to draw the connections on paper to finalise and name each of the themes and sub-themes while referring to the code classifications and descriptive texts on Nvivo.

<u>Step 6: Creating thematic maps (Using mindmup)</u>

Once the themes, sub-themes and categories were finalised for the first set of participants (graduates), the thematic maps were created using the mindmup software which aided in creating thematic maps with multiple levels of hierarchy. Although a free version is available with limited usage, I decided to subscribe for 'Gold' (https://www.mindmup.com/mindmup-gold/) as the features offered with Gold allowed to track all maps created with an editable option. Since forming categories, sub-themes and themes was a highly iterative process, features of both Nvivo and Gold Mindmup aided in creating thematic maps for the thesis. The thematic map of graduate interviews is presented in chapter 4. Screenshots of Nvivo used for analysing graduates interview are attached in the appendices 18 to 22.

<u>Repeating steps 1 to 6 for employers' interview</u>:

The above steps of 1 to 6 was repeated for analysing employers interview. There was no particular preference or order in which the data was analysed. The transcriptions were randomly transferred to Nvivo and the analysis was done according to the order in which the transcripts were placed on the Nvivo (E1 to E9). The thematic analysis and the mapping were done the same as the graduate's interview as explained in steps 5 and 6 and is presented in chapter 5. Screenshots of Nvivo used for analysing employers interview are attached in the appendices 23 to 27.

<u>Writing up</u>:

There is no one particular way of writing up IPA studies. Smith and Osborne (2008) recommend two broad approaches; i) To present a thematic analysis, where the thematic maps are presented with the explanations of each theme along with supportive descriptive statements of participants (result chapter) and this is followed by the chapter linking the findings to the extant literature (discussion). ii) To examine the links to the existing literature while presenting the themes within one chapter (results and discussion). In this thesis, it was decided to use the first method, as it was easier to present the themes arising from the graduate interviews and employers' interviews separately. As explained earlier, the two different sets of participants varied highly in their experiences, the research questions explored with each set of

participants were different, presenting it within one chapter would be very confusing for the readers. It felt easier to present them as two different chapters in the results section. However, the subsequent chapters, 6 and 7 integrate the results from both the chapters to discuss the findings while linking it to the extant literature, drawing conclusions and making recommendations for practice and future research.

3.6 Ethical issues

Before beginning a research study, it is crucial to consider the ethical issues arising within a study. Disagreements around ethical issues arise as people tend to take different approaches while analysing the outcomes. Johnson and Christensen (2012) explains three basic approaches that people tend to adopt when considering ethical issues in research. These include deontoloy, ethical skepticism, and utilitarianism. These are distinguished from each other through the beliefs a researcher holds regarding what is wrong or right. Those who follow the deontological approach believe that certain actions are inherently unethical and they will never willingly go against them under any circumstances. A person believing in ethical skepticism may argue against the deontological approach as they strongly hold onto the fact that these ethical rules are relative to one’s own culture and time. So they advocate for the researcher to do what the researcher thinks right or wrong based on individual’s conscience. The utilitarianism approach depends on the outcome of the research, where the risks versus benefits are considered, and if the benefit for a large population outweighs risks for research participants, the study is deemed to be ethical. Since all three approaches have very different philosophical underpinnings, it is challenging to choose the best approach. However, in this study, all three aspects were carefully considered while applying for ethical approval.

Since the study involved semi-structured interviews, there were no issues concerning physical harm; however, there was a potential for sensitive matters arising during the interview, which might have psychological outcomes (Polit and Beck 2014). Before applying for the ethical approval, all the subtle issues that could arise during the interview were considered, mainly if a participant had a negative experience during their international stay or placement. Having worked with students in higher education, the researcher was confident of possessing sufficient skills to handle emotional situations. Interview questions were carefully analysed for their sensitivity and the intention was to minimise anxiety and stress among research participants, as suggested by Atkinson and Hammersley (2007).

In this study, care was taken not to withhold any information from the participants. The study aims, processes, and how the research would be disseminated were clearly explained to the participants. Participants received information along with the initial email that was sent to them, so there was no intention of deception. It was made clear to the participants that their participation was voluntary, and they were told that they were free to withdraw at any point both before and during the interview. Most participants in the study, other than physiotherapy alumni, were not known to me. It did not appear that the physiotherapy graduates felt obliged to take part in the study. Still, it was made very clear to them that the participation was entirely voluntary. The participants were reassured that their contribution was purely for the research and would have no impact on their career.

To maintain anonymity and confidentiality, the demographic information on the participants' which was collected was known and accessed only by the researcher. A code was given to each transcript to maintain anonymity. All remarks that could identify a participant were removed from the transcript before analysing them. However, due to the small sample size and the nature of the research, there was a possibility of recognition, particularly of graduates. This was clearly explained to all the participants before the interview and there were no concerns raised.

3.7 Reflexivity

Engaging in a critical reflection of my own preconceived ideas and biases was paramount as this could have influenced the research processes and the outcome of the research (Robson 2011). The quality of the study was enhanced mainly by maintaining transparency and reflexivity throughout the research. Newby (2014) argues that quality should move beyond methodological consideration and must be explicit in the research report to maintain transparency. My beliefs about international clinical placement and employability could have introduced bias into the research. I used many strategies to minimise the bias. I had to prepare well before every interview and think carefully about presenting the questions to my participants and probe/respond accordingly during the interview. The sampling used in this study was diverse and some of the participants disconfirmed my beliefs as they presented varying perspectives. Johnson and Christensen (2012) refer this to as negative-case sampling. My position within this research has been explicitly expanded throughout this research, and the reflexivity is further enhanced by reflecting after each interview. I have listened through the audio tapes multiple times to ensure that I fully understood what was being said by the participants.

3.8 Summary

This chapter discussed the ontological and epistemological positions of the researcher, based on which methodologies could be used for such studies were considered. The choice made for conducting phenomenological research was discussed in detail. The methodological framework used in this thesis were mainly drawn from IPA. The study deviated from the main IPA framework by adding employers of healthcare as participants into the study to gain their view on ICP and employability. However, the attempt was made to remain within the IPA framework which aided in the systematic way of data collection and analysis, thus increasing the robustness and rigour of the study. The ethical principles and the need for reflexivity within the research were also discussed. The following two chapters present the results of data collected from graduates and employers.

Chapter Four: Findings - Graduates

4.1 Introduction

This chapter presents the findings from the qualitative interviews of eleven graduate participants who were on international clinical placement whilst they were students. The data from the individual participants were organised and analysed using Nvivo 10. The descriptive presentation of the qualitative data gathered from the study participants is presented which is related to the following questions (the first two research questions identified in this thesis).

RQ 1. How do graduates of healthcare describe their ICP experiences relative to their UK placement experiences?

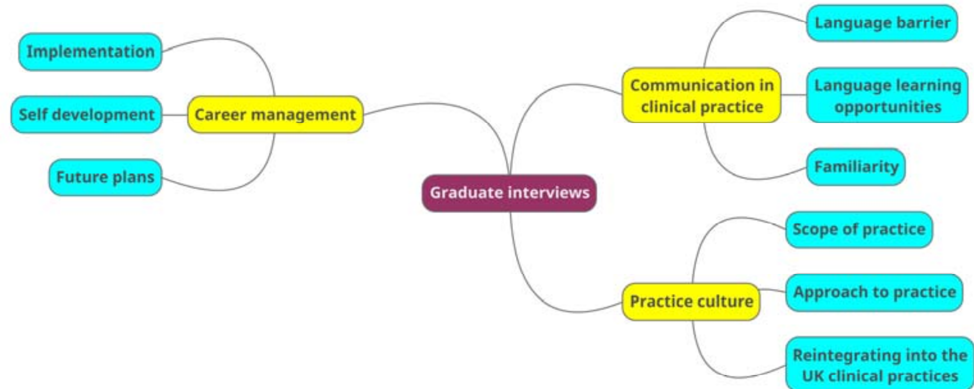
RQ 2. How do graduates of healthcare envisage the influences of their ICP experiences for their professional career?

4.2 The themes and the sub-themes

The following three main themes emerged out of the interviews and the themes together with the sub-themes are shown in the Figure 4G below. Each of these themes with their sub-themes is discussed in detail.

- Theme 1: Communication in clinical practice
- Theme 2: Practice culture
- Theme 3: Career management

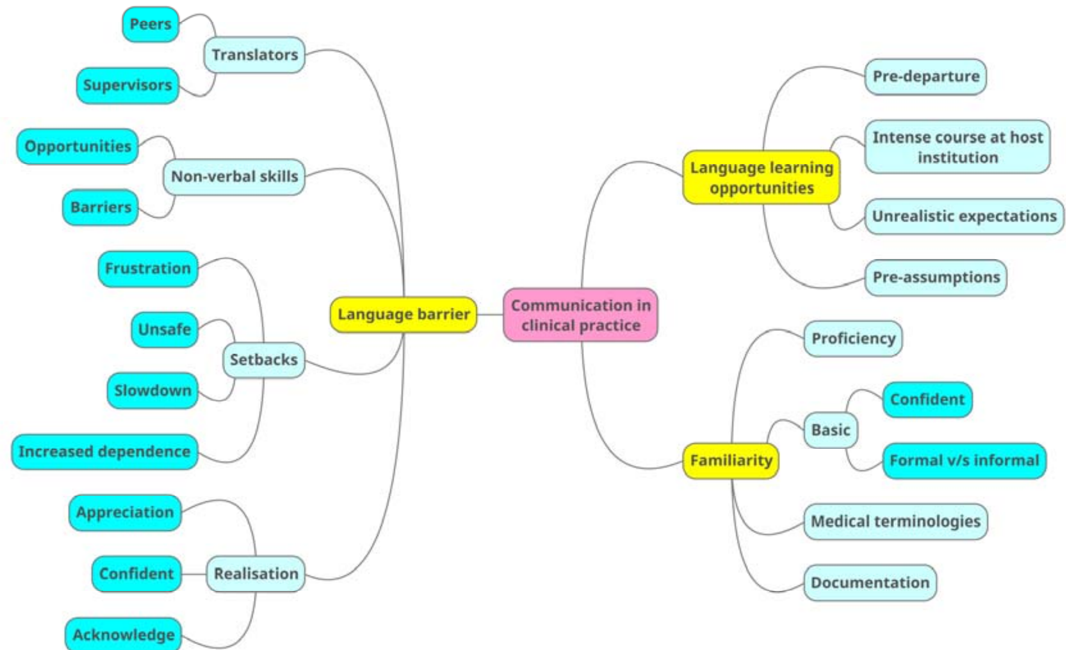
Figure 4G: Themes and sub-themes of graduate interviews



Theme 1: Communication in clinical practice

Communication is one of the integral components of clinical practice. The participants during their interviews made reference to their ability to speak the language of the host country. Various aspects of communication including interacting with patients, peers, and their clinical supervisors, as well as reading patient files for assessment, and documentation were discussed in detail. The figure below, 5G shows the theme together with its sub-themes and categories. The sub-themes identified within this theme are familiarity, language barriers, and language learning opportunities.

Figure 5G: Theme 1 - Categories and sub-categories



Sub-theme 1: Familiarity with the language

Some of the participants were familiar with the host language. Table 2G shows the summary of language proficiency of each participant.

Table 2G: Graduates' proficiency in the language of the host country

ID	Able to read and write the host language	Ability to speak	Unable to speak, read and write
G1		√	
G2			√
G3	√	√	
G4			√
G5			√
G6	√	√	
G7	√	√	
G8	√	√	
G9		√	
G10			√
G11			√

Out of the eleven participants, two participants (G1, G9) had a basic ability to speak the host language - due to their family background originating from the host country. Being familiar with the language and culture they felt at ease as G9 expressed

> *I think it was fine, I felt very confident in my Italian. I think it may be because my classmate was less confident and I ended up speaking more (G9).*

This statement shows that being with a peer who has lesser ability to speak the language provide better opportunities as this increased her confidence further as she had to speak for both of them and by the time they completed the placement, her language proficiency had improved.

As G9 continues,

> *..but, what I noticed that people want to speak English with you because they are very proud that they speak English - so you start speaking Italian and then they just switch to English (G9).*

The peer who was with her on the ICP, unfortunately, could not participate in this study; it would have been useful to gain the alternate view of how this situation impacted on her experience. Two participants in this study G2 and G4 who could not speak the host language found it useful to be with peers who were proficient in the host language.

The words ‘confidence’ and ‘proud’ from the above extracts are positive terms that could help to build trust and rapport between therapist and patients. However, not being proficient in the host language meant that students had to learn the ways of addressing the patients (formal versus informal) and ways of explaining treatment procedures. But following some of the medical notes and completing documentation were challenging to them. Reading a patient file at the beginning of any therapy session and documentation are vital aspects of a clinical experience and if these two are missed, this could impact on their learning.

Four other participants (G3, G6, G7, G8) were proficient with the language of the host country, as they had lived in the country and were in the UK for the purposes of study. Despite this, because medical terminology had been learnt in English, translating some of this vocabulary to the host language was what they found was challenging

> *It was more challenging, as you learn medical terms in English and to translate that in the local terms was very challenging for me (G8).*

G6 had to seek support from their educators or other staff members while reading the case from the file.

> *I was familiar with the terminologies in English, when I started in Norway I did not know how to relay information to my patients in Norwegian and that was an issue and that will be an issue whenever I go back to Norway and am sure it till take some time to remap everything* (G6).

This indicates that ICP made them aware that the medical terminologies in Norwegian were different and was a barrier for effective communication.

<u>Sub-theme 2: Language barrier</u>

Participants who were unable to speak the language faced a different set of problems. The language barrier was seen as one of the setbacks of their ICP experiences, as they were not able to communicate with patients effectively. G4 and G11 felt that the language barrier deterred their learning and was 'frustrating' for G5, and 'not satisfactory' for G11.

> *A lot of the nurses spoke really good English and were able to translate, even doctors, but a lot of patients maybe could not speak as much and ones that could speak English, obviously, I would try and help, talk to them more. It is the language barrier that scared me (G11).*

Being scared, frustrated or unsatisfied during their clinical placement indicate a negative influence for students as this could impact on the quality of patient care.

G10 was with her peer from the UK and neither of them could speak the host language. G10 did not feel that she was carrying out safe practices. Her clinical educator spoke very little English

> *The girl I went with, we both had a mentor each. Her mentor spoke English, really, really well, she was able to explain everything to her - scientific stuff like ECG. My mentor spoke English but not fantastic, we were able to understand each other, but she could not explain to me any science behind what we were doing. It was quite funny - some of the things she tried explaining, and I tried understanding what she was saying, but we both got them wrong. If my placements were in the UK, I probably would have learnt more (G10).*

The fact that her peer's clinical educator spoke English provided a better experience for the students. The description indicate that the language barrier between the student and the educator have a greater effect on learning and development. It could have been worse if she would not have got support from her peer's educator who was better at English. This indicates that students appreciate and value input from educators and highlights the importance of communication between student and educator for active learning within a clinical setting.

Although previous studies on ICP have highlighted language barriers, explicit reference has not been made to peer support in dealing with such language barriers. Most participants during their placements found translators – who were either their peers, educators or other local students. (G5) expressed that having a translator 'increased dependence' and as a final year student, this appeared to be important for her as she did not have her own case load, which is a progression towards becoming an independent practitioner.

For G10, having a translator 'slowed down the work' which had implications on demonstrating effective time management, which is a vital aspect in clinical placement. However, for both G5 and G10, viewed their experiences positively as they realised the importance of language in clinical practice.

> *When I went to meetings, not all patients spoke English and they wouldn't slow down everyone by making the patients speak English or for translation just for two of us. Meetings were in Swedish. It made me realise that how hard it might be for patients in England who does not know English, how daunting it must be for them to sit through the meetings, words going over you and able to pick out a few words and understand what is being discussed. It also made me appreciate the nurses who come to this country to work as a nurse from another country, I honestly don't think I would do it, even if I learnt Swedish, I don't think I will ever be confident enough to look after somebody's life. I think it takes a lot of guts and this placement made me realise that (G10).*

There were a few more examples of positive experience G2 and G4 used that opportunity to develop non-verbal skills particularly hand gestures and facial expression to communicate with patients, however, it was still challenging for G4 as she expressed it as:

> *...whilst I was waiting for someone to help me, the patients were trying to say something which I could not understand, particularly in the ICU. It was difficult as the patients would not always understand what we were trying to say or show. It was challenging if the patients were trying to ask questions, we always had to make more time with others to help us (G4).*

The above description concurs with the previous descriptions of G5 and G10 of increased dependence and slowing down.

<u>Sub-theme 3: Language learning opportunities</u>

Before departure, G4 and G5 had time to learn the host language, although not through formal language courses and G1, G2, G9, G11 had very little time to learn the language as their placements were confirmed very late.

Obviously, it's a shame, I was not offered any Swedish lessons as a part of the programme and obviously, I would have tried to learn Swedish before I left (G11).

The above statement shows that the student expects universities to provide opportunities to learn the language before going on the clinical placement.

A few participants were offered language courses in the host country. Those who already had some language skills found it useful (G1, G9) as it was easier to learn further, particularly phrases related to day to day interaction. But for others who had little or no ability to speak the language, it was a 'waste of time' as it was too advanced for their level (G4, G5). Since their ICP was not organised early enough, they did not have enough opportunity to learn the language in the UK. However, by the time they completed their placement, they were able to understand a few phrases from the conversations and could speak a little.

I did not speak Dutch, I did not pick a word in Dutch when I arrived, I initially felt that my confidence was knocked to death and you have people with all expectations of you (G2)

G2 felt helpless as she had clinical knowledge but could not share or demonstrate her knowledge base to her educators and she determined to learn a few phrases and towards the end of her placement she managed to learn the language.

.. but now I can have a direct conversation with someone native and that was just kind of good experience and you start getting confident, and it's time to come back. (G2)

In this case G2 was proactive and determined to learn the language. With the language barrier it also becomes difficult to set realistic goals and make progressions during ICP and this could have implication on learning. A similar experience was described by G10.

I noted although I got a good range of placements in different areas, I would say it was not long enough even to take on any sorts of personal care or responsibilities myself (G10).

There is a sense of disappointment as G10 had to follow the other nurses and they had to slow down to translate to her, where her learning was mainly through another nursing staff rather than her interacting directly with patients. However, G10 with reflection expressed that although she felt that she could not make much progression during her ICP, she was able to make up with the next few placements back in the UK. Again, the extract suggest that due to the language barrier, the students often

feel disappointed and might not be able to manage patients independently on their own as they would do back in the UK.

A number of doctors, nurses, and therapists spoke English in the host country, and language was not a major issue for general discussions, but they found that they still had difficulties in certain areas related to patient care such as, assessment and treatment procedures, clinical reasoning, and documentation (G2, G4, G5, G10). G10 had pre-assumptions about English being spoken in their host country and expected everyone including patients to speak English. This suggest that lack of information prior to her departure as G10 expressed,

> *We were told that everyone will speak English and naively we believed that. But in retrospect, it is an unrealistic expectation that everyone will speak English (G10).*

Five participants in this study were unable to speak the host language. The initial view of the two participants was that the ICP could provide them with the opportunity to learn a new language and a few studies identify this as one of the main drivers to student mobility (King and Ruiz-Gelices 2003, Krzaklewska and Krupnik 2006). However, the amount of time spent abroad was just enough to learn the basics, which they felt was not enough to carry out a safe clinical practice.

Theme 2: Practice culture

The differences and similarities in clinical practice between the UK and the host country were discussed in detail with every participant. Most participants found that professional practice abroad is distinct from the UK. The codes and categories related to differences and similarities in clinical practice were further categorised and re-categorised into three sub-themes: The scope of practice, approach to practice, and reintegrating into the UK clinical practices. These sub-themes were formed based on categories which are shown in the figure 6G below. Various issues that arose within these sub-themes include clinical skills, organisational differences, application of evidence-based practice, and relationships with their supervisors, patient care, and technological advancement.

Figure 6G: Theme 2 -Categories and sub-categories

<u>Sub-theme 1: The scope of practice</u>

The physiotherapy graduates, particularly those who had placements in Italy felt that the physiotherapy practice was prescriptive (G1, G3, G4, G5, G9) when compared to the UK. They noticed that the doctors were authoritative and often the opinions of other healthcare professionals were dismissed and G5 expressed this as 'what the doctor says is right'. According to them, the physician-in-charge was in control, and prescribed treatment modalities and expected the therapists to follow them. This was a cultural shock as they were not aware of the differences in professional autonomy between countries.

> *I find it difficult to accept that the physios didn't have the same sort of power to choose treatments and if a doctor said something, even if the physios disagreed, there was not much they could do. They just have to follow what the doctors said and I could not get around that…. this I think is because the level of educational training is not same as the UK (G1).*

G1's seems to relate professional autonomy to the level of education. In the above sentence G1 clearly express her feelings about autonomy in clinical practice and it appears that the situation was difficult, where she felt that the approach was related to the professional training being lower. The lack of professional autonomy were also

expressed by G4, G5 and G9 and would help them to decide on their future travel for work as they were not aware of these differences before going on the ICP.

All of these participants were based in a multi-specialty hospital where they saw that multidisciplinary team was smaller when compared to the UK - with mainly doctors and nurses. Unlike the UK, physiotherapists' involvement was limited - as G4 said, 'only doctors and nurses met and no other professionals were involved', and G9 too witnessed similar practice to G4 as she expressed that 'she only saw doctors and nurses and two physiotherapists for a 400 bedded hospital' and G1 further said that 'the communication between them was not always clear'. 'Back in the UK, the different professionals met regularly to discuss various cases and plan the holistic care unlike here in Italy' (G1).

Although in a different context, G10 and G11 noticed that the nursing practices in Sweden were distinct from the UK practice

> *Late shift nurses often prepare medications and pop them in a drawer - I would come in the morning and give those medications trusting the staff nurse on duty. I felt this is bizarre, back in England, you will never find this practice. I did not feel comfortable; I was worried it was not a right thing to do (G10).*

In this extract, G10 refer to being uncomfortable with the practice, still did not do much about it. When the students are experiencing such differences in practice during their ICP, they had reservations in expressing their feelings as they thought that their input might not be valued as they would do in the UK. The extracts suggest that students had the feeling of foreigness similar to the findings of Greatrex-white (2008).

Participants also found that most facilities in Norway, Sweden, Belgium and Italy had a higher budget for upgrading software and purchasing newer equipment than the UK and they all had opportunities to use a range of new equipment. G2 felt that the hospitals in Belgium were more 'technologically advanced than the UK.'

Sub-theme 2: Approaches to practice

The participants found that the policies and practice abroad were relaxed compared to the UK. G3, G6, and G7 described that Norway was 'a bit laid back' and as an example, as described by G2, noted that the infection control protocol in Belgium such as hand washing was not as stringent as in the UK. She was keen to investigate the rate of hospital-introduced infections in Belgium but she could not get access to the statistical data. In Italy, participants noticed that wards were structured differently to the UK with very little privacy being offered to the patients and G5 witnessed that

‘people were able to walk in and out even when patients were being cleaned and washed’.

G10 found that everyone within the healthcare setting – from cleaners to consultants wore a similar uniform and these uniforms were sent to wash every day as a part of infection control. Participants who were placed in Sweden, Norway and Belgium, felt higher collegiality and friendliness among professionals when compared to the UK. G3 found that the hierarchy within a department was not evident in the clinic that she worked in in Norway as she felt that the UK banding system somehow surfaces the hierarchy within a department.

> *Band 6 often think more than band 5 in the UK, it did not feel like that in Norway between colleagues. Since there is no banding, they treat each other equal (G3).*

Contrastingly in Italy, G5 observed

> *One of the doctors working in the oncology ward had cigarettes and a lighter in his pocket and I heard him saying that people should not smoke but you could see through his shirt, things like this would not be accepted in the UK and other professionals would not have tolerated, perhaps there is more rigidity in the UK (G5).*

These two extracts suggest that the hierarchical system vary widely from one country to another.

G11 noticed posters around the ward put up for patients as ‘make your own bed’ and lounges were Scandinavian-style, where patients could sit with their families and eat together rather than on their beds. She appreciated that nurses took greater care in prescribing nutritional menus to the older patient. Very impressed with this practice, after her return to the UK, she conducted a systematic review as a part of her undergraduate dissertation on the role of nurses in keeping up nutrition for older people.

G10 had an opportunity to administer ‘intravenous medications’, to perform ‘venal puncture’ and to draw blood, which she said was not an opportunity that student nurses would have in the UK. This opportunity for G10 was important as she was the only one in her cohort who had this experience and very much valued that experience. However, after her graduation G10 had to do the same cannulation training as her experience from Sweden as a student was not acceptable in the UK.

Likewise, in Italy, G4 learnt to apply ‘kinesio-taping’ for patients who had suffered a stroke. Similarly, G7 learnt to perform ‘tissue mobilization, and deep friction massage’

which he described as 'physically exhausting', but an effective treatment for sports injuries to optimise the performance of injured athletes. G11 was also impressed by the care provided to patients and the ward settings and recalling one of her observations in one of the wards; she stated,

> *During the drug rounds, they were ready with the documentation, and I was so pleased to see that they brought with them their electronic documentation so that they would be going around the ward with their laptop and drug trolley - and this is something that I have not seen before (G11).*

The accounts provided by different participants suggest that the scope of practice and professional standards differ from one country to another.

Most participants reported that the supervision process was much more informal than in the UK. Most places took the 'learn as you go' approach (G3), without much discussion of learning needs as they were used to back in the UK. Some felt that 'sit down and discuss' (G6) with regular formal feedback would have benefited them. However, a few appreciated the non-formal supervision process with the opportunities to learn with an 'open mind' (G2).

Some participants also felt that they could express their opinions in an informal setting and felt their educators valued the input offered by students during their ICP (G2, G3, G7, G8). The following extract of G7 is an example where a student had positive learning experience while appreciating his educator's approach.

> I *felt that I was a part of the team that the guy in-charge was very relaxed since they do not take students, he wanted to give as much practice experience as possible, not formal, whatever problems came up he helped me deal with this. I think after all the placement, I feel that he was one of the educators who did not want to build a copy of himself, so he did not want to throw things up in the air rather encourage independent solutions. It is nice to have someone who thought that there is no one way of exercising but multiple ways (G7).*

The above account of G7 shows the educator's influence on student learning and development. When explored further regarding the attitude of the other team members, he described that as

> *They did not expect me to make independent decisions but have a say/opinion. The knowledge was not as good as a third year student but still expected me to have a general knowledge. I had worked with injuries before I started physio, they expected me to use the prior experiences. They asked me what I think, if they had a different opinion or did not agree with me they always explained the reasons (G7).*

This placement being the first clinical placement, such positive approach and facilitating environment made a huge positive long term impact on G7

> *There was a long term perspective, it gave me a massive head start with how the health care system works in Norway. Half of the job what I do now where and how to refer, how system works especially with mainly private practices around the country, the referral system outside hospitals (G7).*

The experiences of G2, G3, G7 and G8 suggest that students highly value opportunities provided by educator and the other team members. The educator's approach towards students can influence students learning and development.

G2 and G11 felt that their placements were well structured, with a clear plan for their learning. In contrast, the other participants felt that their day to day schedules were not well organised and comparing between England and Italy, G1 expressed

> *If I am honest, probably the dis-organisation that we found was mainly in the hospital - some departments were run really well but it was difficult coming from the UK where everything is very structured and you were often told what you were going do before you do it and often you review what you have done afterwards (G1).*

Also, G1, G3, G6 and G8 felt that the frequently used treatment techniques were anecdotal as G8 expressed.

> *You get these patients and you manage them however you feel correct, from a treatment point of view they are behind when compared to the UK. They are not up to date with the evidence-based practice; I could compare this because I had another pediatrics placement in the UK, and saw the difference (G8).*

Here G8 is referring to the use of evidence based practice. ICP was G8's first clinical practice, and later having another similar placement in the UK helped him to compare.

G7, when returned to the clinical practice in the UK, noticed the difference in the application of evidence based practice as he tried applying the techniques that he learnt during his ICP were not acceptable in the UK.

> *..little bit hard, as in the UK - it was more of evidence based and some of the techniques when I suggested they looked at me like it hasn't crossed them yet, I looked a bit funny, they laughed at me (although I got a good mark). (G7).*

Applying evidence in clinical practice in daily practice is a norm in the UK and again this aspect was important for students and it appears that both in Italy and Norway, not much importance was given to evidence based practice. The importance of evidence in practice in clinical settings is discussed in chapter six.

The participants also found that unlike the UK there was no mandatory requirement to demonstrate continuing professional education for the revalidation of the professional licensure. The participants (G1, G3, G5, G8, G6) felt that many therapists did not keep themselves up to date with the current evidence and felt that this could be due to limited access to journals and other research materials. Furthermore, participants found that some therapists had a limited ability to appraise research articles with poor application of evidence-based practice. Some skills, which were deemed ‘unsafe or redundant’ in the UK were still practised in Italy and Norway, and the therapists said that they had learnt these from ‘experts’, most often their senior therapists.

> *One of the cases we saw, we thought the patient requires chest physio but the Italians instead did the ventilation. That made me think ‘what is the research behind it’, so there must be a reason why they were doing it. It made us critically analyse both treatments and realised that both the treatments are effective, one if not better than another and it is better than not having any treatment at all (G1).*

Some participants did not openly discuss any of the above aspects with their educators, as they thought that it would upset the therapists or feared the ‘defensive nature’ of the clinical educators. However, they learnt to adapt and acknowledged that there are multiple ways of treating patients which helped them to think critically as G5’s view was.

> *There are no chest physiotherapists, they do very minimal on patients unlike in the UK, but still, patients are surviving, so it made me think how important chest physiotherapy is (G5).*

It was interesting to note that the four students on their first clinical placement (which was an ICP) reported having a ‘good’ learning experience as they felt that they learnt better with the relaxed approach in their supervision, and appreciated the team members for their friendly approach when compared to their placements later in the UK. Such positive approaches are seen in students during their early professional career (Benson et al. 2010), the phase where they start to gain their professional identity and a sense of belongingness (Levett-Jones and Lathlean 2008; Christiansen and Bell 2010). This is in contrast to five other graduates who were in their final year and indicated that they learnt very little when compared to the UK placements and they attributed this to the unstructured supervision and poor organisation of day to day activities.

Sub-Theme 3: Reintegrating into the UK clinical practice

Having experienced different systems and approaches to clinical practice abroad, graduates during their interviews spoke about the benefits and the challenges they faced in the UK placements after their ICP experiences. The participants of this study reported having mixed reactions returning to the UK after their ICP. Most respondents described feeling glad to be back in the UK; such feelings of returning home after an ICP are reported by the participants in studies done by Keogh and Russell Roberts (2009) and Charles et al. (2014). Some of the participants had an opportunity in the UK to work in a similar clinical specialty after they returned from their ICP as shown in Table 3G.

Table 3G: Timing and type of ICP

ID	UK clinical experience	ICP Placement areas	Year of study when ICP was undertaken	Further placements in the same specialty as ICP in the UK
G1	Yes	ICU, Neurosciences, Paediatrics, and Geriatrics	3rd year	No
G2	Yes	Operation theatre	3rd year	No
G3	No	Sports and Musculoskeletal	1st year	Yes
G4	Yes	Geriatrics, Paediatrics, and ICU	3rd year	Yes
G5	Yes	ICU, Neurosciences, Paediatrics, and Geriatrics	3rd year	No
G6	No	Musculoskeletal	1st year	Yes
G7	No	Sports Clinic	1st year	Yes
G8	No	Paediatrics and Musculoskeletal	1st year	Yes
G9	Yes	Cardiology and Urology	2nd year	No
G10	Yes	Thoracic Surgery, ITU, Neurology	3rd year	No
G11	Yes	Vascular and Oncology	2nd year	No

Table 3G displays the timings and the areas of clinical specialties undertaken by the participants. Four of the eleven students had their ICP as their first clinical placement experience within their programme. According to those participants, the disadvantages outweighed the advantages, and they mentioned that they would have

gained much more regarding organisational structure and appraising skills and practices if they had a placement experience in the UK before their ICP.

> *The hierarchy is so strong in the UK and works differently, coming from abroad you don't have a knowledge of this, as I never experienced before. So, this was a challenge in the UK for me and how to address different people correctly and whom would you approach, that was a challenge (G8).*

They also said that their preparation would have been better, as being the first placement, both student and educator had no clear understanding of the marking scheme (G8) or the role of the educators (G6, G7)

> *It was challenging to work within a big team and to know how to communicate with everyone, and implementing it towards treating patients, I took a long time to get used to it when compared to my friends. (G6)*

Those who had their ICP in between the other UK placements were able to compare practices, question the reasoning behind a therapeutic intervention, as well as being able to acknowledge the differences. Although G8 expressed that he would have benefited if the placement was later - for the reasons mentioned above - he still thought that this being the first placement, he was more open minded, and was able to embrace practice abroad without any barriers to learning.

The type of placement and the specialty also had a significant impact on students' learning. G7 had his placement experience in a specialty sports clinic where they treated athletic injuries. It is unusual for physiotherapy students to choose a sports clinic for their first placement. G7 had some background in sports science before joining Physiotherapy, hence did not perceive this as a specialty area. As shown in Table 4G, all participants (except G7) had their core placement experiences abroad, particularly in physiotherapy. Musculoskeletal, neurology and cardiorespiratory are well recognised core placements for undergraduate students.

A few felt that the educators abroad were not challenging enough regarding their knowledge of conditions, choices of therapy, clinical reasoning and evidence for the therapeutic skills. The scope of practice in some areas seemed much less than the UK, and this was perceived as 'not enough' learning experience on the placement. G1, G4, G9 and G10 felt they did not make good progress towards being autonomous as this was important for them in the final year of their degree programme as G9 said,

> *When I came back to the NHS, I was desperate to learn and appreciate every opportunity, so coming back - I completed some CPD courses and tried to push myself more, so I think it shifted my focus more to be less passive in my*

> *learning and you know to take the initiative - maybe slightly more. Looking back now, I think going abroad helped I am not moaning about it. (G9)*

G6 had a slightly different view about his experience in Norway, speaking about his experience in Norway felt that '*it was good but not as good as the UK placements'* and when he was asked to expand

> *The clinicians that I worked never had students before, there was no teaching… I had to use my own books, journal articles and I had to study this on my own. There was no any form of teaching, my development could have been a lot better if I had done the placements in the UK (G6).*

Although it appears that G6 was proactive in his learning, this being the first placement, G6 needed structured and directed learning.

G3 who was also in her first placement in Norway too had no structured approach still had a good learning experience.

> *The Head said 'learn as you go'. We did not write any objectives as we do in England, and I found that very helpful as I wrote down things after trying it out. He was always sure what kind of patients would come in and would say 'this is the knee replacement and with that we do this and that'…it was not as planned and it was not as structured as in England* (G3).

From the two extracts it appears that ICP provide opportunities to explore different ways of learning on the clinical placements.

Most participants (G2, G3, G5, G6, G7 and G8) used the clinical skills learnt abroad on their next few placements. A few were also able to apply hands-on techniques back in the UK such as manual technique (G3), soft tissue massage (G5), kinesiotaping (G1) and deep friction massage (G7). They felt that they were creative while treating patients back in the UK although some educators did not approve. Not all the skills learnt on their ICP were appreciated or accepted in the UK as G7 said,

> *Some of the techniques when I suggested they looked at me as if it hasn't crossed them yet, I looked a bit funny, they laughed at me (although I got good marks)…In Norway, I had seen so many patients with a certain type of injuries and when I saw similar patients in the UK with the staff and I spoke against some of the exercises they were doing, they did not like it. I am a straightforward person, I knew at that time I was right, they were a bit conservative. (G7)*

G3 was also in a similar situation to G7 where her educator did not approve of some of the techniques that G3 was applying on the patients without clear evidence and reasoning, but she continued doing those exercises as she felt that 'the patients were happy, that is what matters to me' (G3). Some reported that there were not many

opportunities to use the clinical skills when they returned to the UK, as the type of placements in the UK were very different from the ICP and were not in the same specialty (G1, G4, G9, G10, G11), and G1 was anxious going back to the placement in the UK.

> *I was very nervous when I started my last one in the UK. One of the major differences was that we did not do any notes in Italy. The notes that we did write were very brief and they were just abbreviations and we just wrote down a few letters and signed, so it was almost like a text sheet, so it was not the same structure as in the UK because it was our last placement coming back, I did worry as I felt that I did not have the experience (G1).*

Most participants acknowledged that skills they learnt abroad were not applicable in the UK due to the non-availability of equipment (G2, G4, G7, G8), stringent policies and guidelines (G2), and also some were not within the scope of practice (G5, G10, G11). However, all the participants in this study felt that their ICP was a good experience for students.

> *It was good exposure - that I could see different patients with different treatment strategies and patient groups. As well as you can draw from both negative and positive aspects and decide, 'I am not going to do this, I am going to do this'. I think it is a very healthy way, where you can see two different situations in two different countries, it still works by all means, but each one has their own strengths and weakness (G8).*

A few had limitations on transferring some of the clinical skills learnt abroad to the UK clinical environment due to a few factors including lack of evidence (G7) and stringent policies or procedures (G10). Despite being confident in a clinical skill learnt in her ICP, G10 could not apply it without having to retake the formal training in the UK and said,

> *I did the cannulation training recently and I was confident that I could do this course easily because of my previous experience in Sweden. In spite of having these experiences, I still had to go through the formal training here in the UK. They didn't consider any of these experiences from my placement in Sweden (G10).*

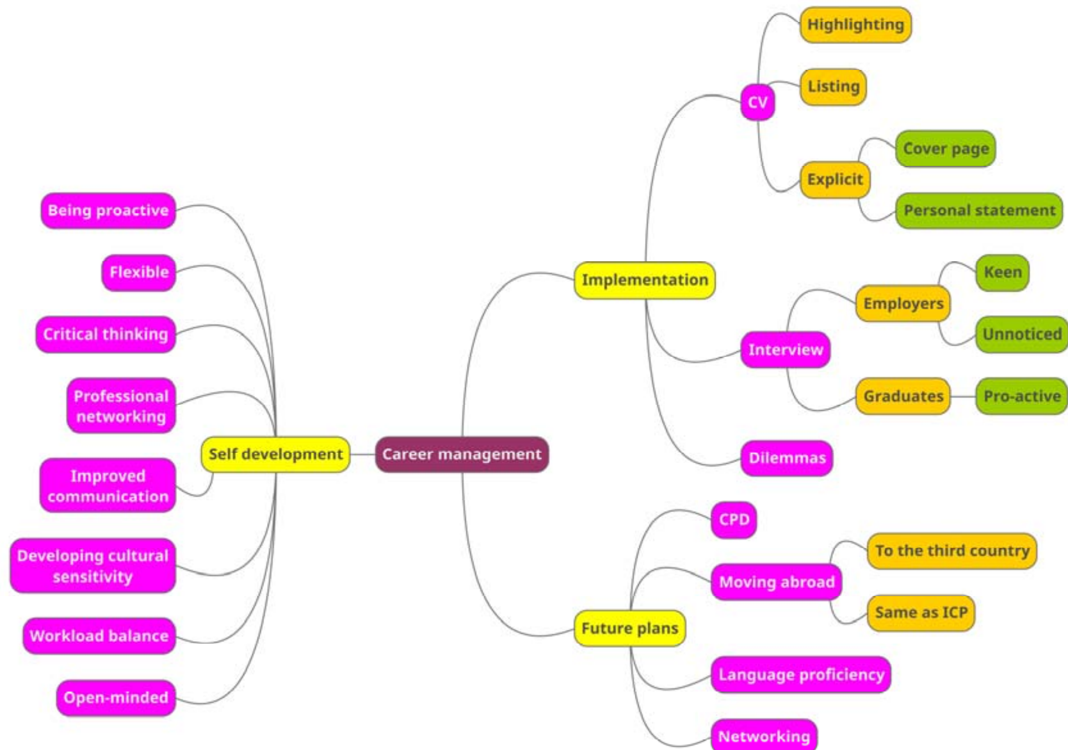
Further, many of them realised that the funds are limited within the NHS which enabled them to be more realistic in transferring of their ICP skills in the UK (G2, G4, G5, G8, G10).

> *I didn't feel it was easy to transfer clinical skills across as they used loads of equipment there, and still never seen things like that in the UK, but I would never forget the experience I had, so I think from that point of view it makes it invaluable (G5).*

Theme 3: Career Management

This theme is based on the participants using their ICP experiences in their employment, their perception of self- development, and their future aspirations. These are categorised into three sub-themes – implementation (application), self-development, and future plans as shown in fig 7G.

Figure 7G: Theme 3 - Categories and sub-categories



Sub-theme 1: Implementation (application)

This sub-theme presents the dilemmas and decisions with the application of ICP experiences for employment. G2, G4, G9 and G10 reported that they filled in the required information by listing all the placements done (UK and ICP) during the programme on a standard job application form. They did not highlight their ICP experience as they were not sure how the ICP experiences would be perceived by the employers. On the other hand, G1, G3 and G6 were of the opinion that highlighting their ICP experience would help them to stand out from the other applicants and found

it challenging to balance this correctly as they had additional credentials and experiences such as first aid for sports injuries (G1) and previous work experience (G6) which they thought were of equal importance for their employment. G5 elaborated her placement experiences on her personal statement in both her first and second job applications. Similarly, G8 highlighted the clinical conditions seen, and the skills practised abroad ‘that I wouldn’t normally see in the UK’ for both his job and doctorate applications, as he thought he would ‘stand out’ from others. G9, who felt that her ICP experience was not beneficial to her, still decided to include the details in her personal statement as she said,

> *Although my clinical experience wasn’t that good, I still wrote it in my statement as I thought it will look good. I spent three months gaining these clinical experiences and some of them in niche settings which I thought was an incredibly privileged position although it is not exactly core physiotherapy experience (G9).*

G3 and G7 thought that it would be interesting for the employers to see that they had a placement abroad but did not highlight as the ICP was their very first placement, and they felt that the employers would be more interested in the last few placements rather than the first. On the other hand, G6 said that he wrote a few lines explaining how his experiences abroad influenced his current thinking. G2 highlighted the experience as she thought that,

> *There was no job for everybody, there was scarcity but I never thought it would be negative, the placement was endorsed by the university and they wouldn’t do anything that is not worth it (G2).*

G8 thought that it would add value to his application as he stated,

> *I had exposure to two different systems, countries, cultures and ways of doing things and that is the strength that the employer might be looking for – who is different rather than who gained higher marks (G8).*

The attitude between G2 and G8 were different, both decided to use this their job application. The above two extracts demonstrate that students do not have enough information on how employers perceive their experience of ICP.

Although all of them had their ICP experiences on their job application, only a few were asked about it in their job interview(s). G4, who decided to keep the relevant passage short

> *On my NHS application, nothing I wrote was striking, I think the words ‘placement in Italy’ that stood out, I think as there was nothing I wrote other than the word ‘Italy’ in all my 3 job applications. But the interviewers picked*

this up in all my 3 interviews. They were interested in what I saw there and how I would make the difference to practice back home (G4).

This above extract shows that students are also not clear on how much information needs to be provided to gain attention from the employers. There is not much reference made in the existing studies in this regard.

G1 included her ICP experience on her cover page, personal statement and specified what placements she underwent, as she thought it was unusual for students to have done this. During her job interview, her interviewers showed a keen interest in her ICP experience and asked about the reasons for taking up the ICP, the differences in clinical practice between the UK and abroad and how she dealt with the language barrier.

Based on the experience of using mechanical equipment in Italy, during G5's second job interview, she was asked to explain how she would transfer that knowledge into the UK system, particularly in using some of the cost benefit strategies, for example, they were interested to know how mechanical equipment would replace an assistant. G2 recollecting her second job interview explained that she initiated the discussion about her ICP experiences.

For my second job, yeah I spoke about theatres and about… I was like, just kind of my communication skills I picked up… and, how the placement abroad enhanced my communication skill (G2).

The participants thought the ICP experiences contributed positively to one or more of their job criteria and were expecting the interviewers to ask about their ICP experience. G6 was 'disappointed' as he felt that the interviewers did not show much interest in his ICP experiences. Similarly, G10 attended seven interviews, and got six offers; she too had ICP experiences on her job applications but was only asked about it very briefly in one of the interviews.

G3 too had a similar experience as her interview focused on her few final placements rather than the first one, which was an ICP. Similarly, for G11 out of the seven interviews, only one interviewer was interested to know about her ICP experiences. In contrast, G5's first job interview focused very much on her ICP experiences and the applicability to the UK workplace of those skills that she had learnt abroad. Although these experiences give some indication about the interest employers hold regarding ICP experiences, it is not clear how and what aspects of ICP they would be interested in.

Sub-theme 2: Self-development (personal development)

The participants described how the ICP experiences contributed to their personal development and there were codes that were identified within the data collected that were related to self-development. The attributes described by the participants included acknowledging others, learning to appreciate, being proactive, creative, flexible, open mindedness, critical thinking, enhancing their communication skills (both verbal and non-verbal), developing cultural sensitivity, supporting peers, and professional networking.

> *If I hadn't done my placement abroad, I would not have developed so much confidence as I started to believe in my abilities, I did know, where within a safety standard to do my own kind of things and kind of achieve my goals set within that placement (G2).*

Even though the challenges faced were upsetting for a few, on reflection, they appreciated the opportunities, and as G9 said, 'it shifted my focus more to be less passive in my learning and you know to take the initiative maybe slightly more' (G9). G1 too had a very positive outlook when she said

> *I think all things that you find challenging in life whether it is professional or personal, I think they do develop you and challenges make you a bit stronger, a bit broader and open minded, and it is quite good actually to have different opinions, different opinions is a positive thing (G1).*

According to G6, the most important lesson learnt through ICP was 'how to learn independently' as he felt his placement was to follow therapists around and observe the different therapists without structured learning.

G2, G4, G7 and G10 felt that it was important to keep in touch with the educators and other therapists. One of the referees for G4 was her clinical educator. G7 was kept informed of the new projects in the speciality clinic where he had his ICP. G2 wrote to her educators regularly with the intention of keeping the options open for future employment.

Some participants said having done their ICP, their perception of themselves changed and they thought that they were more open to ideas, flexible, easily adaptable, and also felt it improved confidence.

> *…lots of confidence because even if I am thrown into any sort of situation, I am now able to handle much better because you were exposed to such circumstances (G5).*

G10 was overwhelmed with opportunities to administer intravenous injections to her patients, which is not a part of student training in the UK and said that,

> *I knew that I could take a lot from there which I could use this in the future. I was able to administer IV medicines when compared to my classmates - some of my classmates were jealous. It was all exciting to draw blood, and, these are the skills that you will learn after you graduate, early exposure as a student was a good feeling (G10).*

G1 having coped well with uncertainties expressed,

> *I felt quite out of depth at times, but still, we had to get on with it. I grew a lot in confidence to cope with different situations, and now I guess I am not so worried. If I am thrown into a situation like - I am a bit calm about it and logically go through - how I am going to deal with it (G1).*

Some participants like G4, G5, G9 and G10 had academic submissions along with their ICP which they felt was very challenging without access to the physical resources or the tutors.

> *Yes, we had a presentation and three essays to do. It was a high workload, I do feel that we did not have much time to explore the place (G10).*

It was apparent from the participants that, meeting different people from different cultures enabled them to develop cultural sensitivity. G8 explained this by stating:

> *Exposure to two different cultures as a student was a good thing, England, although is much more diverse than Norway, you still learn a lot from both. This made me realise that there is never one approach that fits all (G8).*

Sub-theme 3: Future plans (aspirations)

The participants were asked about their plans for working abroad in the future. Three out of eleven graduates were abroad when the interview took place (G7, G8, G11). G9 was not sure what her future plans would be as she was just thinking of her first job that she was looking forward to starting in the UK.

G8 moved to the United States of America (USA) for further studies after having worked for one year in the UK. He had special interest in sling therapy, which was used widely in Norway during his placement abroad

> *If possible I would like to get certified during this fall. Having used the equipment back in Norway, I think it would be a new concept as I have not seen much even in the US (G8).*

G10 reiterated that ‘the ability to speak the language’ was a crucial factor to consider working abroad, and said,

> *...not Sweden, it is going to be in an English speaking country, I have a lot of respect for other countries. I have not made any decisions on what country to get. Even if I hadn't gone to Sweden, I would have still realised that I wouldn't be able to work confidently in a non-English speaking country as I am not that brave (G10).*

With G10's extract, the language barrier is one of the deciding factors for future work. Similarly, G11 although enjoyed her experience in Sweden, language was a deciding factor and she felt that she might not be able to carry out safe practice unless she was proficient in a language to care for patients.

> *You know you always think the government gives you Swedish lessons if you want to come and be a nurse here. I don't feel that confident as a nurse there, probably when I always preferred to go to places like Australia or Canada or America, and it is mainly because of language (G11).*

When the interview took place, G11 had already immigrated to Australia with the plans of working for a few years as a nurse.

G1 at the time of the interview was pursuing her master's degree in London. She did not perceive language as a major barrier, but the scope and the practice culture was a deciding factor besides the presence of family,

> *It made me a lot more aware that the practice is not the same as England, it is much more prescriptive, like France. That was the main thing that I realised, I will look into how physios are different before I go into another country. I am not sure if this is going to be temporary or permanent I have looked into the States where I have a family, but the process is a bit complicated (G1).*

For G1, the professional autonomy seemed to be crucial for future move as the language was not a barrier since she could speak Italian. Although G1 wanted to move closer to her family, this did not seem to be the criteria as she had family connections in Italy too and language was not a barrier.

Similar to G1, G6 wanted to broaden his experiences, but was unsure of where he would go; however the below extract suggest that he was mainly focusing on those places which were similar to the UK.

> *I am thinking of New Zealand or Australia. They have good environments to learn and study. The profession is well recognised, and I can see myself there, and not anywhere else. The culture is similar to the UK and it would be a smoother transition than going into the country where I don't know the culture or language (G6).*

G4 with her first time staying away from her family in Italy for her ICP, said that

If I wanted to go to Italy it would be easier to apply because, I had that three months of experience - which may not look massive and communication wouldn't be a problem, I know the system, the doctors, and physios where I have kept contact with. If I want to go there, it will be easier for me when compared to someone else who has never been there (G4).

G4 in this extract does not suggest anything definitive of moving to Italy for future work and suggesting that this could be an option in the future, which could be a positive feeling. A similar feeling was expressed in the extract below by G2.

G2 was extremely grateful for the opportunity provided by her university to undertake ICP in Belgium and ICP provided her life-changing experiences. She said that she missed Belgium and wanted to work there as her manager at the time had told her that he would offer her a job anytime she wished to move.

I would go back there in a heartbeat. I love Belgium. It is a beautiful country, it is a friendly country, it is a supportive place to work and the conditions of working are amazing (G2).

Both G4 and G2 seem to be in touch with their educators and other team members. G7 returned to Norway after his graduation and using the network that he had developed during his ICP; he opened his sports clinic as his view was the UK salaries for physios were just enough to live and not pay back huge student loan abroad.

Salaries for physios are not high enough in the UK to start paying back the student loan. In Norway they are three times higher, I had plans… they were hard to accomplish in the UK (G7).

G5 and her husband had plans of moving abroad in another few years. G5 had travelled abroad on voluntary work to India before undertaking ICP and expressed that:

Moving abroad in a couple of years, I would like to do more work in the underdeveloped country, Italy is much westernised. I would like to do it in the third world countries; I had some experience in India and now, after qualified, I would like to go back (G5).

G3 thought that her experience in Norway had influenced her greatly and had intentions of returning to Norway after gaining some more experience in the UK

My Norway experience is still making an impact on my career and growth. I am eventually going to move back to Norway, and MSK is the main area where I would be working (G3).

4.3 Summary

In line with the IPA, this chapter explored the lived experiences of eleven graduates of healthcare who had clinical placements abroad while they were students. Using semi-structured interviews, the eleven participants shared their journey from ICP experiences to their current employment. The chapter adequately represents participants' experiences and their voices are retained through descriptive extracts.

All participants had enriching experiences abroad and they were unique as they found more differences than similarities when compared to the UK clinical practice. All eleven participants had been to non-English speaking countries (convergence). All of them experienced communication challenges regardless of their ability to speak the native language. Four participants who were native speakers of the host country too felt that the terminologies used in Norwegian were very different from English, and with little help from their educators and supervisors, they managed well in their placements. Those graduates' basic language abilities appeared to have benefitted more as they had opportunities to develop confidence further. Those who did not know the host language felt disadvantaged as it directly affected their learning.

Most participants felt that the style of supervision was different from the UK. The educators were much more relaxed, and particularly in Norway, the approach to teaching was casual with the 'learn as you go' approach. All participants in this study had one-to-one supervision except in Italy. The students found that one educator managed a large group of students, who were from the local university. They found that some of the wards were overly crowded with students, all trying to care for a few patients, thus limiting their practical experience. All eight physiotherapy participants in this study referred to the limited use of evidence in clinical practice abroad. Many of the techniques applied were anecdotal, and the educators could not clinically reason for some of the therapeutic techniques used in their practice. Some of the participants found that their educators had limited knowledge on the research methods and had no access to some of the key journals.

The scope and standards of professional practice appeared to be limited in Italy. The role of a multidisciplinary team was limited in a large public hospital and the participants observed that the communication with allied health professionals was limited. The physiotherapy practice being prescriptive, doctor-led with limited professional autonomy in Italy appeared to be the crucial factor influencing all four participants for future work. The participants who went to Norway did not make any

reference to professional autonomy and this could be due to two reasons. One, they were all in the first year of their physiotherapy programme and on the first clinical placement when they were on ICP in Norway as opposed to those participants in Italy, who were all in their final year of placement. So participants in Italy might have had a better understanding of professional autonomy. The second reason could be that the professional practice varies from one country to another as it is guided by the national associations.

The three nursing participants did not think of professional autonomy as physiotherapists, but found that some of the nursing practices varied when compared to the UK. One particular practice of the previous shift nurse preparing the medication in one of the Swedish hospitals was seen as unsafe practice by one of the participants. Further discussion on scope and standards of professional practice for both physiotherapy and nursing is discussed in chapter 6.

Six of the eleven participants were with their peers from the UK on the same clinical placement and all of them valued being with their peers. The importance of peer learning and the recommendations for ICP is discussed in detail in the discussion chapter.

The four graduates who were in their first year of placement had opportunities to apply some of the skills learnt abroad, whereas the other seven in the final year of their placement had little or no opportunity, as the placement areas differed widely from the ones abroad. Reflecting as graduates, the type and timing of placements abroad seemed very important in this study and this aspect is discussed in Chapter 6.

Moving on to the second part of the interview regarding their application of ICP in their employment (both first and subsequent), all participants of this study said that they wrote about their ICP experience in their job application. The participants were not clear how much and what type of information was best to highlight in their job application. However, only a few of them were asked about their experience during the interview and this was not proportionate to the amount of information provided in their job application. It seemed that some managers were interested in this experience. There appeared to be gaps in understanding the employment process. Hence it was deemed vital to bring the employers perspectives in this study, and the findings from the employer interviews are presented in the next chapter.

Although clinical placement and employability appear to be two discrete areas, every clinical placement experience (including ICP) regardless of timing and type has shown to have an impact on employability. The challenges faced by students on other UK clinical placements and dilemmas faced by the graduates while applying their first jobs are novel findings of this research. The insights gained from the ICP experience aided graduates in developing an attitude towards their future mobility. All the participants gained both personally and professionally through ICP and their view was that more students should have an opportunity to go on placement abroad.

Chapter Five: Findings - Employers

5.1 Introduction

This chapter presents the findings of the interviews held with the employers, who have had experiences of recruiting or working with healthcare graduates in the UK. The first part of the section is focused on the demographic data of the employers, and the second part is descriptive qualitative data gathered from the employers through a semi-structured interview. The data from the individual employers was organised using Nvivo 10. A new project on Nvivo was created as 'Employer interviews'. The initial codes were produced from the data and were grouped and regrouped to identify the core themes. These identified themes are discussed in detail with supporting quotations that cover the following third and final research question identified for this thesis:

RQ 3: How do employers of healthcare graduates perceive the link between ICP and employability?

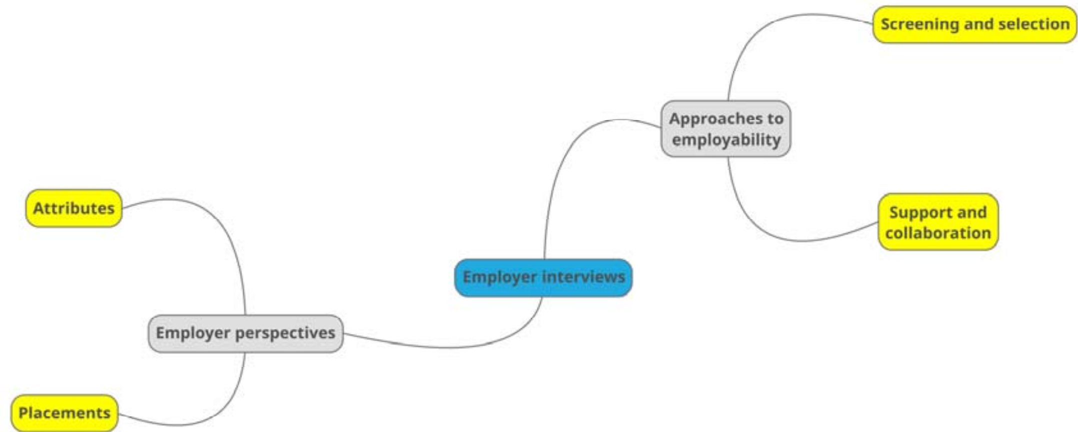
5.2 The themes and the sub-themes

As there were no previous studies considering the perspectives of healthcare employers or the approaches to employability of graduates with ICP, two main themes identified emerged from the data.

- Theme 1: Employers' perspectives
- Theme 2: Approaches to employability

The two themes along with their-sub themes are shown in Figure 8E and each of these themes is discussed in detail.

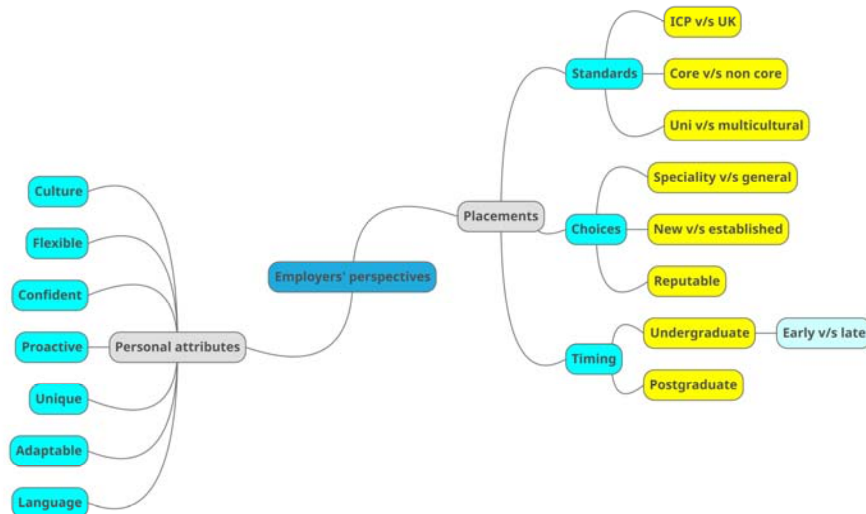
Figure 8E: Themes and sub-themes of employer interviews



Theme 1: Employer perspectives

Most employers viewed ICP in a very positive manner. Previous studies on ICP have shown that ICP experiences prepare students to work in a dynamic and diverse healthcare setting (Greatrex-White 2008; Kent-Wilkinson 2016). The employers in this study acknowledged that ICP helps students to build diverse skills. The skills that the employers thought were developed through an ICP were classified together to form the first sub-theme as ‘attributes’. The second sub-theme ‘placements’ was formed by collecting the employers’ views on how the choice, the timing of the placements, and the standards affect students’ learning and employability. The categories and sub-categories forming the two sub-themes and the theme are shown below in Figure 9.

Figure 9:Theme 1 - Categories and sub-categories



Sub-theme 1: Attributes

A number of employers felt that ICP experiences helped students develop diverse skills that will 'favour' them for future employability. E4 and E7 thought that ICP at an undergraduate level provided opportunities to develop 'personal skills' rather than 'clinical skills'. E8 believed that a person who has been abroad for ICP is flexible, adaptable, open-minded and willing to learn, all of which were perceived as key values for any healthcare professionals.

E2 reflecting on her own placement experiences in the UK versus the experiences of her classmates who went abroad for a clinical placement, after arranging it themselves in a specialty area, believed that the experience gave them an insight into the area in which they wanted to pursue their careers. Also, according to her, these experiences were useful to employers as it showed initiative and pro-activeness. E1's perception was also similar to others as she stated,

> *That shows to me that they have the ability to look after themselves abroad, they have been responsible for themselves, they have shown flexibility, it is not just about working abroad, it is actually living abroad, as a new graduate it would build their confidence, would have helped to shape them as people, broaden their experience and that would have made them understand different people, so those elements. I would be looking very favourably upon that because it would just show to me that they could manage themselves (E1).*

In the extract E1 value students who have been on ICP as she believes that being on an ICP develop important attributes such as flexibility, confidence and independence. Exploring the interview further, E1 further thinks that ICP experiences would 'shape students as people' and improve self-esteem, and considers it as 'learning with no disasters' and with other attributes as,

> *... a way of doing things and being flexible and it is beyond, it is not about language, ethnicity - it is actually the working cultures of those countries, and that will also help them to understand the people coming from different cultures and their managers and how they may have their work ethics (E1).*

E1 as a very experienced manager (22 years) and now in a senior management position view graduates with ICP very positively.

Similarly, E7 from her own experiences of interviewing and recruiting graduates with ICP experience had seen that most of the candidates were 'good team players', as she believed that students had the ability to develop 'a mix of a few things' such as the ability to face new challenges, and better adaptability. She further believed that those who had taken risks to go into a new environment, new culture and new team would have to have, 'a lot of confidence in themselves'. E7 acknowledged that 'not everyone can do it' and it depended on how well one can adapt. If adapted well to the new system, ICP provide students a 'unique opportunity to learn' (E6), as E3 stated, 'I think again it goes with the maturity to have that step to go… and go for that kind of adventurous look'.

E7 thought that it was important not only for students but also for all healthcare professionals to experience a different healthcare system, and she believed that it adds to 'their long-term career' as it enables them to critically appraise the UK healthcare system. 'if you are exposed to only one thing, you think you are the best' (E7).

One of the main drivers for student mobility including ICP is to learn a new language (ERASMUS 2014, Gower et al 2016). In order to carry out a safe clinical practice, it is imperative that 'one is familiar with the language and culture' was E1's view as she said 'a few months of language training might not be enough to carry out safe clinical practice'. According to E2, the language barrier in clinical practice could be a 'frightening experience' and might 'knock students' confidence completely'. What seemed more important to E1 was to recognise the differences in clinical practice, to learn about diseases that are rare in the UK but prevalent in a particular community and people's expectations from the healthcare professionals. E1's perception was,

> *It is not about they are being fluent in another language and proving that - it is of some interest, but we would never use somebody to interpret for somebody for example, so it is not just about the language skills - they might have developed that sort of thing. If you wanted it for a particular job, that's fine, but it is not the criteria in healthcare and it is not in England (E1).*

In this extract E1 suggest that there is no greater advantage of knowing another language as this might not be very useful in their day to day activities back in England. However, many employers acknowledged that a language barrier during the clinical placement could have a negative effect on learning and development.

E5 felt that ICP should provide both personal and professional skills as she stated that,

> *I think if they have spent a substantial amount of time in a different country, they have to be learning good skills. We want these people to be competent practitioners, at the end we want them to be able to nurse people or provide good physio, and we want them to do their job properly (E5).*

Most employers in this study viewed ICP positively and they all believed that is an opportunity to develop soft skills and personal skills. In the above extracts, much reference was not made regarding the development of clinical skills.

Sub-theme 2: Placements

Most graduates in the preceding chapter, particularly those in the final year, reported that they were anxious about their early career, and their anxiety stemmed from their perception of limited experience during their ICP. They were unsure of how the skills and competencies gained abroad, particularly in core specialties, would be acceptable to their prospective employers. The following section presents the placement perceptions of the employers.

During the interview, most employers shared their views about the expected standards of placement abroad, the choice and the timing of the placement. Many felt that the UK is one of the best places to provide students with necessary clinical experience. E2 with her own experiences of working abroad for a few years felt that the UK could provide one of the best placements for undergraduate healthcare students in terms of supervision, clinical education, and application of evidence-based practice. A number of research studies highlight the importance of integrating evidence-based practice into clinical practice to improve the quality of patient care (Finkel et al 2003, Anderson 2008, Melnyk et al 2014). E2 further felt that it was 'unnecessary' to go on an ICP unless it is at a reputable and/or a specialty centre.

> *…at an undergraduate level, they just need to get the basics - forget diversity, forget seeing some other clinical practice, just get the basics right, so you got 50 years ahead potentially of seeing other cultures and other ways of working. I don't think I'll ever do an ICP, I think it is a massive risk (E2).*

As the nursing and therapy standards differ in different parts of the world, E1 expressed her concerns about recruiting graduates into certain specialties without the UK experience, as she stated,

> *...then you will be worried about some of the standards that apply there, I am thinking particularly about safeguarding and meeting people's needs in terms of safety, in terms of communication standards and confidentiality standard, you think it would be the same but actually it is not, that people's understanding, for example, is very different from what they were allowed to do legally and things like that. And there are some risks involved but the risks are manageable but you just have to manage them. The benefit outweighs the risks but you still have to manage the risks (E1).*

E2 as well shared a similar concern about the transferability of skills and competencies particularly with regards to safe practice back in the UK.

> *I just think, the timescale is so tight, you don't want to get anything wrong. I cannot see the benefits, I can see the benefits more during the elective placements (E2).*

In this extract, E2 is referring to the total number of years for graduates to complete physiotherapy programme, which is only three years and within this period, they will have to complete other modules in addition to the thousand hours of clinical placement. Elective placement is a shorter placement, for about four weeks, where students often arrange themselves in their areas of interest.

E4 and E6, recalling their own experiences of recruiting graduates with ICP, felt that the graduates with the UK experience, particularly in the core areas had better clinical skills when compared to the ones that had their placements abroad. They believed that the UK has a structured learning environment to provide timely support and supervision to students. For E4, what seemed important was what they covered during the ICP rather than where the placement was done as he said

> *You had to look at what they were doing on that clinical placement, rather than where the clinical placement was, what were the responsibilities and what skills did they or what were they introduced to in that clinical placement and how were they assessed* (E4).

When E4 was asked to explain the above extract on how he would explore this aspect further, his descriptions were in line with assessment standards as he stated,

> *I think the difference is with an international placement compared to a placement in a local hospital or a hospital that has worked with the University, both the university and the hospital generally has set standards, where standards are very typical and kind of their structure is well built, and that relationship between the two is well built, so when they don't have that if they go abroad, it is very difficult then to kind of standardise that marking criteria or whatever. I think you may not have to look at that mark if you mark them in placements as 100%. I think you have to really look at that and delve a little bit deeper into what they actually did in that clinical placement (E4).*

It was interesting to note that E4 was the only employer in this study who referred to student assessment, and for him, the marks gained in the placement was less important than the quality of learning and standards of practice.

It was the timing of ICP placement that most employers said they would consider while recruiting graduates. Students with the ICP later during their undergraduate programme were the most preferred by employers, as they would have a reference to compare practices and build further from the basic training that they have had in the UK.

According to E5, ICP during the early years of their studies would not be beneficial, and instead, she thought it might undermine their confidence, particularly when they returned to the UK for advanced placements. E7 thought that it was best to have mid-programme placements' and E1 too was of the same opinion that this would give opportunities for students to 'reflect all the other way round'. E5 said that prior UK experience was 'worthwhile' and ICP experiences could further augment their learning. E6 rationalised this,

> *I think at the university you learn a lot, but I don't think you will consolidate information until you have gone on a placement and you realise, 'oh someone has this condition' and this now I really understand what it means and I think you tearn that when you are in a clinical placement with the clinical supervisor who is able to support you. And I think as you develop those skills in your first few placements then you can put those skills into practice. If you are going somewhere with less clinical support, it is more difficult if it is early on [not for first clinical placement]. I do think that they should, for their first placement should not be abroad they should have few placements have been a clinical setting with the clinical support and be able to build on the skills when they go abroad (E6).*

E9's advice was to choose an 'elective' placement abroad, particularly in their own areas of interest or in which they would like to specialise further. E2's viewpoint also was similar as she stated

> *For me, there is no advantage because if they got sub-standard education there is no advantage at all from employability point of view. For me, it would be if they have done all the core subjects in the UK, and then they want to do this. When I was a student, they used to go to Nepal or third world countries, Kenya or something, to get the experience during their elective placement… they have done their core placements in the UK and that for me is fantastic… I just think the timescale is so tight, you don't want to get anything wrong. I cannot see the benefits, I can see the benefits more during the elective placements (E2).*

E2 and E6 further emphasised that it was best to undertake an ICP after graduation. The NHS Trust where E1 worked had a wider diversity, about 55% of the patients were 'non-white English', and recounted one colleague who traveled abroad regularly; E1 appreciated her efforts said that

> *This one person in particular who every year had three months off and went to work in Africa, and what she brought back to that post was great … she was able to influence our team members by talking about that culture. That was the only person from that era when I was her manager. More recently, many people have experiences of working abroad and it would be a balance - I guess, between wanting to make sure that the standards where they were working were high enough that they understood the culture that might be different to here and to use that experience probably to do with meeting patients' needs of the same culture (E1).*

E6 wanted to go abroad to work after her graduation but could not; it was highly challenging while working in the NHS within the first two years of employment due to time and financial constraints. However, she acknowledged that it is easier to go abroad as a student rather than later in a career.

Most employers acknowledged that ICP experiences would benefit students later in their employment as they would have an advantage of having a broader exposure to different cultures. They were of the opinion that healthcare students should be exposed to diverse cultural environments as they may have to deal with people from different cultural backgrounds in their professional practice.

> *For something like just looking in the CV, it does give a plus point to me if they have worked in the different cultures, they have been exposed to diverse culture and population, rather than working with specific population, and depending on where you are hiring them, if I am still hiring them in the same kind of environment, it is a private hospital or private clinic where you know we have expectations of a certain area trained therapist coming in, they are good in practice patient relation skills (E7).*

E3 favoured graduates with multicultural experiences and according to her, such graduates together would make a ‘good’ team as she said,

> *I think certainly people bring different aspects or different treatments from all over the world and that makes a good team, because then, you can share experiences and you know, get different ideas, you can bring the best out of everybody to work as a team and from different aspects of the world is my point of view (E3).*

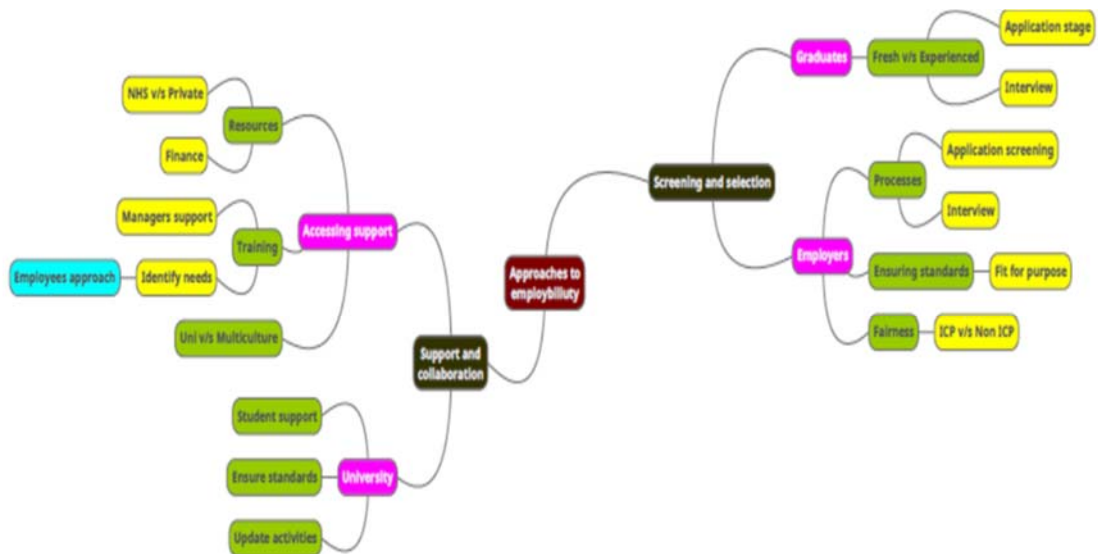
E5’s perceptions were very similar to E3, if E5 had to choose between two candidates with similar qualifications, she would pick the one with more multicultural experience as she thought ‘I think the essence is that they get along with different people and have different values’ (E3). E8 too preferred to employ candidates with multicultural experience and according to her, graduates with such experiences are ‘more flexible and can deal with people of different personalities’ (E8).

E1, E6 and E7 felt that some parts of the UK can provide a better multicultural experiences for students compared to many of the European countries, and in particular they were referring to larger cities such as London, Manchester, and Birmingham which host a multinational community. E1’s view was that universities must aim to provide a few placements in multicultural settings within the UK rather than abroad. E7 shared her experiences of recruiting nursing graduates from different parts of the UK to one of the hospitals in London, whose patients were from diverse cultural and ethnic backgrounds. According to her, many struggled to cope with this diversity and a few left the job within a few months of recruitment.

Theme 2: Approaches to employability

This theme is related to the approaches which the employers said that they adopted while recruiting graduates with ICP experiences. This theme also includes the support that the graduates could access after they were recruited. The sub-themes under this theme include screening and selection, and support and collaboration. The codes and categories that aided in forming this theme are shown in the Figure 10.

Figure 10: Theme 2 - Categories and sub-categories



<u>Sub-theme 1: Screening and selection</u>

The graduate participants expressed that they were unsure of how much and what aspects of their ICP experiences would be appropriate to include in their job application form (healthcare jobs in the UK usually have a standardised online application form). The employers were asked to share their own experiences and views on the processes of recruiting both fresh and experienced graduates with ICP experiences. The questions mainly included screening the application forms, interviewing, and selection processes.

Being familiar with the NHS application form and the UK recruitment process, E1, E2, E3, E6, E8, said that it is essential to list all the clinical placements along with the speciality areas and the country if the placements were abroad. According to them, this would give the employers an overview of the type of experiences the graduates gained.

Further, they said that the supporting section (the section that provides space of up to one thousand five hundred words for the candidates to explain how they meet the criteria for the job. NB. When the graduate participants applied for the first job the iteration of the form in use at the time allowed for only about 500 words) is an opportunity to explain their experiences explicitly compared to earlier forms. E1

thought that the section provided ‘quite a lot of words’ and one could easily explain three to four elements of prior experience in this section, and according to her:

> *When you are working there will be something about diversity there. It is always something you would always have to say - how you would meet the diversity aspects of that role and safeguarding aspects of that role, and how you would develop people - teamwork, whether somebody is at basic grade or a management grade. There is always an element of working closely with colleagues and developing colleagues, there is always that element of role specification, one can do that, and understanding people from different cultures and understanding people who come from different cultures is important (E1).*

E7 said that she would look into various ‘clinical skills’ learnt abroad, especially if this involved a specialty centre and how those could be used in the UK. She said it would be good to explain the strategies used to overcome specific challenges faced abroad, as this served to provide some ideas about the ‘exposure’, ‘flexibility’ ‘adaptability’ and ‘confidence’ of the applicant. E9 said that as increasing numbers of students go abroad for their ICP, the competition also intensifies in a few years, and according to E9, the selection criteria would change and commented that,

> *If we are employing them in the UK, we look how well they know the system, have they worked here, NHS wise, patient care, then again if they have something extra where then from previous international experience that will be the plus point. If they fulfil the criteria to meet this specific job that will be my first step and if 2 or 3 candidates are at the same level and from similar international experience, then have they brought anything special like skills or communication or exposure to wider services (E9).*

In this extract from E9, he views ICP to gain additional experience and stressing on the importance of having the UK experience.

E8 said that she would be keen to know how the ‘differences in culture and practice abroad’ impacted the applicant as this would demonstrate ‘ability to understand others’ and ‘tolerance towards other culture’,(E8). This aspect was crucial for E8 as the hospital that she worked had patients from diverse background and multicultural experience was one of the essential criteria to recruit staff into the hospital.

E6’s viewpoint was that she wanted the applicants to demonstrate how the experience gained through ICP helped to meet the set standards or criteria for the job. E2, reflecting on her own experiences of recruiting new graduates, said that,

> *Interestingly, I interviewed candidates from a University, and they all had exactly the same experience and they saw exactly similar kind of patients…and their application, it was almost dot to dot the same. Obviously, all three of them had done the same thing, no uniqueness to it at all in any of*

these three candidates… It's all about being unique and it is all about selling yourself (E2).

The extract from E2 suggests that she values students with unique experience regardless of where the clinical placement is undertaken. She further believes that such a unique experience can only be gained if a student has worked in a speciality clinic either in the UK or abroad.

When the employers were asked whether or not they would explore the ICP experiences of the graduates during the interview. Some said that they would, but most would not directly bring up the topic as interview questions are standardised. Further, they said that they had limited time to interview candidates, and with an increasing number of applicants, it could be very challenging to get into details. E5 recounting her experience of working with a medical faculty suggested that,

> *Often, the medical students go to third world countries and they help out, that is what they have been doing, gaining really good experience. I really think it is something we can learn from them for our recruitment (E5).*

Most employers said that there were many opportunities for the interviewee to proactively bring up the topic during the interview. According to E1,

> *I would always ask them about equality and diversity and within the topic, graduates could reflect on how different the practice culture was giving an example of how different people react in different ways to being different nationalities, different socialization to various diseases, and to the importance of family would be variable, so I think there are lots of interesting ways you could bring that up (E1).*

E1's extract suggests that candidates can proactively bring up their experience of ICP and describes some of the relevant areas where the students can easily discuss their ICP experience. E6 too expressed this in the similar lines as E1 and the areas where the students can proactively discuss their clinical placement

> *The recent clinical, couple of clinical questions, usually there is a couple of the personal experience and how it is developed them, things like a team player or skills they require for job roles (E6).*

E3 and E7 thought that it is during the initial 'ice breaker session' the candidates have the opportunity to mention about their ICP. E8 suggested students to consider ICP learning as a project which can be discussed during the interview. E9 too believed that ICP can be compared while discussing on improving UK healthcare services. These were in addition to the skills and competencies, adaptability, flexibility which are commonly explored during the interview (E2, E3).

The main focus of recruitment is to ensure that the candidates have experiences relevant to the jobs applied and against UK set standards. E4 recalling his own experience expressed that

> *Again, the people that I know had clinical placements abroad, I think one of them went to Africa, and they helped settle physiotherapy practice in a village, and now, that shows to me that candidate has got a different kind of mind set - maybe than someone who just went through the university, and just done the normal rotations; however, again I would not just take them on if they built a hospital. I'd still be looking at how they used physiotherapy skills in that setting (E4).*

E2 too spoke about the fair selection and equal opportunity to all candidates said that 'it does not matter whether they have done the placement abroad or not'. In line with the fair selection. E1's view was,

> *More recently, many people have experience abroad and it would be a balance - I guess between wanting to make sure that the standards where they were working were high enough that they understood the culture that might be different here and to use that experience - probably to do with meeting patients' needs of the culture in the UK (E1).*

E3 believed that ICP experience would be looked at favourably, but they would still have to prove themselves in the interview and also meet the required criteria.

> *I think it could definitely go in their favour, but, again another person with the same qualifications, and actually it would depend on the actual interview at the time, it's not just about their experience abroad, also about their clinical work and general behaviour, and also if they have an awareness of the hospital that they are applying to. So it's how they present themselves in the interview, certainly open to, in the view both people that had their international placements and others, at the interview day, it's really at that time if they are able to answer the questions and tick all the boxes (E3).*

E4 view was that any experience is important but depends on how it is reflected on and transferred.

> *I think it is positive if they discuss in their interview. From my experience, if they discuss in their interview in a positive way, what they have done on that placement, then yes, but I still think that I would not just take someone into a job, just because they have international experience. As a standalone, I would always think that I would always tie into what skills did they learn, did that clinical placement add anything more when compared to another candidate. Are they more employable just because they did an international clinical placement? I would say probably no, but I would say that it highlights they maybe got little bit more diversity and will depend on what that clinical placement was I would say (E4).*

The extract below show that E5 too prefer candidates to be proactive in bringing up their ICP experience by reflecting on the quality of ICP versus UK experience.

> *If someone is put down on application that they have worked abroad, I think my question might be 'tell me about your experience'. I mean, they need to open that aspect. You know really people know what experience they got, whether is good or not (E5).*

Sub-theme 2: Support and collaboration

A successful practice placement depends upon the collaboration between academics, students and clinical educators (NMC 2015). The employers felt that for any clinical placement experience to be successful in terms of learning and employment, it was important for students to get timely support from the university. E6, from her own experience as a clinical educator, believed that it was important for universities to provide additional support to students while they were abroad:

> *I have had some students that I know who went abroad, they have had a lot more involvement from the university when they were on their placements and a lot more support, because they don't always have the same clinical support they have in the UK and ..I think it was a big help for the students as their lecturers made sure that they headed in the right direction when they were on the placements to carry on their learning (E6).*

In this extract, E6 was aware that the support available during ICP was low. This is largely related to her own experiences of being an educator to some students who went abroad for some of their previous placements. E6 seem to value the support the link lecturers from the university provide during their clinical placement.

Similar to E6, in the below extract E1 value the support students receive from the link lecturers as she felt that not all students had the ability to reflect well on their placement experience as she expressed that it was important for their university tutors to facilitate their reflections,

> *…the opportunity to reflect all the other way round is really important and they are probably not going to do all that, their lecturers can help them, definitely do that when they are back and get those experiences out of them and expect them to able reflect, I think that is really a good opportunity to start off that reflection process with the students, really good opportunity (E1).*

E5 too had a similar opinion as she had seen it work with the medical students and she said:

> *I worked with medical students who all were expected to go abroad to have some time in clinical placement. The professor would encourage them to come back and tell their stories so that it was not just the end when they got back. When they came back they really valued their experiences and opinion,*

to tell the stories about their experiences, show the pictures and show the people they met (E5).

The above extracts from E6, E1 and E5 suggest that the support from the university lecturers are important and how the reflective practice can be encouraged.

E6 and E9 felt that the success of ICP mainly lies with the universities organising placements abroad with wider choices for students. Further, E6 said that the university that she was associated with worked closely with the placements abroad to create a supportive environment for students by training a few healthcare professionals as clinical educators. E9 felt the need for students to have options to choose the placement sites and specialties.

There should be like – options open to the students where they can go, get to choose a renowned kind of institute where they can go in, where you can monitor the quality of care what they provide and they should be, if the placement is monitored by yourself and option is given to the student, I think that is a good idea, it should be done (E9).

Both E6 and E9 focus on two aspects, one - training clinical educators abroad and two - to monitor the quality of clinical education, and both are crucial in clinical education. As an employee, E5 felt that they should be kept informed by the university and involve them in some of the decision-making processes. Her view was that if the employers were not kept informed about the placement sites, they might not perceive ICP favourably and this might disadvantage some of the graduates

I gather that people sometimes are discriminated against, I feel they probably are, but hopefully, that is changing and people are realising we have to accept and welcome and appreciate outside experience. I hope that is changing, I think it is… And, yeah, more collaboration as well, so maybe include managers in this process. Then they will feel 'oh that is good because I am involved'. Of course, they also have some input into the quality (E5).

E5 here refer to changing attitudes of employers toward ICP and suggest that employers could be actively involved in such initiatives.

Another aspect that was explored during the interview was the support available for graduates with ICP experience to professionally develop further or to fill the gaps that they have in skills and knowledge after they are recruited. E1, E5, E6 and E8 expressed that they would like to give as many opportunities as possible for them to develop and even encourage them to go abroad again to broaden their experiences but due to financial implications, it would be harder in the NHS when compared to private facilities.

> I *am looking at the financial implications on the organization, I am not always able to do that to allow them and I know within the NHS you have to be within the organization for 5 years to be allowed time off…, so it is a lot difficult to be able to ask for the someone to have time off, although I love as much as I love to give as much support. I think it's easier in a private practice setting than in the NHS because we don't always have the same financial barriers as we do in the NHS (E6).*

In this account of E6, having worked in both the NHS and private organisation in England, E6 understands the constraints they have to support graduates to go abroad for clinical placement. Although E1 prefers to work abroad after they graduate, but could be challenging for graduates when compared to students.

Having missed some of the placements in the UK, if the graduates felt that they were not competent in certain areas of clinical practice. E8 felt it was 'better to be safe than sorry'. E9's view was that they speak to their manager 'frankly' and if they had missed one or two core areas, his suggestion was to do those rotations towards the end. This is possible in the NHS, as clinical rotations into different clinical specialties are pre-set for new recruits. E3 said that she would have the discussion to identify the needs and 'tag them with one of the senior team members'. E7's view was similar to E3, after identifying the needs,

> *We make sure they are supervised by a senior staff nurse or the educator for that particular unit to gain that skill. If needed, we give them more time and make sure we assist in building their competencies, so that they are competent to do it (E7).*

The extracts from E3, E8, E9 and E7 all seemed very supportive of new graduates and said that they would make arrangements for graduates to bridge the gap if they had any, not only during their ICP but also in any of their placement. The employers preferred the employees to approach the manager to seek appropriate support pro-actively.

5.3 Summary

This chapter mainly focused on the experiences and views of nine healthcare employers who had experience of either recruiting or working with graduates with ICP experiences. The main aim was to explore the link between ICP and employability and bridge some of the gaps identified by the graduates during their interview.

All the nine employers' attitudes towards the ICP were positive and they all believed that the ICP helped in developing personal attributes rather than clinical skills. Similar

to graduates, they too stressed the importance of communication in clinical practice, which is discussed in detail in the next chapter.

Similar to graduates, the scope of practice and standards of placement of ICP were questioned and they suggested that both university and students need to evaluate the quality of placements carefully. Their view concurred with graduates' views regarding the type and timing of placement, suggesting a short, elective mid-placements for students which are discussed in detail in the next chapter.

The employers stressed the importance of outlining the ICP experiences in graduates' job application. The employers believed that there are opportunities for graduates to discuss their ICP experiences in their job interviews. They offered suggestions of how the graduates can pro-actively discuss their ICP experiences during their job interviews (e.g. teamwork, diversity, flexibility, cultural competencies).

The employers were aware of the gaps that graduates would have if the placements were abroad, and their view was that the graduates must identify the training needs and discuss this with their managers or during the recruitment. They all expressed that they would support the graduates in their workplace to bridge the gap. The overall view of the employers was that the cultural competencies gained through the ICP could be an added advantage for employability. The following chapter discusses the results of this and the preceding chapter relates it to the extant literature.

Chapter Six: Analysis and Discussion

6.1 Introduction

This study was established to assess the influence of international clinical placement on employability through the research questions presented below. A review of literature presented in Chapter Two offers theoretical support to explore the participants' experiences based on multiple factors related to the topic. This study has sought to gain insights from two perspectives; that of graduates of healthcare, who had their international clinical placement whilst they were students, and that of employers who have had experiences in recruiting healthcare students. The preceding two chapters identified the core themes through qualitative interviews with two distinct groups of participants. This chapter focuses on discussing the results from both graduates' and employers' perspectives and relating the results to the extant literature. Every attempt is made in this chapter to compare and contrast the views of graduates and employers, thus covering both individual and collective views of both sets of participants.

6.2 Research questions and data collection methods

The purpose of this research was to gain a broader understanding of the long-term influence of international clinical placements. In order to gain multiple perspectives, two distinctive sets of participants with different sets of experience were purposefully chosen. First, healthcare graduates who had been on international clinical placements whilst they were students. Second, employers with extensive experience of recruiting healthcare graduates in the UK. One-to-one semi-structured interviews were held with participants to explore the three focused research questions:

1. How do graduates of healthcare describe their ICP experiences relative to their UK placement experiences?

2. How do graduates of healthcare envisage the influences of their ICP experiences for their professional career?

3. How do employers of healthcare graduates perceive the link between ICP and employability?

Each of these questions seeks to clarify and build upon the long-term and continued influences of ICP experiences. The graduate interviews focused on two aspects; first, gaining the detailed accounts of their international clinical placement experiences, and second, exploring the ways in which they employed these ICP experiences later in their career. As the semi-structured interviews for this study were held after the students' graduation, the participants were able to identify and critically evaluate factors that influenced them in their careers.

6.3 Presentation of results

A thematic analysis was used to analyse the data. Phenomenological thematic analysis is used in many studies on ICP experiences, for example, Grant and McKenna (2003), Callister and Cox (2006), Green et al (2008), Charles et al (2014). The data in the results sections is presented as themes. The ICP experiences of graduates were largely captured within the first two themes and were presented in the results chapter as 'communication in clinical practice' and 'practice culture', which largely covered the first research question. The third theme, 'career management', examined the ways in which the graduates utilised their ICP experiences in their own employment, thus covering the second research question. The third research question was answered in two parts, first, employers' perceptions about recruiting graduates with ICP experience, which was aligned to the theme 'attributes'. The second part was to explore the methods that they employed or would employ in the recruitment of graduates with ICP experience which were collectively themed as 'approaches to employability'. The individual responses of the participants formed the data for this study and were presented in the results chapter as two distinct sets. The discussion in the following sections are largely based on these themes.

6.4 Conceptualising ICP experiences

Clinical placement is regarded as one of the best places for students to integrate theory and practice that promotes learning for healthcare students. The introduction chapter (Chapter One) of this thesis elaborates on the various factors that determine the quality of learning within a clinical placement for students. The results sections showed that the participants on ICP had many enriching experiences mainly through their interaction with supervisors, peers and patients. Undertaking clinical placement

abroad was not mandatory for nursing and allied healthcare students. Despite the options available for graduate participants in this study to complete the clinical rotations in the UK, they chose to go abroad as most of them believed that this would be an opportunity for personal and professional development. The challenges faced by the participants whilst they were abroad have been explored in this study which adds to the current understanding of ICP experiences.

The graduates were aware that their ICP experiences were unique and specific to the individual. The factors that were barriers to their learning and aspects influencing them in their careers were many, as identified by both graduates and employers and as shown in the results chapter. Some of those aspects that are considered crucial for students within a clinical environment and have practical implications are discussed below.

6.4.1 Communication in clinical practice

Communication among healthcare professionals and between peers and patients is considered vital to patient care. The literature on communication in clinical practice addresses verbal, non-verbal and written forms of communication. Students traveling abroad for studies go through a language and cultural experience (HEA 2013). There is a body of literature emphasising the importance of language in clinical practice, particularly concerning healthcare students. Studies on international students in the UK and Canada found that they were low in confidence when speaking to their supervisors and patients, which impacted on their clinical performance (Donnelly et al 2009; Keogh and Russel-Roberts 2009; Crawford and Candlin 2013).

The participants in this study possessed different levels of proficiency in speaking the host language, ranging from being proficient to being unable to speak the host language. As seen in the results section, six of the participants within the study had the ability to speak the host language, and four out of these six identified themselves as natives of that host country. The other two participants had basic language skills, which made it easier for them to communicate with patients and their educators. Furthermore, they were able to find peers from the local university, who helped them with the occasional translation of some of the terms used in the clinical practice and/or in the documentation. They benefitted very little from the language courses offered in the host country upon their arrival due to time constraints. The participants found their therapeutic communication and fluency improved as the placement progressed, with little opportunity to improve their written skills.

In a number of previous studies on ICP, inability to speak the host language was perceived as a barrier to learning by the students (Greatrex-White 2008; Green et al 2009; Keogh and Russel-Roberts 2009; Morgan 2012). Although it appears that some of the participants of this study felt 'frustrated' and that their 'dependence increased' due to the language barrier, in the long run, it did have a positive influence on them. It made them realise the importance of language in healthcare and the need to be empathetic towards non-English speaking colleagues and patients back in the UK.

This study has further shown that language abilities can play a vital role in making future decisions, such as settlement choices, which was evident in the participants' choices of future travel for work to English speaking countries. The perceived benefits of learning a new language or being proficient in a foreign language did not seem very important to the employers in this study and, as one of the employers (E1) clearly expressed, ICP within healthcare should be beyond language and ethnicity. She reiterated the importance of being proficient in the language of the country to carry out safe and effective practice. Further, some of the employers felt that experience within a multicultural city in the UK could provide opportunities to develop better cultural competencies.

6.4.2 Style of supervision

The role of clinical educators in clinical placement is key to students' learning. Students are often closely supervised on a clinical placement both at home and abroad (Green et al. 2009). As discussed in the introduction (Chapter One of this thesis), the priorities and expertise of clinical educators lie in caring for patients. Much of their time is devoted to patient care and clinical supervision of students is often perceived as an additional responsibility. The supervision process depends on various other factors such as individual's workload, qualification, experience and level of interest. This is in addition to the recognition and support given by their employers and partnering HEIs (Dobrowolska et al 2016). Greater interaction between students and educators enhances learning, builds professional identity, and promotes professional socialisation (Wentworth 1980; Shepard et al 1999; Richardson 1999; Boniface et al 2012; Laitinen- Väänänen 2014; Pront et al 2016).

The style of supervision abroad varied greatly whereby most participants found that their educators were much friendlier than the UK educators. Three of the eleven students had structured supervision similar to the UK and the rest described their supervisory experience as being relaxed with a few preferring this approach for better

learning. More than the two-thirds of graduates indicated that if there was a structured supervision and timely feedback from the supervisors would enhance their learning. The language barrier between student and supervisor was found to be one of the significant factors that had greater effect on learning. Further, they had difficulty understanding organisational policies, treatment protocols and rationale behind those protocols.

The above findings are consistent with previous studies on ICP (Keogh and Russel-Roberts 2009; Chipcase et al 2012). As highlighted by Pront et al (2016), the empirical research available on clinical supervision is scarce, still, the existing research highlights the importance of structured learning for promoting deeper and meaningful learning. This study highlighted that poor understanding of the learning objectives and lack of facilitation of day to day clinical activities on an ICP not only affected learning but also undermined students' confidence.

A panel of nurse educators from eleven different countries was interviewed to understand the role of clinical educators. Dobrowolska et al. (2016) found that the qualifications, training, and responsibilities of clinical educators were highly varied in each country. Other than in a few countries like the UK, Ireland and the USA, there was no requirement for the clinical educators to undergo any formal training to be in their role. The authors recommended a standardised system of mentorship training across the globe and in line with this suggestion, the author too believes that there is a need for standardising this system, especially with the growing student mobility for placements. However, there are difficulties in achieving the standards in the healthcare facilities as a clinical mentorship programme is neither mandated by professional governing bodies nor a priority of national health services in many countries.

There are a number of ways of improving supervision processes to provide a better clinical experience for students. One of the ways is to provide timely support and appropriate training sessions (based on their experiences) to the clinical educators (Chang et al 2013; Russell 2016). The other way is to have international funded projects such as Soulbus E-coach programmes as EU funded project to train supervisors on developing or improving multicultural competencies (Tarvainen 2015). However, having personally witnessed the diversity that exists in clinical education between countries, hospitals and individuals, it could be highly challenging for UK healthcare educators to train the therapists abroad. So, the best opportunity could be to train a few educators from each of facility abroad and use the model of a 2:1 ratio

of clinical educator: student as suggested by Stiller et al (2004). Further, it might be easier to monitor the quality of education and ensure better communication between the university tutor and the clinical educator. This concurs with the suggestion offered by Council of Deans of Health and Universities UK International (2017) to recognise experts in the field to clinically supervise students.

In the above model, the students too will benefit from learning with each other (Boniface et al 2012). Although, no reference is made to such supervision in any of the previous studies on ICP, there are studies on clinical education such as Kell and Owen (2008), Copley and Nelson (2012) that have examined the various models of student and supervisor ratio as discussed in the literature review of this thesis (Chapter Two), with most students and educators preferring three students to one educator. But within the ICP context, three students to one educator may not always be practically feasible due to limited numbers of students on an ICP and further, this might increase the burden on one clinical educator. Further exploration is warranted before the practical application of a 2:1 or 3:1 model in an ICP context.

It was also noted in this study that students had a variety of choices in terms of country and clinical speciality. If this could be reduced to a manageable number of hospitals in certain countries and with speciality clinics that provide multidisciplinary care for the patients, it could be easier to identity and train a few clinical therapists. Further, if the clinical facilities were shared by two or more disciplines from the same university, it would reduce the administrative work and the option of one of the staff members from the home institution travelling with students to provide supervision for them; a similar arrangement was explored in a study by Chipcase et al (2012). Although there are funding streams available to support students abroad through ERASMUS, interdisciplinary supervision is still a niche area with certain challenges needing further exploration. Further, in a facility, where clinical education is still emerging, there would be a number of challenges for students. Overcoming these challenges could be beneficial for them as this will prepare them better for their future work (Boniface et al 2012).

Due to limited funding available for ICP, only a few students per year go on an ICP. The clinical facilities are often utilised only for a few months in a year, and if the hospital can accommodate students throughout the year, these facilities can be shared between the universities. Some of the clinical facilities in the UK are shared between two or three universities due to a limited number of clinical placements available for students. Having worked as a clinical link lecturer and co-ordinator, my

experience is that such arrangements, although appearing to be convenient, would present a number of challenges to overcome. First, as the curricula of each university differ from one other, supervision of students with different assessment criteria and expectations could be challenging for clinical educators. It then becomes important to collaborate with those universities that closely match the curricula and assessment criteria. Second, often, there would be requests to accommodate students from different universities at the same time as placement dates vary between the universities. Due to the smaller number of students on ICP, such capacity issues might not be of great significance and this could be avoided with proper planning. Since there are no studies currently on shared facilities, further exploration for feasibility, benefits and challenges of sharing ICP placements is needed.

6.4.3 Being with peers

Peer influence in this study was in three distinct areas; combating social isolation, dealing with language barriers and peer-mentoring. Five out of the eleven participants in this research completed their ICP along with a peer from the UK. The participants valued support from each other; the experiences described by participants suggested that mutual supporting each other was paramount throughout their stay, particularly in the initial few days, when they were orientating themselves to a new place and exploring local areas.

Engaging in social activities is greatly encouraged during such international programmes (Go international 2016). As the students in this study were based outside the university campus in private or hospital accommodation, they had very little opportunity to interact with the students of the local universities.

Two participants in this study, on a few occasions, were grouped together with a larger group of students of physiotherapy from a local university. In the UK, it is not a common practice to be in a larger group in one clinical area for a placement. However, the number of students in a clinical area depends on the type of placement, the number of educators available and the number of patients. None of the previous studies has made any reference to students on ICP being in a larger group.

When a larger number of students from different cohorts within a single discipline like physiotherapy are on a placement at the same time, hands-on learning could become highly limited. Having studied and worked in a large teaching hospital in India, I have personally witnessed situations where students, interns and post-graduates from

different disciplines have their placements together caring for the same patients. If unstructured and unplanned, the placement tends to be much more observational rather than hands-on, and the less motivated students might eventually lose interest in learning and it would be highly challenging for the clinical educators to provide the necessary learning opportunities for their students. If clinical educators from different disciplines plan together and provide opportunities for students to learn with each other, this could become an efficient way for students to learn within a multidisciplinary team (Chipcase et al 2012).

Peer interaction during the ICP has been shown to have had a positive influence on learning. Learning together with a peer provided students with opportunities to critically engage in appraising clinical practice. Often students engaged in clinical discussions and also had a platform for comparing and contrasting UK clinical practice to ICP with each other. Regular interaction and the sharing of views with each other helped them both to problem-solve and to handle challenges with ease. A number of studies have highlighted the benefits of peer learning in the clinical placement, which has been shown to reduce anxiety, increase engagement in critical thinking, and encourage self-efficacy (Nemshick et al 1996; Moore et al 2003; Stiller et al 2004; Green et al 2008; Henderson et al 2011; Austria et al 2013; Stenberg and Carlson 2015; Pålsson et al 2017). Additionally, none of the participants in this study reported facing disadvantages if placed with a peer from the UK. A few studies have reported students facing challenges as a result of being with peers on a clinical placement due to unhealthy competition and incompatibilities (Austria et al 2013; Stenberg and Carlson 2015).

6.4.4 Multidisciplinary team approach

Some of the participants in this study observed during their ICP that the function of multidisciplinary work was limited with the care pathway and patient discharge mainly decided by a team of doctors. This is in contrast to UK practice, where the multidisciplinary team along with the patient and the carer creates a plan for discharge. The functions of a multidisciplinary approach and interdisciplinary team work are considered vital for effective delivery of healthcare (Healthcare team effectiveness project, UK 2014). Professional bodies such as, the Health and Care Professions Council (2013: article 9.2 and 9.4) state that ‘a registrant must be able to contribute and work effectively with the multi-disciplinary team members’. It may be possible to gain some details about the various healthcare teams working in particular settings, practice realities can only be understood through students’ experience. Even

if universities can take a proactive role in exploring the practice gaps prior to students' placement on ICP, addressing these gaps in practices may not be practically feasible as the clinical practice culture and approach differ in each country between and among professionals.

Five graduate participants from physiotherapy in this study had little experience of working with multidisciplinary team members (MDT) during their ICP. The participants also reported that further opportunities were not provided to fill this this gap back in the UK in the same speciality, however, it did not appear to be a concern for any of the participants as they had a number of opportunities of working with MDT members on other UK placements. Graduates placed in areas such as neurology, medical-surgical ward and paediatrics felt that patient care would be compromised without a strong multidisciplinary team. Lack of MDT exposure during ICP did not seem to be a concern for employers. It could further be argued that such limited exposure may be good for students to appreciate the differences in practice and realise the importance of working in teams.

A number of practice guidelines, professional bodies and research studies suggest providing as many opportunities as possible for healthcare students to work in multidisciplinary teams. This aims to heighten students' awareness of the roles other healthcare disciplines (Ericson et al 2012; Morphet 2014). Gaining detailed feedback from the first few cohorts of students on the differences in practice and mechanisms to identify the missed opportunities during their ICP is crucial. This helps the placement co-ordinators to plan their further placements to provide them opportunities to fill the gaps back in the UK.

From the discussion so far, it appears that some of the countries in Europe strongly adhere to the traditional hierarchical system with doctors being on the top of the hierarchy with very little professional autonomy for all other healthcare professionals and there would need to be a considerable shift in thinking both within the organisation and nationally to change this practice. However, the hierarchy, professional autonomy and interdisciplinary approach vary widely not only between countries and organisations but also within a profession (Crowe et al 2017). In a study completed by Grant and Mckenna (2003) the participants realised that the roles of nurses in the UK were markedly different from Australia (where they initially assumed it to be similar in both countries), in terms of hierarchy amongst nurses, roles of doctors and staffing. The participants of the study reported feeling like an 'alien' (pg. 533) during their placement in the UK.

6.4.5 Development of skills

The graduates reported developing new clinical skills which were neither practiced in the UK nor commonly a part of undergraduate training. Having used some of these skills in their ICP, which they thought were distinct from the UK, prompted them to review UK clinical practices and guidelines. A number of participants adapted and utilised some of clinical skills learnt abroad, and following their graduation, some were interested in further developing their skills learnt abroad (e.g. gaining formal certification in sling therapy). They were unable to apply some of the skills in the UK, either due to policy issues or unavailability of equipment.

Comparing the budget and the resources available between the UK and abroad, a few participants of this study expressed that the UK had a lower budget available towards purchases of equipment. Only one participant in this study had a prior experience of gaining work experience (prior to joining the university) in a developing country with some insight into the socio-economic situations and healthcare model in each of these countries. Participants in other studies on ICP such as those done by Morgan (2012), Vlvund and Mordal (2017) had their placements in some of the developing economies where they witnessed lack of access to basic healthcare facilities for their citizens. Such early exposure to various healthcare systems could be beneficial as they were able to engage in critically appraising the UK healthcare system.

Although the participants in this study made a reference to lack of resources in the UK, they acknowledged that these financial limitations in the UK practices did not compromise on the quality of care. They were all appreciative of the UK healthcare system and acknowledged that the experience of their ICP provided them with opportunities to reflect on the UK healthcare system. Thus, this study has demonstrated that ICP provides opportunities to develop new perspectives on practice.

The employers in this study viewed ICP as a platform for gaining an in-depth understanding of alternate approaches to clinical practice. They viewed it as an opportunity to learn clinical conditions that are not prevalent in the UK. Previous studies on ICP - including those involving medical students whose elective placements were in countries within Asia, Africa and some of the American continents where exposure to some of the rare conditions was reported (Holmes et al 2012; Kumwenda et al. 2014; Bohman and Borglin 2014; Burgess et al.2014) - in some

cases reported witnessing major differences in policies and practices abroad such as in relation to policies on hand washing (G11) and the use of open ward systems, which were perceived as offering less privacy for patients (G5), but none of the participants reported coming across any new or rare clinical conditions during their ICP.

6.5 Envisaging the influences of ICP (employment and other career aspirations)

The discussion in this section is on the findings from the graduates that covered the second research question on how they perceived the influences of ICP after their graduation through their early career experiences and to share their future aspirations. Within the same sub-sections, a part of the third research question is also covered by embedding the views and perceptions of the employers.

6.5.1 Obtaining first and subsequent jobs

The graduates in this study reported that ICP had a positive influence on them as an individual, but they could not say with certainty that these experiences had any greater influence than the UK placements in gaining their employment. What emerged from the study was that the participants were young, high achievers, career oriented and aspiring to grow to a higher level in their discipline. They all seemed very aware of the dynamic nature of healthcare and continued to widen their portfolio beyond their ICP. It was difficult to determine the extent to which an isolated experience such as ICP influenced their employability. The participants perceived their employability as a natural progression from their higher education and regardless of their ICP experience, they were confident of getting employed. ICP could be viewed as one of the key resources that equip graduates towards employability as suggested by Tomlinson (2017).

The information that each participant provided in their job application varied widely - from simply listing the placement to explicitly elaborating on the experiences. The job application process for the UK NHS asks applicants to list and briefly provide details of all clinical placements and when these graduates applied for their jobs, there was not much opportunity to provide greater detail as the space available for their personal statement was only five hundred words. The available space has recently increased by a factor of three, which is up to one thousand five hundred words.

However, one should not assume that detail provided on the application form will be picked up during the interview and whether or not this happened did not directly relate to the amount of information provided in the application. Only four of the eleven graduates were asked about their ICP experiences during the interview(s). The employers clearly expressed that it was the candidate's responsibility to pro-actively discuss their ICP experience during the interview. The candidates might be engaged in deeper discussion of their learning experience with some specific examples of how those could be transferred to the UK healthcare setting (Holmes 2013).

In addition, they offered a number of useful suggestions for graduates with ICP experiences to consider at different stages of their employment process. At the application stage, the suggestion was to provide an overview of the placements undertaken both in the UK and abroad, highlighting the main learning from the ICP experiences and how that complemented their other UK experiences. Examples that the employers felt would be useful to include in the job application are utilisation of clinical skills learnt during ICP in the UK (E7, E9), strategies used to overcome specific challenges whilst abroad, (E8) and the uniqueness of ICP (E2). Including such details in the application form would draw interviewers' attention during their job interview as it is uncommon for a graduate to have this clinical experience. They all had a different set of experiences. For some, this expectation was met but for a few it was disappointing. It is difficult to draw a rationale to reason these differences from the employers' perspectives as they all differed in their views.

Brown et al (2015) use the term 'talent' places emphasis on creatively aligning the abilities to the needs of the workplace, which they think is beyond demonstrating all the skills and competencies. The employers in this study expected the graduates to be aware of the job requirements, and to take a pro-active role in aligning their ICP experiences to the job. The employers' suggestions to the graduates were to focus the most on the UK clinical experiences and complement this with their reflection on ICP experiences.

The graduates in this study reported having had little opportunity to apply their ICP skills in their present jobs. They further indicated that they would build on their current profile rather than focusing on a single experience, such as ICP, as they progressed in their careers. The significance of their participation in ICP on their job application would start to slowly diminish in the future because of a need to be more contemporary, according to the needs of the healthcare system. This is in contrast with a study by Potts (2015), where graduates from disciplines outside healthcare

reported that their international experiences had moderate impact on their current work and believed that the impact would be greater later in their careers.

6.5.2 Opportunities for personal development

Learning in a clinical environment is experiential, which is often conceived as transformative in nature and promotes critical thinking (Kolb 2014). The participants' acknowledgement of developing as 'self' was evident throughout their ICP and continued to influence them even after their return, with certain attributes such as believing in themselves, heightened confidence and being independent. It was clear from the narratives of the graduates that they had a variety of cultural encounters with their patients and supervisors, thus enhancing their learning experience. In line with the other studies, this study demonstrated that ICP is a good platform for broadening cultural competencies.

Using an objective measure to identify learning (such as skills and competencies gained) from an ICP experience, Peying et al (2012) and Gilliland et al (2016) used the Intercultural Development Inventory (IDI), an objective scale to measure cultural competencies of students on ICP. Yet, in both the studies, it became necessary to follow up with qualitative analysis due to small sample size and finding the inventory insufficiently sensitive to understand the complex human character (Tashakkori and Teddlie 2010).

Similarly, the employers acknowledged that there are multiple benefits of going abroad for clinical placement. As discussed in the results section, the employers felt that ICP provides students with opportunities to develop diverse skills, which could be beneficial for their future life, both as adults and employees. For the most part, the employers viewed ICP as an experience that helps students develop personal skills rather than clinical skills. The employers in this study believed that these diverse skills and competencies are the highlights of ICP. The sub-theme 'attributes' are those characteristics that the employers expected to be present in an individual with the ICP experiences.

An individual with an ICP experience was perceived as possessing certain characteristics such as flexibility, adaptability, open-mindedness, willingness to learn and promoting independent thinking. These qualities are referred to in a number of previous studies and, particularly, the process of development of these cultural competencies is explained by Deodroff (2006). A number of studies have shown that

ICPs help to develop cross-cultural sensitivities and competencies (Peying et al 2012; Charles et al 2014; Tuckett and Crompton 2014; Gilliland et al 2016).

Inter-cultural and cross-cultural interactions have been increasing in this globalised world and are gaining a greater prominence within higher education settings. They are required to provide effective healthcare, particularly in the dynamic environment in which healthcare graduates work. This does not imply that ICP is the way for personal transformation, but there is a strong potential for personal growth and it offers a different way for an individual to view the world. These were clearly articulated by the employers and substantiated by the narratives of the graduates. Both sets of participants firmly believed that these cultural competencies would go in their favour for employability.

6.5.3 Future aspirations

Reflecting on their ICP experiences, the graduates in this research reported that ICP was instrumental in shaping their ideas about future international activities, including their consideration of future employment abroad. ICP in this study has served greater purpose for an individual by providing a clear sense of the things that should be known before future travel for employment. Nine of the eleven graduate participants in this study showed no greater interest to apply for employment in the same place as their ICP. All of them preferred another English-speaking country with a clinical practice and autonomy similar to the UK with Australia and/or the USA as their major choices. At the time of the interview, three of the graduates were outside the UK and were planning to travel further to other countries for work. Although this cannot be wholly attributed to their ICP experience, it is reasonable to say that the ICP experiences had a considerable influence on them in developing a certain attitude and improving awareness about the importance of language and the scope of practice.

It has been deeply engrained in people's minds that the education and practice standards in the UK are very high when compared to the rest of the world and this can be evidenced through some of the comments made by graduates and employers in this study. Bennett's six stages linear developmental model of intercultural sensitivity published in 1986 is often used in describing students' cross-cultural progression. Bennett's model moves progressively from ethnocentric (denial, defence, and minimisation) to ethnorelative stages (acceptance, adaptation, and integration) (Bennett 2011). The findings from this study suggest that study abroad can help an individual to get an overview of another culture while holding strongly to

ethnocentric views. It could be argued that the progression from ethnocentrism to ethnorelativism seems unrealistic, given that the time spent on an ICP is too short for an individual to progress through these stages.

6.6 Practice perceptions and other considerations

6.6.1 Scope of professional practice

Graduates recognised and appreciated the differences in clinical practice between the UK and overseas. Five of the eleven physiotherapy graduates described practice as ‘prescriptive’ in nature, where therapists had little or no autonomy. Due to the limited scope of practice, the students felt that their ICP did not provide sufficient opportunities to develop their clinical reasoning skills, to consider various choices of assessment and/or treatment available, and to progress from supervised to independent practice. For a healthcare professional student, exposure to independent practice is highly significant as it helps in building confidence to handle patients independently and is an exposure to the real world of a healthcare graduate (Anderson and Kiger 2008). A number of employers in this study had a similar view as Killick and Dean (2013) that students will be able to critically appraise the UK clinical practice if they have exposure to other clinical contexts. The scope of professional practice was one of the major factors influencing future mobility.

According to the Health and Care Professions Council (HCPC) Standards of Proficiency for Physiotherapists (2013), a registrant physiotherapist ‘must be able to practise as an autonomous professional, exercising their own professional judgement’ (proficiency 4, page 8). HCPC professional standards do not have set standards for placements abroad. However, the standards elaborate that a physiotherapist must ‘be able to make reasoned decisions to initiate, continue, modify or cease techniques and record the techniques and reasoning appropriately’ (4.2), and ‘recognise that they are personally responsible for and must be able to justify their decisions’ (4.4). Almost all physiotherapy employers in this study were aware of some of the educational and practice standards in different parts of Europe. The employers would be cautious in employing a graduate if their core placements were in one of those countries with limited practice and to bridge this gap, the suggestion from the employers was to undertake voluntary work in those core areas in the UK.

According to World Confederation of Physical Therapy (WCPT 2017), within the national health services in Italy, the access to patients is only through referral from

physicians. This prescriptive practice is built in the national system of health, but private practitioners have autonomy to some extent when compared to the government supported hospitals. The participants in this study only had exposure to the national healthcare and not to the private sector in Italy. Their understanding of professional practice was limited. In contexts such as this, where the practice standards vary across the sectors, it might be worth considering providing students with both national and private practice placement experience.

On the other hand, Norway has a similar system to the UK, where physiotherapists are first contact practitioners (WCPT 2017). Patients' access is direct, without reference from another healthcare professional in both public and private healthcare sectors. However, the participants in this study who had their ICP there thought that it was the standards of practice that were different from the UK. The regulatory body does not require demonstration of continuous professional development (CPD) for renewal of registration, whereas in the UK, it is a requirement for the renewal of licence to practise. CPD ensures that therapists are up to date with the knowledge and skills required for professional practice.

Similarly, the two nursing graduates involved in this research had to administer medications prepared by nurses from an earlier shift. This meant that they had to completely trust the nurses; both of them said that they reluctantly carried out this practice. This may be the nursing practice in that particular hospital, still participants found that such practices are deemed unsafe and unacceptable in the UK. The NMC has a set standard for students placed outside the UK and they must be consistent with the UK standards of practice. According to point 11 of The Code: Professional standards of practice and behaviour for nurses and midwives (NMC 2015), any delegated task should be fully explained and supervised. The nursing employers in this study also preferred graduates with the UK experience in certain speciality areas, as it is necessary to have a clear understanding of UK practice standards. However, this did not imply that they would not recruit the graduates with ICP experiences, but rather the suggestion for the graduates to reflect and take a pro-active role in requesting a supervised training in the areas of practice that they missed in the UK.

It is crucial for a healthcare professional in the UK to have a clear understanding of the scope of their own professional practice in order to carry out safe and effective practice (NMC 2015; HCPC standards of proficiency 2013). The graduates who participated in ICP in the final year of their degree programme reported that they had limited opportunities back in the UK to bridge any gaps in their practice. These

findings provide a possible rationale for students being anxious when they returned to the UK for further placements, as they were expected to demonstrate independent practice.

6.6.2 Use of evidence-based practice (EBP)

EBP has become an integral part of nursing and physiotherapy education in the UK with an objective of equipping students with the necessary skills to utilise the existing research for providing the best care for individual patients (Melnyk et al 2014). Most graduate participants found that the use of EBP abroad both in physiotherapy and nursing was limited when compared to UK placements with most of them carrying out anecdotal practices. This is reflected in the categories related to 'use of research in practice' within the sub-theme of 'approach to practice' A search on EBP in the previous studies on ICP experiences of students did not yield any results. However, there are a number of studies in clinical practice that discuss various aspects of EBP in healthcare (Hunsley and Mash 2007; Nelson and Steele 2007; Pearson et al 2009; Scurlock-Evansa et al 2014).

Although this research did not explore the reasons for the non-engagement of EBP in their ICP placements, some of the possible reasons were evident from the graduate interviews. Busy schedules, language barriers, lack of access to resources, limited knowledge and skills to appraise evidence. Other possible reasons could be lack of research in a number of clinical issues, lack of clinician's prior exposure to EBP as students, and non-mandatory requirements of CPD hours from the professional bodies in their countries and therapists working in the same clinical environment for a long period of time.

It could be argued that the early exposure of students to prescriptive practices during their ICP enabled them to further understand the importance of EBP. If all their placements were undertaken in the UK, this aspect of their training could be described as common knowledge, as the application of EBP is embedded in the assessments of clinical training, and lack of early exposure is one of the barriers to using EBP later in their career (Nelson and Steele 2007). Furthermore, the critical reflection of the participants with regards to the use of EBP abroad demonstrates that they had developed positive beliefs and attitudes towards EBP as new graduates, and this attitude showed a positive correlation to engaging with EBP later in the graduates' careers (Rubin and Parrish 2010; Gelso et al 2013; Scurlock-Evansa et al 2014).

Clinical educators are also perceived by students as role models to build up the culture of developing EBP (Olsen 2013).

6.6.3 Timing of ICP

Providing an ICP either too early or too late during students' degree programme has its own advantages and disadvantages. While planning this research, it was not envisaged that the experiences of students would bring out the issues regarding the timing of ICP. None of the previous studies have raised this issue. Students of healthcare experience a range of placements which are not necessarily linked to each other (Pront 2016) but individual students link each of their placements as they progress from one stage of their degree programme to the other. The issues of being on either the first or final placement emerged as the data collection progressed. And it became apparent that graduates clearly preferred the mid-placement, sandwiched between the UK placements.

During the early years of their degree, students would not have had enough experiences to compare practices, and in some cases, it might undermine their confidence. The four participants in this study who had their first clinical placement abroad without prior UK clinical placement experience reported feeling very anxious and lack of confidence on the initial UK placements.

There could be several reasons for them to feel anxious. First, all the four participants in this study had no prior work experience in the UK prior to joining the university when compared to many of their peers. Further, the first placement of their degree programme was a pass or fail without a mark being attached to it, while all the other placements were scored and contributed towards their degree classification. Such arrangements often allow flexibility to choose from a wide-range of placements in the first year of their programme and to familiarise themselves with a clinical environment and to feel less anxious. This was true for their first few placements as they were unsure of application skills, protocols, EBP, documentation, and supervision processes. For a better outcome and to avoid stressful situations, it is apt for students to be in the UK for the first few placements to familiarise themselves with the system.

On the other hand, placing the students towards the end too was found to have its own disadvantages. Most participants in this study who were in their final few placements reported that they were worried about their work readiness. It is during the last few placements that students progress towards becoming independent

practitioners and manage cases on their own. The participants did not feel that they had enough opportunities abroad to be autonomous and lacked confidence when they were nearing graduation.

Most of the employers agreed that it is beneficial to consider mid-placements except for the three of them whose views were to wait until after graduation to go on an ICP. They believed there would be less pressure and greater benefits. The graduates in this study, too, aspired to go abroad again after graduation, but not all of them were able to do so (except for three). The reasons were mainly due to lack of policies and funds to support such international placement opportunities, which are consistent with the findings of Owen et al (2013). These aspects were acknowledged by the employers who admitted that, despite limitations, it is practically convenient to go on an ICP as a student. One of the driving factors to be on an ICP in this study was the availability of bursary through ERASMUS, recognised in a number of studies (Kinsella et al 2008; Findlay et al 2010; Kent-Wilkinson et al 2015; Go International 2016).

6.6.4 Type of ICP

Eight out of the eleven participants in this study spent nearly one third of their placement abroad and only one had the opportunity to be on the home placement in the same speciality as that of the ICP. One participant in this study was unsuccessful in her first interview for employment in an in-patient stroke unit and believed that she was unsuccessful as she had no UK experience in that area. The comments made by the employers supported the graduate views in that they preferred candidates to have a UK experience either in the same speciality or in a similar environment, as they were unable to determine the quality of placements abroad.

Several factors are taken into consideration while determining the quality of placements, such as quality of care; patient satisfaction; use of evidence-based practice; therapists' ability to manage their dual role of patient care and student supervision (Dillon et al 2003; Andrews et al 2006; Pollard et al 2006); recognition of clinical educators' roles (Mallik and Gowan 2007); use of evidence-based practice (Melnyk et al 2014), and approaches to teaching and learning (Kell and Owen 2008; Kinchin et al 2008). The collective responses from both graduates and employers (aligned with the themes type of ICP and placement standards respectively) showed that, for most of the placements abroad, quality of student education was perceived as being lower than that of the UK.

The type and quality of placement seemed to be a very important consideration for the arrangement of an ICP. The employers further iterated that the placement abroad is beneficial if it is either in a specialised area or a reputed centre. Only one participant in this study had a placement in a well-known sports centre and this according to him was very useful for gaining initial access to the place. Upon graduation, he used the network from that placement to build his own practice. In order to achieve career goals, it is important for the students to realise the benefits of international relationships and professional networking (Crossman and Clarke 2009). In this study, fostering such international relationships was perceived as beneficial to all stakeholders by both graduates and employers in terms of further ICP arrangements, research collaborations, and future employment opportunities.

6.6.5 Collaborative work

The responses from the graduates in this study suggest that universities to consider providing additional support for students whilst on ICP. A number of students expressed that they would have had a better experience of exploring the country and integrating with the local culture if there was no additional stress of other academic work such as assignments or other academic modules whilst abroad. They lacked support from their tutors and limited access to other resources. Limited access to peer groups, tutors, and library facilities made it difficult to produce a better quality of work and/or complete assignments on time. This is also reflected in a study by Green et al (2009) where the students found it difficult to prioritise workload. This suggests that, with the growing number of students on ICP, it would be better experience for students if the flexible options are available within the curriculum that allows them to engage and immerse in local cultural activities.

The employers and graduates felt the need for a robust method to evaluate placement standards abroad. One of the ways to achieve this was to involve all stakeholders including employers within the region in the process of ICP arrangements. Similar views were held by the employers in a study by Crossman and Clarke (2009) and this could act as a motivational factor for students to undertake international experiences. In this regard, the employers' expectations in this study indicated for graduates to be pro-active in identifying and communicating their further needs either during the interview or soon after joining to their manager.

6.7 Summary

This study was designed to bring together two distinctive areas, firstly, graduates' reflections of ICP experiences and their engagement with the employment process in their early career. The graduates in this study provided rich and reflective accounts of their ICP experiences and employment; secondly, employers' views of ICP and their perception of linking ICP to employability. This study was designed to obtain multiple, longitudinal perspectives in order to gain a holistic understanding of the utility of ICP. To the best of my knowledge, this is the first study that has explored employability aspects from post-ICP healthcare graduates, as well as gaining employer views, which are still considered in the literature as a missing link (Brooks and Waters 2009; King et al 2010).

This study endeavoured to provide a holistic approach in conceptualising the long-term influence of international clinical placement. Graduate employability is discussed in terms of both generic and discipline specific skills, competencies and attributes developed during the ICP. This study has moved research forward by exploring individual components such as concerns and perceptions which combine to reflect different parts of an international student's experience. The profile of graduates in this study was diverse and their responses were highly individualistic. The attitudes, motivation, characteristics, achievements, aspirations of an individual varied and largely determined the outcome of this study, hence it was challenging to study the long-term influences when compared to the actual experiences of their ICP.

One of the distinctive features observed in this study was that the type and timing of placement abroad were important factors to consider while organising clinical placement for students. Since previous studies on international clinical placement had not made many references to these two aspects, it was felt necessary to discuss these aspects in detail. Considering the developmental trajectory of a student, a number of practical suggestions were made by both graduates and employers. The elective, non-core or speciality area with mid-placements was preferred the most by the participants in this study. The graduates who took part in this study were the first few cohorts to be on their ICP as the provision of ICP was newly established and was still at its nascent stages in that university; the practice may have changed in the years since. It might be worth considering continuing this research with new graduates and students further to compare their experiences to the previous ones.

The attitude of UK healthcare employers towards an ICP was largely positive, with employers recognising ICP as an opportunity for developing cultural competencies. However, some questioned the need of an ICP experience for UK undergraduate students. Employers perceived international clinical placement as a much generic value-added concept. Although the employers could not clearly articulate the totalising effect of ICP on students, they did appear to have set ideas around some of the gains. Their perception of gains included opportunities to engage in a clinical practice that is different to the UK practice through exposure to certain diseases that were not prevalent in the UK, patients' attitudes towards their own health and their expectations from the healthcare professionals.

Openness to learning, adaptability, and flexibility were the three major attributes that employers valued in this study. These characteristics were also identified by Jarvis (2003), who had envisioned that the employers would give a greater value to the personal attributes. The author referred them as 'meta-competencies' (pg. 4), which would equip an individual to find the best possible career rather than a perfect job.

In this study, employability of graduates with ICP experiences has been explored from the perception of the employers, thus revealing the complexities of employability. Importantly, this study has shown that how decisions are made by employers whilst employing graduates with ICP experiences. The study also highlights the limited knowledge and exposure of the employers to ICP arrangements. The employers in this study trusted the universities for providing the students with the best ICP opportunities to develop their employability skills. They also firmly believed that the clinical lead of the university would have performed detailed auditing of the clinical facilities abroad prior to arranging students' placement to ensure standards. In order to strengthen this trust further, it is vital for universities to regularly involve, inform and update employers about ICP arrangements and outcomes.

It is important for students to recognise that the delivery of healthcare varies among countries and also prepare themselves enough to reflect and accept those differences to make the ICP much more valuable experience (Grant and McKenna 2003). Students now have more pressure to widen their experiences and build their portfolios as the job market has become more globalised and highly competitive. There appear to be more students pursuing ICP and this number has been increasing globally. This research was timely to gain a deeper understanding of the long-term influences of ICP. Although studies in the past have shown that ICP helps in broadening cultural competencies, this study has taken a number of steps further to demonstrate the role

of cultural competencies in a healthcare career. Despite its limitation of considering a small group of graduates and employers from one context (UK healthcare), it still offers some useful insight for multiple stakeholders such as students, universities, healthcare educators, employers, graduates and researchers.

The outcome of this study cannot always be generalised and applicable to other disciplines. This is because the way in which employability is conceptualised in healthcare is recognisably different from other professions such as business, engineering, and social sciences. The definitions of creativity, flexibility, openness are applied with limitations within healthcare. The curricular and practice standards, policies, and protocols are strictly driven by the UK professional bodies such as Nursing and Midwifery Council and Health and Care Professions Council. These standards are context- and culture-specific and differ from country to country. Thus, the outcome of this study has to be carefully examined before application outside the UK healthcare context. The next chapter is the final chapter of this thesis and offers, through reflections with concluding remarks, practical suggestions for practice and future research.

Chapter Seven: Conclusion

7.1 Introduction

The key focus of this research was to explore the influences of international clinical placement (referred as to ICP in this research) on careers of healthcare students. Following the introduction to ICP in chapter one, chapter two reviewed the literature surrounding ICP and identified gaps in the existing literature. Chapter three focused on justifying the methodology and methods considered for this study. Chapter four and five presented the results from graduates and employers respectively. Chapter six analysed and discussed the results from both graduates and employers. Highlighting the main findings, this seventh and final chapter focuses on two main aspects – one, the ways in which the findings of this study contributes to the theory and two, the implications of the findings for further practice and recommendations for future research.

As highlighted in chapter two, ICP is a subtype of student mobility for work placement. The main focus in previous research on ICP has mainly considered the student clinical and intercultural experiences (Greatrex-White 2008; Keogh and Russel-Roberts 2009; Peying et al 2012; Chipcase et al 2012; Charles et al 2014; Tuckett and Crompton 2014; Gilliland et al 2016; Kent-Wilkinson 2015). This study is distinct from the previous studies as it is an initial attempt towards understanding how ICP experiences continue to influence students later in their careers.

The need to capture the accounts of ongoing experiences was felt when I witnessed some of the challenges faced by students in utilising the knowledge and skills learnt abroad when they continued their clinical placements in the UK. The students also faced dilemmas while applying for jobs following their graduation, as they were unsure of how their ICP experiences would be perceived by potential employers and how these perceptions might affect their employability. Relevant research questions to explore these areas were developed through healthcare graduates, who had their ICP experiences whilst they were students and the employers of healthcare graduates.

The study explored the ICP experiences of healthcare graduates through one-to-one semi-structured interviews of eleven graduates of healthcare, who had ICP

experiences as students. The graduates were first asked to narrate their experiences of ICP. The participants provided detailed accounts of the differences in clinical practice between the UK and the host country. Then, they were asked to explain the ways in which they utilised the skills and knowledge when they returned to the UK for further clinical placements. The next part of the interview explored the ways in which they used their ICP experiences to gain their employment. Finally, they were asked to share their future intentions of moving abroad for work.

A total of nine healthcare employers were interviewed, which contributed greatly to the discourse around employability. They were asked to share their perspectives on ICP and employability as well as how they link together. Gaining employer views was considered timely, as the provision of ICP is growing in the UK, but there is a paucity of research on employer views on student mobility (Brooks and Waters 2009; King et al 2010). The interviews of both graduates and employers formed the data for this research and were analysed using thematic analysis.

7.2 Main findings and contribution to knowledge

There were several themes that emerged from this study which were both unique and novel. The key themes focused on: developing skills and competencies, standards and scope of practice, communication in clinical practice, and employability skills. The attitude of both graduates and employers towards ICP was largely positive – they viewed ICP as an opportunity to gain cultural competencies and develop personal attributes that significantly influence students' career beyond graduation. The findings from this study showed that being on ICP has many personal and professional advantages. Being on ICP provided students not only with a different view of the world but also greatly influenced their decisions regarding their career in another international setting. The benefits of being on an ICP were explored previously but the ways in which these are nurtured by an individual is unique in this research.

The first research question was to explore how graduates describe their ICP experiences relative to their UK clinical placement experiences. The experiences of ICP within the healthcare context were found to be beyond developing clinical skills, which is consistent with the previous studies on ICP. ICP provided opportunities for developing cultural competencies and other major attributes such as flexibility, openness to learning, adaptability, a heightened level of self-confidence, problem-solving skills, planning and organisation, critical thinking, self-management and greater team work. Communication in clinical practice was considered vital by both

graduates and employers in this study. Inability to speak the host language was perceived as a barrier to mobility for future work, as the participants believed that being proficient in the host language is crucial for safe and effective clinical practice.

This study confirms that there are several differences in clinical practice that exist between the UK and the other parts of Europe. Hierarchical structure among healthcare professionals varied widely within the European countries and the participants felt that professional autonomy was limited when compared to that of the UK. The standard and scope of practice was perceived to be lower than that of the UK with little emphasis on evidence-based practice. The graduates believed that ICP experience had influenced them in numerous interlinked ways. Students with exposure to clinical practice which is distinct from the UK found this to have an impact later in their career particularly while making future plans of moving abroad for work.

This study has enhanced our understanding of some of the challenges faced by students upon their return to the UK. The main challenges were related to the transfer of clinical skills and competencies gained abroad into the UK environment. Not all that they learnt abroad was applicable in the UK due to the differences in standards and scope of professional practice. This study highlighted the importance of considering these factors while organising ICP for students, which are unexplored in any of the previous studies on ICP. The graduates felt the gap in their knowledge and skills when they returned to the UK. Many considered filling these gaps through other or additional placements in the UK, but some of them could not due to time constraints.

The second research question explored the influences of ICP on employability. The ICP experiences were utilised by the graduates during their employment process, particularly in gaining their first job and very little for their second and subsequent jobs. During the application stage, graduates reflecting on their ICP were concerned as they were unaware of how their ICP experiences would be perceived by the employers. Reflecting on the gaps in their knowledge and skills, they reported being anxious throughout the employment process. This seemed to worry those who had ICP of more than one clinical rotation in the core area and particularly those in the final year their degree programme.

The third research question was to gain employer views on ICP and how that links to employability. ICP experiences were viewed positively by employers for gaining personal and cultural competencies. They too were of an opinion that the students

would be disadvantaged if they missed core specialities in the UK and some questioned the need for ICP for an undergraduate student. Employers further suggested that they valued student reflections of the learning from the ICP experiences rather than the actual experience itself. It was also evident from the study that ICP provided a basic and firm foundation for personal and professional development with opportunities for lifelong learning.

Although the employers did not directly link ICP to successful employment, their view was that the experience would be well perceived by potential employers, particularly for their first employment. The most common perspectives from the employers were drawn from the interview phase of the recruitment process, which could be useful for future employees to use in their employment process. Firstly, the employers believed that there are a number of opportunities throughout the interview for the graduates to highlight their relevant experiences from their ICP, for example, while discussing differences in clinical practice, diversity and/or teamwork. Secondly, the suggestion was to demonstrate to the employers how they would effectively utilise their ICP clinical experience in the specific clinical context, which demonstrates application and transfer of skills.

The overall experience of students on ICP, its long-term effect and the perception of employers are considered in this study. Such a holistic approach in a single study has not been found in any of the previous studies on student mobility; the design and its findings used in this study are helpful in advancing the research.

7.3 Limitations of the study

The literature on student work mobility is increasing and there have been a number of publications since I started consulting literature for the study. Although I have tried my best to include relevant and recent literature on the subject, I may have missed some of the articles, reports or books available only in print as access to some of the physical resources in the UAE university library was limited when compared to the UK university libraries.

The nature of this study is such that there was a time lapse between the ICP experience of students and their graduation. The graduate participants in this study had to recall their experiences of ICP, at times, they could not completely recall their experience. Further, the graduate participants in this study were early in their career

and it did not evaluate how ICP experience continue to shape their career later in their lives.

It was six to eight years since the students were on their ICP. The ICP provisions would have changed during this period and a number of organisational and supervision arrangements may well have been changed both within the university and the department. Some of the suggestions made by the participants of this study might have been implemented in the departments and some of the outcomes of this study may not be applicable to current practice.

The recruitment practices within the NHS have also changed since this interview was conducted. Recently, there have been a number of changes in the recruitment processes within the NHS. For example, some trusts conduct group interviews for entry-level graduates and this might leave little opportunity for one-to-one interview to pro-actively discuss their ICP experience. On the positive side, the application form for NHS jobs has changed now, allowing one thousand five hundred words as opposed to five hundred words for writing a personal statement. So, the experience of recent graduates might be different to the participants of this study and great care must be taken in application some of the findings to current practice.

The employers were based in the UAE at the time of the interview with the author, their own experiences of moving away from the UK would have changed their attitude towards studying and working abroad. They all had keen interest in this research with rich experiences of recruiting healthcare professionals from all over the globe in the UAE. With this diverse experience, it is likely that they are more prone to be positive than those managers who have not studied or worked abroad.

7.4 Opportunities for further research

The findings from this study are applicable mainly to the UK healthcare context. However, many issues raised in this thesis regarding ICP experiences of graduates in their early career have general relevance to a wide variety of stakeholders. Since nursing and allied health are bound by two different professional bodies in the UK (NMC and HCPC), the findings from this study have to be carefully examined before being applied within these healthcare disciplines. The current literature on student mobility for work placement does not clearly distinguish healthcare professionals from other disciplines and future work is needed to explore these differences and to consider the long-term impact of these experiences for various disciplines. There is

potential to develop a large project expanding the current study to include both graduates and employers from other disciplines which helps in broadening our understanding of this topic.

Further, employer attitudes presented in this study are mainly applicable to the healthcare sector and these attitudes may vary widely in another field of practice. For example, Crossman and Clarke (2009) found that the employers for one of their business projects preferred candidates with international experience. The employers in this study did not perceive ICP as a desirable criterion for employment and had no higher advantage for their employment.

All participants in this study had their clinical placements within Europe and the study completely focused on UK healthcare graduates. The preferred destination for the UK graduates was found to be in one of the English-speaking countries such as the USA, Canada or Australia. It would be useful to gain perspectives on how the ICP experiences of students from those countries shaped their professional career. Further research can consider ICP experiences beyond Europe and also cross-national studies involving graduates from other European countries to compare national differences on the impact of ICP on their careers.

The purpose of the study was to gain UK employers' views as opposed to any other country. The employers recruited for this study had experiences of recruiting healthcare graduates in the UK but were based in the UAE. The employers were asked to reflect on their own experiences whilst or if they were recruiting in the UK and not in the UAE. However, relocated to the UAE, their views and perception towards ICP could be highly influenced by their own experiences having relocated to another country. The future research could compare the perceptions and attitudes of these two groups of employers.

For future research an alternate method of real-time longitudinal study through multiple interviews during various transitional stages of students' career could also be useful. Follow up interviews of longitudinal studies would furthermore allow consideration of materials such as journals, diaries, student reflection, personal statement and CVs.

7.4.1 Overcoming economic barriers

Lack of funds is one of the main barriers to the international mobility of students across the globe in all disciplines (Dale and Robertson 2009) and this was no different

for healthcare students (Kinsella et al 2008). Given that students who chose to go abroad were mainly those individuals who had previous travel experiences, there may be a correlation to the fact that these students might have had higher economic status (Kent-Wilkinson et al 2015). It is virtually impossible for many students to overcome economic barriers, especially with the current economic situation globally. Although not ideal, Strickland et al (2013) suggested an alternative method of using technology in order to create an online community of learners. A pilot project with nursing students was developed involving three different universities from the UK, US, and Finland. They arranged to collaborate via Wiki, which is a web-based technology to connect multiple sites. Eight post graduate and fourteen undergraduate students collaborated for eight weeks to explore the healthcare system in each of these countries. They evaluated the project using an online survey that included questionnaires and testimonials. Their evaluation showed that the students valued shared learning, that they realised that challenges faced by nurses were not unique to their own country and that they appreciated the wider opportunities provided without financial burden. Although the approach used in this study cannot replace clinical experience, it still offers the opportunity for a larger number of students to have a global view of their professional practice, develop networking, gain cultural competencies in their profession, and may better prepare them to undertake a placement abroad in the future. Further research is needed in this field to understand the value of such learning arrangements.

7.5 Recommendations

Reflection on the findings of the study indicates implications for practice and a number of useful recommendations can be drawn which can be influential for HEIs, academics and students.

7.5.1 HEIs

The nature of clinical placement is distinct from the university settings. Social and recreational activities are limited when compared to campus-based students. The students may experience feelings of social isolation as they are placed with clinicians and do not always have opportunities to be together with their peers. Since it is not possible for a larger number of students to be together on a placement from a single discipline, students from multiple disciplines on an ICP might gain a better experience.

It is important to identify clinical educators who can provide a structured and meaningful learning for students. If there is a good co-operation between the home university and the hospital abroad, it would help in recruiting and training clinical educators.

What emerged from the study was that there were gaps in the information provided for students on ICP. There was very little communication between students from different cohorts. The three consecutive cohorts of students were placed in the clinical sites and the students had little opportunity to interact with the previous cohort of students. This could be because the previous cohort of students had graduated and was based in different parts of the country. The alumni office too did not seem to have updated information about the graduates. Organising the placement early enough for students could actively promote networking between cohorts. The process and importance of student engagement before, during and after an international students experience is emphasised by Killick 2018 (pp.154-156). Likewise, if the students take a proactive role in researching the country-specific and organisational policies would help them better in preparation for placement.

Student mobility (even ICP in this study) is often promoted very positively by the faculty, HEIs, and the funding bodies. Further, the funding available for mobility makes it much more attractive to the students. The challenges and other negative aspects associated with undertaking ICP are often overlooked by students. Instead, the HEIs and the faculty take a balanced approach in presenting both benefits and limitations of undertaking ICP might then help students to make an informed decision.

7.5.2 Healthcare educators

Inability to speak and be proficient in the host language can have a significant effect on learning and, could have a poor outcome (Attrill et al 2016). The selection criteria must include a minimum language proficiency of the host country. Their learning could be enhanced if a minimum language proficiency of the host country is included in the selection criteria. Such criteria for any international student coming to the UK clinical setting for placement means a requirement to demonstrate a minimum proficiency in English such as a score of 6.5 on IELTS. A similar standard of language proficiency is not always strictly followed for students going from the UK to a non-English speaking country. Further, recruiting clinical educators who are bilingual might provide a better learning experience for students.

The type and timing of the placements was found to be one of the crucial factors for students learning experience. The findings from this study suggest considering an elective placement abroad for a shorter period of time as a mid-placement rather than it being the first or the last placement of their degree programme. If a core placement is organised, consideration might be given to arranging an additional placement in the UK to minimise students' anxiety later during the employment process. In addition, if the UK clinical educators and the potential employers are informed about the ICP provisions of a university might help to improve students' confidence.

7.5.3 Students

Prior to going on an ICP, particularly to the core speciality areas and for more than one clinical rotation, the impact of the experience on further placements and employment must be carefully considered. The importance of being familiar with the host language and culture for providing safe and effective patient care should be realised prior to applying for an ICP. To maximise the benefits of ICP, students can carefully evaluate their own suitability for that cultural and clinical context.

The hospital or the accommodation may not be always in close proximity to the amenities or to a local university. The opportunities for socialising will be more limited when compared to students in a university campus with other local and/or international students. Being together with a peer/peers from the UK on an ICP is beneficial for professional and recreational reasons. Traveling together to explore the host region or country could also be easier with peers.

In addition, resources such as books, journals and access to the internet may be limited within the hospital premises. Students should plan and prepare well with the necessary books and other resources pre-departure.

One of the intentions of this study is to provide wider information for students who are considering or have been abroad for their ICP. Graduates must deeply reflect on the ICP experiences to identify both clinical and generic skills developed abroad and continue to nurture them for further personal and professional development. It is also advisable for students to identify the missed learning opportunities during the ICP and gaining the necessary training to fill the gaps through additional placements in the UK.

7.6 Final Thoughts

The insights gained from this study contribute further to existing research on student mobility. It has provided a wider understanding of the long-term influence of ICP. The perspectives of graduates and employers shared in this study have several implications for practice which are applicable to several stakeholders including students, graduates, academics, employers, policy makers and researchers.

ICP provided an opportunity to experience the realities faced in clinical settings, in particular the language barrier made participants realise the importance of communication in providing safe and effective care for patients. The clinical placement in a number of European countries is profoundly different from UK clinical practice. The scope and standards of practice are found to be distinct in each country. Communication, scope, and standards of professional practice were to be the most significant factors in developing an attitude towards future mobility. Further work needs to be done to explore and fully understand the differences in clinical practice and how this affects the quality of patient care and student education. This would inform academics, future students for ICP and healthcare professionals for future work.

Organising and facilitating an ICP placement is resource intensive. Equally, the students face a number of personal and professional challenges on an ICP when compared to the UK clinical placements. With no clear understanding of how international placement experiences would be perceived by the employers, graduates do face dilemmas and are often anxious whilst applying for jobs, particularly for their first job. This anxiety can be reduced if the employers are actively involved with their regional universities in understanding the ICP arrangements for students. To make this whole experience positive, effective collaboration between the university and potential employers is vital.

I always wondered how one would quantify the value of these ICP experiences, particularly when it is not even a requirement and/or mandatory within the UK healthcare programmes to have an ICP experience. Moving forward, the bursaries available through ERASMUS for ICP may diminish with 'Brexit' (UK's proposed withdrawal from the European Union) and there might be other funding streams for students to undertake clinical placement abroad. ICP experience can often be a life-changing experience and develops an attitude towards future mobility. None of the graduates in this study regretted having undertaken an ICP. Reflecting on their own

experiences, the participants said that all their experiences, both positive and negative, had a number of benefits and recommended that more students should consider ICP within their degree programme. The research in the field of ICP is nascent, I am hopeful that the research in this field will continue to grow and evolve.

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Appendices

Appendix 1: Scoping study – Application for ethical approval

Faculty of Humanities and Social Sciences

Application for ethics approval for a research project involving human participants

Undergraduates and Foundation Degree Students:
Before completing this form, the ethics review checklist (school form HSS.E1) should have been completed to establish whether this additional application for ethics approval is required. If ethics approval is required, you should complete this form, sign it and submit it to the Faculty Research Ethics Officer, Maggie Wilson at mvwilson@brookes.ac.uk. A decision form, E3 will then be returned to you by e-mail.

Master's Students:
You should complete this form before you start your project and submit it to your supervisor. If he or she is unable to sign it at this stage, the form will be referred to the Faculty Research Ethics Officer, as above, who may seek further information and clarification from you. A decision form, E3, will then be returned to you by e-mail.

All students should refer to the University Code of Practice on Ethical Standards for Research involving Human Participants, available at www.brookes.ac.uk/res/ethics and Faculty guidelines, which are included in the relevant on-line module or course handbook. You should bind a copy of the approved form in your final project or dissertation submission.

1.	Name of Principal Investigator (Student):	Sunitha B Mysore
	E-mail address:	s.mysore@brookes.ac.uk
2.	Name of Supervisor and e-mail address:	Prof Deb McGregor/Dr Jane Spiro
	E-mail address:	dmcgregor@brookes.ac.uk/jspiro@brookes.ac.uk
3.	Working Project Title:	An exploratory research project evaluating the experiences of international clinical placement as a part of the students' undergraduate curriculum and influence of this on the professional development of undergraduate health care students
4.	Project Type (please specify course and give module number):	Master's project : Preparing your research proposal P72007 Master's dissertation

5.	Background to and rationale of proposed research:	The intention of the scoping study is to gather information to provide background and context for the main doctoral thesis titled above. The purpose of this scoping study is being conducted as part of a Doctorate in Education (EdD) at Oxford Brookes University. International mobility of students for clinical placement provides insight into different cultures and ways of living. The rational and motives of higher education institutions for providing clinical placement abroad could be expressed as economic, academic, developmental, competitive, social and cultural (Knight 2003; Middlehurst and Woodfield 2007). At an individual level, participation in the placement abroad provides opportunity not only for developing required academic knowledge and skill) but also intercultural awareness, opportunities to network, interpersonal skills (confidence, adaptation to a new situation). Some academics and students tend to believe that students gain better degree classification through international placements which might lead to greater employment opportunity (Brooks and Waters 2009, King et al 2010). There are a number of studies that focus on the internationalisation experience of undergraduate students. Studies concerning the experiences of international clinical placement and its relation to future learning and employability are scarce. These issues have greater set of implications for higher education institutions, teaching and learning, internationalisation process of an institution and graduate employability. This study is being conducted to explore the current 'gap in research' around the influence of formation of professional identity in nursing and physiotherapy students who have been on the international clinical placement as a part of their undergraduate healthcare programme.
6.	'Gatekeeper' permission If you are conducting your research within an organisation external to Brookes, such as a school or company, has permission been obtained? Attach a copy of the letter or e-mail giving permission.	I intend to conduct the research with at least 2/3 physiotherapy and Nursing alumni (graduated in June 2013) and also 3/4 final year students studying BSc (Hons) Adult Nursing Programme at the Faculty of Health and Life Sciences, Oxford Brookes University. I have discussed the proposed research with the Programme Leads, ERASMUS and International Team Co-ordinators in both Nursing and Physiotherapy. I have also discussed the ethical requirements with the ethical officer Hazel Abbott, Faculty of Health and Life Sciences regarding contacting our alumni, as some of them are currently working in the NHS. I was told that conducting the interviews outside their NHS and approaching them as alumni does not require further ethical approval.

7	Methods of data collection Attach a copy of your draft questionnaire, interview schedule or observation guidelines	Data will be gathered with individuals using semi-structured interviews. The sampling is purposive. The interview will be conducted on 1:1 basis with the questions to explore on how individual experiences of clinical placement abroad have influenced in shaping their professional identity. The example of the interview question is attached attached as **Appendix 1.** The interviews will be audio taped so that the data can be analysed later.
8	Participants involved in the research: Include the target number, age range, source and method of recruitment and location of the research	The target number for the scoping study is about 5 to 6 individuals. The age range of the students in the programme would be normally between 20 and 45 year old. The participants will be invited via email.The study will be introduced to the participants as a scoping study and the purpose of the scoping study will be explained to the participants via an email to find out if they are interested in participating in the study **Appendix 2**. Those individuals who volunteer to participate will be sent the participant information sheet **Appendix 3 and 4** along with the options for interview method (skype/telephone or face to face) and a mutually agreeable time will be fixed with the individual participants. I am mindful that the interviews for the alumni and students might have to be either on a weekend or one of the evenings, especially if they are working or on clinical placements. The interviews will not last more than one hour and it is will be done either face to face at Marston road campus or via Skype/telephone (because the students might be out on clinical placement and the alumni are in the different parts of the country.
9	Are participants in a dependent relationship) as an unequal power relationship) with the researcher? If yes, what steps will you take to ensure that participation is entirely voluntary and is not influenced by this relationship?	I know some of the study participants (physiotherapy alumni) as I was involved in teaching them when they were students. So they might be obliged to take part. I would make it clear to them that the participation is completely voluntary. The study also involves a few alumni and students of nursing where I do not have/had any teaching or tutoring responsibilities All the participants will be reassured that their contribution is purely for the purposes of the research and this will have no impact on their academic and/ or career progression.
10.	Potential benefits of the proposed research:	The scoping study will provide me the background and context for the main study. Additionally, the scoping study will provide me an invaluable experience of conducting and analysing qualitative interviews. The whole process will contribute towards the development of some of the research skills and knowledge for the main study.

11	Potential adverse effects of the proposed research and steps to be taken to deal with them: These are defined as risks greater than those encountered during normal day to day interactions and could include possible psychological stress or anxiety	I do not anticipate any adverse effect as the study is to gain insight into individual experiences of study abroad and linking to their future learning and employability. However, I am mindful that the participants can have some reservations in expressing their views and could become emotional, for which I believe that I have the skills to manage an individual in such situations. I am also mindful of their time and will keep up the time.
12.	Plan for obtaining informed consent: Please attach copy of your participant information sheet and consent form (Note consent forms are not needed for questionnaires)	All the participants who volunteer to take part in the study will be asked to review and complete a consent form. They will be asked to sign on a hard copy or on an electronic before the interview. Consent form is attached as **Appendix 5.** There will be opportunities for the participants to clarify any questions if they have regarding the study or any other research processes before, during and after the interview.
13.	Steps to be taken to ensure confidentiality of data: Outline steps to be taken to ensure confidentiality, privacy and anonymity of data during collection and publication of data.	Anonymity of the participants will be maintained by providing an alphabet to each participant. The data will be kept strictly confidential and the data will not be shared with any other member of the team. However, the participants will be reminded not to discuss any further after their interview. The interviews will be audio-recorded and transcribed so that themes can be easily identified. The data will be anonymised before analysing. Responses will either be combined so that individual participants cannot be identified.
14	Debriefing and/or feedback to participants What debriefing and support will participants receive after the research? How will findings of the research be made available to them?	The complete research process will be presented to the participants and the other teaching team of EdD through written document and presentation. This is purely for the academic purposes. Both alumni and students will have an opportunity to contact me if they wish to discuss further.
15	Data storage and security How will you ensure safe data storage during fieldwork and after publication?	Data will be stored in a secure place and locked away in accordance with university policy of academic integrity The audio/video tapes will be destroyed once decoded after fieldwork

All materials submitted will be treated confidentially.

I have read and understood the University's Code of Practice on Ethical Standards for Research involving Human Participants

Signed: Sunitha Bhagavathi	Principal Investigator /Student Sunitha B Mysore
Signed:	Supervisor

Date:

Appendix 2: Scoping study - Introductory email

Dear ___,

My name is Sunitha Mysore. I am a doctoral student at Oxford Brookes University within the Department of Education working under the guidance of Professor Jane Spiro who is my Director of Studies. I am also a senior lecturer in Physiotherapy at Brookes University. I am writing to you to find out if you are happy to take part in the scoping study for my intended doctoral thesis. I am interested in the area around international clinical placement and influence of this on professional development (eg: on other clinical placements and employability). The objective of the scoping study is intended to provide background and context for the main study.

Your name and contact detail is given to me by your lecturer (insert name).You have been identified as one of the participant for this study as you have completed one or more of your clinical placement abroad. The data for the study will be collected through a semi structured interview (either face to face or via a telephone /Skype) which will not last for more than 60 mins at a mutually convenient date and time. Your participation in this research is entirely voluntary. Please let me know if you are happy to take part in the study so that I can send you further details.

Looking forward to hearing from you.

Kind regards

Sunitha

Appendix 3: Scoping study- Email invitation to participate in the interview

Dear ___,

Thank you for accepting to take part in my study. As mentioned in my previous email, I will be conducting the interview which might take approximately take 45 to 60 mins. My plan is to conduct the interviews either at Marston road campus or via Skype or telephone. Please let me know what is suitable for you so that I can either book an interview room or exchange the phone/skype details. In terms of day/time, I am available to interview over the next three weeks. Please find the optional dates and timings below

[Optional dates inserted here]

If these are not suitable to you, would you please email me some optional and specific time slots when you might be available over the next three weeks. If you are no longer available, please let me know.

I attach a copy of the Student Participation Information Sheet. I also attach a copy of the consent form for your information for you to review and complete before the interview.

Looking forward to hearing from you.

Kind regards

Sunitha B Mysore

Appendix 4: Scoping study- Research participant information sheet

Study title

An exploratory research project evaluating the experiences of international clinical placement as a part of the students' undergraduate curriculum and influence of this on the professional development of undergraduate students

What is the purpose of the study?

The purpose of this scoping study is being conducted as part of the Doctorate in Education (EdD) programme at Oxford Brookes University. This scoping study is an initial phase which is intended to provide background and context for the main doctoral thesis which I am intending to conduct over the next two years.

Background information on the research topic: Participation in the placement abroad provides opportunity not only for developing required academic knowledge and skills) but also intercultural awareness, opportunities to network, interpersonal skills (confidence, adaptation to a new situation). Some academics and students tend to believe that students gain better degree classification through international placements which might lead to greater employment opportunities. However, the evidences are anecdotal and studies concerning the experiences of international clinical placement and its relation to future learning and employability are scarce. This study is being conducted to explore the current 'gap in research' around the influence of formation of professional identity in nursing and physiotherapy students.

Why have I been chosen?

You have been invited to participate in this study as you have been on international clinical placement either as physiotherapy or nursing student at Oxford Brookes University. All the students who have been on international clinical placement at Oxford Brookes University will be invited to participate in this research study.

Do I have to take part?

No. Participation is entirely voluntary and it is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time without

giving a reason. If you decide to withdraw from the project, all data collected from you (including data that has been anonymised) will be destroyed.

What will I be asked to do?

If you agree to participate in this study, I will contact you to arrange a convenient mode, time and place to interview you. You will be sent a copy of this information sheet, the interview questions, and a consent form ahead of time. The interview will last between 45-60 minutes and will be audio recorded.

The interview will be to find out about your experiences of international clinical placement and to explore your perspectives, views and opinions on how your experiences of placement abroad has influenced to shape your professional identity, for example, your academic performances and employability.

What are the possible disadvantages and risks of taking part?

By participating in this study you are agreeing to be tape recorded. There are no material or health risks associated with participation in this project. You will be interviewed by me. I am also a member of staff within a physiotherapy programme at Oxford Brookes University and I have been involved with organising international exchanges for both staff and students of Physiotherapy at Oxford Brookes University. Due to this, you may feel obligated to assist in this project and please remember that your participation is completely voluntary.

Will my taking part in this study be kept confidential?

I intend to protect the confidentiality of your responses to the fullest possible extent, within the limits of the law and in accordance with the university's Academic Integrity Policy. Your responses will be combined with those from other students and alumni of Oxford Brookes Health Care Students, so that your individual responses will not be recognisable. I will remove any references to personal information that might allow someone to guess your identity. However, because of the individual nature of your circumstances, it is possible that you could be

recognised from your experiences. I will seek to avoid this by checking and rechecking the responses following analysis. The data collected as part of this project will be held for 5 years. To prevent recognition of you in the thesis or future research publications your and your demographic data (eg: academic qualifications, year of study/ graduation and clinical and academic work history) will be blurred to protect anonymity. The contribution is purely for the purposes of the research and it will have no impact on your academic and or career progression.

How about the ethical approval for the study?

The ethical approval for the study is provided by Oxford Brookes University, Department of Education. If you have any queries, I am happy to clarify and provide further information, should you have any concerns about the conduct of the study you may also contact the Faculty Research Ethics Officer, Ms Maggie Wilson, Department of Education, Oxford Brookes University.

What will happen to the results of the research study?

The results of the research will be used to inform my doctoral thesis (which will be submitted for a Doctorate in Education). The results may appear in the thesis or in research papers published from data collected as part of the thesis. Any research publications will be publicly available through research journals and the thesis will be stored at Oxford Brookes University. You will not be identified in either the thesis or any research publication.

Who has reviewed the study?

This study has been reviewed by the Faculty of Humanities and Social Sciences Ethical Review Committee at Oxford Brookes University.

For further information, please contact

Sunitha B Mysore

Doctoral Research Student

School of Education

Oxford Brookes University, OX3 0FL

Email: s.mysore@brookes.ac.uk

Thank you for your interest in this study!

Appendix 5: Scoping study - Consent form

Full title of Project (Working title): An exploratory research project evaluating the experiences of international clinical placement as a part of the students' undergraduate curriculum and influence of this on the professional development of undergraduate health care students.

Name, position and contact address of Researcher

Sunitha B Mysore

Doctoral Research Student

School of Education

Oxford Brookes University

OX3 0FL

Email: s.mysore@brookes.ac.uk

	Please initial box
I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
I agree to take part in the above study.	☐

I agree that my data gathered in this study may be stored (after it has been anonymised) in a specialist data centre and may be used for future research. ☐

Please tick box

	Yes	No
I agree to the interview consultation being audio recorded	☐	☐
I agree to the use of anonymised quotes in publications	☐	☐

______________________ ______________ ______________________

Name of Participant Date Signature

______________________ ______________ ______________________

Name of Researcher

Appendix 6: Scoping study - Interview guide

What areas of placement you have covered while you were abroad? Where, when and how long?

What was your experience while you were abroad?

Best/worst experience and why?

Think back to when you applied to go on the clinical placement abroad, what was your motivation and expectations?

How does the clinical placement compare to clinical placements in the UK? Differences and similarities in practice?

How did you use your knowledge and experience that you gained abroad? For example, on your next few clinical placements in the UK or on any other academic modules?

Are you planning to use the experience that you have gained abroad for future employment (for current students)? (If yes, how and why? If no, why?)

or

Did you use your experience that you gained abroad in your personal statement or during your interview for employment (for alumni)? If yes, can you explain how and why? If no, why?

What would you advise anybody who is thinking of going abroad for clinical placement?

Appendix 7: Interview guide modified following the scoping study

Original Question	Comment	Revised questions
1. What areas of placement you have covered while you were abroad? Where, when and how long?	The question used for the scoping study was long and contained too many sub-questions.	1(a) Describe your international clinical placement. 1(b) Which country/countries did you go on placement? 1(c) In what year of your undergraduate course did you have your ICP? 1(d) What was the duration of your ICP? 1(e) What areas/specialities did you cover in your international clinical placement?
2.What was your experience while you were abroad? Best/worst experience and why?	Comments: This question was subjective and broad. I have reframed it with more promotes in line with key themes identified in literature.	2.Describe your experience while your abroad. 2a) What main personal development/challenges while living abroad? (eg: transportation, accommodation, finance, home-sickness) 2b) What were the main cultural issues/learning?

		(language barrier, norms, values) 2c) What professional development/challenges did you have in your work placement (organisational differences, multidisciplinary team work, terminologies, documentation)
3. Think back to when you applied to go on the clinical, placement abroad, what was your motivation and expectations?	Comments: This question was leading and the word 'motivation' could not capture deeper insights and other factors that may have influenced the decisions.	Why did you choose to go abroad for your clinical placement? (reason, motivation, expectations)
4. How does the clinical placement compare to clinical placements in the UK? Differences and similarities in practice?	Comment: Reframing of this question was necessary because of editorial issues.	How do you think your overseas placement was in comparison to your UK placement? (differences and similarities)

5.How did you use your knowledge and experience that you gained abroad ? For example, on your next few clinical placements in the UK or on any other academic modules?	Comment: This question is too broad. This is simplified further.	Reflect on your ICP for a minute or two. What do you think were your learning from the placements? (Look for learning in different learning context.
6. What did you learn on your clinical placement?	Question deleted as this is covered as a part of question 5.	
7. Are you planning to use the experience that you have gained abroad for future employment (for current students)? (If yes, how and why? If no, why?)	Since the sample selection criteria has changed, this question is also deleted.	
8. Did you use your experience that you gained abroad in your personal statement or during your interview for employment (for alumni)??	Too many sub-questions.	8a) When did you get employed? (First, second) 8b) Did you use your ICP experience in applying for jobs. If yes, can you explain how and why? If no, why

9. Do you think you have applied your ICP experience in your job. How, give an example? (skills, competencies and reflections)

10. Do you think your ICP experience has led to your long term professional development? (career, growth, intercultural, awareness, diversity in experience, long term plans)

11. What would you advise anybody who is thinking of going abroad for clinical placement?

Appendix 8: Main study- University ethical approval

Professor Graham Butt
Director of Studies
School of Education
Faculty of Humanities and Social Sciences
Oxford Brookes University
Harcourt Hill

6 November 2014

Dear Professor Butt

UREC Registration No: 140849
An exploratory study on international clinical placement experience and its likely influence on employability

Thank you for the email of 23 October 2014 outlining the response to the points raised in my previous letter about the EdD study of your research student Sunitha Bhagavathi Mysore, and attaching the revised documents. I am pleased to inform you that, on this basis, I have given Chair's Approval for the study to begin.

The UREC approval period for this study is two years from the date of this letter, so 6 November 2016. If you need the approval to be extended please do contact me nearer the time of expiry.

Should the recruitment, methodology or data storage change from your original plans, or should any study participants experience adverse physical, psychological, social, legal or economic effects from the research, please inform me with full details as soon as possible.

Yours sincerely

Hazel Abbott
Chair of the University Research Ethics Committee

cc Dr Jane Spiro, Co-Director of Studies
Dr Eugeine A Samier, Co-investigator, British University of Dubai
Sunitha Bhagavathi Mysore, Research Student
Maggie Wilson Research Ethics Officer
Jill Organ, Research Degrees Team
Louise Wood, UREC Administrator

UNIVERSITY RESEARCH ETHICS COMMITTEE, FACULTY OF HEALTH AND LIFE SCIENCES

Headington Campus Gipsy Lane
Oxford OX3 0BP UK

Tel: 01865 482639
heabbott@brookes.ac.uk

www.brookes.ac.uk

Appendix 9: Main study- Introductory email (sent from alumni office to the graduates)

Dear ___,

My name is Sunitha Mysore. I am a fourth year doctoral student at Oxford Brookes University within the Department of Education working under the guidance of Professor Graham Butt and Dr Jane Spiro who are my Co-Directors of Studies. I was a Senior Lecturer in Physiotherapy at Brookes University. I am writing to you to find out if you are happy to take part in my research study for my doctoral thesis. I am interested in the area around international clinical placement and influence of this on employability/employment.

Your name and contact details were provided to the alumni office by your programme lead. You have been identified as a potential participant for this study as you have completed one or more of your clinical placement abroad. The data for the study will be collected through a semi structured interview via skype which will not last for more than 45 minutes, at a mutually convenient date and time. Your participation in this research is entirely voluntary but highly valuable. I attach a copy of participant information sheet for you to review.

Please reply to 11111085@brookes.ac.uk if you are happy to take part in the study and share your experience. Looking forward to hearing from you.

Kind regards
Sunitha

Appendix 10: Main study - Introductory email (forwarded through Head of programmes or clinical coordinators)

Dear ___,

My name is Sunitha Mysore. I am a fourth year doctoral student at Oxford Brookes University within the Department of Education working under the guidance of Professor Graham Butt and Dr Jane Spiro who are my Co-Directors of Studies. I was a Senior Lecturer in Physiotherapy at Brookes University. I am writing to you to find out if you are happy to take part in my research study for my doctoral thesis. I am interested in the area around international clinical placement and the influence of this on employability/employment.

You have been identified as a potential participant for this study, as you have previous experience of recruiting a nurse or a physiotherapist. The data for the study will be collected through a semi structured interview (either focus group or individual interview) which will not last for more than 45 minutes at a mutually convenient date and time. Your participation in this research is entirely voluntary but highly valuable. I attach a copy of participant information sheet for you to review.

Please reply to 11111085@brookes.ac.uk if you are happy to take part in the study and share your experience.

Looking forward to hearing from you.

Kind regards
Sunitha

Appendix 11: Scoping study - Research participant information sheet (graduates)

Study title

An exploratory study on international clinical placements and its likely influence on employability

Invitation paragraph

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. If you have any questions, please do not hesitate to contact me.

What is the purpose of the study?

This study is being conducted as part of my Doctorate in Education (EdD) programme at Oxford Brookes University.

Background information on the research topic: Participation in placements abroad provide opportunities not only for developing required academic knowledge and skills but also intercultural awareness, opportunities to network, and to develop interpersonal skills (confidence, adaptation to a new situation). Some academics and students believe that students gain a better degree classification through international placements which might lead to greater employment opportunities. However, the evidence to support this is anecdotal and studies concerning the experiences of international clinical placements and their relation to future learning and employability are scarce. This study is being conducted to explore the current 'gap in research' in this field of nursing and physiotherapy.

Why have I been invited to participate?

You have been invited to participate in this study as you have been on an international clinical placement, either as physiotherapy or nursing student at Oxford Brookes University.

Do I have to take part?

No. Participation is entirely voluntary and it is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time without giving a reason. If you decide to withdraw from the project, all data collected from you (including data that has been anonymised) will be destroyed.

What will happen to me if I take part?

If you agree to participate in this study, I will contact you to arrange a convenient mode, time and place to interview you. You will be sent a consent form ahead of this meeting. The interview will be only audio recorded (no video or images will be taken) and the interview will be for about 45 minutes.

The interview will be to find out about your experiences of international clinical placements and to explore your perspectives, views and opinions on how your experiences of placement abroad has shaped your professional career.

What are the possible benefits of taking part?

By participating in this study you are agreeing to be taped/digitally recorded. There are no material or health risks associated with participation in this project. You will be interviewed by me. I was also a member of staff within a physiotherapy programme at Oxford Brookes University and I was involved with organising international exchanges for both staff and students of Physiotherapy at Oxford Brookes University. Due to this, you may feel some obligation to assist in this project, but please remember that your participation is completely voluntary.

Will what I say in this study be kept confidential?

I intend to protect the confidentiality of your responses to the fullest possible extent, within the limits of the law and in accordance with the university's Academic Integrity Policy. Your demographic data will be collected during the interview, but this information will be anonymised and coded before analysis to preclude any chance of personal identification. Your responses will be combined with those from other students and alumni of Oxford Brookes Health Care Students, so that your individual responses will not be recognisable. I will remove any references to personal information that might allow someone to guess your identity. However, because of the individual nature of your circumstances, it is possible that you could be recognised from your experiences. I will seek to avoid this by checking some of those responses following analysis. The data collected as part of this project will be held for 5 years. To prevent your recognition in the thesis, or future research publications, your

demographic data (eg: academic qualifications, year of study/ graduation and clinical and academic work history) will only occur in aggregated form to protect your anonymity. The contribution is purely for the purposes of the research and it will have no impact on your academic and/ or career progression.

What should I do if I want to take part?

After reviewing this information sheet, if you are happy to take part in the study, please contact the researcher Sunitha B Mysore on 11111085@brookes.ac.uk.

What will happen to the results of the research study?

The data will be collected and stored in Abu Dhabi. Some of the data might be transferred between the UK and Abu Dhabi for analysis. The results of the research will be used as data for my doctoral thesis (which will be submitted for a Doctorate in Education). The results may appear in the thesis, or in research papers, published from data collected as part of the thesis. Any research publications will be publicly available through research journals and the thesis will be stored at Oxford Brookes University. You will not be identified in either the thesis or any research publication.

Who is organising and funding the research?

I am conducting the research as a doctoral student in the School of Education, Faculty of Humanities and Social Sciences, Oxford Brookes University.

Who has reviewed the study?

This study has been reviewed by the Research Ethics Committee at Oxford Brookes University.

Contact for further information:

Supervisors

Prof Graham Butt

Professor in Education

School of Education

Oxford Brookes University

gbutt@brookes.ac.uk

Dr Jane Spiro

Reader in Education

School of Education

Oxford Brookes University

jspiro@brookes.ac.uk

Dr Eugenie Samier

Assistant Professor in Education

Department of Education

British University of Dubai

eugenie.samier@buid.ac.ae

If you have any concerns about the way in which the study has been conducted, you should contact the Chair of the University Research Ethics Committee on ethics@brookes.ac.uk.

My contact details:

Sunitha B Mysore

Doctoral Research Student

School of Education

Oxford Brookes University,

Email: 11111085@brookes.ac.uk

Date:

Thank you for your interest in this study!

Appendix 12: Main study – Consent form (graduates)

CONSENT FORM

Title of the project: An exploratory study on international clinical placements and its likely influence on employability

Name, position and contact address of Researcher
Sunitha B Mysore
Doctoral Research Student
School of Education
Oxford Brookes University
OX3 0FL
Email: 11111085@brookes.ac.uk

	Please initial box
I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions about it.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.	☐
I agree to take part in the above study.	☐
I understand that the interview will be audio-recorded	☐

Please tick box

	Yes	No
I agree to the use of anonymised quotes in publications	☐	☐

______________________	____________	______________________
Name of Participant	Date	Signature
______________________	____________	______________________
Name of Researcher	Date	Signature

Appendix 13: Main study – Interview guide (Graduates)

Name:

Profession:

Date of the interview:

Participant information form: Clarifications

Consent form: Signed/agreed

1. International Clinical Placement

(a) Describe your ICP (ERASMUS, exchange programme, international placement)

(b) Which country/countries did you go on placement?

(c) In which year of your undergraduate course did you have your ICP?

(d) What was the duration of your ICP?

(e) What areas of clinical placement did you cover in your ICP?

2. Reason

(a) Why did you choose to go abroad for your clinical placement? (reason, motivation, expectations).

3. Experience

(a) What were the main personal challenges while living abroad? (eg: transportation, accommodation, finance, home-sickness). What was the learning from these challenges?

(b) What were the main cultural issues? (language barrier, norms, values). How did you cope with those? What did you learn from those issues?

(c) What professional /challenges did you have in your work placement (organisational differences, multidisciplinary team work, terminologies, documentation?).

Development:

Challenges:

4. Comparison

(a) How do you think your overseas placement was in comparison to your UK placement/work?

What were the differences ?

(b) What similarities did you find between UK and overseas clinical practice?

How this affect you later in your career?

5. Learning

(a) Did you use your knowledge and experience that you gained abroad? For example, on your next few clinical placements in the UK or on any other academic modules? If yes, how and if no, why?

6. Employability

(a) When did you get employed? (First, second).

(b) Did you use your ICP experience in applying for jobs. If yes, can you explain how and why? If no, why.

CV

Interview stage

(c) Do you share your experience abroad at your workplace? (why if yes or no)

(d) Do you apply your ICP experience currently in your job. How, give an example? (skills, competencies and reflections)

7. Career Development

(a) Are you planning to use the experience that you have gained abroad for future employment? (If yes, how and why? If no, why?)

(b) Do you think your ICP experience has influenced you in long term professional development? If yes, how and if no, why? (Career, growth, intercultural, awareness, diversity in experience, long term plans)

(c) Would you like to go abroad again for work? If yes, where/no why?

8. Advice

(a) What would you advise any student who is thinking of going abroad for clinical placement?

9. Snowballing

(a) Is there anyone within your network that you can refer me to participate in my study.

Appendix 14: Ethical approval extension - amendment and additions

Professor Graham Butt
Director of Studies
School of Education
Faculty of Humanities and Social Sciences
Oxford Brookes University
Harcourt Hill

23 November 2015

Dear Professor Butt

UREC Registration No: 140849
An exploratory study on international clinical placement experience and its likely influence on employability

Thank you for the emails of 27 October and 16 November 2015 requesting a change to the original study approved by UREC on 6 November 2014 for your EdD student Sunitha Bhagavathi Mysore.

I confirm that Sunitha wishes to extend the recruitment of participants to include employers of nursing and physiotherapy (professionals and recruitment agents) who are in UK private health care sectors, and some ex employers of the NHS who are now working in academic institutions or in Abudhabi. The methodology for recruitment remains the same as in the original application to UREC. An updated participant information sheet has been provided for an adequate audit trail.

On this basis I give Chair's approval for this change. The UREC approval remains the same as the original study, so until 6 November 2016.

Should the recruitment, methodology or data storage change from your original plans, or should any study participants experience adverse physical, psychological, social, legal or economic effects from the research, please inform me with full details as soon as possible.

I wish you continued success with your research.

Yours sincerely

Dr Sarah Quinton
Chair of the University Research Ethics Committee

cc Dr Jane Spiro, Co-Director of Studies
Dr Eugeine A Samier, Co-investigator, British University of Dubai
Sunitha Bhagavathi Mysore, Research Student
Maja Cederberg, Research Ethics Officer
Jill Organ, Research Degrees Team
Louise Wood, UREC Administrator

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Appendix 15: Main study - Research participant information sheet (employers)

Study title

An exploratory study on international clinical placements and its likely influence on employability

Invitation paragraph

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. If you have any questions, please do not hesitate to contact me.

What is the purpose of the study?

This study is being conducted as part of my Doctorate in Education (EdD) programme at Oxford Brookes University.

Background information on the research topic: Participation in placements abroad provide opportunities not only for developing required academic knowledge and skills) but also intercultural awareness, opportunities to network and develop interpersonal skills (confidence, adaptation to a new situation). Some academics and students believe that students gain a better degree classification through international placements which might lead to greater employment opportunities. However, the evidence to support this is anecdotal and studies concerning the experiences of international clinical placement and their relation to future learning and employability are scarce. This study is being conducted to explore the current 'gap in research' in the field of nursing and physiotherapy.

Why have I been invited to participate?

You have been invited to participate in this study as you have experience in recruiting physiotherapy or nursing graduates.

Do I have to take part?

No. Participation is entirely voluntary and it is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time without giving a reason. If you decide to withdraw from the project, all data collected from you (including data that has been anonymised) will be destroyed.

What will happen to me if I take part?

If you agree to participate in this study, I will contact you to arrange a convenient mode, time and place to interview you. You will be sent a copy the consent form ahead of this meeting. The interview will last for about 45 minutes and will only be audio recorded ((no video or images will be taken).

The interview will explore your views, opinions and perspectives of employing graduates with international clinical placement. To take part in this study, you need not have the experience of employing graduates with international clinical experience. I am interested in your views and perceptions about employing them. If you have employed a graduates with international clinical experience could add value to this study.

What are the possible benefits of taking part?

By participating in this study you are agreeing to be taped or digitally recorded. There are no material or health risks associated with participation in this project. You will be interviewed by me. I was also a member of staff within a physiotherapy programme at Oxford Brookes University and I was involved with organising international exchanges for both staff and students of Physiotherapy at Oxford Brookes University. Due to this, you may feel some obligation to assist in this project but please remember that your participation is completely voluntary.

Will what I say in this study be kept confidential?

I intend to protect the confidentiality of your responses to the fullest possible extent, within the limits of the law and in accordance with the university's Academic Integrity Policy. Your demographic data will be collected during the interview, but this information will be anonymised and coded before analysis to preclude any chance of personal identification. Your responses will be combined with those from other students and alumni of Oxford Brookes Healthcare Students, so that your individual responses will not be recognisable. I will remove any references to personal information that might allow someone to guess your identity. However, because of

the individual nature of your circumstances, it is possible that you could be recognised from your experiences. I will seek to avoid this by checking some of those responses following analysis. The data collected as part of this project will be held for 5 years. To prevent your recognition in the thesis, future research publications your demographic data (eg: academic qualifications, year of study/ graduation and clinical and academic work history) will only occur in aggregated form to protect your anonymity. The contribution is purely for the purposes of the research and it will have no impact on your academic and or career progression.

What should I do if I want to take part?

After reviewing this information sheet, if you are happy to take part in the study, please contact the researcher Sunitha B Mysore on 11111085@brookes.ac.uk.

What will happen to the results of the research study?

The interview will be collected from Abu Dhabi. Some of the data might be transferred between the UK and Abu Dhabi during the stage of analysis and results. The results of the research will be used as data for my doctoral thesis (which will be submitted towards the Doctorate in Education). The summary of research will be sent to you via email. The results may appear in the thesis or in research papers published from data collected as a part of the thesis. Any research publications will be publicly available through research journals and the thesis will be stored at Oxford Brookes University. You will not be identified in either the thesis or any research publication.

Who is organising and funding the research?

I am conducting the research as a doctoral student in the School of Education, Faculty of Humanities and Social Sciences, Oxford Brookes University.

Who has reviewed the study?

This study has been reviewed by the University Research Ethics Committee at Oxford Brookes University.

Contact for further information:

Supervisors

Prof Graham Butt

Professor in Education

School of Education

Oxford Brookes University

gbutt@brookes.ac.uk

Dr Jane Spiro

Reader in Education

School of Education

Oxford Brookes University

jspiro@brookes.ac.uk

Dr Eugenie Samier

Assistant Professor in Education

Department of Education

British University of Dubai

eugenie.samier@buid.ac.ae

If you have any concerns about the way in which the study has been conducted, you should contact the Chair of the University Research Ethics Committee on ethics@brookes.ac.uk.

My contact details:

Sunitha B Mysore

Doctoral Research Student

School of Education

Oxford Brookes University,

Email: 11111085@brookes.ac.uk

Date:

Thank you for your interest in this study!

Appendix 16: Main study - Consent form (Employers)

CONSENT FORM

Title of the project: An exploratory study on international clinical placements and its likely influence on employability

Name, position and contact address of Researcher

Sunitha B Mysore
Doctoral Research Student
School of Education
Oxford Brookes University
OX3 0FL
Email: 11111085@brookes.ac.uk

	Please initial box
I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions about it.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.	☐
I agree to take part in the above study.	☐
I understand that the interview will be audio-recorded	☐

Please tick box

	Yes	No
I agree to the use of anonymised quotes in publications	☐	☐

_______________	_______________	_______________
Name of Participant	Date	Signature
_______________	_______________	_______________
Name of Researcher	Date	Signature

Appendix 17 : Main study- Interview guide (employers).

Name:

Date of the interview:

Participant information form: Clarifications

Consent form: Signed/agreed

1. Profile

2. The process of recruitment

(a) In your view, where do you think recent graduates who have had an ICP experience should highlight their experiences and what particular aspects do you think they should include?

(b) How does this differ in someone who have been working for a while?

(c) Do you/ have you/ will you provide opportunities for candidates with ICP experience to share and/or demonstrate their experience/ skills abroad during the interview? If no, why and if yes, how?

3. Type of placements

(a) How do you think a graduate with an experience of ICP compares with those who have had their placement and/or studies all in the UK?

(b) They may be also lacking some of the experience for core areas – especially new grads, how will you view such candidates?

4. Development opportunities at their workplace

(a) As a manager, how have you/will you utilize the skills and competencies the graduates bring to their workplace, especially when you know they have been abroad for their clinical placement?

(b) What do you think they will bring to their workplace?

5. Your view and advice

(a) How do you view the link between ICP and employability?

(b) What would you advise any student who is thinking of going abroad for a clinical placement?

Appendix 18: Participants file-Graduates

Graduate interviews

Name	Nodes	References	Created On	Created By	Modified On	Modified By
G8 -transcription	64	144	4/28/2017 12:27 PM	SB	4/28/2017 5:15 PM	SB
G6 - transcription	50	94	4/28/2017 5:16 PM	SB	4/29/2017 7:49 PM	SB
G7 - transcription	44	70	4/29/2017 7:51 PM	SB	4/29/2017 8:53 PM	SB
G11 - transcription	28	54	4/29/2017 9:03 PM	SB	4/29/2017 10:46 PM	SB
G9 - transcription	50	98	5/4/2017 7:55 PM	SB	5/4/2017 8:33 PM	SB
G2 Part 1 (1)	32	46	5/4/2017 7:56 PM	SB	5/19/2017 3:15 PM	SB
G2 Part 2	34	58	5/4/2017 7:56 PM	SB	5/12/2017 5:24 PM	SB
G1- transcription part2	24	34	9/2/2016 10:40 PM	SB	9/10/2016 11:42 AM	SB
G1 - transcription part 1	44	94	9/2/2016 10:40 PM	SB	5/19/2017 3:29 PM	SB
G10 transcription	52	116	9/10/2016 11:54 AM	SB	9/10/2016 3:15 PM	SB
G5- part 1	48	96	9/10/2016 11:54 AM	SB	9/10/2016 12:55 PM	SB
G5 - part 2	36	54	9/10/2016 11:54 AM	SB	5/19/2017 1:20 PM	SB
G4 - transcription	56	122	9/10/2016 3:14 PM	SB	5/19/2017 3:21 PM	SB
GE transcription	56	114	9/11/2016 5:36 PM	SB	9/15/2016 9:51 PM	SB
G3- transcription	70	110	9/15/2016 9:55 PM	SB	4/28/2017 12:16 PM	SB

Appendix 19: Coding individual transcript-Graduate 5

Educational/learning perspective: Italy do not study many conditions, no autonomy, dictated by medical team – still the challenges were dealing with language barrier, cultural differences, dealin with other professionals, living in other country, all very positive but very different what was expected. In England, the expectation is to know prepare presentations, conditions very well, be prepared to answer questions related to conditions, problem solving, clinical reasoning – all those were very differ. A lot of different strategies used some

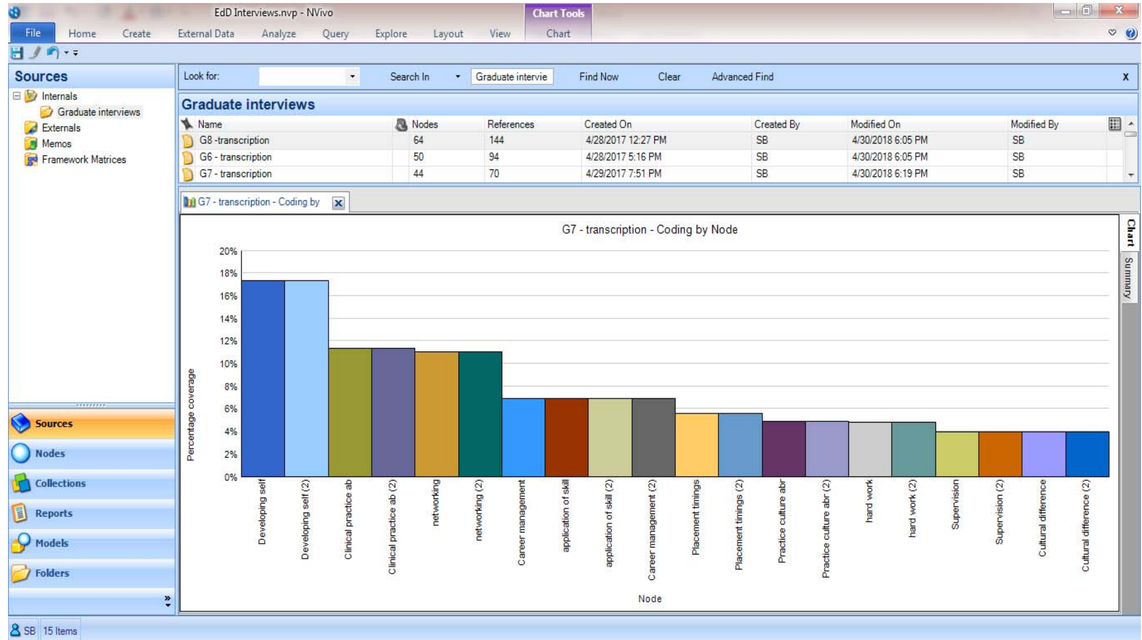
Similarities:

Lot of responsibilities for patients, you are counted as an integral part of the team, support from clinical educators are same.

Knowledge and experience used on other modules/placements: Difficult as there were not many modules, so unable to apply later but would have been useful if used earlier modules done earlier

Interview in current job wanted to know some of the simple strategies, cost benefit strategies eg: small mechanical equipment would replace an assistant. Personal skills communication skills, talki to patients and clinical staff from diverse background.

Appendix 20: Completed Individual Coding -Graduate 7



Appendix 21: Collection of codes-Graduates

All Nodes

Name	In Folder	Created On	Created By	Modified On	Modified By
Reasons for going abroad\travel purpose	Nodes	4/29/2017 10:18 PM	SB	5/19/2017 1:03 PM	SB
Reasons for going abroad\Reason for travel	Nodes	9/10/2016 11:56 AM	SB	4/30/2018 6:19 PM	SB
Reasons for going abroad\previous travel	Nodes	4/29/2017 10:19 PM	SB	5/19/2017 3:55 PM	SB
Reasons for going abroad\Motivational factor	Nodes	9/2/2016 11:13 PM	SB	5/12/2017 7:02 PM	SB
Reasons for going abroad	Nodes	5/19/2017 4:01 PM	SB	5/19/2017 4:10 PM	SB
Misc\Sharing with colleagues	Nodes	9/10/2016 11:39 AM	SB	5/19/2017 3:41 PM	SB
Misc\Recommendation to the researcher	Nodes	9/10/2016 12:40 PM	SB	5/19/2017 3:41 PM	SB
Misc\Recommendation to university	Nodes	9/10/2016 12:40 PM	SB	5/19/2017 3:41 PM	SB
Misc\Prior experience abroad	Nodes	9/10/2016 1:23 PM	SB	5/19/2017 3:29 PM	SB
Misc\Personal perspective	Nodes	9/10/2016 3:02 PM	SB	5/19/2017 3:53 PM	SB
Misc\Personal experience - negative	Nodes	9/10/2016 3:02 PM	SB	5/19/2017 3:53 PM	SB
Misc\Expectations before going abroad	Nodes	9/10/2016 1:22 PM	SB	5/19/2017 3:53 PM	SB
Misc\Contribution to curricular development	Nodes	9/10/2016 12:05 PM	SB	5/19/2017 3:53 PM	SB
Misc\Advise to students	Nodes	9/2/2016 11:36 PM	SB	4/30/2018 6:19 PM	SB
Misc	Nodes	5/19/2017 3:40 PM	SB	5/19/2017 4:11 PM	SB
Developing self\workload balance	Nodes	5/4/2017 8:02 PM	SB	5/19/2017 11:36 AM	SB
Developing self\Working with elite	Nodes	5/12/2017 4:55 PM	SB	4/30/2018 6:19 PM	SB
Developing self\self learning	Nodes	4/29/2017 7:05 PM	SB	5/19/2017 11:36 AM	SB
Developing self\Personal development	Nodes	9/2/2016 10:50 PM	SB	5/19/2017 3:28 PM	SB
Developing self\Peer learning\Reasons for going abroad\travel purpose	Nodes	12/1/2017 6:50 PM	SB	5/19/2017 1:03 PM	SB
Developing self\Peer learning\Reasons for going abroad\Reason for travel	Nodes	12/1/2017 6:50 PM	SB	4/30/2018 6:19 PM	SB
Developing self\Peer learning\Reasons for going abroad\previous travel	Nodes	12/1/2017 6:50 PM	SB	5/19/2017 3:55 PM	SB
Developing self\Peer learning\Reasons for going abroad\Motivational factor	Nodes	12/1/2017 6:50 PM	SB	5/12/2017 7:02 PM	SB
Developing self\Peer learning\Reasons for going abroad	Nodes	12/1/2017 6:50 PM	SB	5/19/2017 4:10 PM	SB
Developing self\Peer learning\Misc\Sharing with colleagues	Nodes	12/1/2017 6:50 PM	SB	5/19/2017 3:41 PM	SB
Developing self\Peer learning\Misc\Recommendation to the researcher	Nodes	12/1/2017 6:50 PM	SB	5/19/2017 3:41 PM	SB
Developing self\Peer learning\Misc\Recommendation to university	Nodes	12/1/2017 6:50 PM	SB	5/19/2017 3:41 PM	SB
Developing self\Peer learning\Misc\Prior experience abroad	Nodes	12/1/2017 6:50 PM	SB	5/19/2017 3:29 PM	SB
Developing self\Peer learning\Misc\Personal perspective	Nodes	12/1/2017 6:50 PM	SB	5/19/2017 3:53 PM	SB

Appendix 22: Themes with categories and sub categories-Graduates

EdD Interviews.nvp - NVivo

Nodes

Name	Sources	References	Created On	Created By	Modified On	Modified By
Career management	13	65	5/7/2017 8:56 AM	SB	5/19/2017 4:10 PM	SB
CV stage	10	14	9/2/2016 11:32 PM	SB	5/19/2017 3:28 PM	SB
Realigning CV for employability	1	1	9/10/2016 3:11 PM	SB	5/19/2017 3:29 PM	SB
Interview stage	10	19	9/2/2016 11:32 PM	SB	5/19/2017 3:28 PM	SB
second interview	1	1	5/5/2017 1:00 PM	SB	5/5/2017 1:00 PM	SB
successful interview	1	2	5/5/2017 12:54 PM	SB	5/5/2017 12:56 PM	SB
2nd time interview	1	1	9/10/2016 1:09 PM	SB	5/19/2017 1:21 PM	SB
Transferred into current practice	5	6	9/10/2016 11:31 AM	SB	4/28/2017 9:56 AM	SB
difficulty recalling	1	1	5/5/2017 12:49 PM	SB	5/5/2017 12:49 PM	SB
Confident in getting employed	1	1	5/5/2017 1:07 PM	SB	5/27/2017 10:43 AM	SB
futue employment	4	6	4/28/2017 9:55 AM	SB	5/19/2017 1:26 PM	SB
third country	4	4	4/28/2017 1:23 PM	SB	4/30/2018 6:19 PM	SB
planned placement for job	1	1	4/29/2017 8:23 PM	SB	4/30/2018 6:19 PM	SB
Future plan of working abroad	8	10	9/10/2016 11:34 AM	SB	5/19/2017 3:20 PM	SB
Using ICP for the future jobs	3	3	9/10/2016 11:39 AM	SB	5/19/2017 3:20 PM	SB
Chosing the same country	4	5	9/16/2016 2:36 PM	SB	5/19/2017 3:17 PM	SB
Reason for returning	1	1	5/5/2017 11:03 AM	SB	5/19/2017 3:29 PM	SB
Employability - negative aspect	1	3	9/10/2016 3:06 PM	SB	5/19/2017 3:41 PM	SB
application of skills in practice	5	12	4/28/2017 9:58 AM	SB	4/30/2018 6:19 PM	SB
job as a driver to mobility	1	1	4/28/2017 1:34 PM	SB	5/19/2017 3:47 PM	SB
Getting your first job	1	1	9/10/2016 5:46 PM	SB	5/19/2017 3:55 PM	SB
Keeping in touch	1	1	9/10/2016 5:41 PM	SB	5/19/2017 3:33 PM	SB
Clinical practice abroad	14	77	5/19/2017 11:22 AM	SB	5/19/2017 4:10 PM	SB
Developing self	15	53	5/19/2017 11:39 AM	SB	5/19/2017 4:10 PM	SB
Bringing change	1	1	5/5/2017 1:03 PM	SB	5/19/2017 11:36 AM	SB
Being proactive	1	1	5/5/2017 12:37 PM	SB	5/19/2017 11:36 AM	SB

SB 198 Items

Appendix 23: Participants file-Employers

Employer interview.nvp - NVivo

Employers

Name	Nodes	References	Created On	Created By	Modified On	Modified By
E4	11	17	5/6/2017 7:35 PM	SB	6/2/2017 9:05 AM	SB
E3-1	11	13	5/15/2017 3:37 AM	SB	6/1/2017 11:03 PM	SB
E3-2	5	5	5/15/2017 3:38 AM	SB	6/1/2017 11:19 PM	SB
E6	21	25	5/15/2017 4:14 AM	SB	6/2/2017 12:30 AM	SB
E9	23	32	5/31/2017 7:12 PM	SB	6/17/2017 12:52 AM	SB
E1	25	35	5/31/2017 11:11 PM	SB	6/11/2017 3:52 PM	SB
E7	13	14	6/1/2017 7:37 AM	SB	6/11/2017 5:43 PM	SB
E8	12	14	6/1/2017 4:41 PM	SB	6/2/2017 8:34 PM	SB
E5	19	23	6/1/2017 5:43 PM	SB	6/3/2017 10:41 PM	SB
E2	22	32	5/5/2017 8:43 PM	SB	6/2/2017 8:39 PM	SB

SB 10 Items

Appendix 24: Coding individual transcript-Employer 5

Appendix 25: Completed Individual Coding -Employer 6

Appendix 26: Collection of codes-Employers

All Nodes

Name	In Folder	Created On	Created By	Modified On	Modified By
International candidate vs ICP	Nodes	5/31/2017 11:54 PM	SB	6/11/2017 3:52 PM	SB
Employers perspectives\Placements\Timing\UG \Early vs late\Timing of the placement matters	Nodes	5/6/2017 10:42 AM	SB	6/11/2017 3:52 PM	SB
Employers perspectives\Placements\Timing\UG \Early vs late	Nodes	6/3/2017 9:42 PM	SB	6/3/2017 9:42 PM	SB
Employers perspectives\Placements\Timing\UG \dont take chance with your education	Nodes	6/2/2017 8:35 AM	SB	6/2/2017 8:39 PM	SB
Employers perspectives\Placements\Timing\UG	Nodes	6/3/2017 8:09 PM	SB	6/6/2017 10:27 PM	SB
Employers perspectives\Placements\Timing\PG\UG level ICP unnecessary	Nodes	5/6/2017 9:44 AM	SB	6/2/2017 8:39 PM	SB
Employers perspectives\Placements\Timing\PG	Nodes	6/3/2017 8:10 PM	SB	6/3/2017 8:10 PM	SB
Employers perspectives\Placements\Timing	Nodes	6/3/2017 7:52 PM	SB	6/3/2017 7:58 PM	SB
Employers perspectives\Placements\Standards\Uni vs multicultural\working in multicultural matters	Nodes	5/15/2017 4:01 AM	SB	6/11/2017 3:52 PM	SB
Employers perspectives\Placements\Standards\Uni vs multicultural\Uni vs multicultural experience matters	Nodes	5/15/2017 4:07 AM	SB	6/2/2017 8:34 PM	SB
Employers perspectives\Placements\Standards\Uni vs multicultural\Multicultural	Nodes	5/5/2017 8:56 PM	SB	6/11/2017 5:43 PM	SB
Employers perspectives\Placements\Standards\Uni vs multicultural	Nodes	6/3/2017 8:07 PM	SB	6/3/2017 8:07 PM	SB
Employers perspectives\Placements\Standards\ICP vs UK\UK a better place for core placement	Nodes	5/6/2017 9:57 AM	SB	6/2/2017 8:39 PM	SB
Employers perspectives\Placements\Standards\ICP vs UK\ICP vs home standards matter	Nodes	5/6/2017 8:06 PM	SB	6/2/2017 9:33 AM	SB
Employers perspectives\Placements\Standards\ICP vs UK\Getting basics right at UG	Nodes	5/6/2017 10:57 AM	SB	6/2/2017 8:39 PM	SB
Employers perspectives\Placements\Standards\ICP vs UK	Nodes	6/3/2017 7:52 PM	SB	6/3/2017 7:52 PM	SB
Employers perspectives\Placements\Standards\different standards might be safety issues	Nodes	5/31/2017 11:57 PM	SB	6/11/2017 3:52 PM	SB
Employers perspectives\Placements\Standards\Core vs non core\Core placement matters	Nodes	5/6/2017 9:31 AM	SB	6/2/2017 8:39 PM	SB
Employers perspectives\Placements\Standards\Core vs non core\Core placement abroad	Nodes	5/6/2017 9:33 AM	SB	6/2/2017 8:27 PM	SB
Employers perspectives\Placements\Standards\Core vs non core\choose elective over core	Nodes	5/6/2017 9:53 AM	SB	6/2/2017 8:39 PM	SB
Employers perspectives\Placements\Standards\Core vs non core	Nodes	6/3/2017 8:07 PM	SB	6/3/2017 8:07 PM	SB
Employers perspectives\Placements\Standards	Nodes	6/3/2017 7:51 PM	SB	6/3/2017 7:58 PM	SB
Employers perspectives\Placements\Choice\where ICP is done matters	Nodes	5/6/2017 8:07 PM	SB	6/2/2017 9:33 AM	SB
Employers perspectives\Placements\Choice\Speciality vs general\Pathological conditions seen matters	Nodes	5/15/2017 3:42 AM	SB	6/4/2017 10:50 PM	SB

Appendix 27: Themes with categories and sub categories-Employers

Nodes

Name	Sources	References	Created On	Created By	Modified On	Modified By
CV	1	1	6/3/2017 8:20 PM	SB	6/11/2017 3:52 PM	SB
Highlighting ICP in the CV	6	12	5/5/2017 8:55 PM	SB	6/11/2017 3:52 PM	SB
How you evidence your ICP matters	1	1	6/1/2017 12:02 AM	SB	6/11/2017 3:52 PM	SB
evidencing your experience CV	2	2	6/1/2017 12:12 AM	SB	6/11/2017 3:52 PM	SB
CV	6	8	5/5/2017 8:44 PM	SB	6/11/2017 3:52 PM	SB
Interview	0	0	6/3/2017 8:21 PM	SB	6/3/2017 8:21 PM	SB
New graduate interview	2	2	5/5/2017 8:48 PM	SB	6/2/2017 7:53 AM	SB
How you present matters Interview	7	8	5/5/2017 10:32 PM	SB	6/11/2017 3:52 PM	SB
Highlighting pros and cons in the intervi	1	1	5/15/2017 3:55 AM	SB	6/2/2017 9:33 AM	SB
Reflecting and responding to failed ICP	1	1	5/15/2017 3:58 AM	SB	6/2/2017 12:26 PM	SB
How you present ICP matters	3	4	5/15/2017 4:05 AM	SB	6/2/2017 8:27 PM	SB
Students to authenticate information	1	1	5/31/2017 10:40 PM	SB	6/2/2017 8:27 PM	SB
Experienced	0	0	6/3/2017 8:20 PM	SB	6/3/2017 8:20 PM	SB
interview later in their career	2	2	5/5/2017 9:01 PM	SB	6/2/2017 7:53 AM	SB
Applying ICP later in their career	3	6	5/30/2017 7:48 PM	SB	6/11/2017 3:52 PM	SB
Employers	0	0	6/3/2017 8:04 PM	SB	6/3/2017 8:04 PM	SB
Process	1	1	6/3/2017 8:22 PM	SB	6/6/2017 10:12 PM	SB
Ensuring standards	1	1	6/3/2017 8:22 PM	SB	6/6/2017 10:07 PM	SB
Fair selection	0	0	6/3/2017 8:22 PM	SB	6/3/2017 8:23 PM	SB
Collaboration	1	1	6/3/2017 8:04 PM	SB	6/11/2017 3:52 PM	SB

Appendix 28: Summaries of studies that have explored ICP experiences of students

	Study based	Country of ICP	Sample details	Method and Data Analysis	Key findings
Grant & McKenna (2003)	Australia	USA, China, Hong Kong, Malaysia, Northern Ireland and UK	Nursing students - out of the 22 invited, 9 accepted to take part in the study	Transcribed journal - entries (6) and interviews (9) Thematic content Analysis	To describe the experiences of students who undertook ICP. The main findings were understanding, a different nursing culture, understanding self through coping and continuous reflections, appreciating differences in health care
Callister & Cox (2006)	Australia	Argentina, Guatemala, Jordan,	Nursing students -20 participants	Phenomenological enquiry with open interviews Van Manen's phenomenological analysis	The purpose of this study was to explore the personal and professional meaning of participating in ICP. They found that "Opening hearts and minds", enhanced understating of social and political issues, making interpersonal connections, developing cultural competence.
Greatrex-White (2008)	United Kingdom	Not mentioned	Nursing students- 26 participants	Qualitative, Hermeneutic phenomenological study using students' dairy The method used for data analysis is unclear	"Foreignness", detached from all that is familiar and also detached from the host community, cultural shock was very evident, cultural awareness, development of cultural competencies.
Green et al (2008)	United Kingdom and Sweden.	Norway, Denmark, Spain, Holland, USA, South	Nursing students -18 participants from UK and 14 from Sweden.	Case study with individual and group semi structured interviews and schools'	Placement experiences were enriching and enlightening with opportunities to enhance both

		Africa and Hong Kong.		documentary analysis. Qualitative content thematic analysis	professional knowledge and personal development
Keogh & Russel-Roberts (2009)	Germany	Finland	Nursing students- 7 participants	Semi-structured interview Mayring's content analysis	Assessing the strengths and weakness of their own healthcare system rather than trying to understand the new system. (They were comparing and contracting), personal development, faced a few challenges such as communication difficulties, limited supervision
Chipcase et al (2012)	Australia	Vietnam	Inter-professional students (2 students each from medicine, physiotherapy, occupational therapy and speech and language therapy) – total of 8 participants and 4 supervisors	One to one Semi-structured interviews with students and focus group interview with supervisors Thematic analysis	The purpose of the study was to gain an account on interprofessional supervision in an international setting. The students' valued interprofessional supervision as it encouraged them to actively seek and use different learning strategies. However, the students felt the need of supervisors from their own discipline in order to achieve the learning outcomes effectively.
Morgan et al (2012	United Kingdom	The location of ICP was not disclosed for anonymity, students had a mixture of developing and	Nursing students – Ten students	Semi-structured interviews Thematic analysis	The purpose of the study was to gain understanding of the risks involved in ICP. The three types of risks identified through students interviews are personal risks (travelling in overcrowded and poorly serviced

		developed countries			vehicles), professional risks (due to language barrier and malpractice) socio-cultural risks (isolation and misfit).
Peiying et al (2012)	Australia	China and India	Physiotherapy, Occupational therapy and Speech and Language therapy students – 17 students	Intercultural developmental inventory (IDI) and guided journals – Mixed method SPSS and thematic analysis	The purpose of the study was to explore the experiences of ICP and development of cultural sensitivity. Initially unfamiliarity with the culture, experiencing illness insomnia and fatigue, participants were ethnocentric, where they believe that the approach at home was much superior and gradually they moved to ethno related, with immersion into host culture. They recognised and appreciated difference in education, healthcare and living standard, reflections, they appreciated the privilege patents had in accessing healthcare.
Charles et al (2014)	Australia	India	Nursing – 5 students	Reflective journals Colaizzi's descriptive phenomenological analysis	The purpose of the study was to describe the lived experience of ICP, particularly cultural immersion. The students found a number of differences in practice between India and Australia. Initially, they found dealing with change and overtime they started to accept change but later started to realise that the healthcare

					systems are structured differently to suit a particularly society. The experience enhanced their own cultural awareness