Declaration

Name of candidate: Yohanna Marian Davidson

This Research Project entitled "An Investigation into the Transition from Student to Practising Osteopath" is submitted in partial fulfillment for the requirements for the Unitec degree of Master of Osteopathy.

CANDIDATE’S DECLARATION

I confirm that:

- This Research Project represents my own work;
- The contribution of supervisors and others to this work was consistent with the Unitec Regulations and Policies.
- Research for this work has been conducted in accordance with the Unitec Research Ethics Committee Policy and Procedures, and has fulfilled any requirements set for this project by the Unitec Research Ethics Committee.

Research Ethics Committee Approval Number: 2009-1027

Candidate Signature: _______________________ Date: ______________________

Student number: 1020395
An Investigation into the Transition from Student to Practising Osteopath

Yohanna Marian Davidson

A dissertation submitted in partial fulfilment of the requirements for the degree of Master of Osteopathy, Unitec Institute of Technology, 2011.
Abstract

As osteopathy within New Zealand continues to gain recognition as an integral component of the mainstream healthcare system, it is important to understand the transition process which occurs as new graduates enter the profession. With this knowledge, it may be possible to facilitate the transition into the workforce from studying. The aims of this study were to determine the experiences of new graduates, identifying key themes that arose and possible strategies which could be implemented to ease the transitional period for future graduates.

The method deemed most appropriate for this empirical research was that of a case study. In order to create triangulation in this research, both a questionnaire and interviews were used. Twenty new graduates responded to the questionnaire and seven also volunteered to be interviewed. All participants had studied osteopathy at Unitec and had been working in New Zealand for fewer than 18 months.

The findings were similar to those in the literature. New graduates often had an unrealistic perception of practising life leading to ‘transition shock’. Stress, uncertainty, a lack of confidence, a feeling of isolation and both physical and mental exhaustion were common feelings. Participants found expectations placed on them, especially by patients but also from colleagues and even themselves, were difficult to cope with initially. Despite generally feeling prepared, there were a number of procedures which new graduates struggled with when first practising, such as referring patients to their GPs or for x-rays, ACC and other business-related aspects. There was also a common feeling of needing more time practising techniques and clinical reasoning as a student. With time and experience came a greater sense of preparedness and confidence in their ability. Self-care was important in helping participants cope with the difficulties they encountered initially. Mentoring and support were also identified by respondents as being very beneficial. This research has implications for education providers, the osteopathic profession and new graduates, involving educational curricula, professional support programmes and an increased awareness of the realities of practising osteopathy.

Key words: transition; student; new graduate; practitioner; osteopathy; experience; expectations
I would like to thank the participants who took part in this study, in particular the seven who gave their time so generously to share their experiences in the interviews. Without you all this research would not have been possible.

Thank you Isabel, for the time you so freely gave during the middle stages of my research which saved me many hours of hard work. For that, and the use of your house, I am most grateful.

Jonny, although I didn’t always appreciate it at the time, thank you for telling me to stay home and work rather than go out and be sociable. I owe my reclusive tendencies to you! Thank you also for the support and encouragement which I relied so much on.

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### Abbreviations

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<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
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<tr>
<td>BLT</td>
<td>Balanced ligamentous tension (technique)</td>
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<tr>
<td>CPD</td>
<td>Continuing professional development</td>
</tr>
<tr>
<td>FCC</td>
<td>Final Clinical Competency</td>
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<tr>
<td>HPCA</td>
<td>Health Practitioners Competence Assurance (Act)</td>
</tr>
<tr>
<td>HVLA</td>
<td>High velocity low amplitude (thrust technique)</td>
</tr>
<tr>
<td>MET</td>
<td>Muscle energy technique</td>
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<td>NG(s)</td>
<td>New graduate(s)</td>
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CHAPTER I - INTRODUCTION

Introduction
This chapter will briefly define the profession of osteopathy and discuss it in the New Zealand context. It will continue on to outline the rationale for the study and the aims it seeks to achieve. A brief summary will conclude the chapter and provide a brief framework of how this dissertation will be presented.

Osteopathy
Osteopathy is a form of manual therapy which originated in the late 1800s. It has been defined as a “system of diagnosis and therapy, based on the interrelationship of anatomy and physiology, for the study, prevention and treatment of disease” (Magoun & Sutherland Cranial Teaching Foundation, 1976, p. 1). It is deemed to be a holistic form of treatment which considers the person as a whole rather than focusing purely on their presenting problem. Stone (1999) discusses how if one component of a system changes, this in turn will influence and change the whole system. The ability of the body to self-heal and self-regulate, which is dependent on a number of factors including normal structural integrity, is also recognised in osteopathy (Chaitow, 1982). It is important for osteopathic practitioners to bear all this in mind while treating patients. A patient may present with a myriad of complaints and the practitioner must determine which is the primary problem and which form of treatment would have the greatest overall benefit for the patient. This knowledge can only be built up over a period of time and through the physical act of performing the techniques and seeing the result at following sessions. The ability to maintain this broader view is no easy task and comes with experience.

Although originally developed in the Mid-west of the United States of America, osteopathy has been embraced throughout the world. Until the 1970’s osteopathy within New Zealand was viewed as a fairly marginal and alternative form of healthcare treatment but has gradually become better known and accepted to the point that it is now recognised as a “fully professionalised heterodox medical system” (Baer, 2009, p. 26). Despite remaining relatively true to the fundamental osteopathic principles, unlike osteopathy’s American counterparts who have adopted a very biomedical model of treatment, some might argue that the osteopathy practised in other countries including New
Zealand has also been somewhat biomedicalised by progressing along the path to professionalization and legitimisation (Baer, 2009).

This acceptance into the mainstream medical system was highlighted by having obtained statutory registration under the provisions of the Health Practitioners’ Competence Assurance (HPCA) Act 2003 which came into law in September 2004. This legislation is upheld by the Osteopathic Council of New Zealand and replaces the profession-specific regulations that were in place prior (Osteopathic Council New Zealand, 2010). Under the specifications of the HPCA act, anyone wanting to practice under the title of osteopath must be registered with the Osteopathic Council, hold a current Annual Practising Certificate and adhere to the scope of practice specified for the osteopathic profession. Prior to the commencement of the Act it was possible for anyone to call themselves and practice as an osteopath which could have given rise to questions of practitioner competency and public safety.

For many years it was not possible to train as an osteopath in New Zealand, rather people generally went to one of the osteopathic schools in England or, more recently, Australia to study. It was not until about the 1980’s when the Osteopathic College of New Zealand opened that people were able to train within New Zealand. This college was replaced in 1999 when training facilities opened at Unitec New Zealand providing a Bachelor of Applied Science (Human Biology) which led into the Master of Osteopathy degree. The Masters is a two year degree consisting predominantly of clinical work and the writing of a research thesis. It is not until both aspects are completed and passed that it is possible to register as an osteopath. Once the Final Clinical Competency (FCC) exam is passed at the end of the second year, students are deemed capable and competent and are no longer required to practice in the student clinic. However, as there is no designated completion date for the thesis, it commonly takes students longer than the two years of the Masters degree to complete. This can result in students having months, and in some cases years, where they have limited opportunity if, in fact, any at all to practice the skills they just spent five years acquiring. There has been talk about the possibility of putting in place an interim registration for students as they finish their thesis in order to allow them to maintain their practical skill-set but at present nothing is in place.

Currently Unitec is the only educational institution in New Zealand to provide a registrable qualification for osteopathy. The Trans-Tasman Mutual Recognition Act allows people who train in Australia to work freely in New Zealand without having to sit an entry exam. The Osteopathic Council does not presently recognise qualifications from any other country, therefore, overseas applicants from countries other than Australia are required to pass an entry examination prior to working in New Zealand.
Within New Zealand, the working situation for osteopaths tends to be that of a sole trader or contractor. It is uncertain whether in fact there are any osteopaths who work for a wage. This means that it is important for newly graduated osteopaths to have an idea about how to conduct themselves professionally and how to run a small business. This is essentially what they are doing even if contracting to work for an already established clinic as opposed to setting up their own private practice. Presently, the osteopathic scene in New Zealand is entirely based in the private health sector, that is, osteopaths are not yet incorporated into the public health setting of hospitals. This allows for a very autonomous and individual style of practice, with no seniors or hierarchy that need to be reported back to.

**Rationale for the study**

Despite the osteopathic profession having grown over the past thirty years, it is still a relatively small profession compared with other healthcare providers and because of this has many areas where research is limited. Currently there is very little understanding of the experience of new graduates as they transition out into the working world of an osteopathic professional. As almost no research has been conducted on this topic in the osteopathic field worldwide, it is important to establish how new graduates manage during this period in order that effective measures may be implemented to ease the transition.

This research intends to provide an insight into the issues that arise throughout the transition period that takes place during the first 18 months of practising as an osteopath after graduating. New graduates are faced with complete responsibility for their patients and no longer have supervisors to report back to or to ask for help. While some may relish this concept, others can find it to be incredibly daunting and stressful. For this reason it was necessary to investigate whether there were any key themes that recur for new osteopathic graduates, areas of stress or difficulty or areas where they felt ill-prepared, how they dealt with these and whether there was anything they felt could be instigated to make the transition smoother and easier.

With this knowledge new graduates can be better informed of what to expect as they enter the workforce. This will help to reduce the stress and anxiety that is commonly experienced by new graduates of any discipline and in doing so should speed the development of expertise and professionalism. The findings of this research could potentially influence change within the teaching curriculum, offering suggestions that could tailor the course content to ease the transition period. While a full investigation into the curriculum of the osteopathic training in New Zealand is beyond
the scope of this research, it is thought broad themes may emerge indicating areas that are currently perceived as lacking in depth of tuition, as well as highlighting the strengths within the present curriculum.

It may also identify common issues experienced by new graduates which the osteopathic profession may need to address. Research in other healthcare modalities suggests that the transition is significantly aided by access to mentorship. This is an area where the osteopathic professional bodies and employers in particular can assist the transition process. This could be in the form of specifically structured professional development programmes, peer groups or offering time to mentor new graduates.

Investigating what issues New Zealand’s osteopathic graduates encountered and how they managed them, will give information about what methods could be employed by students and graduates, educational providers and the profession to minimise the transitional difficulties.

**Aims**

This study had four primary aims:

- To determine the experiences encountered during the transition from student to practising osteopath and the extent to which they apply to the cohort

- To identify any key issues arising

- To determine techniques the graduates employed to manage these key issues

- To determine possible strategies and structures that could be put in place to help future graduates through the transitional period

**Summary**

Accredited osteopathic education in New Zealand is relatively new having only produced eight cohorts of graduates since its inception in 1999. For this reason, and the fact that very little osteopathic research worldwide has been conducted in this field, it is timely to investigate the experiences of new graduates from the Unitec osteopathy programme as they transition into osteopathic practice. Anecdotally it had been observed that there were many aspects of practising life with which new graduates had difficulties. This matched with the experiences demonstrated in
other healthcare professions. This study gives insight into experiences of newly graduated osteopaths, discussing key issues they encountered, methods used to overcome the issues and strategies which could potentially facilitate the transition period for future graduates.

This dissertation has been written in six chapters. Chapter I introduces the history of osteopathy and places it in the current New Zealand context and then explains the rationale and aims of the research. Chapter II reviews the literature which discusses the transition period, the development of expertise, professional socialisation and mentoring. It does this in the context of the minimal osteopathic literature that exists and the nursing, physiotherapy, occupational therapy, dentistry and chiropractic fields. Chapter III outlines the research procedures used in this research with consideration of the methodology, methods of data collection and analysis, participation criteria and ethical concerns. Chapter IV presents the results from the questionnaire. Interview findings, however, will be incorporated into the discussion. Chapter V discusses the key interview findings, how they match with the questionnaire results and how the key themes and concepts relate to the findings in the literature as discussed in Chapter II. Chapter VI offers recommendations for future research, reflects on the limitations of this study, and outlines the implications of the findings for educational providers, the osteopathic profession and future graduates. Concluding thoughts are given at the end of this chapter.
CHAPTER II – LITERATURE REVIEW

Introduction
Throughout life there are many transitions that each individual may experience. Not all will encounter the same transitions and not all will respond to them in the same manner. One such transition that is commonly encountered is the transition from study to the world of work.

Research has been carried out on the transition from student to practitioner for many healthcare professions, with a considerable amount of that coming from the medical and nursing professions. A lesser but still substantial body of work investigates the occupational therapy, physiotherapy and dentistry professions. This research will be drawn upon in conjunction with the limited osteopathic data on this topic. Internet-based searches were unsuccessful in finding published articles regarding the transitional process within the chiropractic or osteopathic fields. Only an unpublished manuscript, written as part of the fulfilments of the Master of Health Science (Osteopathy) degree for Victoria University, was found, entitled ‘From Twilight to Clarity: A Qualitative Study of the Transition from Student to Osteopath’ (Hagi, 1999). The studies reviewed draw on the experiences of graduates from Australia, Canada, USA, Britain, and New Zealand. The aim for this research is to highlight factors that occur during the transition period for osteopathic graduates, and compare these with the aforementioned professions’ experience during the transition phase.

A review of the literature was conducted using internet and database searches. ‘Google Scholar’ at http://scholar.google.co.nz/ was the primary search engine used. The primary databases searched included ScienceDirect, EbscoHost, OstMed, and ChiroIndex using key terms such as transition, student, new graduate, practitioner, novice, competency, and preparation with reference to osteopathy, physiotherapy, occupational therapy, chiropractic, manual therapy and nursing. Reference sections of the original articles were reviewed to see if any related literature had been missed. Data ranging from 1984 to 2010 was used.

Key themes which emerged from the literature included feelings which were experienced during the transition period, the development of expertise, professional socialisation and the importance of mentoring.
The transition period

According to the Oxford dictionary, the definition of a transition is “a passing or change from one place, state, condition etc., to another” (Deverson & Kennedy, 2005, p. 1196). Other definitions expand on this such as the definition from ("Transition," 2011) “a passing from one condition, form, stage, activity, place, etc. to another; the period of such passing.”

The transition from study to work is particularly evident when the individual has trained for a specific profession in which graduates work independently once training has been completed, rather than progressing up a hierarchy and gradually easing into each new role with the support of others. The osteopathic profession is one such example of this relative autonomy.

Osteopathic education is specifically tailored and geared toward the autonomous role that students will take on once they have graduated, with the situation in New Zealand enabling students to practice within a supervised clinic during their final two years of study. The Unitec student clinic has experienced practitioners available to guide and assist students through any uncertainties, yet the majority of the time is spent working independently with the patient. Research has shown that students who have had the opportunity to work independently during their final stages of learning feel much more confident when entering the workforce due to the skills and knowledge acquired during their period of independent practice (Anderson & Kiger, 2008). However, anecdotal evidence from newly graduated osteopaths suggests that this system does not entirely eliminate the stress and anxiety that is commonly encountered in those first transitional months in practice. This was supported by the research conducted by Hagi (1999) and is reinforced by research in other fields such as dentistry and occupational therapy (Blanchard & Blanchard, 2006; Tryssenaar & Perkins, 2001) and may be due to the gap between university knowledge and professional knowledge (Ebrall, 2007). Once qualified and working out on their own, the safety net that was provided by tutors is no longer present for new graduates to rely on.

Aside from the work by Hagi (1999), the transition research that has been conducted tends to be from a fairly different setting to that of osteopathy. In the osteopathic field, which as mentioned is relatively autonomous, it is not uncommon for practitioners to have little opportunity to associate with, and discuss problems or matters of interest with other osteopaths, whether that be due to being the only osteopath in the clinic or not having breaks that coincide with their colleagues. That contrasts starkly with the professions and experiences of doctors and nurses who tend to have a well-established hierarchy which aims to support and nurture the development of the new graduates (Duchscher, 2009). In occupational therapy and physical therapy, there is also often a
degree of teamwork and hierarchy which, although not as extensive as with doctors and nurses, is still more than is present in osteopathy.

Studies into the transition from student to practitioner tended to be carried out during the first twelve to eighteen months of practice as it is “known to be a time of intense professional development” (Tryssenaar & Perkins, 2001, p. 19). According to Smith and Pilling (2007), it is within this time that graduates perceive their initial transition into the profession to occur. Many researchers conducted longitudinal studies to give an account of how participants perceived the transition as they progressed through it. For example, Tryssenaar and Perkins (2001) collected fortnightly reflective journal entry data during students’ final fieldwork placement and then throughout their first year of practice. Smith and Pilling (2007) collected monthly data over a ten month period during the initial practising year and Toal-Sullivan (2006) gathered data from occupational therapists while they were in their third month practising and again during their eighth month. This helped to gain a deeper understanding of the progression of the new graduates through the transition period.

During this transition period, there were common themes in the literature which new graduates struggled with. Not only were there the feelings of isolation due to being expected to practice competently without guidance, there were also feelings of inadequacy, uncertainty, a lack of confidence, stress and exhaustion (both physical and mental) (Lee & Mackenzie, 2003; Smith & Pilling, 2007; Solomon & Miller, 2005; Toal-Sullivan, 2006). There were areas in which new graduates felt unprepared such as communicating with other health professionals, planning treatments and managing the business side of practice (Dombroski, Reynolds, & Stevenson, 2010; Hagi, 1999; Toal-Sullivan, 2006). These areas of perceived deficiency were often attributed to the discrepancy between the academic setting and the reality of practice (Blanchard & Blanchard, 2006; Tryssenaar, 1999). Over time graduates became more accustomed to their role as a practitioner and as experience was gained, they felt more comfortable with what was expected of them and what they were capable of achieving, finding ways to face the difficulties (Tryssenaar & Perkins, 2001).

It is important to understand the experience of new graduates as they transition into the practising profession in order to implement procedures that may facilitate the process of entering professional practice (Tryssenaar & Perkins, 2001). Solomon and Miller (2005) discuss methods in which this greater understanding can be applied, including educators preparing students for the “realities of clinical practice ...and its impending challenges” (p. 191) and developing strategies with employers and colleagues to assist the transition. This second point is a critical one. Many studies regarding the transition period emphasise the importance of support from those working with the new graduate
Although osteopathy within New Zealand is still a relatively small profession, it is a growing one (Ministry of Health, 2009). As osteopathy’s profile increases, the numbers of people likely to pursue it as a career are also likely to increase. Research has shown that it is essential to understand the experiences of new graduates as they progress into the world of work in order to address any commonly encountered problems (Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001). It has been suggested that the first months of practice are crucial in forming and shaping the values and assumptions of a practitioner regarding their profession (Solomon & Miller, 2005; Tryssenaar & Perkins, 2001). This is achieved through the new graduates experiences and interactions with both patients and other practitioners. If the experience of the transition from student to professional is markedly different to what is anticipated, it has the potential to be a much more difficult period and may lead to disillusionment and discontent regarding the profession (Duchscher, 2009). For any profession it is important to maintain numbers within the profession (Rugg, 1996; Sutton & Griffin, 2000), thus eliminating any undue stress and difficulties from the early stages of the working life ought to help to reduce the drop-out caused by these.

The development of expertise

To have expertise is to have expert (or special) skill, knowledge or judgement in a particular field, as defined by the New Zealand Oxford dictionary (Deverson & Kennedy, 2005). This skill and knowledge is not and cannot be taught in full to students while they are studying as it is not something that can be learnt purely out of a book or by having someone tell them about it. Rather, that theoretical knowledge must be combined with the act of doing, trying and engaging in the field for oneself, in order to gradually build up to a level deemed to be that of an expert.

“While practice, without theory, cannot alone produce fully skilled behaviour in complex coping domains such as nursing, theory without practice has even less chance of success. In short, theory and practice intertwine in a mutually supportive bootstrapping process as the nursing graduate develops his or her skill. Only if both are cultivated and appreciated can full expertise be realised.” (Benner, Tanner, & Chesla, 1996, p. 29)

This is true for the osteopathic profession which, like nursing, requires appropriate action in complex coping domains.
Various criteria exist indicating what constitutes a profession although there is debate surrounding some of these. Fields that require an advanced level of learning or science are typically classed as professions (Deverson & Kennedy, 2005). Tight (1996) recognised that not only is an advanced level of learning required, which could also be found in training, but it is an advanced level of understanding gained through education which characterises a profession. A commitment to furthering the knowledge of the profession through research and passing this knowledge on through teaching was also considered necessary by some authors as this distinguished the knowledge base of one profession from another (Yielder, 1997). A profession also offers a service to its clients. As this is provided through a relationship, with the professional tending to be in the dominant position, there are certain standards of conduct and ethics which must be adhered to and are self-regulated within the profession by its professional body (Penington, as cited in Yielder, 1997). It is also characteristic for there to be control of entry into the profession, generally in the form of a formal testing process, to ensure an adequate level of competency upon entering the profession, and registration to show the required standard was met (Houle, as cited in Yielder, 1997). Although osteopathy meets all these suggested criteria, some might argue it is still only an emerging profession. This is because a large proportion of the research is conducted by the Masters students rather than the profession itself and, within New Zealand, the profession has only recently gained recognition as part of the mainstream medical system, becoming able to be registered under the HPCA Act 2004 as discussed in Chapter I.

It is generally accepted in the literature that the process of becoming an expert in a profession tends to be long and several stages can be identified during the transition from novice to expert. While the authors agree that varying competency levels exist (Benner, 1984; Kasar & Clark, 2000; Yielder, 2009), there is ongoing debate amongst them as to the number of stages present and the terminology used to classify them varies between individual authors. The model of skill acquisition by Dreyfus and Dreyfus was expanded on in the commonly cited work of Benner (1984). This experiential model proposed five stages of learning: novice, advanced beginner, competent, proficient and expert.

Benner (1984) explored the models with particular reference to nursing. The novice practitioner is someone who has very little experience of the clinical situations in which they are required to perform thus they adhere closely to the rules they have been taught theoretically (Benner, 1984; Kasar & Clark, 2000). However when put in the context of a real situation these rules may not be the most relevant to use and, may in turn impede successful care. Because of their limited experience, the novice lacks the skills to make these context-dependent judgements (Benner, 1984).
Practitioners who have great experience in one area can be reduced back to the novice level if they find themselves in a setting in which they have no experience.

Advanced beginners, although having some clinical experience behind them, still require guidelines from which to work. Because of the experiences they have encountered, they are now able to recognise aspects of a situation in order to draw on the most relevant guideline. Although guidelines can be given by a more experienced practitioner, without having encountered a particular situation it is a very difficult task for NGs to apply given guidelines to individual patients as their situational perception is still limited. Benner (Benner, 1984) found people in this stage of expertise struggle with integrating the situational aspects and attributes, and continue to give them all equal importance. It is noted in Mattingly and Fleming (1994) that therapists in their second year of practice often switched between procedural and interactive modes while treating their patients thus suggesting they were still in this advanced beginner stage of expertise.

The third stage is competence. Here, practitioners are able to see their action in terms of its long-term goals and are consciously aware of this planning. With this analytical awareness of the situation they integrate and cope with many different aspects and are able to determine which are of greatest importance at that point in time, in a manner not possible when an advanced beginner (Benner, 1984). Although having standardised procedures which they routinely use, they have yet to master the efficiency and flexibility of a proficient practitioner (Benner, 1984; Kasar & Clark, 2000).

The proficient practitioner is able to piece together the various aspects, view them as a whole and see what in the situation is most important (Kasar & Clark, 2000). Through experience they develop an ability to perceive what ought to be present given the context and are able to detect deviations from this norm. This in turn improves their decision-making ability because the efficient recognition allows them to accurately detect the problem. As a result of their deeper understanding of situations, proficient practitioners are able to use maxims which, because of their variable meaning depending on the situation, would not be comprehensible during the earlier stages of expertise (Benner, 1984).

In the five stage model of expertise by Dreyfus and Dreyfus (as cited in Benner, 1984), expert is the highest level attainable, although authors such as Raiola and Rolfe offer slight alternatives to this (as cited in Yielder, 2009). In the Dreyfus’ model, the expert no longer relies on the rules, guidelines or maxims that were necessary at the lower levels in order to take appropriate action. Rather, because of the vast experience they have now gained, they demonstrate an intuitive grasp of the situation which allows them to hone in on the priority aspect without spending time unnecessarily analysing
what else might be needed. Only when a problem occurs or an uncommon situation arises does an 
expert have to resort back to an analytical approach. According to Benner (1984, p. 35) what 
separates the expert from the proficient practitioner is their vision of “what is possible”.

As mentioned, there are several other experiential models that have been put forward. Raiola’s 
expertise model contains just four stages which he describes as being cyclical because when 
presented with a new situation the cycle starts again as one learns what is required for that 
situation. The stages are: unconscious incompetence, conscious incompetence, conscious 
competence and unconscious competence (as cited in Yelder, 2009). Another model by Rolfe, is 
initially the same as the Dreyfus and Dreyfus model used by Benner but rather than a single “expert” 
level, he suggests there be first a level of “technical expertise” and a top level of “advanced 
practitioner”. Yelder (2009) also agrees with this model. The reason for deviation from Benner’s 
model is that ‘expert’ does not encompass fully the need for reflexive thought while practising. Rolfe 
recognises that while the practitioner may be at expert level in terms of technical skills, it is the 
“advanced cognitive abilities” (as cited in Yelder, 2009) that allows him or her to attain the level of 
‘advanced practitioner’. Kasar and Clark (2000) also agree that employing clinical reasoning is the 
key for the novice to progress to mastery. “Experience alone is not enough to ensure learning; the 
reflection on that experience is essential” (Henry, as cited in Spalding, 2000, p. 394).

Cognitive models of expertise are also offered to account for the cognitive capacities involved during 
the development of expertise as these are lacking from experiential models. As mentioned, 
reflecting on one’s ability is necessary not only to recognise areas requiring development and ways 
in which this development could be achieved, but also to contribute to a database of knowledge 
which can allow faster recognition of presenting problems. Deliberate feedback on performance is 
needed in addition to experience (Sakai & Nasserbakht, 1997). Although many models of cognitive 
expertise exist, this review will focus on the model proposed by Schmidt, Norman and Boschuizen 
as cited in Eraut, 1994) as it is based in the medical profession which bears a significant number of 
similarities to the osteopathic profession.

Memory is a key feature of Schmidt et al.’s model (Eraut, 1994). Unlike the experiential model, this 
recognises that with experience, medical practitioners build up an ‘illness script’ in their memory 
which enables them to identify conditions more readily based on the conditions they have 
previously encountered. It seems likely that osteopaths would also create such a script as they 
encounter conditions and increase their familiarity with these through reflection.
Throughout the four stages of this model the organisation of knowledge evolves from using causal relations to more temporal ones (Yielder, 2009). Because the thought-processes involved in the cognitive model require an accumulation of knowledge based on repeated experiences, it is not purely time in practice that enables a practitioner to progress towards stage four, the highest stage. Rather, what prompts advancement through the stages is the experience which comes from repeatedly seeing a condition and reflecting on how the clinical presentation compares with the academically-taught presentation. It is accepted that an ‘expert’ may not be expert in all areas due to limited exposure in some fields. In the experiential model this lack of knowledge may be seen as a ‘regression’ to a lower level, however, Schmidt views this as the practitioner using his/her best skills given the situation (Yielder, 2009). Johnson & Mervis note that this is recognised in a number of cognitive psychology studies where the expert is able to maximise their skill to efficiently transfer it to different contexts (as cited in Yielder, 2009). Experts tend to use a non-analytical approach. However, in situations which pose a greater difficulty, they will resort back to the more analytical ‘illness-script’ approach. Schmidt et al. state that because each method may lead to a solution, neither is preferred over the other (as cited in Eraut, 1994).

Although Eraut (1994) refers to this model by Schmidt et al. as being ‘sophisticated’, he notes that it has little focus on the process of diagnosis. There is little inclusion of the “interactive or progressive nature of decision-making” meaning that many or the relational processes between the practitioner and the patient and their families are neglected (Yielder, 2009, p. 91).

Despite the differences, both the experiential and cognitive models agree on certain factors. Both accept that experts excel in their own domains although the cognitive model believes experts are better able to transfer this knowledge to other fields more readily than is suggested in the experiential model. Both agree experts are faster and more efficient than novice practitioners based on their memory and intuition of what they expect ought to occur (Benner, 1984; Yielder, 2009). Farrington-Darby and Wilson (2006) also agree with these features of both models and went on to say that experts analyse problems using different qualitative methods than those used by novices.

This progression from novice to expert or advanced practitioner is an accepted and, indeed, expected phenomenon in many industries, not just the healthcare fields. People acknowledge that those who are new to working in a certain domain are less likely to be as skilled as someone who has had much more experience in the area. However, while experience is a major aspect, it is not necessarily a matter of mere time on the job as other factors such as values, role perception and clinical reasoning also play a part (Kasar & Clark, 2000; Mattingly & Fleming, 1994).
Searches on the EbscoHost, ScienceDirect and OstMed databases did not reveal any studies on the progression from novice to expert within the osteopathic field, however, there is no reason why osteopathy should be an exception to the experiential or cognitive models. Like other healthcare modalities which have demonstrated this process, such as nursing, physical therapy and occupational therapy, osteopathy also has students who find themselves working alone as new graduates with limited general experience. They are thus likely to be situated around the ‘advanced beginner’ stage of the Dreyfus and Dreyfus experiential model or ‘stage 2’ of Schmidt et al.’s cognitive model. As they build up their experience and continue with their professional development, it would be expected that they too would move up the ranks of expertise.

**Professional socialisation**

The term socialisation comes from the word social meaning “of or relating to society or its organisation” (Deverson & Kennedy, 2005, p. 1070). One online dictionary described socialisation as “a continuing process whereby an individual acquires a personal identity and learns the norms, values, behaviour, and social skills appropriate to his or her social position” (“Socialization,” 2011) while the American Heritage Medical Dictionary (“Socialization,” 2007) defines it as “the process of learning interpersonal and interactional skills that are in conformity with the values of one's society.” Professional socialisation is often described within the health sector as a continuing process during which the individual acquires the knowledge and skills, and learns the values, attitudes and beliefs of their professional role (Miller et al., 2005; Solomon & Miller, 2005).

From day one of osteopathic education, students begin to learn the expected behaviours and attitudes of the osteopathic profession. However during this time they are socialised more towards the role of the student rather than that of the osteopathic practitioner. It is not until they are completely immersed in the profession and experience it that they can fully learn, appreciate and conform to the role expected of them (Cowin & Hengstberger-Sims, 2006). Not only are new graduates leaving behind the student role for that of the osteopath, they are also taking on the role of the professional. Although the process of socialisation is an evolving one, the first few months in particular can be a steep learning curve as they discover for themselves the real meanings of being both a professional and an osteopath. According to Solomon and Miller (2005) it is the first year of practice that has the greatest impact in forming the values and attitudes towards the profession, which are key aspects to professional socialisation. Smith and Pilling (2007), Toal-Sullivan (2006) and Tryssenaar and Perkins (2001) all agree that the first year of practice is one of intense learning with several typical milestones along the way, including the “three month stress peak” and the ensuing
“settling in” period (Maben & Macleod Clark, as cited in Toal-Sullivan, 2006, p. 517). Miller et al. (2005) also described organisational socialisation where the novice physiotherapist “gradually adopted the culture of the organisation and adapted to her new role” (p. 150). This worked in conjunction with professional socialisation to provide a grounding on which the graduate was able to construct a framework to understand and fulfil her role as both an individual practitioner and member of a team and profession.

Tryssenaar (1999) discusses how professional socialisation can be powerfully influenced by clinical work experience. Although already partially learnt while studying, new graduates’ time in practice serves to cement within them the learnt processes and skills, the norms, expected outcomes, behaviour, language and values. It is noted that a change in position may require a degree of relearning in certain of these areas as the degree of importance placed on them changes (Benner, 1984; Raiola as cited in Yielder, 2009). Yet through the early stages of practice and learning, there is one aspect that the research agrees on, the process of socialisation is made all the more easy with the help of mentoring (Blanchard & Blanchard, 2006; Miller et al., 2005; Tryssenaar, 1999; Tryssenaar & Perkins, 2001).

**Mentoring**

A mentor can be defined as an experienced and trusted advisor (Deverson & Kennedy, 2005). This experience may be in the personal or professional realms depending on the purpose of the mentoring relationship. The concept of mentoring is not a new one as it can be traced back to approximately the eighth century in Homer’s *Odyssey* where the young Telemachus was entrusted into the care of Mentor who was to act as an advisor, coach and teacher, as well as a guardian, to the boy (Johnson & Ridley, 2004). Over the years the mentoring relationship in society has evolved from a rather hierarchical one, where the older, more experienced person taught and helped the less experienced junior, to one that tries to follow a more flexible, mutually beneficial structure (Shea & Gianotti, 2009).

Currently, mentoring relationships tend to be “dynamic, reciprocal, personal relationships in which a more experienced person (mentor) acts as a guide, role model, teacher, and sponsor of a less experienced person (protégé)” (Johnson & Ridley, 2004, p. xv). While some mentorships are still quite purposeful and directed, others may be evident in an informal manner as the result of an already established friendship or strong working relationship.
There is much literature available (Cowin & Hengstberger-Sims, 2006; Solomon & Miller, 2005; Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001) depicting mentoring to be a highly valuable asset in enabling new graduates or junior professionals in the workplace to reach their full potential. This appears to be as true within healthcare professions such as nursing and occupational therapy, as it is for the more corporate professions which are so commonly described in mentoring texts (Johnson & Ridley, 2004; Shea & Gianotti, 2009).

When starting out in a profession there are many aspects which will be learnt on the job as a result of being exposed to the experiences and attitudes and values of the work place. Regardless of how much one is taught while at university or while training for a specific vocation, there will always be a discrepancy between the situational learning environment and that of the reality of the working environment (Benbelaid, Dot, Levy, & Eid, 2006; Blanchard & Blanchard, 2006; Tryssenaar & Perkins, 2001). This may be caused by an inconsistency between the theoretical knowledge and its application (Blanchard & Blanchard, 2006) and may be heightened by a lack of support, no longer having supervision, a difference in ethos resulting in having to learn how the professional role should be approached in this new setting, or unrealistic expectations of what clinical practice would provide (Tryssenaar, 1999). Some of these aspects are felt not only by new graduates, but may also be apparent when starting at a different workplace despite being in the same role. In such situations a mentor figure can be of great help and comfort as a safe and trusted person from whom to seek advice, support and encouragement. Tryssenaar (1999) discussed how the “development of a new identity led to growing pains and the need for counselling and guidance” (p. 107).

While most agree that a mentor plays a crucial role in helping new graduates transition into the working environment, both Johnson (2004) and Shea (2009) stress the importance of knowing clearly each person’s role within the mentoring relationship and its expected requirements and boundaries. In particular, it is important to avoid dependency on the mentor. Because a new graduate has little experience in the working environment it is likely they will look to their more senior colleagues as people on whom to base their ideals, values and beliefs about the role. This can place a large responsibility on these senior members to ensure that they are acting in a manner that is “fair, just and honest” towards those around them, whether colleagues, clients or the new graduates themselves (Johnson & Ridley, 2004, p. 38). It is in this way that the senior colleagues or mentors play an important role in the socialisation of people into the profession. Tryssenaar and Perkins (2001) propose that an effective mentor experience does not happen automatically but requires access to a good role model. Blanchard (2006) expands on this by saying that not only is it
important for a mentor to be a positive role model, he or she must also be patient, knowledgeable and have enthusiasm for the profession.

Mentorship in health professions is becoming an increasingly common educational strategy to enhance career satisfaction and professional growth which in turn contributes to job retention (Blanchard & Blanchard, 2006; Toal-Sullivan, 2006). In one study investigating the experiences of novice physical therapists in acute hospital settings, the general consensus was that having access to a “buddy” programme or a formal mentor would have been “ideal” to help cope with the many difficulties that were faced in the early months of working (Miller et al., 2005, p. 149). Recent graduate occupational therapists working in rural New South Wales identified professional support as easing their transition (Lee & Mackenzie, 2003). These graduates were questioning their competence and their decision-making ability but found that discussing their insecurities with more experienced practitioners helped to increase their confidence. In the study by Toal-Sullivan (2006) which investigated occupational therapists’ experiences of learning to practice, the participants often learnt in collaboration with physiotherapists. While they found this useful in some regards, they felt that in the beginning stages of practice they were better to learn from an experienced occupational therapist. By having someone from the same profession, they felt they could be better inducted “into the culture of occupational therapy, help them to develop their competence and assist them in understanding the connection between theory and action” (Toal-Sullivan, 2006, pp. 520-521). These same participants acknowledged that there were no formal or structured mentoring programmes in place for them, yet they felt they gained considerably from the informal interactions that occurred in day-to-day practice.

Summary

Despite the fairly extensive research in similar healthcare settings, only one study concerning the transition from student to professional could be found which was specific to osteopathy. As such it was felt that an ‘up to date’ insight into the experiences of the recent graduates from the Master of Osteopathy at Unitec New Zealand was necessary. As part of the transition process, new graduates are faced with the need to learn the many facets that comprise the role of a practising osteopath. Although aspects of professional and organisational socialisation can be taught at university, it is not until graduates are immersed in the osteopathic role that they are able to fully learn and understand the intricacies that form the profession. While initially there is a steep learning curve, it is an ongoing process which allows adaptation to the situational changes occurring around the person. Equally the development of expertise is a continual one. Although starting this developmental
process while studying, the real progress becomes much more evident as the number of patients seen, and in turn the experience, increases. While it is possible to go through this transitional process alone, research points clearly to the fact new graduates in many healthcare professions find the process much easier with the help a mentor figure who is willing to assist them through this time. Regardless of whether the mentoring takes place in a formal or informal setting, the outcome and benefits appear to be equally positive.

The transitional process for osteopaths in the New Zealand context is not well researched and therefore is not well understood. As the profession is a growing one and it is important to retain practitioners once they have trained, it is necessary to gain better insight into experiences of new graduates during their first 18 months of practice. This will serve to highlight the difficulties and problems that were encountered and the methods employed to overcome them. With this information it may be possible to instigate change within the educational system or the work places of recent graduates in order to facilitate a smoother transition into the osteopathic profession.
CHAPTER III – RESEARCH PROCEDURES

Introduction
This chapter will discuss the methodology and the methods that were used for this research. Inclusion criteria for participants of both the questionnaire and interviews will be outlined. Methods of data collection are outlined and the ethical considerations given. An evaluation of the methods used is included, followed by a brief chapter summary.

Methodology
The method deemed most appropriate for this empirical research was that of a case study. According to Yin (2003a, p. 4) case studies are best suited when the “phenomenon under study is not readily distinguishable from its context”. Because it is not possible to look at the transition from student to practitioner away from its context, the case study provides a suitable method to look at the event systematically. He also states that the studied phenomena should be contemporary, in its “real life context” and that evidence should be gathered via various methods. Using several sources to collect information is known as triangulation and is agreed by many authors to be a highly important aspect in qualitative methodology (Flick, 2006; Verschuren, 2003; Yin, 2003b) as it strengthens the validity of the overall findings by compensating for any weaknesses found in each individual method.

Data collection method
In order to create triangulation in this research, both a questionnaire and interviews were used as methods of data collection. This approach helps to validate the findings of each method, and also “obtain knowledge about the issue... which is broader than a single approach” (Flick, 2006, p. 40).

A questionnaire is a cost and time-efficient method which effectively gathers information from a large participant population and allows a broader sample frame. However, the depth of a participant’s response can often be limited and clarification of both questions and answers poses difficulties (Domholdt, 2005).

Although extensive searching of the EbscoHost, ScienceDirect, OstMed, and ChiroIndex databases was undertaken as well as a general Google Scholar search, a pre-validated questionnaire on this topic was not found; either the relevant articles did not include it or, more typically, the research
was primarily conducted using interviews. For this reason, the questionnaire was generated by drawing on topics of discussion from within the text of published articles in the transition field. The questions were peer-checked by three Unitec osteopathic graduates who were ineligible to participate due to having been practicing longer than 18 months in order to ensure clarity and understanding of the questions asked.

The questionnaire was sent out by the Unitec osteopathic clinic manager who had a list of past graduates’ email addresses. Because of the staggered nature of graduating and commencing work, this email was sent to all graduates and relied on them to determine whether they fitted the criteria of having been practicing for 18 months or less. People who had been working for longer than 18 months were asked to disregard the email. The email (see Appendix A) gave a brief explanation of the research and contained a link to the questionnaire which was accessible through SurveyMonkey, a frequently used, valid and reliable internet-based surveying website (Ewing, Bruce, & Ricketts, 2009). The introductory page of the questionnaire contained more detailed information about the research and explained that submission of the questionnaire implied informed consent.

Over a period of six weeks, three requests for participation in the questionnaire were sent out, each time via an email from the Unitec clinic manager. This brought in 20 responses from an estimated 36 eligible respondents.

To account for the questionnaire disadvantages, interviews were also employed because, despite being time-consuming, they allow greater depth to responses and any uncertainties can easily be clarified (Domholdt, 2005).

Participants for the interviews were recruited through the questionnaire which explained the interview process and allowed interested people to fill in their details on the final page (see Appendix E). Of the 20 questionnaire participants, seven volunteered and took part in the interviews. These practitioners had been working for 3 to 18 months. The interviews took 40 minutes on average.

Although interviewees were to be selected randomly from those who had expressed an interest in participating, the number of respondents was not great enough to allow this to be done. Nor was it possible to divide the participants into groups of 3 – 6 months or 12 – 18 months spent practicing, as had been intended, due to insufficient numbers and an even spread across the spectrum. Initially interview participation was to be limited to people within the Auckland region, however with the use of the web-based programme Skype which enables free calling, it was deemed acceptable to include people beyond the Auckland region in order to increase participant eligibility. Using the
details given, participants were contacted either by email or phone and a time and location was agreed upon for the interview to take place.

Before beginning each interview, the process was explained to participants and they were requested to sign a form for informed consent. The consent form was posted to interviewees outside the Auckland region and included a stamped and addressed envelope for them to return it in. Each interview was recorded using a Cowon iAUDIO portable media player. Interviews using Skype were recorded using PowerGramo, a downloadable programme which works in conjunction with Skype to record the entire conversation.

The interviews followed a semi-structured guideline of questions (see Appendix D) which were closely related to those in the questionnaire, expanding on the common themes already found, although care was taken to ensure that questioning was open-ended so as to limit interviewer bias and to allow the participant to describe their experience. This helped to give a fuller understanding of the common issues and their implications for the new graduate.

Interview participants were offered a $20 petrol voucher as a thank you for their time and input.

Participants
Inclusion criteria were that participants had trained at Unitec and had been practising in New Zealand for 18 months or less. Asking the clinic manager of the Unitec osteopathic clinic to send out an email request for participants to osteopaths on her class list of graduates meant that only people who had gone through the Unitec clinic would receive it. People who had trained at overseas colleges would not receive the email. As stated previously, it was not possible to limit the email to people who had only been working 18 months. This is due to everyone starting work at different times depending on when they finish their research, and whether they start work immediately upon completion. There are no records held on this at Unitec and the Osteopathic Council of New Zealand (OCNZ) was unable to disclose information about when people had registered. Because of this, the email was sent to all graduates and relied on them to participate only if they fitted the criteria. It was decided to limit the participants to 18 months or less so that the memory of the transition from being a student to being out practicing was still fresh in their minds and literature shows it is during this time that the transition period is most evident (Solomon & Miller, 2005; Toal-Sullivan, 2006).
Participants for the interview were self-selected by expressing an interest and filling out their details at the end of the questionnaire. Had the number of respondents been greater, they would have been selected randomly.

Data analysis
Data from the questionnaire gathered using SurveyMonkey was then downloaded and collated into an Excel spread sheet where it was able to be analysed question by question using descriptive statistics where suitable or thematic analysis of the qualitative responses. This was then compared to the themes which arose from the interview data.

The recordings of the interviews were transferred onto the computer in an MP3 format so they could be transcribed verbatim using Express Scribe, a free digital audio transcription programme. Express Scribe assists the transcription process with the use of the function keys to stop, start, rewind or alter playback speed. Once all seven interviews had been transcribed, the transcripts were emailed back to participants to read in order to verify that what was said was a true representation of their thoughts and experience. They were able to add or subtract information in order to ensure this. This adds to the strength of the study as it helps to avoid misinterpretation of their stories (Toal-Sullivan, 2006). The transcripts were then read repeatedly, taking note of the key points that were made and their frequency before categorising them into themes. Such cross-sectional thematic analysis helps in trying to establish an understanding of the participants’ experiences. A file was made for each theme to contain key quotes as a quick reference.

Each interview was compared to the others to gain overall themes. The overarching themes were then compared to those found in the questionnaire. Carrying out the analysis in this manner enables the data to be compared and contrasted within and between the more detailed interviews and then allows further comparison of emerging themes with the more general questionnaire responses. Comparative analysis tends to be the means of analysing case study data rather than statistical analysis common in quantitative research (Verschuren, 2003).

Ethical considerations
A participant information page was included at the start of the questionnaire detailing the purpose of the study, what it entailed for participants and included the researcher’s contact details in case further clarification was needed (see Appendix B). Participation was voluntary and completion of the
questionnaire implied informed consent had been given. Because the questionnaire was anonymous, participants were not able to withdraw information once completed. However, those who volunteered to participate in the interviews entered their personal details at the end of the questionnaire. When questionnaire results were collated for analysis, these were removed so that each respondent remained anonymous.

Participation in the interview was also voluntary however participants had the right to withdraw without reason for up to a month after their interview. Anonymity and confidentiality was assured.

Signed informed consent was gained for the interviews – including stating they understood the purpose of the research, they had been given the opportunity to ask questions and had had them answered, and they were aware of the form the interview would take and that they would be voice recorded (see Appendix C).

Questions were selected carefully to avoid being of a sensitive or personal nature.

Participants were assured of secure storage of data and dissemination of results.

Pseudonyms have been used in the discussion to maintain participant anonymity while retaining their individuality so as to provide clarity for the reader who is following their responses.

Ethical approval for this research was granted by the Unitec Research Ethics Committee (UREC) on 18 November 2009 for data collection until the 18 November 2010.

**Evaluation**

Although the questions asked in the questionnaire were peer-checked and changes were made, this was done before the questions were set out in SurveyMonkey. Due to certain layout restraints within the website, some questions had to be formatted to fit the programme. Despite being essentially the same question, these changes may have altered the understanding and clarity of some questions.

Certain questions such as Question 3.2 and 4.1 did not have complete response rates. For example it was noted that one respondent only answered every second question. It may have been that the long list they were expected to rate discouraged them from answering all of them.

Other questions made sense when formulated, however, it became clear from the responses that the intended meaning was missed. Question 6.5 asked if there were other areas participants would
prefer to work in. This was intended to mean in addition to the fields they already worked in but it was realised it could also mean instead of.

Questions were asked in the questionnaire which although appeared to be worthwhile considerations, when analysed with respect to the key themes found in the interviews and the literature, they did not contribute greatly to the overall findings. All questionnaire results are presented in Chapter IV, however, only those which were felt to contribute to the key themes are discussed in Chapter V.

If this questionnaire was to be used again, it would be worth considering these factors and refining them in order to gain a more accurate and complete picture of the transition process.

**Summary**

This empirical research used a case study methodology as it was deemed the most appropriate to investigate in context the transition process from student to practising osteopath. Triangulation through the use of both a questionnaire and interviews was created in order to give strength to the data gathered.

A pre-validated questionnaire was unable to be found from database searches, however, the questionnaire was generated by drawing on the data found within articles. This was peer-checked by graduates who were no longer eligible to participate in the research, before being emailed by the manager of the Unitec osteopathic clinic to all the osteopathic graduates.

To be eligible participants had to have studied at Unitec and have been practising in New Zealand for 18 months or less. Graduates were relied on to judge their own eligibility as there is no accurate information accessible on how long participants have been working.

A link contained in the email took participants to the questionnaire which was produced on the SurveyMonkey website. The final question informed respondents of the option to also participate in an interview and allowed them to leave their details if they were interested.

The researcher contacted those who had expressed an interest in the interviews and a time and location was agreed upon. These were either conducted face-to-face or using the free internet-based calling programme, Skype. Each interview was recorded and then transcribed verbatim. The transcripts were analysed through repeated readings and key themes began to emerge. These
themes were compared to those found during the thematic analysis of the questionnaires and also to themes found in the literature.

Ethical factors were given consideration, including clear information sheets for all potential participants, the voluntary nature of the research and questionnaire anonymity. Informed consent was gained for the interviews and the right to withdraw information was given for up to one month following the interview. Again, anonymity was assured through the use of pseudonyms and secure storage of data. The questions of both the questionnaire and interviews were carefully selected to avoid being of a sensitive nature.

Upon analysis of the questionnaire results it became clear that certain factors need to be considered if this questionnaire were to be used again. For example, limitations using SurveyMonkey meant the formatting of some questions was not as clear as was needed, and there was ambiguity in the wording of certain questions. Such factors may have contributed to a lower response rate or a potentially inaccurate representation of participants’ experiences in some questions.

The results from the questionnaire will be presented in the next chapter and will be discussed in Chapter V in conjunction with the interview findings.
CHAPTER IV - RESULTS

Introduction
Since this research was carried out using both a questionnaire and interviews, only the results from the questionnaire will be presented in this chapter. These will be divided into four sections as per the questionnaire: demographics, preparedness for practice, support and clinical situation. The results from the interviews will be integrated into the discussion chapter.

Of the 36 estimated new graduates who were eligible to participate in this research, 20 responded to the questionnaire. However, some respondents left questions unanswered. Rather than eliminating partially-completed questionnaires, it was deemed necessary to include them due to the relatively small sample size.

Demographics
The first section of the interview gathered demographic information about the participants. Of the 20 respondents, 15 were male and five were female (Fig. 1) and the ages ranged from 24 to 57 with the majority between 26 and 40 years (Fig. 2). The mean age was 33 years old.

![Q 2.1 - Gender of participants](Fig. 1)

![Q 2.2 - Participant ages](Fig. 2)

Because the criteria for participation was working less than 18 months, the years of completion of study and passing of the Final Clinical Competency exam (FCC) ranged from 2006 through to 2009 (Fig. 3), while the years of completion of the thesis spanned from 2007 to 2009 (Fig. 4).
The mean time participants had been in practice was 9.6 months (Fig. 5) with two thirds of people practicing osteopathy for less than 30 hours each week (Fig. 6).

Just over half the participants said that the reality of practice was different to what they had expected when they first began studying. The proportion of respondents who felt that the reality of practice was different from their expectations after completion of study, but prior to starting work, had changed to just less than half (Fig. 7). One fifth of participants (4 of 20) had had previous clinical work experience before starting as an osteopath (Fig. 8). This experience included physiotherapy (18 months), manual therapy (11 years) and two had practiced massage, both for five years.
Preparedness for practice

The second and third sections related to how well-prepared participants felt for practice. This was looked at in terms of when they had just finished studying (before starting in practice), and then once they were working (Fig. 9). This enabled comparison which helped to see whether areas of insecurity were warranted or whether it was more a case of a fear of the unknown.

On leaving university three quarters of participants felt adequately prepared to go into practice. Although the majority remained feeling adequately prepared once practicing as an osteopath, some people found they felt poorly prepared while others felt better prepared than they had originally felt.

Participants were asked to rate the following factors as they felt about them before starting practice and now that they have been practicing. These factors can be grouped into intrinsic factors (Fig. 10.1 – 10.5), practical skills (Fig. 11.1 – 11.3), theory skills (Fig. 12.1 – 12.4), business skills (Fig. 13), and communication skills (Fig. 14.1 – 14.4).
Intrinsic factors

**Fig. 10.1** Q 3.2/4.1 - Preparedness to work unsupervised

**Fig. 10.2** Q 3.2/4.1 - Personal capability

**Fig. 10.3** Q 3.2/4.1 - Individual accountability
Practical skills

Q 3.2/4.1 - Preparing for action and working speed

Fig. 10.4

Q 3.2/4.1 - Ethical awareness

Fig. 10.5

Q 3.2/4.1 - Practical skills/Techniques

Fig. 11.1
Theory skills

Fig. 11.2 Q 3.2/4.1 - Ability to adapt techniques for different situations

Fig. 11.3 Q 3.2/4.1 - Accuracy and reliability of your findings

Fig. 12.1 Q 3.2/4.1 - Applying theoretical knowledge
Q 3.2/4.1 - Applying evidence-based practice

Fig. 12.2

Q 3.2/4.1 - Applying clinical reasoning

Fig. 12.3

Q 3.2/4.1 - Using knowledge of research and developmental work

Fig. 12.4
Business skills

Q 3.2/4.1 - All aspects of managing and running a business

Communication skills

Q 3.2/4.1 - Reporting, documenting and writing patient care records

Q 3.2/4.1 - Communication/interaction with patients
Question 4.2 explored the feelings regarding work that people experienced in their first three months out practising as an osteopath. Participants were asked to indicate their top five feelings ranking these from most felt to fifth most felt. The question included a set of feelings from which participants could chose the applicable ones but it also allowed them to think of their own. Nineteen respondents filled out their top three feelings, however, the response rate decreased for the fourth and fifth categories. Nine of nineteen respondents showed their most common feeling to be a positive one, although the numbers of positive feelings became more prominent in the second and third categories. The most commonly occurring feeling overall was ‘excitement’ followed by feelings of being ‘unsure’, ‘positive’ and then ‘inadequacy’. Other feelings that were seen only in the fourth or fifth placings (and are therefore not shown on the table) were ‘secure’ (mentioned by two people), ‘dread’, ‘solitude’, ‘unsupported’ and ‘tired’ (each mentioned only once).
Below is a graph demonstrating the feelings experienced most frequently as new graduates (Fig. 15).

Most respondents felt there were areas of the Master of Osteopathy curriculum that could have had greater emphasis in the teaching schedule (Fig. 16). The primary area indicated was that of professional topics such as small business skills where almost 85% of participants felt this was lacking. This was closely followed by clinical topics of associated disciplines, such as radiology or orthopaedics, with 74%; and then osteopathic content, both theory and technique, with 63% of respondents. Just over a quarter of the participants thought there needed to be more learning of basic anatomy and physiology material. Participants were also given the opportunity to suggest other areas needing work. It was suggested by one person that more time be spent practicing hands-on skills and diagnosis. One person considered that all areas were covered adequately.
People were then asked to rank up to three main specific areas that they thought could have used greater emphasis. This question required participants to type in an answer rather than select a generalised one, thus giving fairly individualised responses. However, the nature of the responses were able to be grouped into three main categories: ‘core osteopathic curriculum’, ‘clinical topics of associated disciplines’ and ‘professional topics’ (Fig. 17). Overall, ‘clinical topics of associated disciples’ was found to be most in need of further emphasis. Second was ‘core osteopathic curriculum’, and ‘professional topics’ were third.

![Figure 17](image.png)

**Support**

This section looked at the level of support available to new graduates. Four of nineteen participants were part of a formal osteopathic peer group that met regularly (Fig. 18), although the degree of regularity varied from once or twice a month to more occasional meetings. These groups tended to discuss osteopathic techniques, patients of interest, research articles and other general aspects of practice.

![Figure 18](image.png)

![Figure 19](image.png)
Fourteen of the nineteen respondents (Fig. 19) had a more experienced osteopath who would act as a mentor to them, giving support and advice. This mentor or role model generally was the principal osteopath in the practice, although sometimes just a colleague or a friend. New graduates reported having a mentor to be valuable due to being able to discuss difficult cases and clinical reasoning, get guidance with different techniques, advice on patient management and expected outcomes, and generally helping to improve knowledge while offering support to provide reassurance and build confidence. Some participants were able to sit in to observe treatments given by the principal osteopath, give “double” treatments with the principal so they were both treating the patient at the same time, or have the principal examine their patient if they were unsure about an aspect of the case, thus gaining a second opinion.

**Clinical situation**

Participants were asked to indicate the kind of clinical setting(s) they work in. The majority (12 of 19) worked in private practice premises where osteopathy was the only discipline practiced. This was closely followed by work in multidisciplinary centres (10 of 19). Home visits and working from their own home each had three people select them. One person wrote that he worked part-time in a manufacturing company as the osteopath for its workers.

The most common location of work was in inner city suburbs close to the central business district (8 of 19), followed by city suburban (5 of 19), central business district (4 of 19) and then provincial town (3 of 19). Rural country and villages were not applicable for any of the respondents.

The types of patients seen had a fairly even spread over gender, age and nature of presentation. Babies and children were seen slightly less frequently than the older age groups but were still treated by over half of respondents. The majority of people most commonly saw patients who were female, middle-aged (40 – 64 year olds) and had chronic conditions.

Participants were questioned about the mode of treatments they most commonly used (Fig. 20). Articulatory techniques were the most commonly utilised treatment method followed by high-velocity-low-amplitude (HVLA) manipulations and muscle-energy techniques (MET). The gentler, more subtle treatment methods were not so commonly employed by the new graduates, who generally used them on less than half of their patients. In particular, cranial osteopathy, balanced ligamentous techniques (BLT) and visceral techniques had a fairly high proportion of people reporting that they hardly ever used the technique or did not use it at all. Other treatment methods that were mentioned included harmonics, inhibition and soft tissue work, myofascial release and patient education.
Participants were asked whether there were other fields of osteopathy that they would prefer to work in for example structural, visceral or cranial. Twelve of the nineteen who completed the question stated that yes there were other areas they would like to work in. Nine of seventeen responses said that there were also other methods of treatment they would like to use within the fields in which they already practice (Fig. 21).

People who had answered that there were other areas that they would prefer to work in were given the opportunity to expand and say which areas these were and whether anything in their training could have helped them to know this earlier. The general comments implied that the level of structural training in the course was good. Although one person felt that it was important not to take too much time away from the structural side, seven of the ten people who commented said a greater visceral component needed to be incorporated. Cranial and functional techniques also featured quite prominently. One person also felt acupuncture was an area they would like to work in. Several people acknowledged that some of the skills require time to build up the necessary palpatory ability and awareness, therefore completing postgraduate courses such as courses for continuing professional development (CPD) points was a good way to learn these other skills.
Reasons for wanting a wider range of treatment approaches were to provide them with a broader spectrum of skills and techniques to offer patients depending on the presenting complaint, and to give more variety to prevent treatment from becoming “boring”.

Participants’ working situation satisfaction was looked at in terms of their current place of work and their performance as a practitioner. Satisfaction with their current working situation was rated from one (not satisfied) to five (very satisfied) (Fig. 22). Ten participants gave their working situation a four out of five, while four people rated it five, and the ratings of three and two each had two people select them. No one was unsatisfied with their situation. One person did not answer the question.

In terms of satisfaction with their performance in their role as an osteopathic practitioner, the same scale was used (Fig. 22). Again, ten people rated their performance satisfaction as a four (satisfied), six people gave themselves a neutral three and there was one person for either end of the spectrum with ratings of five and one. No one selected ‘not very satisfied’, and again, one person did not answer the question.
The quality of treatment was found to be affected by many factors. Participants were asked to select from a list of barriers the ones which they found to be most problematic (Fig. 23). Patients with unrealistic expectations were ranked as being the greatest barrier to the quality of treatment given, with nine of nineteen respondents saying this was an issue for them. Second most difficult was the time constraints that came with a full patient list or being booked to a tight schedule; eight people cited this to be a problem. Next, each with seven people stating them to be barriers, were complicated presenting complaints; late patients; stress and fatigue; and finding a balance between work and home life. Five people found their physical ability to perform techniques an issue, whether it be due to strength or stamina, and two people reported barriers from difficult patients. One person reported not having any barriers. Both building rapport and cultural or language barriers were not found to be a problem for anyone. Some people described other areas to be a problem. These included a lack of business skills – not knowing how to run a clinic, market oneself, or budget oneself; limited technical skills both generally and affecting the ability to adapt to different situations; clinical reasoning; and patients whom the practitioner does not actually like.
Just over half of participants (ten of nineteen) had found ways to overcome the barriers they encountered (Fig. 24). These methods included clear explanations to patients including what they should expect and realistic timeframes; allowing longer treatment sessions and taking regular breaks to maintain focus; reading osteopathic texts and discussing any uncertainties with other osteopaths, getting their advice; keep questioning the patient as well as yourself to find the answer; trying new techniques and practicing them to build confidence; the more time spent practicing as an osteopath, the more you experience and the easier it becomes to find “good ways” to proceed; relax; and of course coffee, a vital aid in the lives of many professionals.

![Q 6.8 - Have you found ways to overcome these barriers?](image)

Finally, participants were asked what considerations were most important to them when considering prospective osteopathic jobs (Fig. 25). An interesting job was ranked highest as being the overall most important factor when looking at jobs, followed closely by a supportive environment, ability to work independently and job security. High income, location and availability were deemed to be less important factors.

![Q 6.9 Considerations when choosing a job](image)
CHAPTER V - DISCUSSION

Introduction
This chapter discusses key findings in the transition from student to practising osteopath, from both the interviews and questionnaires, and compares them in conjunction with literature from occupational therapists, physical therapists, dentists, nurses, chiropractors and the limited osteopathic literature. The key findings are grouped into three main themes: intrapersonal, interpersonal and educational deficiencies. The limitations of this research are discussed and possible avenues for further research are proposed. Pseudonyms are used to maintain anonymity of interviewees.

Intrapersonal
This first theme examines the intrapersonal factors experienced by newly graduated osteopaths. It discusses how the reality of osteopathy compared with their preconceived notions of what practice life would be like, how new graduates perceive their own ability, feelings of isolation and methods of self-care.

Reality of osteopathy
For significant number of participants the reality of osteopathic practice did not match with their preconceptions of what practice would entail. This is illustrated in Question 2.8 of the questionnaire where 55% of respondents said that the reality of practice matched the expectations they had upon graduation. This proportion is higher than the 45% of participants who found the reality of osteopathy corresponded with the expectations they had when embarking on study. These findings show that the five years of osteopathic education coincided with a closer alignment of graduates’ expectations with reality, despite a continuing substantial gap between the two.

One area that featured prominently in participants’ reasons for the mismatch in expectation was that of financial factors. These matched up with themes found in the existing literature (Dombroski et al., 2010; Kleinbaum, 2009). Thomas expressed shock at the amount of money he needed to spend just to start practising. There were costs for registering as an osteopath, the annual practising certificate, insurance, business establishment fees and accountant fees:
So coming out of a five year degree as a student there’s a bit of a shock that ‘oh I’ve actually got to spend more money now to actually start to work’, and it’s not suddenly an influx of money like I was hoping (Thomas).

Comments from the questionnaire included, “hard work, slave wage” (Respondent 17) and “it takes a long time to get from completing your thesis to having a job that pays enough to live off” (Respondent 14). Participants from both the questionnaire and interviews expressed surprise at the amount of time spent waiting during their early days of practice and the amount of time it took to build a patient list. Many appeared to believe that they would be able to walk into a full time job. Even those who showed an awareness of the time needed thought it would be easier than the reality. Kelly commented in her interview that although she was not under the impression that she would be given a full patient list, the amount of time she spent waiting and having to be available for patients in case they booked in was frustrating and hard. She found initially that some days she would be available for twelve hours but might only see three patients. During these times of waiting she was very well aware that she was not actually earning any money. However, this gradually changed over the period of several months as she established a patient list.

Louise found the financial aspects of osteopathy to be scary not only because she did not start earning as readily as anticipated but also because all of the financial outgoings she had not taken into consideration:

It’s scary seriously...How do I start? You have a percentage for tax that you have to take off and you’ve got your ten percent for your [student] loan, you have to do GST sometimes depending on how much you’re making and who you’re with. That’s a s**t-load (Louise).

She continued to point out that despite feeling guilty because patients pay relatively high consultation fees, the newly graduated osteopath when working for someone else actually does not see much of that fee.

For someone who has never worked as anything other than an employee being paid a standard wage, these factors may well come as a shock. They may never have had to pay to join a profession or to set money aside each week for tax as this would normally be taken out of their wages. New graduates (NGs) may never have needed to consider these factors in past employment, thus if inadequately discussed as part of the curriculum, NGs may have been unaware of the financial impact such factors would make when entering the profession.
Others may not have fully considered the implications of being self-employed. One questionnaire participant mentioned this with regard to the lack of paid leave and social services. While some thrived on the flexibility it could offer, others found the lack of guaranteed income disconcerting as seen in the study by Kleinbaum (2009) which investigated why osteopaths choose to leave the profession.

The largest proportion of questionnaire respondents (7/20) reported they only worked 11 – 20 hours per week (Fig. 6). These respondents had been practising for periods ranging from one month to fifteen months. Interviewees indicated that over the course of several months of practice, their patient lists filled substantially which would make it seem unlikely that this group consisted entirely of those who were still building a patient list. It cannot be determined from the data whether it is by choice that the participants worked these limited hours or if perhaps they have only included time working with patients, leaving out the number of non-contact hours worked. Participants of Hagi’s (1999) research expressed difficulties finding osteopathic work. Although not specifically mentioned by participants in this research, limited job opportunities may have led to low practising hours. Regardless of the reason, the limited hours worked by such numbers are likely to be contributing to participants’ remarks regarding poor pay.

As mentioned, the non-contact hours may have just involved waiting for patients but it may also have incorporated time spent on finishing paperwork and working on marketing schemes. Five of the seven interviewees mentioned marketing as something they spent time on. Often this was the protocol of the clinic they were working in. Marketing techniques ranged from leaflet drops around the area, to introducing oneself to the other healthcare practitioners, or writing courtesy letters to GP’s in full first time, (or midwives in the case of pregnant patients), when they had seen new patients or had had patients referred to them by these other health practitioners. All of these methods take time and energy and do not immediately see monetary return although it may pay off by raising the profile of the clinic and practitioner and by encouraging further referrals.

Not only is there often time with little or no patient contact, there is also commonly little opportunity for contact with other practitioners. This may contribute to feelings of isolation and loneliness as a result of the perceived lack of support services available to NGs. Isolation was mentioned by three people in the questionnaire when asked how the reality of osteopathy differed from their expectations (Q. 2.8) and by four of the interview participants. Interestingly, despite isolation being fairly prominent throughout the interviews and Question 2.8, it was only alluded to twice in Question 4.2 on most commonly experienced feelings. ‘Solitude’ and ‘unsupported’ were mentioned once each in fourth and fifth place respectively, both by the same respondent who also
felt support services from clinic owners were poor. Although other participants in the questionnaire noted similar isolation problems in Question 2.8, none mentioned them as frequently as Respondent 12. Whether this participant was subject to more isolating circumstances than most, making these feelings more evident, is uncertain. One might expect that if a person lacked in confidence then he/she may be more aware of how isolated and unsupported he/she was. This did not appear to be the case in this situation however, as the participant indicated moderate levels of confidence and preparedness throughout the questionnaire. These feelings of isolation and the need for support will be discussed further in subsequent sections.

It is interesting to note that in Question 4.2, which asked about participants most prominent feelings during the first three months of practice, eleven of nineteen reported a negative feeling to be most common. While feelings of anxiety, uncertainty, and being overwhelmed are commonly reported in the literature (Miller et al., 2005; Solomon & Miller, 2005; Toal-Sullivan, 2006), the question must be asked if this is necessary and whether there is anything that can be implemented to reduce these feelings and replace them with more positive ones. Several authors found that the negative emotions seemed to be generated from a set of unrealistic expectations and attitudes held by the participants regarding their first job (Lee & Mackenzie, 2003; Solomon & Miller, 2005; Sutton & Griffin, 2000). Ensuring NGs are well versed in the many realities of osteopathic practice could reduce the shock they experience once working and alleviate the role stress they experience.

Smith (2007) discusses how the early impressions and experiences of the profession can influence the trajectory and longevity of a person’s career. Thus it would seem important to maximize the positive experiences and minimize any undue causes of stress in order to optimize one’s career. Creating an environment where one feels confident and safe would seem more likely to retain people within the profession. If the shock of reality due to a mismatch of expectations is too great, new graduates may find dissatisfaction and reason to leave the profession (Kleinbaum, 2009).

As cited above, the majority of participants identified a negative emotion as being most commonly felt, however when analyzing the three most commonly experienced emotions, ‘excitement’ was the feeling mentioned most frequently. This suggests that despite the nervousness and anxiety there were still some positive emotions being experienced. This may be due to the fact that participants were finally able to practice what they had spent five years studying for, and to earn money from it. It is worth considering whether the layout of the question influenced the responses; excitement was first on the list of emotions from which participants could choose. For some it may have been easier simply to choose the first option rather than reading the remaining options or thinking of their own responses. Tryssenaar and Perkins (2001) do however mention that among the narratives written by
the participants in their study, there was a degree of eager anticipation woven within the concerns of practice.

Within this research, a similar balance of emotions was displayed in the interviews as in the questionnaire. Although participants spoke freely about aspects that were difficult and challenging, they were also quick to point out that in the end it was nothing they could not cope with. “I definitely had problems with my confidence which I found really hard but I was really pleased to be finished [studying], really ready for it. There were challenges but it wasn’t too bad” (Kelly). The outlook, especially from those who had been working for more than a year, tended to be positive. “As long as you enjoy it, it’s not going to be too big a stress or strain” (Karl).

Literature shows that over time new graduates develop more realistic attitudes towards practice and their competency (Lee & Mackenzie, 2003; Miller et al., 2005; Solomon & Miller, 2005). As they become more comfortable with the understanding that they are not expected to know everything, the pressure they put on themselves reduces and allows greater enjoyment of their role. The osteopathic graduates also appear to follow this pattern of anxiety followed by acceptance of the realities of their role.

Question 6.6 regarding working satisfaction showed that the majority of participants felt satisfied with their working situation (Fig. 22). Two were neutral and two were not satisfied. In terms of how they felt regarding their performance as an osteopath, nine of the eighteen who answered the question felt less satisfied with their performance than their working situation. Six were equally satisfied with both and only three were more satisfied with their performance than their working situation. Despite this, satisfaction levels generally remained between neutral and very satisfied. There was only one outlier who felt very dissatisfied with his personal performance as an osteopath. The reason such a proportion felt less satisfied with their performance than their working situation may come down to a natural desire people often have to want to improve and better themselves. Karl commented that it did not matter how many years of experience you had, you should always want improvement otherwise you end up limiting yourself and preventing further growth.

Three of the interviewees commented on feeling as though they did not start learning until they entered the profession: “I’ve heard people say before that when you get out [of university] you’ve been trained to start learning and that is really the way I think” (Aaron). Mrozek, Till, Taylor-Vaisey, and Wickes (2006) observed the impossibility of teaching students everything they will need to know for practising life because as Hamby and Miller (1990) noted, many aspects of professional life and practice can be difficult to convey in an academic setting. To enable continued learning once
practising, it is important therefore to ensure that students are equipped with the knowledge of how to learn for themselves, to have a curriculum that guides “students toward becoming lifelong learners able to cope with an exploding information base” (Mrozek et al., 2006, p. 764). It would appear that the participants did have this skill of lifelong learning because despite having areas in which they felt their knowledge or skill was substandard, they reported feeling able to find the required information in order to improve their areas of deficiency.

**Ability**

This subtheme will be divided into several parts. First, general preparedness for practice will be discussed before addressing coping with the psychological side of practice, followed by the technical and then theoretical aspects. Lastly topics which do not fit these categories will be discussed.

**General Preparedness**

In general participants felt adequately prepared for practice. This was the case across both the interviews and the questionnaire participants. Interestingly, once people were practising their opinion of how prepared they felt changed. Some felt better prepared than anticipated while others felt more poorly prepared. This may be due to the reality of practice differing from their expectations. From the questionnaire, the four respondents who reported that they were well prepared once practising showed an overall level of greater confidence throughout the questionnaire. Whether this confidence was a result of feeling well prepared, or whether their preparedness can be attributed to being generally confident people, is unable to be determined from the data. Which came first is an interesting point to ponder. One respondent who felt well prepared both prior to and following practice had had eleven years of experience as a manual therapist which may well have helped to prepare him for the realities of practice. However another respondent who had five years of massage experience still felt poorly prepared. For this respondent the reality of osteopathy did not match his expectations, although he did not elaborate in which ways. This may have been a contributing factor for feeling poorly prepared. However, examining his responses throughout the questionnaire suggests that despite feeling ill-prepared, his confidence remained high. Again, this may reflect a personality trait or it may be that his previous experience helped to fill the gaps where he thought the osteopathic training was lacking. Most of the questionnaire respondents who felt poorly prepared displayed lower levels of confidence overall. While this would suggest that feelings of preparedness are closely related to general levels of confidence, the significance of personality in this equation cannot be determined.
The interviews reflected similar views, with some respondents feeling better prepared than they had expected, and others feeling less well prepared. Melody reported that she felt prepared in terms of having sufficient clinical reasoning and technical skills to make a difference but the reality was quite different and she found it to be a “rude awakening” to her actual capabilities. Amanda, however, found that despite feeling very anxious about starting practice, she did not feel ill-prepared but rather found she knew a lot more than she thought she knew. She attributed some of this to the help and encouragement she received from the people she worked for but also put it down to being able to see results from her work. “I see that from my results in clinical practice, so seeing what I’ve been able to achieve and saying, ‘look, I actually can work’, a lot of the stuff is alleged when you leave university”. As with the questionnaire findings, these differences in preparedness may have developed from various sources, whether a difference in personality, a difference in what NGs expected in practice, or even the working situation itself. Whereas Amanda received support, which she found to be beneficial, Melody, who happened to be working part time in three different practices, may not have had such backing. Coming from the supportive university environment, where uncertainties could be discussed with a tutor before treating a patient, it may have been that Melody, without any such assistance, found it to be a much greater shock than Amanda who was still able to talk problems through with more experienced osteopaths.

The common theme which emerged from the interviews and questionnaire was that overall new graduates felt adequately prepared for practice however not equally in all areas. This will be discussed further in the following sections.

**Psychological Resilience**

There appears to be a considerable psychological component involved during the transition from student to practising osteopath. The interviews with the new graduates showed that each of them found there to be a significant amount of mind involvement as they came to terms with practising as a qualified osteopath.

Words such as trust, faith, doubt, and questioning repeatedly emerged during the conversations. New graduates struggled to trust what they were palpating and that what they were doing was right. Several of them put this down to the fact that while at university everything was questioned, everything had to be justified:

> It’s good that you have to justify yourself... but you don’t trust what you feel and you don’t trust what your instincts tell you, and so much of what we do is intuition and instincts and trust and our abilities and what we can do (Aaron).
Students are taught to question, to have an inquisitive nature, a necessary trait that encourages one to keep investigating possible avenues rather than settling for the first possible option. However, this questioning, while beneficial, may also lead to doubt and a lack of trust in one’s own capabilities, especially in NGs who already tend to question their knowledge for fear of making mistakes (Lee & Mackenzie, 2003). Amanda made the comment that students tend to get “quite mentally broken” in clinic at university and once practising and responsible for people’s wellbeing, you continue to have the voice of a tutor questioning your every decision and action, noting that “you are almost traumatized before you even start work”.

Feelings of being a fraud also emerged as part of this lack of faith in their abilities. New graduates did not feel they were able to try new techniques on patients as they were unsure of their ability to perform them and whether they would work as effectively as the techniques they regularly used. They also wondered whether by trying these new techniques, “am I actually doing this patient out of their treatment time?” (Melody). Graduates spoke of having to convince themselves that they knew more than the patient and in terms of gathering the confidence to portray that, “you just had to fake it” (Louise). This correlates with findings by Benner et al. (1996) who describes nurses in the advanced beginner stage where they “act like a nurse but don’t feel it on the inside” (p. 59). Although this may not seem to be helpful to new graduates, it is likely that this increased awareness of themselves will enable them to be more conscious of their limitations.

New graduates felt pressure from both themselves and their patients to look the part of the professional osteopath that they were trying to be, yet under the surface graduates reported a disquiet caused by the anxiety from the pressure and uncertainty of their ability. Amanda recalled, “Feeling like a professional was quite hard... taking myself seriously”. Having spent five years studying and being the student, new graduates were now expected to be the practitioner, the one who gives information and advice rather than being the one who receives it. The extent of this mind-shift was evident as several interviewees recalled having to convince themselves that they were competent as practitioners, they had studied for five years, they had passed their exams and therefore as mentioned, they must know more than the average patient:

I just tell myself I’ve trained for five years, I obviously, to have qualified, have enough knowledge to be considered smart and safe and competent and, you know, I think if I just make sure that I’m really thoughtful about what I’m doing, open to looking at different ways of doing things, then that is actually the best I can do (Kelly).
Yet with time and greater experience participants expressed that they began to feel more in charge of the consultations and no longer had to act the part. As participants practiced longer they began to see that good results were achieved because of their treatment. It is known that people operating in the novice or advanced beginner stages feel little or no responsibility for the outcomes they achieve as they are acting strictly with the rules they have been taught (Benner et al., 1996). The fact that longer-practising participants reported feeling that the results were now of their own doing suggests that they were moving beyond these stages towards competency. With the feeling of having greater control of the situation comes feelings of greater confidence. It is important to realise that it is not merely the passage of time that contributes to higher levels of confidence and competency, but rather the amount of ‘hands on’ time with patients that builds a practitioner’s experience. This is known as experiential learning and requires “a change in one’s assumptions and expectations in a situation” (Benner et al., 1996, p. 99). This experiential learning was exemplified with Karl’s past experience as a physiotherapist and how that had eased his transition from student to practitioner.

Interviewees reported beginning to feel much more comfortable “just doing what’s needed” (Thomas) as opposed to feeling they had to exhaust every testing measure, give the treatment that a patient might demand, or feel that they were short-changing the patient if they did not give a certain amount of treatment. This shows they were beginning to feel more confident in their clinical reasoning and decision making, and were able to act with the patients’ best interests at heart rather than acting by a set of rules or guidelines. Studies by both Jenson, Shepard, Gwyer and Hack (1992) and Solomon and Miller (2005) demonstrated that novice practitioners tended to be governed much more by rules than master clinicians. Participants’ confidence in their own judgment was also helped by the realization that doing the best they can is all that can be expected:

> When you’re a new graduate you want to get out there and fix the world, and get everybody better in one treatment, and it’s just a matter of coming back to reality and realizing that you do the best you can, and hopefully people get better (Thomas).

This realization was also found in Atkinson and Steward’s (1997) study of occupational therapists, and appeared to aid the confidence of their participants. It seemed that new graduates had an expectation that their role was to cure and it became difficult for them when they were not able to fulfill this role. Again this relates to Benner et al.’s (1996) discussion regarding nurses during the advanced beginner stage who become frustrated or distraught when they witness what they perceive as being a failure because their understanding of medicine’s capacity to heal is challenged.
Exhaustion was also a large factor that new graduates experienced early in joining the profession. While some of this was physical tiredness, there appeared to be some surprise at the degree of mental fatigue also felt. “It’s more the brain, being brain tired at the end of the day rather than physically tired” (Louise). This level of tiredness was attributed to several reasons. Aaron felt that it was due to constantly having to engage with patients, with busy days being especially hard:

You’re constantly engaging with people, it’s quite tiring, constantly engaging with people, and you’re constantly thinking about what you’re doing, and whether it’s the right thing and whether it’s appropriate and if there’s something else that might be going on.

He also joked that just working a full day was difficult after having been a student for so long. Although both were stressful, working was a different stress to that of being a student. Both Aaron and Karl commented on the fact that osteopathy was not like other jobs:

It’s not like an eight hour job where you go there and you start the system and you sit in front of it, you have a cup of coffee, or, you know, you can’t do that, you’re treating people, talking, you’re always communicating, you’re always thinking, framing your differential diagnosis or framing your treatment techniques that you want, so you’ve got to be on your mark all the time (Karl).

Participants in Smith and Pilling’s (2007) research also found working a full day to be a challenge having come from the slightly less structured day of a student, while Miller et al. (2005) found that the participants felt the early weeks of practice were particularly mentally fatiguing due to being wrought with emotions such as being exhausted, terrified, intimidated and overwhelmed. Similar emotions were reported by the osteopathic graduates who completed the questionnaire. It appears that these are relatively commonly experienced feelings as people learn the protocols, values and expectations and become socialised into their chosen profession. Although there is a vague idea of what is expected, there is still much to learn within a short space of time (Solomon & Miller, 2005), and this is likely to vary from practice to practice.

Interview participants also felt their fatigue was often due to the amount of worrying they were doing about patients. This left them feeling emotionally drained, as the prolonged concern for both their patients’ welfare and their own competence consumed much energy. Sleepless nights as a result of worry, typically compounded the exhaustion they experienced:
I was going home worrying, I’d get sleepless nights and the next morning when you have
to go to work you’d be so knackered it just, everything was building up... I didn’t have
much energy at all even though I wasn’t seeing all that many people (Melody).

For some the tiredness acted as a barrier to the quality of treatment that they were able to provide.
“I mean definitely when I’m tired it’s not as, I don’t think it’s as good and as much as you try to give
the last patient of the day the best as the first, it’s sometimes quite difficult to do that” (Aaron).
Some had noted that although not a conscious action, they often tended towards gentler techniques
which involved less physical input and energy from them. One found he was able to cope with the
fatigue by reminding himself that despite one day being very busy and tiring, the next day may be
quieter, enabling him to find a balance.

Stress and fatigue and balancing home and work life were each listed in the questionnaire (Fig. 23)
by seven of the nineteen respondents to be barriers to the quality of treatment given. Taking regular
breaks to help remain focused, relaxing and taking care of oneself were methods mentioned to
overcome these barriers included. All of these approaches allow the practitioner time to gather their
thoughts and come back to the situation refreshed and all demonstrate the awareness of a need for
self-care. This will be discussed further in the ‘Self-care’ subtheme.

Technical Ability
Technical ability encompasses the physical ability to perform techniques, the practical aspects of
palpation and actually performing techniques.

There were mixed opinions in both the interviews and questionnaire as to whether physical ability to
perform techniques, such as strength or endurance, provided a barrier to treatment. Five of the
nineteen questionnaire respondents in Question 6.7 felt it was a barrier compared with three of the
seven interviewees. Two other interviewees said that while it did not create a barrier for them,
osteopathy could be very physically demanding. It appeared that a higher proportion of females
found their physical ability caused difficulties. This may be due to their physical strength and their
size in comparison to their patients however this cannot be conclusively established from the data:

I am little in stature, so that does affect what techniques I do on some people... I’ve
some reasonably big patients so although technique is a big part of it, essentially I’m
going to struggle a lot more than someone who is a little bit bigger (Amanda).

Although size and physical ability may create a barrier, it does not seem to mean they were unable
to treat these patients. Rather, they talk about adapting the techniques that had been taught at
university to create a method that works for them. Students are taught that no two patients are the
same and each should be treated individually. Equally, no two practitioners are the same, thus it makes sense that they will need to individually tailor techniques to suit themselves. Amanda also found that her physical capability reduced when she was feeling psychologically stressed. This may well be due to the mental fatigue factor that stress introduces, as discussed previously. Occupational therapists have also discussed the physical and mental energy required for practice (Tryssenaar & Perkins, 2001).

A comparison was made of the number of hours worked per week by each participant who considered physical ability to be a barrier as this could have been an indicator of whether endurance was a factor. Only one respondent was working more than 40 hours per week and she had been practising for only two months. In this respondent’s case, she may well have been still building up endurance as she was still fresh in a very busy job. In addition, her small stature may have contributed to difficulties with physical ability for this respondent. Three participants were working hours ranging from 21 – 40 hours each week and their time in practice ranged from five to sixteen months. The fifth practitioner who found physical ability a difficulty was only working 11 – 20 hours each week and had been practising for ten months. These five participants who found physical ability to be a barrier appear to provide a balanced representation of the questionnaire respondents. There did not seem to be any common factors among the five that would contribute to them struggling with their physical ability to perform techniques.

In terms of technical skill and ability to perform techniques, general consensus over the interviews and questionnaire was that the skills acquired during study were adequate for practice. Several interviewees felt that even though they were not very good practitioners initially, they were sufficiently prepared with the skills to make a difference for patients. Participants were aware that there was always going to be room to improve and appeared reasonably comfortable with accepting their ability because they knew that with experience, they would progress. This improvement was already evident with talk of becoming much more efficient in examining and treating, and certain aspects were becoming automatic as they felt a sense of what was occurring for the patient. Often it was not a conscious effort to improve the skill set, “I mean you just get better because you’re seeing like 10 patients a day so your skills, they just get better, without you” (Louise).

I guess just having more practice and more experience you get better, like you know, you find that as a student as well, when you first start palpating say a lumber SP [spinal process] you’re like “I can’t feel that” and as you keep going, every year you can feel more and I guess that keeps continuing but because you’re doing so much more
practical stuff when you’re working it probably improves faster, but I guess I’ve just got a better palpatory library or whatever it’s called. (Kelly).

This development in skills is seen in Questions 3.2 and 4.1 of the questionnaire, which demonstrates how participants’ confidence in their practical skills, ability to adapt techniques and accuracy and reliability of findings has improved (Fig. 11.1, 11.2 and 11.3). While an improvement in the confidence of one’s skills is likely to correlate with an actual improvement in technical ability, it must be noted that perceived confidence is an entirely subjective measure. While some say that confidence is indicative of ability, others point out that evidence shows a lack of congruity between a person’s performance and confidence (Bisiacchi, 2010).

Palpation is an aspect of osteopathy in which all interviewees agreed they had improved greatly. As seen in Kelly’s quote above, the more she practiced, the more she considered her skills developed. A major component that initially inhibited graduates’ palpatory confidence was their lack of trust in their ability. This may in part be due to being situated around the ‘advanced beginner stage’ which relies heavily on recognition rather than understanding (Benner et al., 1996). New graduates do not have the experience to understand that when a patient presents to them with a condition they have not seen before, or a tissue feel they do not recognize, this may just be a variant of a condition which they have encountered before. Much effort is required to recognize this fact. It is not until after having exposure to a wide range of conditions and how they present that NGs begin to trust the feedback gained from their hands. Part of their ability to trust what they are feeling comes from the realization and acceptance that they do not need to be able to give everything a name:

It’s not a frank objective palpation that I’m more confident with now, it’s more the subjective feeling like what I perceive, people say that you have a sense of something isn’t right somewhere and I feel something and I think, there’s just something not right there, but I can’t say that it’s superior or posterior or anterior... you go to the area and you feel that there’s just something not right there, and sometimes initially you can’t objectify that, and you have to think, you just have to approach it from a few angles and then over time things get better, so I’m more comfortable with my subjective perception with my palpation (Amanda).

Some people felt that they learnt to be more comfortable with a more general impression from their palpation of what was occurring. They felt that a sense of the bigger picture was more important at least initially when seeing a patient rather than trying to focus on the “teeny little specific lesions
that everyone has...you don’t have time to be so specific so you look at more general big movements and stuff” (Louise).

As participants spent more time practising and gaining experience, they all felt that they had to focus much less on what they were palpating:

After a while you learn to trust that feeling, it becomes more of a, not sub-conscious, but you have to not necessarily concentrate everything you’ve got on feeling what’s under your fingers. And so you’re able to spend more time considering the implications of what you’re feeling, and get a greater appreciation of how that relates to the rest of the body and not just what’s under your fingers at the time (Thomas).

However, this greater recognition and understanding of what was occurring did not stop them from still having moments of doubt or a lack of trust. It merely meant that gradually they became more comfortable with the fact that most of what they saw they would recognize and be able to treat with ease. While it is highly likely that their palpatory ability improved over the period that they had been practising, much of it may be attributed to their greater confidence and trust in themselves:

I still have times when I perhaps doubt what I am feeling and I guess I can feel a lot more now, but I always have those moments of, am I actually feeling what I think I’m feeling, but that’s where you’ve really got to trust that you are getting some sensory stimulus from what you’re feeling, so you’ve just got to go with it (Melody).

It is also likely that time and experience has brought them a greater appreciation and awareness of their capabilities and limitations.

In terms of technical ability of performing techniques, the teaching at Unitec has a very structural approach. Although all interview participants felt they had adequate skills to be an effective practitioner, there was debate over whether there was sufficient emphasis on all aspects of practical technique. Everyone agreed that the structural basis of the teaching was a very good starting point. However, while some were quite happy with this base of knowledge, others felt a broader base, including more gentle and subtle techniques such as functional and cranial, would have been beneficial.

Question 6.4 of the questionnaire examines the different techniques that people use. There was a much stronger tendency toward the structural methods of articulatory techniques, high-velocity-low-amplitude (HVLA) thrusts and muscle energy techniques (MET) with the majority of participants using them on 75% of patients or more, while the more subtle approaches of balanced ligamentous
tension (BLT), strain-counterstrain, functional techniques and cranial osteopathy tended to be used only on 25% of patients or less. This may well be due to emphasis given to each style of treatment while training and how confident graduates felt to perform them. As mentioned earlier, some participants felt anxiety with regard to trying a treatment approach if they were not sure it would work. They felt fraudulent charging a patient if they were uncertain of the treatment’s effectiveness. This subject of treatment choice and whether sufficient modes of treatment were covered as a student will be discussed further under Educational Deficiencies.

**Theoretical Ability**

This sub-theme will discuss topics including formulating diagnoses, clinical reasoning and the theoretical knowledge required to give expected timeframes for progress.

The formulation of diagnoses was commonly seen by the interviewees as a difficulty early in their careers. This again was expressed to be due to a lack of trust and confidence in their abilities:

> I just wasn’t confident to diagnose everything and what to do. We don’t have a lot of acute patients come through the clinic, or when I was there we didn’t, and then in practice you see a lot more acute and so you see people in a huge amount of pain – I wasn’t used to that at first, I am now (Louise).

Having experienced new presentations and found ways to deal with them, participants’ confidence grew. Recalling the basics of osteopathy and building on these was a method employed to overcome the initial lack of confidence. Again, there was the realization that it was not necessary to be absolutely correct and have a perfect diagnosis. Also during the course of treating the patient, the presentation may change as the condition improves. This may reveal new factors that had not previously been evident thus the NG needs to be comfortable with a changing and evolving diagnosis.

These findings match those of Jenson et al. (1992) who studied the attributes distinguishing novice and master clinicians. Their findings found that novice clinicians were much more intent on gathering as much data as possible in the hope that it would help them to arrive at an understandable diagnosis. Master clinicians, in comparison, were more comfortable with the uncertainty of not immediately knowing a diagnosis and found they could plan their treatment accordingly.

It has been said that questioning oneself when lacking in confidence can actually play a beneficial role in maintaining a high standard of care for one’s patients (Benner et al., 1996). With experience and an increased familiarity with a broad range of cases comes the danger of becoming complacent.
One of the interviewees noted that it could be very easy for new graduates to let their guard down as they became more familiar with situations:

The more you see a particular problem, the greater weight it has in your mind that if you have something similar it will probably be that problem, so there’s the danger that somebody comes in and you put your hands on them and you go, oh yes I know what this is, and don’t worry about doing any more examinations, which you’ve really got to be really quite cautious about avoiding, because there will always be that time that you think you know what’s going on, and then you go to your examination and find that you’re absolutely completely wrong, and you have to be willing to admit that to yourself and change what you’re thinking (Thomas).

This realization is crucial in maintaining the standard of care for patients when confidence in one’s ability is improving. As in all areas of practice, participants’ confidence in diagnosis grew with increased experience but they admitted often reverting back to doubt and questioning at times: “You still get people coming through the door and you go, my gosh, how do I deal with this, am I actually dealing with this in an appropriate way” (Melody).

While the questioning may have a negative impact, creating a barrier to treatment if it becomes too great, it also contributes to patient care and can enable the practitioner to consider other options when expected progress is not being made with a patient. As mentioned, the first diagnosis may not always be wholly correct. It may encompass only part of the problem, the part that was initially obvious, thus it needs constant reevaluation to assess if other courses of treatment are preferable. This is true whether the practitioner is the first person to see the patient or the fifth. Practitioners need to always be reassessing the situation to determine if there are more appropriate and effective treatment approaches that could be implemented:

If they’ve got neck pain and they’ve been to the physio for sixteen treatments on ACC you ask what has the physio done – they manipulated the neck and they’ve stretched it and they’ve METed it, you’re like ‘ok, they’ve done all the structural stuff, what am I going to do differently’ (Louise).

In this way questioning can be very beneficial to the advancement of treatment.

The lack of experience and ‘not knowing enough’ were two closely related factors that came up repeatedly throughout the interviews. Participants conceded that this was expected and although they felt some areas could have done with greater emphasis during university, it really was experience that proved to be the greatest teacher. Three of the interviewees spoke specifically about
university training people to learn and it was not until out working and being immersed in the profession that their actual learning began to occur. Beginning out in clinic was simply a license to learn (Hagi, 1999). All the participants had methods in place to help them address the areas of knowledge that were lacking. These included talking with other osteopaths and asking for advice, reading, doing internet searches and making a conscious effort to always be improving one’s knowledge. “The problem is with this sort of practice you’re never going to know everything so it’s just making sure that you continually do educate yourself and get that experience up” (Thomas).

Taking initiative and being proactive were two key points mentioned on how to improve as an osteopath. The Osteopathic Council New Zealand also requires practitioners to complete continuing professional development (CPD) activities each year in order to renew their Annual Practising Certificate (Osteopathic Council New Zealand, 2011).

During early practising life, participants found choosing the best course of action to be difficult because they felt their clinical reasoning did not have a solid foundation due to a lack of experience. This was especially obvious when seeing a condition for the first time. Melody talked about thinking that she had adequate clinical reasoning skills upon graduation but once faced with patients with problems she had not encountered before, she became aware of the limitations of her skill. Although she managed to cope, it required much more effort than she had anticipated and did not come as naturally as she had hoped. This could be contributed to unrealistic expectations of the clinical environment and what she would be able to achieve. Amanda commented that early in her practising career she had had the tendency to try to achieve too much. At this point in their career, with limited experience, it is often a challenge for NGs to prioritize tasks (Benner et al., 1996; Miller et al., 2005; Toal-Sullivan, 2006) and they appear to struggle with the concept of quality versus quantity:

Sometimes I look and see too much stuff, they come in with low back pain, it’s acute, but really if I treat this area am I going to just flare things up, am I better to work away from the area, try to loosen up the thoracic spine, or through the hip, what’s going to be the biggest bang for my buck, and that’s what I find really difficult, going from clinic when you do have a bit of time or freedom to do different things (Melody).

According to Benner et al. (1996), advanced beginners have “minimal capacity to attend to the patient as a person. Rather, what absorbs their attention and energies are the complex inventories of things to be done, all of which appear to be equally relevant” (p. 49). With limited experience it can be difficult to determine which mode of treatment to which areas will give the greatest benefit:
Even though you see loads of stuff in the student clinic, there’s still heaps of stuff you don’t see, so when it’s the first time you’ve seen something when you’re out by yourself that’s when you don’t have any clinical experience to draw on and you don’t have anybody around you to ask (Kelly).

Clinical reasoning was also specified in the ‘Other’ category of Question 6.7 by one questionnaire participant as an area in which they struggled.

One area of particular difficulty was not having the experience or knowledge to be able to estimate expected recovery timeframes for dysfunctions. “My osteopath that I work for, he will be like, ‘ok, this is what’s wrong, it’s probably going to take about six months for us to get it right,’ and I just find that so hard to say” (Louise). Kelly also found that often her expectations for timeframes for problems were quite different to what more experienced practitioners would expect. This in turn made giving patients a clear timeline for their recovery very difficult.

Although signs of uncertainties emerged during interviews, the results of the questionnaire did not show significant findings. Questions 3.2 and 4.1 asked about levels of confidence in applying theoretical knowledge, clinical reasoning, evidence-based practice and applying knowledge of research and developmental work. The majority of respondents rated themselves as being confident before starting work and this improved overall once working with more saying they now felt very confident. Only one or two people in each question felt unconfident (see Fig. 12.1 – 12.4). It may be that because the questionnaire only gave the opportunity to rank their confidence, there was no chance for respondents to expand on their perceived confidence in the same qualitative manner that the interviews allowed. One must be aware that minor uncertainties may still have been present despite the overall confidence that the questionnaire responses portrayed.

Other

Many authors have shown that an aspect of the transition from student to professional that graduates struggle with is time management (Atkinson & Steward, 1997; Benbelaid et al., 2006; Blanchard & Blanchard, 2006; Miller et al., 2005; Smith & Pilling, 2007; Solomon & Miller, 2005; Tryssenaar & Perkins, 2001). The osteopathic graduates in this study also highlighted time management as an issue.

The challenge of time management caused anxiety for some of the participants. Amanda found that it was the source of most of her anxiety. Both Amanda and Kelly admitted that time management had been a cause of worry during their time as students as well. New graduates coming from university commonly have a shorter timeslot in which to see patients and they are often booked with
back to back patients. In the student clinic, students often have gaps between patients, which makes it much easier to catch up on notes and keep up to date with the paperwork side of clinic life.

Dealing with time constraints was ranked second in causing barriers that influence the quality of treatment (Fig. 23), with eight of nineteen respondents finding it an issue. Reasons which came up during the interviews included trying to achieve too much, learning to direct conversation to more effectively and efficiently get the required information from patients, over-testing patients for fear of missing some vital information, and quality versus quantity. There was the perception in participants’ early practising lives that each patient deserved the same amount of treatment because that is what they were paying for. This caused problems when the complaint was complicated meaning more time was spent questioning and examining, leaving the practitioner feeling like he/she must run over time in order to give the patient their due treatment.

Miller et al (2005) found that ineffective time management also contributed significantly to the stress experienced by novice physiotherapists. With experience and confidence, graduates developed strategies to help cope with time management. These included feeling more aware of the information required and more in charge of the situation to draw it out of the patient, excusing oneself from the room as the patient redressed then meeting them in reception and gaining an understanding that the patient was paying for the consultation as a whole. Other research suggested mentoring as a way to enhance graduates’ time management skills (Blanchard & Blanchard, 2006; Tryssenaar & Perkins, 2001).

All participants agreed that they had improved in time management and for most it was no longer an issue. Kelly felt that although it could be a challenge, time management did not affect the quality of treatment “any more than it would affect anybody who had an appointment schedule”.

Initially participants found charging people to be difficult. Closely related to the psychological aspects previously discussed, there were feelings of fraudulence as issues of uncertainty made them question whether they were doing what they were trained to do and whether it was good enough. This concern was particularly evident for one participant who had begun work the week after passing her FCC exam. She found that going from charging $20 in the student clinic to suddenly charging $65 placed a lot of pressure on her:

You want them to be really happy and that becomes a lot, it sounds quite bad but it becomes more important than it was. You feel as a student like they should just cut you a little bit of slack because you’re learning and stuff like that but you feel much
more of an obligation to get people better and that can be quite hard when they’re not getting better and not responding and you don’t have that experience... (Kelly).

This was a common sentiment – if patients were not improving new graduates did not feel justified in charging them because they felt they were not doing their job correctly. As mentioned, if they struggled with time management and found they only had ten minutes to treat rather than the usual twenty they would spend on a patient, there were feelings of guilt for having short-changed the patient and they felt obliged to run over time to make it up.

Talking with colleagues helped to ease graduates’ concerns over charging patients. It helped to put in perspective that as practitioners they were paid to investigate and do their best, not necessarily to cure. Colleagues helped them to understand their role in the situation as described in the literature (Benner et al., 1996). This role may be one that alleviates pain and helps the patient to understand the cause behind it, or it may be referring the patient on to someone else who is able to provide them with the necessary treatment. There was also a realization that what the patient does in their own time may be reducing the effectiveness of the treatment and causing the recurrence of symptoms. “Sometimes you feel really stink, they’ve paid money, and basically they’re no different and, it can be due to all sorts of things, but I still feel bad about that” (Louise). This was one area where participants realized they were paid to investigate and the best form of treatment for the patient may be education.

Participants found charging patients difficult because it seemed to them that patients were paying hundreds of dollars over the course of several sessions. However reminding themselves of the years of money and study they had invested to come to be in that position, they realized that it was justifiable to charge what they do. Louise pointed out that of much of what the patient paid they, as new graduates, did not see as it went towards the running costs of the practice and the principal osteopath. “There’s always going to be a split, and that’s fair enough because you’re working for someone, and they carry all the overheads” (Aaron).

Ultimately, piece of mind seemed to come from remembering that patients choose to have treatment and equally they are able to choose to stop receiving treatment if they feel it is not working.

Interestingly, the issue of charging patients did not seem to arise in the literature. This may be that new graduates in the professions studied were on a wage rather than being a sub-contractor who earned per patient seen. By working in this manner, osteopaths tend to have more say over consultation fees, as opposed to it being a set price which they have no part in deciding.
Isolation

Isolation in practice emerged from the data as an important factor for which many of the interviewees were not prepared. In a profession where practitioners are constantly interacting with people, the concept of feeling isolated may at first seem a strange one. However as a new graduate, there are many scenarios and patient presentations which may not have been previously encountered, despite two years of postgraduate training in the student clinic. This lack of experience appears to contribute to feelings of isolation when faced with new and unfamiliar clinical situations (Yielder, 1997).

It’s just you and when you have someone come in and you have no idea what is going on because you have never seen it before, and you freak out... a lack of supervision I think would be one of the problems (Aaron).

The lack of supervision or people to run problems past was found to be quite difficult for many of these new graduates. This was the case for both people who were alone in the clinic as well as those working as an associate. As Melody explained,

I’m working at really quite a busy practice where the other osteopaths who have got a lot more experience than me are tied up for the whole day, and I don’t have anyone to go and talk to other than calling up my friends from Unitec and having a bit of a natter over the phone, and so that’s what I find really, it’s still hard even now.

Isolation was also mentioned in Question 2.8 of the questionnaire which asked if the reality of osteopathy was as expected. When given the opportunity to expand on how it differed, one respondent recalled the constant interactions with tutors and peers while studying, “there was always discussion to be had”, but in practice, “it is much more isolated, even if you work with other osteopaths you might speak to them at lunch for a few minutes but otherwise you’re with patients all day long.” Another respondent noted that it was “a bit lonely” because despite seeing so many people every day, they are still working alone. This resulted in feelings of being isolated and unsupported.

One interviewee observed that the isolation is an aspect of practice that is difficult to prepare for even if you are aware that if may be a factor. It was his own research topic that had raised his awareness of the likelihood of feeling isolated but he remained of the opinion that due to the one-on-one nature of osteopathy, it is not until people experience and engage in the profession that they are able to appreciate just how isolating it can seem. He felt that being told about isolation can
partially help to prepare for it but it is not until isolation is experienced that the extent of this feeling is realised.

The experience of isolation is entirely personal and appears from the interviews to be influenced by how confident the practitioner is. People who came across as being more confident in their ability and clinical reasoning placed less, if any, emphasis on feelings of loneliness or isolation. This may have been because they felt more able to logically work through cases especially in scenarios they had not previously encountered. Previous clinical experience may also have contributed to greater confidence. Karl, who had worked for 18 months as a physiotherapist prior to re-training in osteopathy, appeared very confident in most aspects of practice and did not mention anything that indicated he had struggled with isolation as other participants had. The work he had done in physiotherapy may well have prepared him for the transition in this regard as he says, “being a student and being a practitioner is a bit easier with the previous training.”

Five of the seven interviewees had experienced elements of isolation in their practice since graduation. The narratives showed this predominantly occurred when their lack of experience and lack of confidence made the problem-solving of a new case more difficult. Kelly agrees with the sentiments expressed by the questionnaire respondent who found the lack of discussion with other osteopaths isolating:

> What I found really hard was going from the clinic where you are talking about stuff all the time, to just being on your own and yeah like not having anybody to go ‘this is what I think, is that ok?’ and having that kind of reassurance, that I’d checked everything off or that I was making the right kind of decisions and stuff... Where I first worked, I was always the only person in the clinic, there would have been people I could ring and talk things over with if I needed to, but not like just pop out to the seminar room and check that I am doing the right thing.

Louise expands on this thought and how it relates to other professions:

> I mean in other professions, or well in other health professions, you have someone watching over you, you don’t make primary decisions on your own. In heaps of things, like graduate engineers don’t go out and start working on their own, they have lots of people looking over their work, and we don’t get that, we go out and just do our thing.

She puts her feelings of being “very, very unconfident” and “so scared” on her first day down to this lack of initial supervision. Being entirely in charge and responsible for each patient and the decisions
you make for them appears to be, for most participants, an incredibly daunting reality and a big step from the supervised world of studying at a student clinic.

Personality would seem likely to play a part in how well people adapt to the feeling of isolation when in practice. Some people thrive on one-to-one interactions. One respondent gave this as one of the reasons for choosing to study osteopathy. Five other respondents mentioned the desire to work with people among their reasons. Although osteopaths are constantly interacting with patients, the reality for these participants may in fact be one of isolation due to the giving nature of the work. The one-sided giving may not be what they had in mind when thinking that osteopaths work with people. Although they are working with people, in many regards they are actually working for people. The patient is buying the services of the osteopath and with that comes associated expectations and pressures. There are necessary professional boundaries which must stay in place. If the respondents of the questionnaire were expecting more of a reciprocal relationship, it may be that the reality fell short of meeting those expectations. The dual constraints of the patients’ expectations and the professional boundaries preventing a more personal relationship, may overshadow the satisfaction of seeing a patient improve and get better. A practitioner’s personality and how he/she naturally relates to others will play a part in the level of isolation or solitude experienced.

Smith and Pilling (2007) recognized that feelings of isolation and inadequacy were common for newcomers in a first professional role. They discussed the importance of opportunities for new graduates to share how they are feeling with other new graduates in order to realize the commonality of these feelings and thus gain reassurance and reduce the associated emotional isolation.

Although this would not address the apparent desire for immediate support when in difficult situations, peer groups could pose an effective method for gaining the reassurance that Smith and Pilling (2007) discuss. By providing a safe environment where NGs can discuss with each other the issues that they encounter in practice, peer groups may help lead to a realisation that these problems are quite normal and by doing so reduce feelings of isolation. Peer groups could also provide the opportunity to resolve problems by drawing on the experience of others. Peer groups and support will be discussed further in the ‘Interpersonal’ theme.

As mentioned, it was observed that only in the working situation can one fully realise the extent of feelings of isolation. Thus, other approaches need to be considered that may be able to ease this aspect of the transition period. Within the education system, it should be emphasised that isolation is commonly felt initially in many professions, including nursing, occupational therapy and
physiotherapy (Duchscher, 2009; Lee & Mackenzie, 2003; Smith & Pilling, 2007), so that NGs are not taken by surprise if they experience it in practice. It may be possible to incorporate a period at the end of Master of Osteopathy, once the Final Clinical Competency (FCC) exam has been completed, that allows the student to continue practising in the student clinic as they have been, however, without the supervision of tutors. This would allow them to experience working alone and being in charge of the entire consultation. Taking place in the student clinic, would allow the opportunity to debrief and discuss any problems with a tutor at the end of the day if deemed necessary. As it is fairly a common phenomenon for osteopathy students to take longer than the two years of the Masters programme to finish the research component, a possible time to instigate such an opportunity could be while waiting for the research to be marked. This could help to reacquaint people with the thought processes and the practical hands-on elements required when practising. Melody mentioned that doing extra time in clinic would have been helpful to ease her back into practice, having taken almost a year post-FCC to finish her research:

I was helping do a bit of hands on tutoring with a class. I guess that kept me in it to an extent, but in terms of using your clinical knowledge and that sort of thing, it just wasn’t happening.

Once working, new graduates may want to actively seek jobs that will provide them with support. The narratives from some of the interviews suggest there are osteopaths offering positions and support to NGs, however, because of the small size of the osteopathic profession in NZ, it may be difficult to secure such a job. A greater awareness of the needs of new graduates by the principal osteopath may help to smooth the transition if this awareness is then acted on to accommodate these needs. The topic of support will be expanded on in the ‘Interpersonal’ theme.

Self-care
Wells (2005) defined self-care as, “a process whereby an osteopathic practitioner functions on his or her own behalf in health promotion and in illness prevention and treatment” (p. 3). Although this research did not specifically ask about self-care, aspects did arise during the interviews and were also mentioned by several of the questionnaire respondents.

As Dahlqvist, Söderberg, and Norberg (2008) noted new graduates in the nursing profession are particularly vulnerable to stress as they are unaccustomed to the responsibility they now carry. This seems to be a similar situation for newly graduated osteopaths. Several reported the pressure of being the sole person responsible for patients. As Amanda explained, “you go out there responsible
for people lives...”, “I always felt responsible but I didn’t feel that I had control of the situation initially”. When faced with the reality of practice, graduates need to be able to deal with “the stress of not always measuring up to their ideals” (Kelly, as cited in Dahlqvist et al., 2008, p. 477). To promote psychological health that may be affected by this stress, self-care plays an important part by increasing satisfaction and self-confidence (Thrasher, 2002).

Many methods have been suggested as helpful and effective for self-care. In the study by Dahlqvist et al. (2008) which investigated methods of self-care and dealing with stress among healthcare students, these methods were grouped into ‘Ingressing’ (which included subthemes of unloading, distracting, nurturing oneself, withdrawing, and reassuring) and ‘Transcending’ (with subthemes of opening up and finding new perspectives). Interestingly the methods which emerged from the data of this study also fitted into these categories.

A number of people, both in the interviews and the questionnaire, mentioned the importance of talking to others, which correlates with the subtheme of ‘unloading’ discussed by Dahlqvist et al. (2008). “Talking to other practitioners where I can get the chance also is a big self-care thing like, if you don’t share anything it can get bigger in your mind than the issue might really be” (Melody). Not only can unloading help to air issues and get them off your chest, it can also be very beneficial in helping to gain a better perspective, as Melody mentioned. In this manner, unloading is very closely related to the ‘Transcending’ subtheme of ‘finding new perspectives’ (Dahlqvist et al., 2008). It is also possible that the ‘Ingressing’ subtheme of ‘reassurance’ can also be gained by talking with others especially colleagues. According to the interviewees, this reassurance appeared mainly to come in the form of encouragement and advice. One anecdote related by Amanda shows how a few simple sentences from a more experienced colleague can bring such immediate reassurance and a change in perspective:

One of my bosses said to me, when you’ve got a chronic patient they’ve probably been to see twenty people, and none of them have worked and if yours isn’t working it’s not a complete failure... the common denominator through all of them, is that patient, so either we’ve got to try and find a way to change how they’re perceiving the issue, or they go and see the next person that might be able to do it, so that was quite marked.

It appears to be not uncommon to focus on the negative, thus it would seem important to discuss and gain feedback on the successes seen in clinic. This would help to reassure the new graduate that despite their uncertainties and feelings of inadequacy they are still capable of treating patients successfully.
Exercise was also seen by interviewees to be very important for self-care. Although categorized in the ‘Distraction’ subtheme of Dahlqvist et al.’s (2008) research, as described by several interviewees of this current study it seems to fit equally well, if not better in ‘Transcending’. This is because the participants tend to describe it not so much as a way of escaping but rather as a chance to clear their heads:

I just make sure that I get in exercise, work is really quite physically demanding but still I’ve realized that I really need to get out and use my body in other ways, like running, to burn off all that nervous energy and keep myself in more of a centered place… (Melody)

Some people meditate, I do Tai Chi, just to… because I think a lot of it is not just physical tiredness, its mental tiredness, and yeah, just to take care of yourself (Aaron).

Exercise is viewed by participants as necessary not just for physical health but also for mental health, as it helps to keep one grounded, clear-headed and in a more centered place where the challenges that osteopathic practice brings, especially as a new graduate, are better able to be faced. One interviewee admitted that making time to exercise more would probably be helpful in preventing some of the aches she often experienced.

As suggested by Dahlqvist et al. (2008), personal nurturing was also considered important by participants, aspects of which included ensuring early nights and an adequate diet:

I can’t push it as much when I’m not working, like, when you’re a student you can stay up til late at night and get up late the next day but when you work it’s just not an option. I’ll have one or two late nights at the weekend and I’ll feel it for the rest of the week, you know, because you constantly have to be engaged (Aaron).

It appeared that most participants learnt these self-care methods from having pushed themselves too hard at times and then realizing that it was not beneficial for their health. Melody mentions that, “you’re seeing patients back to back, not having time to eat, and all that sort of thing, you get worn a bit thin”. Melody also thought one aspect often overlooked by osteopaths was the need to get osteopathic treatment themselves. As noted by a number of people, osteopathic work can be physically demanding and result in aches and pains in their own bodies which easily go unheeded when working in a busy practice. However, as many authors declare, to be able to care effectively for others, you must first care for yourself (Johnson & Ridley, 2004; Kravits, McAllister-Black, Grant, & Kirk, 2010; Radey & Figley, 2007).
Taking sufficient breaks, whether during the working day or taking time out at the weekend was yet another way that participants sought to care for themselves. This fits into the ‘Ingressing’ subtheme, ‘withdrawing’, proposed by Dahlqvist et al. (2008). Taking this space can allow the opportunity to contemplate any issues and put them in perspective and to gather thoughts and strength. As exercise did for some, taking a break from practice can help to address the mental fatigue that comes from engaging with patients all day. It is a well described phenomenon that people within healthcare settings need to be careful not to take on patients’ problems and make them their own as this may lead to conditions such as compassion fatigue or vicarious trauma (Bride, Radey, & Figley, 2007; Radey & Figley, 2007). This subject will be further explored in the ‘Interpersonal’ theme of this discussion. Thomas ensures he takes adequate breaks throughout the day,

I was seeing probably about eight to ten patients in a row back to back on the half hour list, now I throw an occasional break in just because I feel I can and I’m entitled to it if I want to sit down and have a cup of tea.

Although he went on to say that he coped with seeing that number of patients back-to-back, he admitted that taking the occasional break reduced stress in the day. He also enforced down time from practising as an osteopath, “one thing that I set out is that I don’t work in the weekends, so as soon as Friday evening comes around it’s the weekend and that’s my time to sort out my home stuff” (Thomas).

Although questions regarding self-care were not asked specifically, one aspect that was questioned can be classed as a component of self-care. The topic of balancing work and home life arose in the first interview and due to being fairly prominent in the literature, it was deemed worthy to follow up in the ensuing interviews.

All of the seven interviewees were well aware of the importance of finding a balance between their work and home life. They all recognised that initially it was quite difficult to find this balance yet it appeared to be a factor that over time they became more effective at doing. Many have devised methods to assist them in managing this. For Aaron the separation of work and home is more of a mind-set,

You can do little things, you can do mental things like, ‘I am now leaving work, I’m leaving work behind’ kind of making it a definite thing. For me, it’s uniform, I get home I take my uniform off, I put on my social, my casual clothes and it kind of separates the two, those are some things...

Thomas sets very clear boundaries for what must be done at work,
I try very much to make sure at the end of the day, I don’t leave anything overhanging, finish up all the notes, tidy up all the loose ends at the end of the day and then put that away and go home, and be at home.

Not all participants succeeded in completing tasks before heading home. Kelly commented that she often struggled to write the notes straight after each patient which sometimes meant she took work home to finish. On the other hand, Amanda, like Thomas, was diligent about finishing everything before leaving for the day, however she had noticed that,

I spend a lot longer at work and non-contact hours, making sure I keep up. It’s actually keeping up on my notes and making sure that I’m calling patients when I need to. I can keep my home life separate but I am finding my home life gets a little bit reduced.

Although experience may help a practitioner to be more effective at separating work from home, it seems unlikely to be a relative relationship where increased experience as an osteopath equals a decreased difficulty balancing the work and home lives. Rather it appears in the narratives to be more a mix of ups and downs, good days and bad days, which gradually over time give way to a higher frequency of good days. For Amanda the more difficult days came when stress and exhaustion meant she felt less able to cope with daily scenarios. Fortunately, she found that with the good support around her it was never a repetitive problem. Others found that as they built their patient base, worrying about individual patients was not such an issue:

I’ve noticed the more patients you have...you don’t focus on them as much, you can’t just sit and dwell on one person because you don’t have time, everyone just kind of gets mangled into one person when you get home at night after seeing fourteen patients, so in a way it’s better seeing more as you don’t have time to think about them in depth, over analyze, that kind of thing (Louise).

However, both Melody and Kelly felt that although the overall level of anxiety about patients had reduced, there would always be certain patients that you go home and worry about:

I don’t lose sleep over it, but I will wake up in the morning and wonder how so-and-so is today... it’s not like I’m obsessing over it and I’d rather stop, it’s just, I’m just still pretty enthusiastic about being an osteopath (Kelly).

This reduction in concern and worry may be an indication that these new graduates are progressing beyond the advanced beginner stage of practice as described by Dreyfus and Dreyfus (as cited in Benner, 1984). During the advanced beginner stage it is hypothesized that the concern for patients
develops more from a concern for themselves and their own competence rather than the patients wellbeing (Benner et al., 1996). Initially they are anxious to ask all the right questions, complete all the testing measures and cover all bases so as not to be seen as negligent, however as time progresses and experience builds, graduates get a clearer picture of what is actually necessary and in the best interests of the patient:

I felt there was just so much to process and when you learn things, it seems as though you just absolutely exhaust every testing measure in order to be safe, and I guess you learn all that and you refine all that as you go on (Amanda).

But after a while that becomes automatic and you can spend a lot more time considering the greater implications of what’s going on (Thomas).

This is not to say that concern was only for themselves when discussing their early work experience, but rather their concerns for the patient’s wellbeing was often overshadowed by it despite being interwoven through the narratives.

As mentioned, the interview participants all felt they had improved their ability to balance work and home life. Yet there was considerable variation in how much of a problem it now was for them. In analysing the responses, it appeared that those who had been practising for greater than one year felt more comfortable with the balance they had now achieved. This concurred with the questionnaire results. Of the 19 respondents, seven felt balancing work and home life affected the quality of treatment given, and of these, five had been practising for twelve months or less. When the interviews were conducted, those who had been working five to ten months seemed on the whole to still have some apprehension over their ability to find an appropriate balance. It could be concluded from this that it is within those first twelve months of practice that people discover what works for them to achieve balance between work and home life. This is supported by the literature which shows that graduates’ confidence and competence demonstrates marked improvement during the first year of practice(Dombroski et al., 2010; Toal-Sullivan, 2006). However, it is important to note that those struggling to find a balance also tended to be female. It is interesting to question whether gender plays a part in how well people achieve a balance, and whether it is more within a female’s nature to take work issues home and spend time worrying about patients. Due to the small sample size it is not possible to draw a definite conclusion as the three males that volunteered for the study had at least twelve months experience while only one of the four females had practiced for longer than twelve months.
All participants agreed there was great importance in finding a suitable balance and that there were certain dangers that could occur if it was not reached. This matches the findings in Hagi’s (1999) work which found the “process of clearly delineating work from leisure aided in their maintaining motivation and enjoyment in their work as osteopaths” (p. 20).

As soon as you start taking work home, work becomes your life and you don’t escape from it... there is the real danger of letting it bleed over into your home life, and I think that you could very quickly overwork yourself doing that sort of thing (Thomas).

Not only is there a very real danger of overworking yourself, there is the impact that the worry and stress can have on both your treatment of patients and your home life. Melody talked about having sleepless nights worrying about patients then feeling “knackered” at work, “I wasn’t dealing with my stress as well as I could, and so in that way it definitely did impact the way that I was practising...” Karl agreed with the need to deal with that stress:

You should definitely make sure you are differentiating work from home. The work can follow you, it can just chase you... it becomes stressful, you go home and you want to enjoy your dinner, you have a spicy Indian curry but you can’t enjoy it!

**Interpersonal**

This theme will discuss the interactions that new graduates have with patients and with colleagues, both osteopathic and from other healthcare professions.

**Interactions with osteopathic colleagues**

A common theme that is predominant in the literature is the need for support when entering a profession from study (Anderson & Kiger, 2008; Blanchard & Blanchard, 2006; Cowin & Hengstberger-Sims, 2006; Doherty, Stagnitti, & Schoo, 2009; Duchscher, 2009; Hamby & Miller, 1990; Lee & Mackenzie, 2003). The form that support might take varies, ranging from formal programmes to informal discussions with colleagues, often mentors or peers. Most important seems to be the opportunity for new graduates to discuss any problems with a colleague within a safe environment free of judgment (Smith & Pilling, 2007). The participants of this study appeared to place equal value and appreciation on the mentor relationship.
Question 5.3/5.4 of the questionnaire found that fourteen of nineteen respondents had someone who acted as a mentor to them. This tended to be the principal osteopath in the clinic where they worked, although one respondent said their mentor was simply a friend who was also an osteopath. Several people made the comment that they were not sure whether their mentor was technically a mentor, which suggests a less formal nature to the relationship yet achieves similar benefits. Within New Zealand’s osteopathic profession there is no formal mentoring programme. While some clinics may run a more formal mentoring scheme, there is nothing in place across the profession to implement or regulate this.

This research found there were many ways the mentoring relationship was carried out and each proved beneficial for the new graduates. These included the mentor figure helping with difficulties regarding the patient (including clinical reasoning, diagnosis and patient management), being someone to bounce ideas off and discuss cases with, helping to develop different treatment styles and techniques, offering reassurance and advice, or allowing the new graduate to observe their own treatments. Respondent 20 summarised, “1) being a role model, who you want to try and emulate, 2) being a guide, helping/advising in areas you need help on, 3) being a friend, who you can rely on and trust on, be it whatever”.

The place of a role model is covered in the literature often referring to the important part role models play in professional socialization. It is through role modeling, interactions and role repetition that the professional role is realized and assimilated by NGs (Tryssenaar & Perkins, 2001). Even in an informal mentoring role, it is important to be aware of the influence a mentor may have on an impressionable NG. Johnson and Ridley (2004) discuss how mentees can learn just as much from a mentors unintentional teachings as the intentional ones. “Implicit attitudes and explicit behavior communicate more to the protégé than any lecture the mentor might offer” (Johnson & Ridley, 2004, p. 38).

Having a guide or someone able to teach the new graduate and extend their knowledge was seen to be particularly beneficial. It was in this regard that most participants noted the value of a mentor figure. Respondent 8 said the graduation is the beginning of the real learning and he found having someone with years of clinical experience to be very helpful. Knowing that there is someone available to voice any uncertainties to without judgment is vital as it helps to reduce the feelings of fear that accompany the perception of incompetency and the possibility of being found out (Duchscher, 2009).
Having a mentor, who can also be related to as a friend suggests increasing mutuality in the relationship leading to a shared trust and respect (Johnson & Ridley, 2004). With a friend there is likely to be a stronger feeling of reassurance and support. As Respondent 3 put it, “the support mentoring offers means that when I feel out of my depth I can always turn to them for help”.

All seven of the interviewees had access to a support person, whether or not they felt it was technically a mentor. As was expressed in the questionnaires there was little in the way of a formal structure for this support. It appeared the reassurance and advice given from a more experienced colleague was found to be particularly beneficial:

I think that’s what’s really important for a new graduate, that you’ve got people to fall back on, that you can talk to about cases that are stressing you out, or perhaps aren’t shifting [improving], and so you have someone else who can say, ‘hey I’ve been there, or perhaps what you could do, is do this instead’. We don’t have all the answers when we come out, that’s the biggest thing (Melody).

While more experienced practitioners may offer the advice gained from the years of practice, the literature shows that peer discussions are also of value (Dombroski et al., 2010; Duchscher, 2009; Hagi, 1999; Smith & Pilling, 2007). This however does not seem so strongly recognized by the NGs in this study. Question 5.1/5.2 shows four of nineteen respondents to be part of a peer group. Only two of these mentioned how often they met - the first, once or twice a month, and the other only very occasionally. Of the interview participants, one person met with a peer group and this happened only two or three times each year. Another interviewee did theoretically belong to a peer group however due to the rural setting and the distance between each of the osteopaths they had met only once in the six months that she had been practising there. Participants who were peer group members reported they tended to discuss patient cases, research and practice techniques on one another. One interviewee felt he did not need a peer group as he was also involved in tutoring within the osteopathic programme which meant he was regularly in contact with osteopaths:

I don’t feel that, and I may be deluding myself, that I need to sit down and have a formal discussion each week about particular things because there is that ability for me to just bring up matters as and when I need them (Thomas).

The remaining four interviewees, although saying they had no peer group, spoke throughout the course of the interview of discussing aspects of practising life with their peers, the “more interesting cases and scenarios... what we could have done, what they could have done” (Karl). These tended to be fairly irregular and informal conversations. Despite recognizing the potential benefit that could be
gained from a peer group, the low percentage of NGs in peer groups is indicative that participants did not view them to be a high priority in practising life or an important aspect of the NGs transition into the osteopathic profession.

According to Dombroski et al (2010), the presence of peers when senior support is unavailable was found to enhance the environment for new graduates. Peers can also offer reassurance that inadequacy and uncertainty were common feelings thus helping to reduce feelings of isolation (Smith & Pilling, 2007) and provide an “important link to the ongoing professional development” of graduates (Duchsch, 2009, p. 5). It may be that if these connections with peers were strengthened, the feelings of isolation that were so commonly expressed may be reduced. One participant did mention that the possibility of starting a formal group had been discussed with peers because “we’re all feeling in the same boat of being so fresh and a bit clueless over some things, so I think that’s really good to have that kind of group together, so that you don’t feel quite so lost” (Melody). This shows there is a growing awareness of the potential value a peer group holds. One study found that fourth year physiotherapy students who were starting clinical placements showed that they found it very beneficial talking to new graduates as they were able to gain insight of the “most pertinent aspects of the placement” (Roe-Shaw et al., 2003, p. 20). It would seem likely that talking with other recent graduates would have similar benefits for NGs.

Talking to peers in informal situations and getting support from other osteopaths was mentioned, both in this research and that of Hagi (1999), as a method which was employed by new graduates to help overcome barriers and difficulties that they faced in practice. Four of nineteen questionnaire respondents reported this in Question 6.8 and it also matches with the responses of all the interviewees. Again, being part of a peer group may facilitate access to other osteopaths within a safe environment where difficulties and uncertainties can be discussed freely.

Question 6.9 which asked the factors participants considered when looking for work showed supportive environment to be the second most important factor. An interesting job was ranked highest but the answers were not expanded on so deeper insight of what actually comprises an interesting job could not be gained. The fact that supportive environment rated so highly, again, suggests an awareness of its importance for new graduates. Solomon and Miller (2005) found this to be a key theme in their research into the experiences of novice physical therapists. One respondent in Question 2.8, regarding the reality of osteopathy, stated that there were poor support services from clinic owners. When the same respondent’s answers from Q6.9 were analyzed, it was found supportive environment was ranked as most important. It would be interesting to know whether
supportive environment was ranked so highly based on hindsight or whether it was a factor that had been considered when searching for work but the position had not lived up to the expectations.

The literature outlines many ways in which mentors, colleagues and peers can provide a supportive environment for new graduates. While feedback on how to improve is useful, it is also essential for NGs to gain positive feedback and affirmation that their work is adequate and they are doing the right things. This was displayed by the poignant comments from participants of Duchscher’s research (2009) which showed the “transforming capacity of both supportive statements and displays of acceptance by senior colleagues” (p. 4). Similar findings regarding the power of affirmation were found in this research:

I’ll share patients with my bosses [mentors] if there’s something I’m unconfident about, often two of us will be in with one patient, or I’ll refer my patient off to one of them to see what they think about the situation. Often they’ll come back to me and say, you were right, or this is what I think is going on, so that’s quite good, just to not feel that I have to know everything as soon as I come out, because you don’t (Amanda).

Sometimes you just have bad days and you feel like no one’s getting better or something upsets you or you don’t know what’s wrong with someone, just like, oh my God, why did I choose this? At least with my partner [also an osteopath], he has those days too so you know they come and they go and it gets better, you don’t kind of freak out as much (Louise).

These quotes demonstrate the encouragement and renewed perspective that participants found could be gained by sharing problems with colleagues and having support networks which enabled this. Research by Atkinson and Steward (1997) found that when participants realized they did not need to know everything, an increase in confidence was able to develop. This was seen in Amanda’s narrative and was aided by her bosses’ support.

By accessing this support, a greater sense of professional identity gradually develops in NGs, helping them to adapt to their new role (Blanchard & Blanchard, 2006; Dombroski et al., 2010; Duchscher, 2009; Tryssenaar & Perkins, 2001). As discussed previously, there is frequently a knowledge gap present in NGs between what was taught in university and what is needed for practising life which can lead to feelings of fraudulence and being an imposter (Johnson & Ridley, 2004). It is important that this gap and its consequences are recognised by education providers, the osteopathic profession and the new graduates themselves. Once recognised, steps can be taken to reduce its impact. Education providers could stress the value of finding a job that supports and assists the on-
going learning of a NG. Tryssenaar and Perkins (2001) emphasise that educators need to teach students how to search for and find a suitable mentor. New graduates themselves could reflect on the areas they feel may most need support so they know what they need from an employer and/or a mentor. A greater awareness within the osteopathic profession of the areas where NGs feel less confident and where support is most useful could also help to ease the transition period. Sutton and Griffin (2000) suggest that employers and employees would benefit from having a detailed understanding of the other party’s expectations upon employment and regularly review it. It may also be worthwhile to look into the benefits of instigating a mentoring relationship, matching new graduates with experienced osteopaths, or forming peer groups with a compulsory number of attendances each year.

Mentoring is increasingly being advocated in health professions as it helps to improve readiness to work while reducing the transition shock and the likelihood of graduate attrition (Cowin & Hengstberger-Sims, 2006) While research has found mentoring programmes to be effective (Blanchard & Blanchard, 2006), other authors suggest that a formal structure is less important (Miller et al., 2005; Toal-Sullivan, 2006). This study cannot conclude definitely that formal mentoring programmes were effective, however the informal interactions that were had with mentors and colleagues certainly appeared to assist new graduates in establishing themselves during the transition period. All of these factors could aid the process of entering the professional world, giving NGs a stronger sense of identity and confidence in themselves.

Only two interviewees mentioned difficulties relating to osteopathic colleagues. One was only an occasional short-term problem and the other was a situational difficulty. For Thomas there were periods when one of the osteopaths he worked for would be away leaving him to cover both their patient loads. Although he found it quite overwhelming at times, he found he was able to cope due to the short timeframes he was expected to cover for and the fact he could reduce his hours once the principal had returned.

Melody also struggled when her principal was away however this was because he tended to keep his patient notes with him, which meant that she had nothing to refer to when seeing his patients. She found this made time management difficult as she knew none of the patients’ history or presenting complaints and needed to establish all this before feeling safe to treat them. Explaining this to a patient who expected the exact same treatment as that they would normally receive from the principal was also difficult:
It’s really awkward when people come in and they jump straight on the table, because they’re used to doing that with him [the principal], and you say, come here and we’ll have a chat, and then you find out that they’ve had this crazy history of all these surgeries... and you’ve got to take the time to get the history, but you’re still looking at your watch going oh my gosh, I have to examine this person, I have to treat this person too and again that person expects the same kind of treatment that they may have got from the other osteopath (Melody).

Melody was aware that this situation was probably fairly unique but she did feel it was something for NGs to be aware of as she felt it did provide a barrier to the quality and quantity of treatment she was able to give.

It is noted in the literature that there can be bullying tendencies within hierarchical professions (Kelly & Ahern as cited in Dombroski et al., 2010; Duchscher, 2009). While there is not a great degree of hierarchy within the osteopathic profession, it can exist if more experienced practitioners think themselves to be superior to the newer graduates. Although none of the interviewees mentioned being personally affected by bullying, one did give an anecdote about a new graduate he knew who would regularly lose new patients to the principal osteopath if the principal did not have a patient of his own. Based on this research bullying does not appear to occur frequently in osteopathy but it is known to take place and can be the cause of people choosing to leave the profession (Kleinbaum, 2009). An awareness of its potential presence will help practitioners to recognize if they find themselves or colleagues in such a situation. Again it is in this type of situation where a mentor or support person could be very beneficial by being there to listen and offer advice as necessary.

**Interactions with other healthcare professionals**

Four of the seven interviewees discussed their interactions with other health professionals, namely doctors, midwives and radiologists. Each of them saw the importance of making themselves known to the other professions. This was partially from a marketing and networking perspective but it also helped to acquaint them with the services available and the best manner in which to refer to each profession. Louise found that some doctors had preferred procedures when it came to referring patients. “Some doctors don’t like you referring straight to orthopedic surgeons with their patients, they want [the referral] to go through them, and you have to learn who likes that and who doesn’t.” She also felt it was good to take note of how doctors and surgeons wrote their letters to gain insight on what they like to have included because as she pointed out “they’re busy and they don’t want to read a whole lot of s**t”.

Interprofessional practice was viewed by Smith and Pilling (2007) to be an important part of professional life that needed fostering in new graduates in order to help them fully assert their role as a member of a team of health professionals. Initially the NGs found the interactions with other healthcare professionals to be nerve-wracking, however, with confidence and experience the prospect became less daunting and more a part of everyday practice. Amanda worked in a multi-modality practice which enabled her to share patients with doctors and question them as necessary. She found this made the doctors “a bit more human”. Where she had once felt nervous referring to doctors for fear of being scrutinized, she had now come to realize that there are aspects in patient care that osteopaths cover but doctors do not. Both Dombroski et al. (2010) and Toal-Sullivan (2006) found newly graduated physiotherapists and occupational therapists, respectively, also struggled with communication with fellow health professionals, stating that they felt ill-prepared in this area.

Thomas found that when starting in a practice that was newly established, it was important to take the initiative, finding out what health services were in the area and introduce oneself to them. He found that often people had limited knowledge of the osteopathic profession and by talking to them he could raise their awareness of the profession and the practice he worked for. It also enabled him to learn the procedures they would like him to follow if referring patients to them. The practice Kelly worked for had a similar approach, building up databases of other health professionals to refer to:

> If a pregnant lady comes to see me, I write to her midwife to say I am seeing her patient and that is more from a marketing perspective... but it’s just keeping that communication going, so hopefully they will refer more people (Kelly).

Question 3.2/4.1 explored how confident participants felt when it came to referring patients for further investigation and/or treatment. When asked to rate their confidence at the time of graduation, an interesting spread of results was seen, with six feeling unconfident or very unconfident, eight feeling confident or very confident, and five rated neutral. There are a number of factors that may be contributing to this. As with all aspects of the osteopathic profession, some people may naturally be more confident when it comes to communicating with others (although it is noted that barring one exception, all participants felt confident when it came to communicating with patients), but possibly a stronger influence came from the amount of referral practice NGs had gained during their two years practising in the university clinic. While there is some training in writing patient referral letters, it tends to depend on whether the patients you see actually need to be referred. It is possible to go through training without having to write any referrals apart from the few required for assessment purposes. This means that some graduates may have had ample practice thus improving their skill and confidence while others may only have had minimal
experience. When asked to rate their confidence as it was now that they had been practising, only one respondent still felt unconfident, four were neutral, nine confident and four very confident (Fig. 14.4). Once working full-time it is likely that NGs would have experienced more cases requiring referral thus improving their confidence in this area. This lack of experience regarding when to refer and difficulty in doing so was also seen in the work by Dombroski et al. (2010).

**Interactions with patients**

This subsection is divided into four parts: communication; expectations; acute versus chronic patients; and taking on patient issues.

**Communication**

A key theme that emerged repeatedly was the importance of communication with patients. There were certain aspects with which participants were very confident but in other areas a lack of experience appeared to hinder their perceived ability. Research has found that new graduates often feel ill-prepared to communicate with patients and colleagues (Dombroski et al., 2010) yet communication with patients is one of the most important skills for practitioners (Benbelaid et al., 2006). It would make sense that a lack of clear communication may result in poor clinical judgements being made as not all the required information is conveyed or understood.

Question 6.7 did not find any respondents who felt building rapport with patients or cultural/language differences caused barriers to the quality of treatment they gave. One respondent did say that patients whom he did not actually like could cause a barrier. It is likely that osteopathy attracts practitioners who enjoy the personal interaction that is involved with patients which could account for why communication issues were not seen in these areas.

Question 3.2/4.1 asked participants to rate their confidence in communicating and interacting with patients. Over half rated themselves to be very confident in this area both before practising and now having had greater experience (Fig. 14.2). Their confidence in informing and instructing patients and relatives was marginally lower but the vast majority still felt confident or very confident. Only one respondent before starting practice felt unconfident in this area (Fig. 14.3).

Interestingly, despite the overall high level of confidence in communication displayed in the questionnaire, the interviews revealed several areas of difficulties. Case history taking sometimes proved difficult for NGs and was very dependent on the ability to communicate well with the patient. “You’ll get the people who’ll just want to tell you everything and you get the people also who don’t tell you anything” (Melody). In these situations participants found they tended to resort to asking quite specific questions to gain the required information, doing what they were told not to
when at university and “ticking the boxes” (Melody). With patients who had the tendency to be overly forthcoming with information or went off on tangents it was a case of steering the conversation back to the necessary subject and suggesting other topics be discussed later:

I don’t feel too much that I can’t steer the situation back, I just try and bring them back to why we are here and what we are actually talking about and then sometimes say stuff like ‘that’s sounds really interesting, tell me about that while I am working on you’ (Kelly).

With patients that talk a lot, you just have to try and keep asking – there are a certain amount of facts that you just need, so you try and get those then you get them on the table and they can keep talking while you are doing stuff (Louise).

Participants all had methods for handling these situations, however their narratives indicated that generally it was not the actual act of communicating that was difficult but rather the pressure added by time constraints. Perhaps this explains the discrepancy in confidence between the responses of Question 3.2/4.1 and the interviewees.

Clear communication was also very important for participants when trying to establish a clear timeline for the presenting complaint and the influencing factors that may be preventing the anticipated improvement rate. Louise found this especially important when she felt she had diagnosed correctly and done all she could for treatment, yet progress was still minimal. By going over with the patient what they do in their daily lives, often seemingly insignificant details would emerge that were influencing the progress: “Usually something will come up like they hold their tennis racquet really weird or, there’s always little things”.

Once the problem had been established, several interviewees mentioned the importance of clearly explaining to the patient what you think is happening and what you can do for them. When explaining to a patient, Amanda found it extremely important “trying to clarify and trying to be as correct as possible, thinking that your version is going to be told to someone else next potentially”. Frequently she had patients recall what the last practitioner they had seen had said and often she could not make any sense of it. She also was of the opinion that taking the time to explain and educate people was a huge part of treatment and recovery:

Because often they’ve got some stuff going on that no one’s ever explained to them so they feel like something’s seriously wrong and that they’re sort of left on their own, and there’s no one to give them some kind of justification as to why they feel the way they
She found that often the explanation and communication side of treatment was equally as important as the physical treatment she gave them. Increasing a patient’s awareness of the factors influencing their presenting complaint was mentioned by three of the participants to be a valuable part of care.

Amanda also commented that without education, patients found it harder to trust the practitioner. “If they can’t trust me, and they can’t relax, that’s probably the biggest barrier to treatment quality”. Building trust with the patient was also viewed as essential because without it, communication diminished. As said, without effective communication it is much harder to establish the case history and convey what the likely diagnosis and course of treatment will be and in turn raises concerns over safety.

As discussed under ‘personal ability’, interviewees found communicating timeframes to patients a challenge due to their limited experience and lack of patient management skills. Smith and Pilling (2007) found that new graduates often struggled to convey their opinion to others with confidence. This is similarly seen in this research and may have stemmed from a desire to give specific answers but not feeling they had adequate knowledge or experience to do so. Louise was aware that over time she had become more generalized with her wording when explaining to a patient the expected timeframes for the resolution of their problem:

> The way you word things gives more of an open [end], you’re not saying ‘I don’t know’ that sounds really bad, you just say, ‘usually it takes this long but you know, obviously everyone’s different so we’ll just see how, we’ll monitor it’ (Louise).

She found it helped to listen to the explanations her colleagues gave to patients. “The guys I work with they just have these amazing sentences that, you go, ‘man, that’s utter s**t’ but it sounds very good and the patients are ok about it”. The interviewees’ confidence grew as they became more comfortable not giving a specific answer, and as they gained a more realistic idea of expected timeframes through experience.

When considering patient/practitioner communication, it is important to bear in mind that non-verbal cues can also be highly informative (Ishikawa et al., 2006; Mrozek et al., 2006). Although non-verbal communication was not discussed by participants in this research, a lack of confidence can be portrayed through the practitioner’s body language even if their verbal communication conveys confidence, and it can help to establish trust with the patient (Ishikawa et al., 2006).
As emphasized during university, it is important for practitioners to maintain professional boundaries between themselves and their patients. Toal-Sullivan (2006) discussed the satisfaction that participants found from their interactions with patients and the caring attitude with which they spoke of certain clients. However, it is this caring that has the potential to make the professional relationship difficult: “And some patients you really care about, and you almost become friends with some patients, you have to be careful” (Louise). It is important that clear communication is established, setting boundaries and guidelines for expectations and behaviour to prevent the line between acceptable and unacceptable being crossed.

In a study by Benbelaïd et al. (2006) over 75 % of participants rated the patient/practitioner relationship to be a low-level challenge. Although five of the seven interviewees spoke of communication with patients, it did not appear to present quite the same challenges as other aspects of clinical life. Rather, it was viewed more to be an important consideration that one needed to remain aware of.

**Expectations**

Four of the seven interviewees acknowledged the difficulties that could arise due to expectations. Mostly these related to expectations placed on them by the patient but NGs also had expectations of the patients. Participants found these expectations placed them under a lot of pressure which was initially difficult to cope with.

Patients would come in with a preconceived idea of how long they felt their recovery should take. Participants spoke of patients who wanted to be better immediately, who had heard from friends or family stories of being pain-free straight after treatment, so they expected the same. There were patients who had previously improved after x-number of treatments so they wanted the same outcome again:

> People think that their injuries the second time will be the same as the first and it’s not necessarily the way, so I guess also you’ve got to learn how to deal with people in that, setting expectations for them will be from outright, from the beginning so that they don’t put the added pressure on you (Melody).

Again that came down to NGs being able to communicate well with patients in order to align the patients’ expectations with their own. According to Thomas, it is a case of explaining what can and cannot be done for patients, and ensuring they do not have false expectations of what can be achieved. He felt this was essential when patients came in expecting him to be the answer to their problems:
You can have patients who have chronic problems and have been through the mill and seen all these different practitioners and come to you and pin all their hopes on seeing you. And that you’re being looked at as, ‘you’re my final hope’, and there’s this real pressure on you to make them better (Thomas).

Amanda had a similar situation with a patient who was sick of being seen by different practitioners so was demanding to gain improvement with her. Amanda felt that kind of demand changed her responsibilities and again, placed her under huge pressure. Not only was she trying to convey her capabilities and limitations to the patient, she was “trying to change [the patient’s] perception of pain. We might not be able to change the situation structurally, but we might be able to change the way she views it”. Discussing the situation with her bosses helped to give her a renewed perspective.

Not only do patients have expectations of when they expect to experience improvement but often the NG does too. Without the experience to know how long certain conditions tend to take to improve, it can be difficult when patients progress more slowly than expected. Kelly recalled that while working at the university clinic she felt patients should “cut you a bit of slack because you are learning” but once practising she felt much more obligated to get patients better. This was particularly hard when patients were slow to improve as she was very aware of what treatment was costing them, as mentioned in the ‘ability’ subtheme. Again colleagues helped to put things in perspective and gave insight into the progress rate of common conditions based on their experiences.

Melody found it difficult when patients arrived demanding a specific type of treatment:

A lot of people would rock up into your room and just say, ‘my osteopath just clicks me here and I feel right as rain’... well for me, for someone to rock up and basically demand a specific treatment, I would just get a bit terrified and really worried, and so I would psych myself out.

As time has passed, she has gained the confidence to explain to the patient what she would prefer to do and why, realising that she is not doing them a disservice by not giving them what they wanted. Instead she was using her clinical judgment to determine the best course of treatment before explaining this to the patient and progressing in the manner deemed most appropriate.

Thomas discussed the sense of guilt that came if he took time off work, regardless of whether it was a holiday or due to illness. Despite the majority of patients being okay with him taking time off, he still experienced guilt from some patients’ expectations as well as his own feeling of responsibility for his patients. He felt initially that he had a duty to be available for patients when they wanted to
be seen. Others also commented on the long hours they often worked due to the number of patients who preferred to come after work. Thomas came to recognise it was in everyone’s long-term interest to take a break occasionally so as not to wear himself out. This links back to methods of self-care and it is important that NGs recognise it as such, rather than try to continue working because they feel obliged to be there.

Unrealistic expectations are known to cause anxiety (Solomon & Miller, 2005) and it would seem likely to be the case regardless of whether these were expectations placed on NGs by themselves, their colleagues or their patients. All seem to contribute to increased feelings of pressure.

**Acute versus chronic patients**

As a patient group, acute patients tended to be the ones who caused most concern to participants. Mostly this was put down to the lack of experience NGs had had in treating acute cases:

> I saw very few acutes at student clinic and I guess now because I’ve seen a few more, you become a lot more prepared when they do come through the door you don’t have that kind of anxiety well up when you see this person who’s crawling through the door (Melody).

There was an initial wariness when seeing acute patients that stemmed from the concern that perhaps there was serious injury and the osteopathic clinic was not the most appropriate place for the necessary treatment. “Initially I found it really hard because I was just scared that they might have broken something, you always think the worst” (Amanda). “You’ve always got to assess is this the right place for this person or should I be referring them back to a doctor or for an x-ray” (Melody). They all agreed that their treatment of acute patients improved with experience and the ability to more readily recognize presentation patterns.

Much of the difficulty of treating acute patients came down to the expectations the patients had. Both Karl and Melody found them to be quite demanding because just as they had a sudden onset of pain, patients also expected it to be gone equally rapidly. Melody found because of these expectations acute patients were the ones “I probably beat myself up the most over”. Thomas talked of realising that even though you, as the practitioner, would also like the patient to walk out pain-free after treatment, it was a matter of accepting your limitations and discussing with the patient what could be done, ensuring that they do not have false expectations. The five interviewees all felt that communication was one of their greatest tools when facing patients’ expectations.

While some participants still struggled with acute patients, others relished treating them now that they were over the initial shock of the amount of pain that some people came in with. Amanda now
found them much more satisfying and enjoyable to treat because “you’re basically dealing with mechanical damage, rather than all of the other stuff, and that’s quite soul destroying”. For her, seeing patients with chronic conditions again and again with little improvement and having to find new ways to explain it to them each week was much more difficult than coping with the expectations of acute patients. It is interesting to note that the difficulties and methods of approach for both acute and chronic patients involved clear communication and dispelling unrealistic expectations.

In order to ease the shock that was associated with treating acute patients it would seem that similar techniques as for all other areas of difficulty must be employed. Gaining as much exposure to such cases as possible before graduating would increase NGs experience. However, because it is difficult to ensure that all students get equal exposure to all patient types, much of this would be reliant on students taking the initiative to observe clinical consultations. This may also be beneficial after graduation as it provides insights into the methods other practitioners employ to manage such cases. A period for the practitioner to debrief with the NG afterwards could allow any points of uncertainty to be discussed, furthering their learning.

**Taking on patient issues**

Six of the seven interviewees spoke of ‘taking on’ patients’ issues. It seemed the compassion they felt for their patients often placed more pressure on them and heightened feelings of stress. Questions were raised regarding whether this was worse for them as new graduates or whether it was a fact of practice life. “I don’t know if it’s just because we’re just starting out, but you take it really personally, you put their problem, or I do, on me, like I have to fix it” (Louise). Aaron felt it was during the first three to four months when he really took on the patients’ issues, thinking constantly about them and waking in the night wondering what else could have been done in the treatment. It was this that made him feel strongly about the importance of leaving work at work as a form of self-care. As mentioned in the ‘self-care’ subtheme, if care is not taken to avoid taking on patient issues, there is the potential to experience compassion fatigue (Bride et al., 2007).

Participants talked of spending a lot of time considering the more difficult cases, especially those that appeared to have psychosocial elements. The patients’ emotional involvement in their pain influenced the way the practitioner viewed it and contributed to the pressure felt to improve their condition. There was a lack of confidence about how one should deal with such cases: “You get people with a lot of psychological issues going on, emotional issues going on and that’s when you feel really ‘what am I going to do here?’” (Karl). He continued to say how emotionally draining it could be when patients broke down crying while telling their story: “You have to handle them
professionally, you can’t give them a hug though you really want to... so you’ve got to put on a
screen and be professional”. Amanda found that in cases where the patient was emotionally
involved, especially in chronic pain cases, she too would begin to feel psychologically broken
because of the feeling that she was not able to fix the problem. This concurs with the finding that in
some of the emotional aspects of patient care, novice physiotherapists found themselves
unprepared (Miller et al., 2005).

You’ve got other patients who are in a really bad place in their life, whether they’ve had
a really bad home life, are really stressed at work, or whatever, and of course they’ll
then transfer that on to you and in to the treatment. You’ve got to find a way to deal
with that and distance yourself necessarily from taking on their problems for them completely. But once again as long as you are able to deal with those it’s not, it’s just
getting used to the fact that these are these people’s problems, they’re not necessarily
your problems, and you don’t have to take on everything they’re trying to push on to
you (Thomas).

Although over time ways were found to cope with the stress, it would seem that upon entering
practice, NGs do not feel adequately prepared for the emotional burdens that are placed on them,
whether intentionally or not, by patients. As taking on patient issues seems a fairly common
occurrence for NGs, it is worthwhile considering how they could be better prepared for it.
Educational providers could look at the curriculum to determine whether a component addressing
this issue could be beneficially integrated. As with other factors in the transition, a large amount of
the anxiety and stress could likely be reduced by familiarizing students with the realities of practice
(Solomon & Miller, 2005) and thus reducing the transition shock. Again support groups and
colleagues could help to reduce the emotional isolation by providing a safe environment for NGs to
voice their problems (Smith & Pilling, 2007).

Educational deficiencies
This theme will discuss the areas which participants felt could have greater emphasis in the teaching
curriculum.

Business skills
A lack of education about business skills resounded repeatedly through both the questionnaire and
the interviews. Having spent five years studying, new graduates were faced with a challenge that
some felt university had not prepared them for – finding a job. The literature shows that the
uncertainty and challenge that finding a job presents is not uncommon in NGs (Hagi, 1999; Tryssenaar & Perkins, 2001). Melody was one participant who felt unsure about the process of finding employment:

I would’ve felt a lot better if I’d had just a little bit more talk surrounding when you leave, this is what you should expect out of the place you work for, these are your rights, and this is perhaps how you should run a business financially (Melody).

Louise agreed. She had no idea what to ask potential employers or what to expect because she did not know what was normal practice. There were many aspects which Aaron felt could have been discussed further during training, again, to help build a better concept of ‘normal’. Areas he thought were important to have a solid understanding of included contracts, pay splits and retainers. In terms of how osteopathy as a business is run, he says, “I know there is a lot in the degree, but that’s one thing that you’re not prepared for”. This could be a difficult field to teach because, as in NZ’s private physiotherapy field, there are no standard guidelines for employment, each practice has the freedom to employ people, NGs included, on their own terms (Dombroski et al., 2010). While it would not be possible to cover every possible employment intricacy, there are commonly accepted terms which are considered to be normal practice.

Participants in Hagi’s (1999) research commented on the “financial burden” (p. 12) caused by trying to meet the requirements of registration. The actual process of registering was a shock to some graduates in this research as they had not realized the time and the costs involved. “There’s a bit of a shock that ‘oh, I’ve actually got to spend more money now to actually start work’” (Thomas). Aaron learnt the hard way that a police check could take up to four months - he was ready but the police check had not been completed:

So there are those little things that it would have been quite nice if you were told about before like, ‘look, you’re going to finish your project soon, you need to do a police check for your registration, you need this much money for it, this much money for your APC, this much for the insurance, that’s what you need, get it ready so that when you’re ready you don’t need to think about it’ (Aaron).

Once working, participants were still aware of many uncertainties they had regarding how to conduct themselves as a contractor. Typically this revolved around putting money aside for various expenses:

...knowing that you need to be putting away your ACC levies, people don’t always tell you, you should really be working in this way of putting your GST away, and this
percentage for your tax, I think we had one person, an accountant come by for one session and explained it all, but really there’s a lot to understand and a lot to get right, and if you don’t get it right it can be quite stressful (Melody).

Thomas felt it was important to understand the laws and responsibilities regarding tax and GST, and how these differ depending on whether you are a business or a sole trader. Issues with tax and basic accounting are areas where graduates often feel they require more information (Hagi, 1999). Thomas realized that although it would be helpful to have further information on these areas taught during university, there was only limited space in the curriculum and “the more you add to one thing, the more you’ve got to take away from the other”. He had found there were free government services available to offer advice which, combined with a small business course and finding a good accountant, reduced the stress he felt he may otherwise have encountered. Although Thomas accessed all this information while waiting for his research to be marked, others found learning the business side of osteopathy while coming to terms with the clinical side more challenging:

I went and I looked and learned for myself, but when you are still trying to develop your clinical skills, that’s a lot of extra time on something else, something totally different, it’s quite hard to get your head around (Melody).

Aaron agreed that learning both osteopathy and business when you first graduate is no easy task. For that reason Amanda, who claims to have “absolutely no business sense whatsoever” felt extremely lucky as her boss did everything for her while explaining the processes to her.

One respondent in Question 6.7 specified a lack of business training, especially in regard to marketing and budgeting, to be a barrier when entering the osteopathic profession. This may be in part due to the difficulties participants expressed of trying to learn these aspects while still attempting to grasp all other aspects of the osteopathic role.

One interviewee also mentioned marketing as an area of practice life where he did not feel competent. “You are not trained to market yourself. You are trained to treat people or heal people and that’s what you focus on in the student clinic... not trying to market yourself” (Karl). Because students are not trained in marketing, they are not assessed in this area. Mrozek (2006, p. 765) writes, “The match between the undergraduate programme and the assessment method(s) is important because assessment drives student learning and thus ultimately shapes the curriculum”. Osteopathic students are not assessed on their business ability thus as Mrozek (2006) acknowledges there is nothing to push students’ learning. Business skill is the one area which is not assessed in the FCC exam or by any other method throughout the five years of study. This could be the reason that
there is a significant lack of confidence felt in all aspects of managing and running a business, as shown in Question 3.2/4.1 (Fig. 13). Of all the different topics covered in Question 3.2/4.1, business skills rated significantly lower with ten people feeling very unconfident in this area upon graduation. When rating their confidence at the time of the research, one third of respondents still lacked confidence to a greater or lesser extent. Only one participant felt very confident in both categories and this may have been due to having had eleven years of experience as a manual therapist which would likely have involved business elements.

Question 4.3 asked participants to select areas which they felt needed greater emphasis in the teaching schedule. ‘Professional topics’ was selected by the greatest number of respondents with 16 of 19 feeling it required more emphasis (Fig. 16). However despite the high number of participants who thought this area would benefit with more emphasis, when asked in Question 4.4 to rank specific areas for emphasis, professional topics such as business skills was rated third most in need. Clinical topics of associated disciplines, (such as reading imaging and exercise rehabilitation), was found to be most in need of emphasis and core osteopathic curriculum, (such as technique, diagnosis and physiology), was second. The discrepancy between Question 4.3 and 4.4 may be due to the fact that although many people lack confidence with professional topics, it is less critical for effective care and safety of the patient. Business skills appear to be a factor that NGs are able to acquire as needed once graduated. Conversely, in order to ensure quality care, knowledge of clinical topics and core osteopathic curriculum presents more of an immediate need during an interaction with a patient as it is not always possible or appropriate to search for answers to questions during the consultation.

The Accident Compensation Corporation (ACC), a unique part of the NZ health system which provides treatment compensation for accident-induced injuries (Accident Compensation Corporation, 2008), was another aspect of business where four of the seven interviewees mentioned they had difficulties. Participants of Dombroski et al.’s (2010) also felt there was a “lack of preparation for ACC legislation and paperwork” (p. 9). Louise thought a better knowledge of how ACC works would be helpful because, “80% of my patients are on ACC at the place I work now, and I just had no idea about ACC. You just don’t do it in clinic [at university]”. Kelly recalled, “I don’t think I’d ever filled out an ACC form by myself or anything, I think it was, ‘hmm do I tick this box or that box?’”. She too estimated at least half her patients were on ACC.

It appeared that initially participants struggled with the ACC paperwork, learning the many injury codes (read codes) and which codes they, as osteopaths, were allowed to claim. Some felt it would be good to have more in-depth discussions about the forms which are less commonly used, ‘32R’
forms, for example, which are used to apply for a continuation of treatment or to add additional diagnoses. One interviewee had never heard of ‘32Rs’ until she was practising. This led to feelings of anxiety as she had to learn the procedure for each new form.

Louise also felt it would have been helpful to know if there was a standard procedure to follow if ACC did not accept the claim:

If something does go wrong and ACC doesn’t fund it, they decline after you’ve done 8 treatments, what to do then and how to sort that out with your patient, you need to get that money from somewhere and that’s kind of stressful in itself, if it’s not your business, you know. If you’re running your own business then you can make your own decisions about what you want to do, but if you are working for someone else they want the money.

Once participants had had more experience with the requirements and needs of ACC claims, they became much more comfortable dealing with them. The initial anxiety and distress from not understanding the processes involved gradually diminished. As with other aspects of business life, NGs were able to access information on the intricacies of ACC once graduated, whether by asking colleagues or ringing the ACC provider helpline. However, they were aware that the transition to practising life may have been eased had they had a greater understanding of these aspects prior to entering the profession.

As Sutton and Griffin (2000, p. 386) stated, “Educators are in the position of being able to provide more realistic job information beyond the experience of fieldwork”. This would seem particularly pertinent in the aspects of professional life which are not fully exposed in daily proceedings at the student clinic.

**Osteopathic skills**

This subtheme will discuss perceived deficiencies in participants’ clinical skills and ability to perform techniques.

Throughout the questionnaire and interviews, the general consensus was that more time spent practising the practical elements of osteopathy would be useful. It was felt that more ‘hands-on’ time would help to develop their palpation and could contribute to a feeling of greater confidence. Occupational therapists and physiotherapists have also been found to express a need for more practical time while studying (Doherty et al., 2009; Dombroski et al., 2010). Some suggested more
time in practical classes, while others thought more clinic time would be beneficial. Aaron was of the opinion that had he been given a greater variety of techniques and had more time to practice during the undergraduate programme, he would have felt less “barren” upon starting in the student clinic. “Start earlier with a few more techniques to play with and kind of develop your hands a bit more, doing more technique actually, because that’s what you use. More hands-on I think would be good.”

Question 4.3 showed 12 of 19 participants thought practical osteopathic content could have had greater emphasis in the teaching schedule and 14 of 19 thought clinical topics such as radiology and orthopedics needed more emphasis (Fig. 16). Core osteopathic curriculum, including technique and basic skills, was ranked second and clinical topics of associated disciplines was rated first when asked in Question 4.4 to rank specific areas needing emphasis (Fig. 17). As mentioned in the previous subtheme, it is thought these may have rated higher than professional topics because of the more immediate need for this information during the patient consultation.

The perceived need for greater teaching of practical aspects can also be seen in Question 3.2/4.1 where a moderate lack of confidence can be seen in relation to practical skills upon graduation (Fig. 11.1). Participants’ confidence was seen to improve with practice, which makes it likely that more practical experience while studying could have improved the proportion of respondents who felt confident with their practical ability upon graduation.

Two respondents in Question 6.7 expressed their limited technical skill to be a barrier to the quality of treatment they gave. One had not yet found ways to overcome this barrier, possibly because he was fairly new to practice, while the other found discussing problems with his mentor, attending courses and “practising techniques I find difficult even if they do not always succeed” beneficial for his improvement. The last point made by this respondent appears to be one that some NGs struggle with. One interviewee questioned, “Am I a bit of a fraud if I use this technique that I don’t even know if it will work?” This suggests a slight fear of trying new treatment methods in case they are ineffective. This correlates with Kelly’s comment that in the student clinic it was easier to try new techniques because there was the understanding that you were learning. Once practising, it appeared common for NGs to feel they were expected to know everything. A sense of obligation to improve the patient’s condition often deterred them from attempting new techniques.

Opinion is divided among the research participants about whether various branches of osteopathy were adequately covered in the curriculum. As discussed in the ‘Personal’ theme, subtheme ‘Technical ability’, while some participants felt happy with the grounding given by the structural training approach, others felt this could have been expanded to more gentle techniques such as
functional and cranial: “It’s kind of like, there’s these two sides of osteopathy and we only get taught one side” (Aaron). Evidence of participants feeling more comfortable with structural techniques was seen in Question 6.4 where articulatory techniques, HVLA and MET were used much more frequently than functional, BLT or cranial techniques (Fig. 20). This imbalance between the treatment styles used may be attributed to the style of training they received.

All interviewees agreed there was a much greater emphasis on structural techniques and felt it was a good starting point of training. But some also thought it could have been beneficially expanded to incorporate a wider variety of techniques. Those who were happy with the skills they had, argued that it was better to put energy into becoming as good as you can be at your main focus rather than being a “jack of all trades, master of none” (Melody). They felt it was better to leave university knowing that your treatment approach would be effective and feeling comfortable in that knowledge.

Others were of the opinion that a wider variety of treatment approaches would enable them to treat patients more effectively, saying that “if all you have is a hammer then everything will start to look like a nail” (Aaron). These participants noted that all patients are different and will respond to treatment differently, therefore different treatment styles will be better suited to some patients and as practitioners they need to be able to adapt to that.

Louise felt the balance in treatment types taught was fine as it allowed her to build a sufficient palpatory awareness before learning the gentler techniques which require a more subtle palpation. She was of the opinion that learning cranial techniques requires a lot of time, thus it would be difficult to incorporate into the curriculum anything more than an introduction. She had chosen to expand her knowledge of cranial treatment by attending postgraduate courses and sitting in with experienced osteopaths who treat in that manner.

Although Louise found it possible to broaden her treatment repertoire once graduated, some found the lack of feedback when trying new techniques difficult. On reflection, Melody realized how valuable it was while studying to have an experienced lecturer available to give advice when she felt unsure about performing certain techniques:

You’d have a bit more of a backup [at university], in that if you weren’t confident on something you could go back and talk to a tutor, whereas now as an osteopath I can go on a weekend course but if I come home and go, ‘hang on, I’m not really too sure about this’, I’m then at a bit of a loss... it’s a lot more difficult to really pick up things and run
with it, if you’ve only had a brief introduction to it, without any supervision afterwards in practice (Melody).

Again these feelings of uncertainty resulted in questioning whether it was reasonable to practice techniques on paying patients who were expecting to improve when she was unsure whether the treatment would be effective. For this reason Melody was undecided on the benefits of learning all modes of treatment equally. She felt it was very important for her to have a solid understanding of basic techniques in order to feel comfortable treating most conditions, and she was also very aware of the benefit of being able to access advice from tutors.

Four respondents in Question 4.4 suggested that greater emphasis to functional, cranial, visceral and indirect techniques would have been useful. These responses again may indicate a realization of how valuable it is to be able to practice such techniques in an environment where support is available. Those same fields of treatment (functional, cranial and visceral) were also given in Question 6.5 by 12 of the 18 respondents who said there were other areas they would prefer to work in. Interestingly, three respondents expanded on this saying that a more supportive environment in the student clinic would have helped them to identify these areas of interest earlier. One respondent noted that, “encouraging me to engage more with functional techniques would have made the clinic years [at university] more interesting than only using structural techniques”. This lack of technique variety may have contributed to a respondent in Question 2.8 stating that he found the reality of osteopathy to be rather repetitive.

Beyond the standard osteopathic techniques, Question 4.4 had seven respondents who would have appreciated a greater emphasis placed on rehabilitative techniques and exercises. This was also mentioned by several interviewees and appeared to correlate with participants’ feelings of insufficient skills in patient management. Melody recalled, “What would have helped me a lot, in clinic is if I’d learned a base set of exercises to give for different presentations, ranging from what you do for someone who’s very early stages to later stages of recovery”. Louise also had similar sentiments, thinking a better knowledge of which exercises to give and how long the problem might be expected to take to recover would have been useful. Although participants were aware of where they could find information on rehabilitative exercises, often they found the range of possibilities overwhelming as they did not have the experience to guide them in deciding which option would be best for their patient. It was here that they relied on the knowledge of colleagues who had greater experience in patient management.
Aaron made an interesting observation that, “the thing about osteopathy is so much is passed on, its verbal transmission”. He, and several other interviewees, commented on how beneficial they found pattern recognition of conditions. This was not something that had occurred to him until his mentor highlighted it with a patient:

> There’s a difference between spoon-feeding and helping and showing, and I think there’s benefit of someone showing you those things, and it can be as much as, ‘yip, rib 2 on the right, scalene, C2-3.’ There’s a connection there, there’s an anatomical connection and often when you have that going on, that’s what’s happening with the patient... it’s a really nice little guide to go on, and then you see that it does really solve it and change it and then you know it for the next time, it’s something you can look for (Aaron).

Aaron realized that while pattern recognition was not always going to provide the answer, it did provide a logical starting point and had the potential to save time by recognizing connections and how they fitted together. He continued to say that verbal transmission of information was not unique to osteopathy but was seen in many professions:

> [Novices] learn a lot from the people who have been doing it for many years, because they [the expert] go, ‘hey look, I know that’s how they tell you to do it in the procedures but if you do this little adjustment to it then it works a lot better’ (Aaron).

He found being passed knowledge that was gained by experience invaluable because it was often information that could not be found in books. He felt that the verbal transmission of such information from tutors and mentors would be hugely beneficial to students and NGs because he found it helped him make connections that he had not previously thought of.

In the same manner, passing advice on to NGs about patient management could also help to build their confidence by knowing that they are not simply guessing at a timeframe for recovery but rather basing it upon accumulated knowledge of an experienced practitioner. Three of the interviewees indicated they lacked a set of protocols for expected recovery rates for certain conditions, especially in post-operative care. This was also seen in the recent study by Dombroski et al. (2010). Again, although each patient will have a slightly different recovery rate, certain conditions tend to have a range within which recovery can be expected.

Benbelaïd et al. (2006) found that clinical decision-making was one of the three main difficulties that NGs experienced. It was also evident in this research as demonstrated by the NGs angst over whether their choice of treatment and exercises were the best choice. They found that the lack of
experience often made deciding the course treatment difficult, as they did not know the typical tissue response. They also struggled initially with their thought processes and clinical reasoning. Kelly thought this could have been eased by having an opportunity at university to observe an experienced osteopath taking the patient consultation then having the opportunity to debrief with the practitioner and discuss their thought processes and clinical reasoning. While this may sound a beneficial idea, it may be somewhat difficult because proficient and expert practitioners have replaced reasoned responses with intuitive behavior (Benner et al., 1996). This means that they may struggle to explain what they were thinking during the consultation. The literature discusses the relationship between clinical skills and self-confidence (Doherty et al., 2009; Dombroski et al., 2010) and shows that both can be effectively improved with access to support (Tryssenaar & Perkins, 2001). A greater confidence in their ability has also been found to lead to greater job satisfaction because of the “greater understanding of the complexity of their work” (Neistadt, as stated in Doherty et al., 2009, p. 347).

Imaging was also mentioned by interviewees and in Question 4.4 as an area participants felt deficient in. Imaging encompassed knowing how to both refer for and read x-rays, CT scans and MRIs. Thomas summed up interviewees’ thoughts well: “It would be nice to have more information about what sort of imaging is best for which conditions and the best way to refer to those”. Dombroski et al (2010) found that three quarters of NG respondents discussed their lack of experience in knowing when to refer. Another respondent, despite having 12 months experience, said she still hoped for a report to be included when patients brought in imaging for her to look at.

Pediatrics and obstetrics was mentioned by three participants in Question 4.4 as needing further teaching during study. Kelly also discussed it during her interview: “Pregnant women go to osteopaths reasonably frequently, as a group of people and I really think that needs to be covered more, and pediatrics as well”. There appeared to be a sense of anxiety in her narrative as she spoke of her initial treatments of obstetric and pediatric patients, which may have stemmed from her perception of deficient training in these areas.

As discussed in ‘Interactions with patients’, participants often found it difficult to cope with the psychosocial elements of patients’ presentations. Six interviewees spoke of the importance of avoiding taking on patients’ issues, and three of the interviewees specifically mentioned the psychosocial aspect. There was a common feeling that there was insufficient training in how to avoid being drawn in to the patient’s problem. “There needs to be a way that we can try and incorporate processing that [psychosocial issues], because so much of it is around” (Amanda). She felt it was particularly evident in chronic pain syndromes where the patient becomes “psychologically broken”.
Not only did Amanda feel upon graduation that she needed better skills to help the patient manage the psychological elements of their problem, she also felt inadequately prepared to cope with effect the patient’s problem had on her, “Likewise I get psychologically broken because I don’t feel like I can fix it”. Karl agreed that you do see many patients with psychological issues and often it can be difficult to know how to manage them professionally:

I think if you know how to handle psychological issues it would be a bit more helpful when you get a patient who’s crying in pain or has so much emotional trauma or abuse going on so that that person physically has a pain. Psychological counseling or a bit more training in how to deal with them, you know, to make you a bit more of a primary practitioner (Karl).

Having a greater understanding of commonly-occurring psychosocial issues that may be encountered will improve NGs ability to cope with such situations as they arise. Also understanding the effects that other people’s issues can have on themselves ought to help them recognize if they are suffering from elements of compassion fatigue or vicarious trauma (Bride et al., 2007; Radey & Figley, 2007). Again, as mentioned, being able to recognize when patient problems are becoming difficult to cope with, and taking appropriate action, is an important method of self-care.

Although all the aspects mentioned in ‘Educational Deficiencies’ were brought up by participants as areas they felt could have benefited from greater emphasis in the curriculum when studying, they all felt adequately prepared for practice and these areas of difficulty were seen to improve over time. While it is worthwhile for education providers to consider if any of the mentioned aspects could be effectively incorporated into the teaching schedule, many of the participants were aware that the course was already extremely busy and “the problem is everything you want to introduce takes time away from the other things which may have been more or less important” (Thomas). The osteopathic profession, especially mentors and employers of NGs, should also maintain an awareness that these are areas where NGs may struggle and would benefit from any support and advice given.

**Summary**

This current study’s participants support the findings from Hagi’s (1999) study of the transition from student to practising osteopath, in that there are a number of common stressors faced by NGs and there tends to be a relatively predictable pattern seen during the transition process. This pattern is
also seen in the literature of other healthcare professions (Dombroski et al., 2010; Smith & Pilling, 2007; Tryssenaar & Perkins, 2001).

New graduates often held an unrealistic expectation of practising life which may have contributed to feelings of anxiety and stress during the initial months as they became accustomed to practice. As they were socialised into the osteopathic role and gained experience in practice, their confidence grew. This confidence was reflected in how they perceived their ability in the many facets of practice. Although initially NGs found the transition to work to be filled with many mixed emotions, over time these feelings settled, enabling NGs to feel more comfortable in their new professional role. One feeling which participants appeared particularly unprepared for was that of isolation. Despite constant interaction with patients, the lack of interaction with colleagues often left NGs feeling isolated. Having come from the student clinic where there is a large amount of interaction with tutors and peers who can offer support and answer uncertainties, it was often a shock to no longer have this same level of support. This feeling of isolation was also seen in other healthcare professions (Duchscher, 2009; Lee & Mackenzie, 2003). NGs employed various self-care techniques to help them during the transition period, including ensuring adequate rest, exercise, and being careful to leave work at work.

Talking to colleagues and peers was also found to be a very useful method to cope with problems. Drawing on the support and experience of others often gave NGs a clearer perspective and this support is known to play an important part in professional socialisation (Hagi, 1999). Many participants had access to someone who acted as a mentor, generally the person they worked for. This was seen to be very beneficial for them. Interactions with other healthcare professionals was seen as important but it was an area where NGs lacked confidence initially due to a lack of experience in areas such as referring patients or communicating with other professions in a networking context. Patient interactions also had a number of areas which participants found difficult. The expectations held by patients reportedly placed a huge amount of pressure on NGs who were still learning their own capabilities. Clear communication was seen as the key method to cope with these issues.

Participants noted a number of areas which they felt could have benefited from greater emphasis in the teaching curriculum. Low levels of confidence were reported in many aspects regarding business, such as marketing, tax, GST and ACC. Though this was an area of difficulty for many, it was not rated as most in need of emphasis possibly because it does not compromise patient care and graduates felt able to learn it themselves either by doing a small business course or learning from others while practising. Rather it was the area of osteopathic skills that participants felt would have helped them
more once in practice. More time learning techniques, rehabilitative exercises, and how to read diagnostic imaging, were all cited as areas worthy of further emphasis.

The final chapter of this dissertation offers recommendations for further study, discusses the limitations of this present study and identifies implications for educational providers, the professional bodies and new graduates. It finishes with concluding thoughts on the importance of understanding the experiences of NGs as they transition from being a student to a qualified practising osteopath.
CHAPTER VI - CONCLUSION

Introduction
This dissertation investigated the transition from student to practising osteopath by examining the experiences of new graduates in New Zealand who had been working for 18 months or less. The aims were to identify any key issues arising and the extent to which they applied to the cohort, to determine techniques used to overcome these difficulties and to determine any possible strategies which could be utilised to facilitate the transition of future graduates.

The research was conducted through the use of a questionnaire and interviews. An email was sent out to graduates from Unitec’s Master of Osteopathy programme inviting people who had been practising for less than 18 months in New Zealand to participate. Of an estimated 36 who were eligible, 20 completed the questionnaire. Of those, seven also volunteered to be interviewed.

Thematic analysis of both components revealed a number of themes, many of which matched those found in the literature. The themes were divided into three categories: intrapersonal, interpersonal and educational deficiencies. Subthemes were evident within these major themes. ‘Intrapersonal’ included the reality of osteopathy, ability, isolation and self-care. Interactions with osteopathic colleagues, other healthcare professionals, and patients comprised the ‘Interpersonal’ theme. And ‘Educational deficiencies’ consisted of business-related skills and osteopathic skills.

Recommendations for further research
As mentioned in the literature review, it appears that only Hagi’s (1999) research investigates the transition from student to practising osteopath. Hagi found there were several stages involved in the new graduates’ transition process and outlined each of them. The phenomena of this transition period and all that occurs within it cannot be adequately covered by two research projects alone. There are still many areas which could be further researched, including further detail into NGs expectations of practice, work satisfaction, and self-care practices used during these first 12 to 18 months of practising. It would also be interesting to know whether there were any methods NGs employed to help prepare them for practice, especially if they had an extended period between finishing university and beginning practice, or whether, in hindsight, there was anything they could have done to better prepare themselves.
A number of researchers conducted longitudinal studies into the transition period for various health professions. This may be a worthwhile option for future studies in the osteopathic field as it would give a more accurate impression of people’s transition into the osteopathic profession by following them as they progress rather than relying on memories of their experiences. Such research might be conducted as a survey and/or interview upon graduation plus a follow-up approximately one year into practice. This may however be difficult to monitor due to the staggered nature of graduates entering the profession.

A study into the expectations and requirements within the osteopathic profession when employing new graduates would be beneficial as it could be used to build a more realistic image of what is expected of NGs on entering the profession. Being familiar with the needs of both parties will also assist the transition (Solomon & Miller, 2005). A study could also be done asking employers their perceptions of the preparedness of new graduates as this would help to create a more accurate depiction of how NGs perform in the workplace.

Although there is much evidence advocating the benefits of mentoring and support programmes (Blanchard & Blanchard, 2006; Miller et al., 2005; Toal-Sullivan, 2006), anecdotal evidence has suggested that the realities of instigating such support for NGs could be difficult due to time and monetary constraints. Research could be conducted interviewing, for example, the programme director of the Masters of Osteopathy and key figures from the Osteopathic Council or from osteopathic societies to gain insight into realistic methods which could be developed to facilitate NGs’ transition into practice.

As mentioned, this research investigated the experiences of new graduates who had studied only at Unitec. It would be interesting to widen this to educational organisations in other countries to see if the transition experience is comparable for all newly graduated osteopaths or whether other factors, such as place of study or the work environment in different countries, contribute to differing experiences.

**Limitations of the research**

This study explored a little-researched field in the osteopathic profession, that of the transition from student to practising osteopath. It was based on the experiences and opinions of a self-selected group of newly graduated osteopaths as conveyed through a questionnaire and interviews. The questionnaire response rate at 55% (20 of the estimated 36 eligible) was still a fairly small sample size and although covering several cohorts from Unitec, it was from only one training institute and
therefore cannot be generalised across the entire osteopathic profession. This small sample size was deemed appropriate, however, due to the use of interpretive description and the exploratory nature of the investigation. Research in other health professions demonstrated the transition from student to practitioner to be full of challenges, and anecdotal evidence suggested that it was no different for newly graduated osteopaths. This research project was then designed to gain insight of the difficulties and challenges faced by newly graduated osteopaths in NZ.

As the invitation to participate in this research was sent out to all past graduates via email, it is possible that not everyone received it if the email addresses were invalid or unused. The instructions for eligibility required potential participants to decide for themselves whether they met the criteria of practising 18 months or less. This had the potential to deter people if they did not read it correctly.

Although the questionnaire had been peer-checked, some responses suggested questions may not have been entirely understood. In some cases, this may have been due to the limited possibilities of question layout that are available on SurveyMonkey. If this questionnaire was used for future research, clarification of these questions would be necessary.

The findings of this research cannot definitively represent the viewpoint of all newly graduated osteopaths, as those who volunteer to participate in research may be more introspective or hold strong opinions on this subject. Participants may also have had altruistic reasons for contributing to the knowledge of the experience of newly graduated osteopaths, as noted by Tryssenaar and Perkins (2001) and Dombroski et al. (2010). As a result of the small number of practitioners in the osteopathic profession, many of the new graduates who were eligible to take part in the study were known to the researcher. This may also have influenced people’s decision to participate. Despite knowing six of the seven interviewees, every effort was made to avoid allowing this to affect the interviewing process. Because participants had to self-report, there was a risk that they may have responded in a manner that was not truly representative of their thoughts or experiences due to the perception a certain answer was required, or having a vested interest in the outcome of the research (Doherty et al., 2009).

The researcher’s lack of experience at conducting semi-structured interviews was another limitation to this study as it resulted in lost opportunities to follow up on information given by interviewees. For example, participants were not able to give detailed responses about work satisfaction in the questionnaire and this area was not followed up sufficiently in the interviews to gain deeper insight. More in-depth questioning could have provided interesting data as work satisfaction is closely
related to retention (Sutton & Griffin, 2000) and may have revealed links with Kleinbaum’s (2009) research into why osteopaths choose to leave the profession.

Given that the participants of this study were all Unitec graduates, it would be interesting to repeat the study as there have been changes in the curriculum since these graduates were studying.

Implications for the profession

A number of implications have emerged for educational providers, the professional bodies and employers, and the individual osteopaths from this research.

Educational providers

All potential osteopaths must study at an accredited educational programme. This places responsibility on the educational programme to provide students with a curriculum that ensures they are adequately prepared for all aspects of professional life upon graduation. Necessary skills include not only osteopathic skills, but a sound understanding of business factors, such as tax, GST and also ACC; referral procedures; and self-care.

Support also plays a hugely important role for NGs during their transition. Education programmes could stress the importance of having access to support and perhaps instigate or encourage a peer support network to provide on-going backup. As Hummell & Koelmeyer (as cited in Doherty et al., 2009, p. 348) explain, it is only “when the learning needs of practitioners are appropriately addressed, more skilled practitioners result, and better services are provided”.

Professional bodies and employers

An increased awareness of the areas that generate difficulty and anxiety for new graduates would be valuable as the professional bodies and employers, in particular, are well positioned to provide assistance to NGs as they transition into the profession. Again, a huge part of this is support, whether it be welcoming NGs into a peer group or, if employing a NG, taking the time to ask how they are adapting to their professional role and offering help if required. Reassurance was a factor that was seen to be helpful by NGs in this research and in the literature (Anderson & Kiger, 2008).

Having left an environment where feedback was constantly given, it was a shock for many participants to suddenly be without it. For this reason, feedback and reassurance were always appreciated. The profession plays an essential part in the socialisation of NGs who readily pick up on the attitudes and beliefs held by colleagues, thus it is important the profession remains aware of this to ensure a positive socialisation process. It may be beneficial to consider whether a structured
support programme would aid the transition process especially during the first four to six months which appears to be the most stressful period (Smith & Pilling, 2007; Tryssenaar & Perkins, 2001).

**Individual osteopaths**

For the individual newly-graduated osteopath, it appears that having a realistic expectation of practising life is highly beneficial as it can lessen the transition shock. Observation before starting practice can provide the opportunity to see how a practice is run and enhances socialisation into the profession. Discussing with peers and other NGs their experiences during the first months of practice can also help to align expectations with reality. Being part of a peer support group can be valuable by providing a safe place to discuss concerns and by reassuring NGs that they are not alone in experiencing these feelings or uncertainties. Mentor support has also been found to be very beneficial for NGs by providing guidance based on a wealth of knowledge (Blanchard & Blanchard, 2006).

New graduates need to be aware that it is not possible to be prepared for every clinical eventuality (Solomon & Miller, 2005). A confidence across a broad base of knowledge covering clinical reasoning through to technical skills will enable NGs to cope with new situations through a process of logical problem-solving.

This research can help to provide an understanding of the areas where NGs struggled and faced challenges, and the strategies they employed to cope with these. This knowledge is important as some factors may be recognised by individuals as affecting them in their own transition period. Hopefully, it may help to reduce feelings of isolation by demonstrating that these difficulties are common-place in the transition from student to osteopath and, with time and experience, diminish and become easier to face.

**Concluding thoughts**

This is only the second known study to investigate the transition from student to practising osteopath, and the first to explore the experience in the New Zealand context. The aims of the research were met as new graduates recounted their experiences. Despite a small sample size, the key themes raised reflected those found in the literature. Minor differences unique to the New Zealand context were evident such as understanding the workings of ACC, and referral procedures. Such factors could well be considered by educational providers for further teaching.
New graduates often held unrealistic expectations of professional life which led to experiences of a ‘transition shock’. They were suddenly aware of what they did not know and what they needed to know. They still felt like students with much to learn, yet they were expected to fit the role of the professional. Despite feeling moderately well-prepared for practice, there were many aspects where new graduates lacked confidence.

These difficulties were overcome with time, experience, and assistance from mentors, colleagues or peers, all of which contributed to a more realistic expectation of the osteopathic profession. The role that support plays during the transition period must not be underestimated as it is central to the socialisation and continuing education of the new graduate.

It is inevitable that every newly graduated osteopath will experience a transition period upon entering the profession and starting in practice. Even in the New Zealand context, the participants’ narratives suggest they too follow a relatively predictable transitional process as seen in Hagi’s (1999) research and many other health professions such as physiotherapy, occupational therapy and nursing (Dombroski et al., 2010; Smith & Pilling, 2007; Tryssenaar & Perkins, 2001). These findings add to the literature which demonstrates a similar transition pattern across the private and public sectors, and the allied health and nursing or medical fields.

Despite the transition process following a relatively predictable pattern, there is variance for each new graduate depending upon personal attributes such as past clinical experience and overall level of confidence. While some graduates will find the transition into practice a more challenging time than others, once the initial shock had resolved, the participants in this study were able to build on their skills and confidence to improve as osteopathic practitioners. A successful transition was evident in all participants.

As the curriculum has changed significantly since these new graduates studied, it would be worthwhile researching whether these changes have an impact on how the upcoming cohort of graduates experience the transition period. Further studies conducted with overseas-trained osteopathic graduates would also be beneficial to gain insight into the effect different curricula and professional bodies might have on the transition process.

There is no way round the transition from student to practitioner but to go through it. Educational providers, professional bodies and the individual graduate can all act to ease the transition, especially as its apparent predictability can enable a more targeted approach to areas of need. However a transitional period will remain, and as Melody found, “You’ve just got to go out there and actually find out for yourself”.
REFERENCES


APPENDIX A – EMAIL TO UNITEC GRADUATES

15 minutes is all it takes, please help me out!

Hello, my name is Yohanna Davidson and I am a fifth year osteopathy student at Unitec. With the help of my supervisors Clive Standen and Jill Yelder I am researching the transition from student to practising osteopath.

By taking part in this research project you will be helping us to better understand the process that new graduates undergo as they start practice. This will assist in developing better ways to prepare students for professional practice.

If you have been working as an osteopath for 18 months or less, please take a moment to click on the link below to access the questionnaire. It should take no longer than 15 minutes to fill in. If you have been working for LONGER than 18 months, please disregard this email.

http://www.surveymonkey.com/s/3TTXPXR

Thanks for your participation, your help is greatly appreciated!

Yohanna Davidson.
APPENDIX B – INFORMATION SHEET

You are invited to take part in a research project conducted by Yohanna Davidson, a student of the Master of Osteopathy programme at Unitec. The research topic looks at how recent graduates from the osteopathy programme found the transition from studying to being a practising osteopath.

**What I am doing**

I aim to find out if there are any common experiences encountered by recent graduates as they leave study behind them to enter the workforce as a practicing osteopath, in particular looking at the difficulties met and how they were dealt with.

By taking part in this research project you will be helping us to understand how graduates find the transition process, which will assist in developing and employing appropriate ways to minimise these difficulties for future graduate years.

**What it will mean for you**

If you choose to take part, the link below will take you to the questionnaire which should take about ten minutes to complete. Participation in this survey is entirely optional and anonymous. Please bear in mind that the success of this research is directly proportional to the number of respondents.

In addition to the questionnaire that is being sent to all graduates who have been working for up to 18 months, I will also be conducting interviews with people who have been working for 3 – 6 months and 12 – 18 months. This is in order to gain deeper insight on the same content than is possible through just the questionnaire. The interview will be conducted at a time and location convenient to you and take approximately one hour. If you are interested in participating in this also please contact me at: yohannadavidson@yahoo.co.nz

I will tape the interviews and later transcribe them. All features that could identify you will be removed and the tapes used will be erased once the transcription is done. A file will be made for your transcript and a summary of your significant statements, and you will be given the opportunity to read these to ensure they accurately reflect your experiences. All information collected from you will be stored on a password protected file and only you, my supervisors and I will have access to this information.
Consent

If you agree to participate, submission of the questionnaire will be taken as your informed consent. Those participating in the interview will be requested to sign an additional consent form. Information gained during the interview is able to be withdrawn up to one month after the interview.

Please contact me or my supervisors if you need more information about the project or if you have any concerns about the research project:

Yohanna Davidson (principle researcher)  yohannadavidson@yahoo.co.nz
Clive Standen (principle supervisor)  cstanden@unitec.ac.nz
Jill Yielder (associate supervisor)  jyelder@unitec.ac.nz

UREC REGISTRATION NUMBER: 2009-1027

This study has been approved by the UNITEC Research Ethics Committee from 18 November 2009 to 18 November 2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
APPENDIX C – CONSENT FORM

Participant consent form

AN INVESTIGATION INTO THE TRANSITION FROM STUDENT TO PRACTISING OSTEOPATH

I have had the research project explained to me and I have read and understand the information sheet given to me.

I understand that I don’t have to be part of this if I don’t want to and I may withdraw at any time up to one month after the completion of the interview.

I understand that everything I say is confidential and none of the information I give will identify me and that the only persons who will know what I have said will be the researcher and her supervisors. I also understand that all the information that I give will be stored securely on a computer at Unitec for a period of 5 years.

I understand that my discussion with the researcher will be taped and transcribed.
I understand that I can see the finished research document.
I have had time to consider everything and I give my consent to be a part of this project.

Participant Signature: …………………………… Date: ……………………………

Project Researcher: …………………………… Date: ……………………………

UREC REGISTRATION NUMBER: 2009-1027

This study has been approved by the UNITEC Research Ethics Committee from 18 November 2009 to 18 November 2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
How did you find the transition from student to osteopath?

How confident did you feel when you first graduated? How well prepared for practice did you feel?

How has your confidence and perspective changed now that you have been working for a while?

In terms of confidence in your palpation, what has changed under your hands since you’ve been practising?

What aspects did you find difficult or stressful? Tell me about one of those situations.

How did you deal with these difficulties?

Are there any barriers that affect the quality of treatment you give? Eg. difficult patients, building rapport, complicated presenting complaints, back-to-back patient lists etc…

Have you found ways to overcome these barriers?

How have they caused you to change the way you practice?

Are there things in your training that could be implemented that could have eased the transition?

What types of patients do you tend to see?

Are there other areas you would prefer to work in? Could anything in your training have helped you to know this earlier?

Do you have an osteopath who acts as a preceptor or mentor to you? Describe their role and how beneficial you find the relationship.