The Dual Role of a Clinical Educator as Mentor and Assessor: Influence on the Teaching-Learning Relationship

By

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Declaration

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Abstract

At the core of clinical education, within the allied health professions, is the teaching-learning relationship between the clinical educator and the student which is reinforced by and grounded in the explanatory theories of socio-constructivism, experiential learning and positioning. A good teaching-learning relationship is fundamental to the success of the students' learning in the clinical environment. Clinical educators fulfil a dual role as mentors and assessors to students. The purpose of this study is to explore the students' and clinical educators' perceptions of the dual role of a clinical educator of students in the physiotherapy clinical environment, and how the perceptions of both parties influence the teaching-learning relationship. By following a phenomenological qualitative research approach with an interpretivist paradigm the researcher obtained data from focus groups and individual interviews. Data analysis involved a contextualised interpretive content analysis paradigm. The perceptions of the participants in the teaching-learning relationship, their particular expectations, challenges and preferences, reflect their experiences and are presented in the findings of the study. The findings of this study are comprehensively discussed and recommendations are made to transform the teaching-learning relationship by repositioning the participants (both students and clinical educators) in order to enhance the quality of the clinical learning experience within the physiotherapy clinical environment.

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Opsomming

Die onderrig-leerproses-verhouding tussen die kliniese dosent en die student vorm die kern van kliniese onderrig, ondersteun deur en op grond van die verduidelikende teorieë van sosiale konstruktivisme, leerervaring en posisionering, vir verwante gesondheidsberoepe. Die onderrig-leerproses-verhouding word daarom beskou as die grondslag vir die sukses van leergeleenthede, aangesien die kwalitiet van die verhouding deurslagggewend is om studente se leerproses in die kliniese omgewing te ondersteun. Kliniese dosente speel 'n dubbele rol as mentors en assessore vir studente. Die doel van die studie is om studente en kliniese dosente se sienings van die dubbele rol van 'n kliniese dosent van studente binne die kliniese onderrigveld van fisioterapie in die kliniese omgewing te ondersoek, asook hoe die persepsies van albei partye die onderig-leerproses-verhouding beinvloed. Die data word verkry van fokusgroepe en individuele onderhoude deur 'n fenomenologiese kwalitatiewe navorsingsbenadering met 'n interpreterende paradigma te volg. Die data is ontleed volgens 'n kontekstuele interpreterende inhoudsontledingsproses. Die persepsies van die deelnemers aan die onderrig-leerproses-verhouding, hul spesifieke verwagtinge, uitdagings en voorkeure as drie breë temas van hierdie tesis, weerspieël hul ervarings en word weergegee in die bevindings van die studie. Die navorsing bespreek hierdie bevindings en doen regstellende aanbevelings oor die bevindings. Hierdeur kan die onderrig-leerproses-verhouding, deur herposisionering van albei partye (studente sowel as kliniese dosente), getransformeer word en die gehalte van die kliniese leerervaring in die fisioterapeutiese kliniese omgewing verbeter word.

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Glossary

Affective domain: a learning dimension that addresses the complexities of emotional and attitudinal states.

Assessing process: a process that it is based on educational goals and objectives previously established. The assessing process allows the clinical educator to establish the level of the student's performance.

Assessor: the clinical educator assessing the students' procedural knowledge, skills and attitudes during clinical education in the clinical environment.

Attitudes: opinions or feelings, a component of the affective domain.

Attributes: students and clinical educators acquire skills, attitudes and practices during clinical education.

Authentic learning: the learning environment which incorporates a real-life situation.

Beliefs: personal understanding that contributes to thinking, feeling and doing.

Clinical education: the process whereby students apply knowledge, acquire skills, attitudes and behaviours in the clinical environment.

Clinical educator: a student supervisor in a clinical environment who helps to facilitate effective learning and learning relationships.

Clinical placement: periods spent at locations where students are provided with opportunities to engage with patients, practise skills and apply theoretical frameworks, care for patients and establish meaningful therapeutic relationships.

Cognitive domain: a learning dimension, involving the thinking process.

Collaboration: an active on-going partnership, often between people from diverse backgrounds, based on sharing, co-operating and coordination in order to solve problems and provide services.

Community: in health care organizations, the community refers to a group of individuals working together in some form of social connection in planning, providing care and services to a patient population.

Competencies: a combination of attitudes, knowledge, skills and behaviour that result in competent or effective performance, taking into consideration the nature of the tasks and the organizational context.

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Continuous quality improvement: an approach to quality management by emphasizing the organization and systems; focuses on process rather than the individual.

Feedback: formative, to assess students' progress towards educational goals, or summative, to judge students' achievement of goals by a clinical educator.

Mentor: someone who provides an enabling relationship that facilitates another person's personal growth and development.

Patient: also referred to as a "client": an individual who is a consumer of health care services.

Professional practice or experience: refers to the experience of a student within a clinical placement, also called, fieldwork or field placement.

Professional practitioner: health care worker who provides preventive and curative interventions to the patient or client.

Professional supervision: the process aimed at enhancing the effectiveness of the person supervised. It may include the acquisition of practical skills, mastery of theoretical or technical knowledge and personal professional development.

Quality improvement: a process that focuses on continuously assessing and improving the quality of the internal operational teaching-learning relationship within clinical education.

Social-constructivism: a philosophical stance in which learning is seen to be constructed individually through language and group interaction.

Student: also called learner or trainee, is an individual learning in practise to gain professional competencies to be able to work as a licensed professional.

Teaching-learning relationship: a relationship that exists between a student and a clinical educator which enables a student to have meaningful learning experiences in the clinical environment.

Chapter 1: Orientation of the Study

The aim of this chapter is to address specific aspects of the rationale behind the study and to explain the context within which this study was undertaken. The concepts and context of clinical education, the roles of the clinical educator and the teaching-learning relationship are presented. The research question and aims of the study are also provided. The chapter ends with an outline of the remainder of the assignment.

1.1 Introduction

Clinical education is considered to be the cornerstone of health profession education and is described as the key component that prepares health practitioners for practical experiences (Kilminster, Cottrell, Grant & Jolly, 2007; Laitinen-Väänänen, 2008). The main aim of clinical education is to ensure that graduates are fit for practice in their chosen disciplines (Wass, van der Vleuten, Shatzer & Jones, 2001). Clinical education in a clinical environment remains a powerful teaching context as it provides an authentic experience while students are actively engaged in the learning process (Ker, Cantellon & Ambrose, 2008; Griffiths & Ursick, 2004; Webb, 2004). The learning process in clinical education occurs through a cycle of action and reflection (Kolb, 1984; Schön, 1995). Rooted in the principles of action and reflective learning theory and centred in communities of practice (Wenger, 1999) personal identities can develop, as required from health professionals in training. Affective, psychomotor and cognitive skills are combined in a socio-emotional environment and new, meaningful knowledge is acquired (Boud & Falchikov, 2007). Students are, therefore, holistically involved in clinical education in the clinical environment (Bloom, 1956). Being holistically involved is seen as essential for learning as it facilitates socialization in a practice community and ensures personal and professional growth (Laitinen-Väänänen, 2008).

In addition, the success of students' learning in clinical education depends on the manner in which teaching, learning and assessment (Vermunt, 2005) are conducted during the teaching-learning relationship between the clinical educator and a student. The teaching-learning relationship between the clinical educator and the student is reinforced by and grounded in the explanatory theories of socio-constructivism, experiential learning and positioning of participants as equal partners in communities of practice. Vygotsky's learning principles shed further light on the importance of working in a community of practice, in which collaboration and language are emphasized (Vygotsky, 1962).

In clinical education practice, as a form of experiential learning, students are involved in learning while being engaged in a real-life context (Strochschein, Hagler, & May, 2002; Chan, 2001; Higgs, 2004; Kilminster, Cotrell, Grant & Jolly, 2007). In this clinical context, students learn to interact with others and develop competence to become life-long learners (Higgs & Titchen, 2001; Hobbs, Henley, Higgs & Williams, 2000). Students learn to integrate theory and practice and develop

competency in problem solving, clinical reasoning and communication skills. The clinical environment is considered to be the best area for teaching and refining these required skills (Torre, Daley, Sebastian & Elnicki, 2006; Higgs & Edwards, 2002; Molloy & Clarke, 2005). In this environment, students become aware of the many needs of a patient and they develop an understanding of the different roles of the health care team (Ponzer, Hylin, Kusoffsky, Lauffs, Lonka, Mattiasson & Nordström, 2004; Bleakley, 2006). Students further develop the ability to express their opinions for the treatment they offer patients by providing evidence to support their choices (Higgs, Jones, Loftus & Christensen, 2008). Through these meaningful learning opportunities the students gain confidence and high levels of competency can develop in becoming proficient physiotherapists (Rose & Best, 2005). During their encounters with patients in the clinical environment students are constantly facilitated by a variety of clinical educators who act as expert role models (Cruess, Cruess & Steinert, 2008) while providing direct supervision to students.

In the healthcare profession, the terms 'clinical supervisor', 'clinical instructor', 'clinical teacher' and 'clinical educator' are used interchangeably. For the purpose of this study, the following definition will be used to describe a clinical educator: "A clinical educator is a qualified practitioner who directly supports students' learning during clinical education to acquire knowledge, skills and values and to develop students' competencies in these practices" (Dowling, 2001; McLeod, Steinert, Meagher & Mcleod, 2003; Strochschein, Hagler & May, 2002; Kilminster, Cotrell, Grant & Jolly, 2007). Harden & Crosby (2000) listed the many roles of a clinical educator as being assessor, mentor, role model, advisor, counsellor, teacher and manager. Molloy & Clarke (2005) added that the role of the clinical educator is generally understood by healthcare professions, as monitoring, guiding and supporting students in matters of personal, professional and educational development in the clinical context.

Several researchers agreed that the relationship between a clinical educator and a student is probably the most important aspect of clinical education as the clinical educator provides support and a sense of belonging, therefore, feeling inclusive (Kilminster & Jolly, 2000; Jones, 2001; MacDonald, 2002; Kilminster, Cottrell, Grant & Jolly, 2007; Skaalvik, Normann & Hendriksen, 2011; Gallagher, Carr, Weng & Fudakowski, 2012). Learning not only occurs from what is taught, but also from the clinical educator-student relationship itself. However, the quality of the relationship between a clinical educator and a student can affect learning negatively, particularly if there is any disparity in either parties' expectations (Hodges, 2009). Students identify relationships with their clinical educators as critical to the satisfaction of their learning experience (Miller, 2012). Their relationship will affect their confidence and willingness to engage actively in the learning process (Delany & Bragge, 2009).

The expertise and experience of the clinical educator are essential qualities needed to perform the role of assessor, to determine the level of competency of students, is a complex process

(Alexander, 1996). Assessment includes many facets to and varieties of assessment methods or strategies which further add to the complexities of the assessor's role. This is substantiated by Bernard and Goodyear (2009) who added that a clinical educator's role as assessor serves as a gatekeeper for those who are to enter the particular profession. A reliable assessment practice, assessing the required competencies depends on the clinical educator's objective assessment of students' performances before they are promoted to the next level, or graduate from the programme. For a clinical educator to assess the students' level of competency reliably, is challenging, and attempts to standardize this process are essential (Cross, 2001).

1.2 Background of the Study

In the Division of Physiotherapy at the Faculty of Medicine and Health Sciences, Stellenbosch University (SU), the undergraduate physiotherapy programme is a four-year Bachelor of Sciences (BSc) degree course. The programme contains a practicum component module, namely, Clinical Physiotherapy. Clinical education in the undergraduate BSc in Physiotherapy degree is seen as a core component in the educational training programme.

The National Qualification Framework (NQF) requires a minimum of 480 credits to be awarded the degree BSc in Physiotherapy (CHE 2011; HEQF,2007). According to the level descriptors of the South African Qualification Accreditation (SAQA) a minimum of 96 credits at level eight is required to qualify as a “professional” degree (SAQA, 2010). The Clinical Physiotherapy 474 (CPT 474) module comprises the necessary 96 credits at level eight. Such a qualification constitutes a thorough grounding in the knowledge, skills, principles, attitudes and the ability to apply these in a professional physiotherapy practice context. The regulatory body, namely, the Health Professions Council of South Africa (HPCSA), expects physiotherapy students to complete at least one thousand clinical hours over the period of four years for the duration of the programme (HPCSA, 2012).

In the first and second years of training, the programme covers mostly theoretical concepts. The practical component is introduced in the second year (CPT 272) of study. During the third year, the CPT 373 module runs concurrently with the problem-based theoretical modules. The CPT 373 module is divided into three clinical rotations of one four-week and two five-week blocks. Students are placed in a variety of clinical placements for their medical and surgery, orthopaedic and neurology blocks. After each clinical block the students are expected to complete a clinical assessment. Assessment of undergraduate physiotherapy students' clinical performance at the Division of Physiotherapy, SU, involves the direct observation by clinical educators while students evaluate and treat patients during their clinical education. The direct observation of students' practices involves a range of circumstances which include the history-taking and physical examination of an unknown patient or the re-evaluation and treatment of known patients across a spectrum of patient types and needs. Students continue with the CPT 474 module until the end of

the final year of study. Fourth-year students are exposed to five clinical blocks of six weeks each (medical and surgical, orthopaedics, neurology, community and a speciality block) as well as an elective rotation of two weeks in the June vacation period.

Students are exposed to clinical education in a clinical environment under the guidance of the clinical educator. During their clinical education physiotherapy students acquire clinical skills, values and attitudes through interaction with clinical educators in the clinical environment at a variety of clinical placements. The clinical educators are either employed permanently in academic full-time posts, in permanent part-time clinical posts or in clinical contract posts at SU. The third-year students receive two hours' supervision per week by a clinical educator over a period of four to five weeks during their clinical placement. The fourth-year students receive one hour's supervision per week by the clinical educator over a period of six weeks during their clinical placement. The intention is for clinical educators to focus specifically on educating students during these supervision sessions. In the final week of a clinical rotation the clinical educator takes on the role of an assessor. Assessment occurs in the context of various clinical settings with a variety of patients.

During the course of the module, continuous formative and summative assessments are administered by clinical educators as assessors on students' performances, based on direct observation. Students have to demonstrate the application of knowledge, skills and attitudes in a specific context on real-life patients to determine whether they have met the necessary standards and outcomes (Miller, 1990). The standards of assessment on the outcomes of the module are based on the Assessment Policy of SU which states that the assessment processes should be "valid, reliable, transparent, fair and achievable with timely feedback and academic integrity" (Assessment Policy and Practices at Stellenbosch University, 2012). Summative block assessments are administered by the clinical educator in the last week of each clinical block, during the midyear examination period as well as two exit clinical examinations at the end of the year. These exit assessments involve two assessors: the clinical educator and an external assessor. The external assessor focuses on ensuring that the required standards are attained as prescribed by the regulatory bodies and the curriculum. Specific pre-determined criteria and weighting of the assessments are used to determine the pass or fail status of borderline students and are made explicit to the students.

1.3 Motivation for the Study

Some clinical educators were faced with challenges which caused friction between them and the students. All clinical educators fulfil a dual role and are expected to act as mentors to students for the first few weeks during a clinical block after which they take on the role of assessors in the final week. Having to change from being a mentor to being an assessor may present particular challenges for both the clinical educator and the students. These challenges can affect the

teaching-learning relationship between the clinical educator and the students. Some clinical educators are appointed in clinical contract posts at SU. As they are not directly involved with the students' academic programme, disparities in the expectations of both parties arose as students easily used the excuses such as, "I don't know"; or "We were never taught this". Furthermore, some clinical educators reported that they found it difficult to address the needs of the students effectively as some students were reluctant to reveal their lack of knowledge. Other students did not create their own learning opportunities for which they were responsible in the clinical environment. The challenge was then for clinical educators to determine the students' level of knowledge so that they could provide efficient support. The learning outcomes guide students in their preparation for their clinical blocks and could be used by the clinical educators to determine their level of knowledge. In another situation it happened that a clinical educator failed a student on one of her clinical blocks. The student ended up with the same clinical educator as assessor on a different clinical block. This led to anxiety and a lack of confidence in the student, which could influence the learning experience negatively. These disparities could cause friction and could jeopardise the safe learning environment. It was necessary for the researcher to determine whether these challenges affected the teaching-learning relationship between the clinical educator and students at the Division of Physiotherapy, SU. Therefore, the following question was posed: should the assessor and the mentor be the same person?

The *modus operandi* of the clinical educator, being the mentor and later the assessor, seems to be a common national and international practice (Maxwell, 1995; Cross, 1995; Alexander, 1996; Neary, 2000a; Power & Bogo, 2003; Anderson, 2006; Bray & Nettleton, 2007; Brown, Douglas, Garrity & Shepherd, 2012). Therefore, the results of this study could inform and benefit clinical educational processes worldwide. Although this model of education, the dual role of clinical educators, is widely used in physiotherapy practices globally, a qualitative study exploring the perceptions, views and experiences of both the clinical educators and students in a physiotherapy clinical environment as respondents, could not be discovered in any literature in the South African context. This research is, therefore, timeous and relevant as it attempts to investigate how the dual role may influence the relationship between the clinical educator and the student which in turn may affect learning.

Another reason for researching this topic is that this study elaborates on a study that was done by Ernstzen, Bitzer & Grimmer-Somers, (2006) in which the roles and attributes of the clinical teacher that contributed to favourable learning environments, were investigated. Their study indicated that the dual role of a clinical educator as facilitator of learning and assessor of learning needed further investigation. There has been little research conducted that has examined how clinical educators and students conceptualize the influence that the dual role of the clinical educator can have on the teaching-learning relationship within the physiotherapy practice in the South African context.

Moreover, according to the World Confederation of Physical Therapy, (WCPT, 2011), all physiotherapists have a professional obligation to support quality clinical education for undergraduate physiotherapist students. Steinert, Mann, Centeno, Dolmans, Spencer, Gelula & Prideaux, (2006) proposed that it is reasonable for institutions to expect that faculty development will "result in improved teaching performance and better outcome for students." Such improvements include new perceptions about factors that influence relationships between students and educators and increased commitment to educational scholarship-investigation of teaching and learning processes (Hendriksen & Kaplan, 2003).

Various authors have identified the need to develop adequate and sustainable structures for clinical education as there is growing tension noted between clinical educators and students to create effective learning of students in the clinical environment (DeClute & Ladyshewsky, 1993; Ladyshewsky, Barrie & Drake, 1998; Maxwell, 1995). Personal epistemologies, beliefs about knowledge and sources of knowledge, can influence clinical educators' and students' approaches to the teaching-learning relationship in the clinical environment (Kilminster & Jolly, 2000; Delany & Bragge, 2009). The relationship between the students and the clinical educator regarding the dual role and its impact on the students' learning, therefore, needed further investigation.

It therefore became necessary to address the following key elements in the learning process of students in the Division of Physiotherapy at SU, namely,

- the dual role of the clinical educator as a mentor and an assessor,
- the relationship between the student and the clinical educator and its impact on the student's learning, and
- the nature of the experiences of the students and the educator during the assessment process with regard to this relationship.

The following research question and study aims were formulated with the above-mentioned motivation in mind. Research was conducted to investigate how the clinical educator and the students constructed meaning from and explained their experiences of this aspect of physiotherapy clinical education in order to improve the quality of the students' learning. Drawing on the theories that support the teaching-learning relationship, the researcher will take a reflexive stance and follow an iterative approach to evaluate the influences pertaining to the dual role of an educator. A qualitative study to explore the students' and clinical educators' experiences during the teaching-learning interaction may help to provide insight into students' learning.

1.4 Problem Statement

The dual role of a clinical educator may present particular challenges for both clinical educators and students within the clinical education of physiotherapy. These may influence the teaching-

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learning relationship between the clinical educator and the student and eventually influence the quality of the clinical learning experience.

1.4.1 Research Question

How does the dual role of the clinical educator as mentor and assessor at the Division of Physiotherapy SU, influence the teaching-learning relationship?

1.4.2 Aims

The aims are:

1. to explore the students' and clinical educators' perceptions of the dual role of clinical educators as mentors and assessors of students, and
2. to explore how the perceptions of both parties may influence their teaching-learning relationships.

1.4.3 Objectives

The objectives of this research are:

- to describe the students' perceptions of how the dual role of the clinical educator as a mentor and assessor of students influences the teaching-learning relationship,
- to describe the clinical educators' perceptions of how the dual role as a mentor and assessor of students influences the teaching-learning relationship,
- to describe the students' and clinical educators' perceptions of how the assessment sessions influence the teaching-learning relationship when a clinical educator changes from a mentor to an assessor, and
- to determine what the implications are on the teaching-learning relationship between the clinical educator and the student when a clinical educator is both the mentor and the assessor.

1.5 Assignment Outline

In chapter two a number of research studies and articles which were conducted in recent years to investigate various factors that could influence the learning of students, are analysed. Learning theories that support the roles and relationships in clinical education are discussed. Challenges which both the clinical educator and the students faced in clinical education are highlighted and the influences that these challenges may have on the teaching-learning relationship, are considered.

The research design and methodology are described in chapter three. In chapter four the findings of the study are presented. In chapter five, these findings are interpreted and discussed. Suggestions are offered to address the challenges, expectations and preferences that were identified.

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In chapter six, the findings of the study are synthesized in relation to the research question. Conclusions are drawn, limitations of the study are identified and recommendations are made for further research.

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Chapter 2: Literature Review

This chapter studies the available literature to determine the possible challenges and factors which may influence the teaching-learning relationship between the clinical educator and the students when clinical educators act as both mentors and assessors. This chapter focuses on the abovementioned relationship which is supported by and grounded in the relevant explanatory theories of social constructivism, experiential learning and positioning of the participants in communities of practice. Concepts such as learning and teaching approaches, roles and responsibilities of the key players, feedback, assessment and communication within the clinical setting are also reviewed.

2.1 Clinical Education

The clinical educational process is defined by Kilminster, Cottrell, Grant & Jolly, (2007) and Ernstzen, Bitzer & Grimmer-Somers, (2009) as the provision of guidance and feedback on personal, professional and educational development in the students' experiences, while providing appropriate patient care. It is, therefore, a form of authentic learning as it involves the acquisition of clinical skills in a real-life environment (Delany & Bragge, 2009). The acquisition of important clinical skills essential for treating patients, is considered and widely recognized as a core component of the training of undergraduate physiotherapy students while the overall aim of clinical education is to enhance students' learning (Higgs, 1992; Lekkas, Larsen, Kumar, Grimmer, Nyland, Chipchase, Jull, Buttrum, Carr & Finch, 2007; Kilminster & Jolly, 2000; Strohschein, Hagler & May, 2002; Laitinen-Väänänen, 2008). Students actively build and integrate their theoretical and practical knowledge (Kilminster & Jolly, 2000) through these experiences.

As early as 1956 Benjamin Bloom's taxonomy of learning addressed the holistic process of educational activities in which students should be involved. Bloom (1956) identified the three domains of learning as the cognitive or mental skills (knowledge), the psychomotor or physical skills (skills) and the affective or feelings (attitudes) domain. It is important for clinical educators to incorporate all three domains in the education of students as clinical education, within the allied health professions, aims to equip entry-level students with the necessary knowledge, skills and behaviours to work competently and safely in the clinical environment (Chipchase, Buttrum, Dunwoodie, Hill, Mandrusiak & Moran, 2012).

2.2 Clinical Environment

Clinical education in physiotherapy is described by the World Confederation of Physical Therapy as the delivery, assessment and evaluation of learning experiences of students in the clinical environment (WCPT, 2011). To understand the clinical education curricula in physiotherapy is to understand knowledge, how it is constructed, the context and the way in which the knowledge is used in practice. This can be accomplished by extending the students' knowledge-base by means

of formal and informal interactions among stakeholders and applying the knowledge in the complex setting within a real-life environment (Higgs, 1992; Strohschein, Hagler & May, 2002; Lekkas, Larsen, Kumar, Grimmer, Nyland, Chipchase, Jull, Buttrum, Carr & Finch, 2007; Delany & Bragge, 2009; Delany & Molloy 2009). The stakeholders, among others, include the student, the clinical educator, the patient, peer students, the medical doctor and the nurses as part of the health professional team. They each play an important role in the students' clinical learning experience.

This socio-emotional environment provides the students with opportunities to be holistically involved where they can generate new knowledge which becomes meaningful (Boud, Cohen & Samson, 1999). Several factors in this complex setting of the clinical environment can influence the students' learning process and subsequently affect the outcomes of a given learning experience (DeClute & Ladyshewsky, 1993). The expectations and the relationships between the clinical educator and the students, within the dimensions of diversity including social, cultural and learning styles, presented in the clinical learning environment can pose as facilitators or as challenges to learning, highlighting the students' need for pedagogical and psychological support (Ferguson, 2000; Saarikoski & Leino-Kilpi, 2002). These factors may influence the quality of students' learning in the clinical environment. However, valuable opportunities for students to develop their understanding of the physiotherapy profession are offered in the clinical environment. The clinical educator therefore needs to understand how to construct the learning opportunities, to engage the students actively and to support them in the learning process.

According to Barr and Tagg (1995), in the traditional teacher-centred paradigm the focus is on the educator where knowledge is transferred to passive learners. The requirement for educators in this context is complete mastery of the content. The students are silent and passive recipients of knowledge. However, in the clinical context of Higher Education, SU, the focus is placed on student-centredness where students are actively engaged in order to construct, discover and transform knowledge (SU, Strategy for Teaching and Learning, 2012:2). This involves the facilitation of learning with the focus on the quantity and quality of students' learning. By incorporating a student-centred paradigm the clinical educator facilitates the growth and personal development of the students in becoming self-directed and autonomous learners. Encounters between the clinical educator and the students are mediated by all the people involved as well as by previous knowledge (Rideout, 2006). These encounters may be through direct observation by the clinical educator or by indirect encounters such as conversations during the learning sessions (Pickering, 1990). The clinical environment, therefore, includes the context of learning, the variety of placements, the clinicians, the different assessment methods and the clinical educator.

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2.2.1 Clinical Placements

Clinical placements are dynamic educational environments which present opportunities for teaching and learning and are therefore fundamental to the educational experience of all undergraduate students in becoming competent health professionals (Kilminster & Jolly, 2000; Chan, 2001; Koontz, Mallory, Burns & Chapman, 2010). Students are placed in a variety of clinical placements where they are expected to demonstrate and apply their acquired knowledge and skills during clinical education in area-specific contexts. These placements range from acute care with patients in tertiary institutions, to secondary institutions, to longer term rehabilitation settings in rural communities, primary healthcare settings, community health clinics and to non-clinical settings in schools and industries. Placements act as a bridge between academic and experiential learning (Chan, 2001; Newton, Jolly, Ockerby & Cross, 2010; Rodger, Fitzgerald, Davila & Millar, 2011; Torre, Daley, Sebastian & Elnicki, 2006). Tetik (2006) added that experiences *per se* do not lead to learning. It is also the context in which the learning experience takes place that adds to the students' learning. Ferguson (2000) acknowledged that a student can find learning an anxious experience when they have to enter a new clinical environment. The teaching-learning relationship between the clinical educator and the student in this environment is, therefore, of paramount importance as it can lessen or intensify stress and anxieties and influence the student's learning. Studies by Ramsden (1997) and Beaty, Gibbs and Morgan (1997) identified that students' levels of anxiety, their interests, as well as the tasks to be undertaken, influence the approach they adopt to learning and therefore their learning outcomes.

2.3 Learning Approaches

Entwistle and Peterson (2004) mentioned three different ways in which students can approach their learning. Students may use the deep, the surface, or the strategic approach to learning. These approaches to learning were identified by Biggs (1999) as interactions between different strategies and motivations for learning. To be able to contextualize and internalize what students learn, it would be ideal if students used the most appropriate learning approach.

Using a surface approach to learning during clinical education, the students' intentions are to cope with the requirements in the clinical environment and their interests are to qualify through extrinsic motivational methods. In a strategic approach to learning, students' intentions are to achieve the highest possible grades. These students are highly organized, will investigate the criteria and weights of the marking of the assessment and will rely on previous assessment procedures to predict performances (Entwistle & Peterson, 2004; Newble, Jolly & Wakeford, 1994; Ramsden, 1997). The deep approach to learning fosters an active participant in the learning process where knowledge is created to give personal meaning to the student. These students are interested in learning for learning's sake. They are intrinsically motivated. Rose and Best (2005) confirmed that motivation is essential for students' learning. These approaches form the psychological context of

learning (Mann, 2008). Students' approaches to learning can be influenced by the learning environment, the educational activity and the assessment process (Best, Rose & Edwards, 2005). The experience in the clinical environment may facilitate a change in the learning approach (Best, Rose & Edwards, 2005). The challenge for clinical educators is thus to facilitate students to engage in a deep approach to learning by encouraging and motivating them.

Clinical educators, therefore, need to understand how knowledge is constructed and applied within the teaching-learning relationship for good practice and for sound clinical education. Students develop confidence and are encouraged or intimidated by the nature of the teaching-learning relationship and other factors such as the environment and other personnel (Best, Rose & Edwards, 2005). Some explanatory theories about the roles and relationships between a clinical educator and a student are used to provide frameworks by which teaching and learning methods can be better understood.

2.4 Explanatory Theories

Explanatory theories which support students' learning provide clinical educators with insight into using opportunities for students to integrate their learning. These theories may assist the clinical educator to make sense of what is happening in the clinical environment in order to encourage students to develop a deeper understanding of clinical phenomena. This section will focus on explanatory theories of social constructivism, experiential learning and positioning, as they specifically describe and encourage interaction between the clinical educator and the student, which can help to establish a positive teaching-learning relationship.

2.4.1 Social Constructivist Theory

The social constructivist paradigm is the theoretical perspective of the social interaction that is relevant in the teaching-learning relationship to support the students' learning (Webb, 2004). Students are actively involved in the clinical environment and learn by creating meaning from their experiences (Torre, Daley, Sebastian & Elnicki, 2006). Through these experiences students articulate their thoughts and feelings to clinical educators and are thus holistically involved in a social process of learning. The social-constructivist model calls for a curriculum that is student-centred, that is related to students' prior knowledge and emphasizes a hands-on, real-life experience. When using this model the students acquire knowledge by collaborating and communicating with others in practice communities. The social interaction influences the teaching-learning relationship between a clinical educator and a student and provides an important context for learning (Chipchase, Buttrum, Dunwoodie, Mandrusiak & Moran, 2012). Figure 2.1 illustrates

the iterative relationship between teaching, learning and the learning environment in the social constructive model.

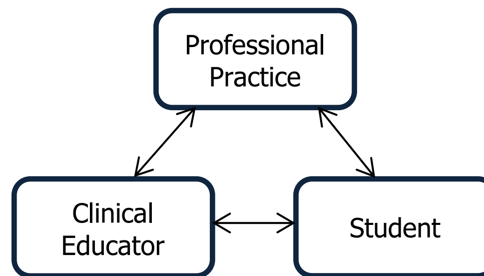

Figure 2.1: A Social Constructivist Model of Clinical Teaching and Learning (adapted from Webb, 2004).

Engaging in a teaching-learning relationship between a student and a clinical educator often contains an affective element. A relationship between two people refers to the state of being connected in an emotional association (Brown, 2002). According to Rogers and Freiberg (1994), for this to happen, certain key conditions must prevail such as respect, acceptance of each other, honesty, genuineness and being able to understand situations from each other's point of view. In any mutually beneficial teaching-learning relationship, the key that underlies these conditions is trust. The student should actively explore relevant learning opportunities while the clinical educator supports the student's learning by familiarizing himself or herself with the needs of the student. Billett (2001) indicated that social-constructivism has a direct application to learning in a clinical environment as it provides an overall approach which includes theories such as experiential and reflective learning.

2.4.2 Experiential Learning Theory

Experiential learning during clinical education can be described as learning that happens in a clinical environment where the theory that has been learnt, is applied and put into practice by working with real patients (Brown, William, McKenna, Palermo, McCall, Roller, Hewitt, Molloy, Baird & Aldabah, 2011; Yardley, Teunissen & Dornan, 2012). Experiential learning is not a new concept (Delany & Molloy, 2009). As far back as 1938, Dewey proclaimed that knowledge is constructed from real-life experiences. The studies of Kolb and Knowles confirmed this (Dewey, 1938; Kolb, 1984; Knowles, 1980). Schön (1995) has drawn on Dewey's work and placed great importance on the rational reflection of one's own practice to ground learning. Kilminster, Cottrell, Grant and Jolly (2007) elaborated on the above theories and said that experiential learning needs to involve the student holistically. The clinical educator is present during these encounters to facilitate, guide and ensure safe practice.

Cooks and Scharrer (2006) placed the emphasis on interactions that are necessary between the clinical educator, the student and the patient from which knowledge emerges. Delany & Molloy

(2009) agreed with all the above researchers and summed up their statements by saying that clinical education comprises the learning of professional skills, while dealing with patients and the interaction between the clinical educator, student and patient, and not simply by learning a collection of behavioural skills.

2.4.3 Positioning Theory

Davies & Harré's (1990) positioning theory is characterized by explaining the position of a person in relation to that of another during interactions between individuals as a means of facilitating learning. A “position” is a figurative location taken by a person in a particular clinical conversation, whereby any participant may publicly claim responsibility or duty to act. Using one’s position during interactions between individuals can be extremely dynamic and one’s position can change easily. Positioning theory can be a useful analytical tool to share the assumptions on the interactions and conversations in the teaching-learning relationship between clinical educators and students (Davies & Harré, 1990). This theory includes the main features of thought, language and action and reveals how these features are related to each other. Positioning theory is relevant in the teaching-learning relationship as the teaching and learning of students occur in everyday discussions between the clinical educator and the students in communities of practice. Positioning theory, therefore, may also play a major role in the assessment process.

2.5 Students’ Learning in the Clinical Environment

2.5.1 Learning in Communities of Practice

Communities of practice are defined by Wenger (1999) as “groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly.” Communities of practice are useful for exploring what students know and what they need to learn within the clinical environment. During their interactions the clinical educator and students collaborate and participate socially in practice by engaging in clinical education in the clinical environment. By participating in a community of practice (Wenger, 1999), students practise their skills, reflect on the theoretical basis and develop their values and norms within the profession. Wenger, (2002) added that although change and diversity are sometimes valued as sources of creativity and learning, a community of practice is still referred to by some as familiarity, continuity and shared frameworks. Communication forms an essential key element in a discursive community of practice. These social structures provide opportunities in which the student and clinical educator communicate to form close relationships, share interests and develop their self-identities (Strohschein, Hagler & May, 2002; Wenger, 1999). These are important qualities needed for a successful, discursive community of practice.

Furthermore, effective communication skills are essential within all teaching and learning situations (Gopee, 2008). It is important to note that clinical educators and students should engage in

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intentional, structured processes where essential competencies such as communication, collaboration and reflection are developed (Strochschein, Hagler & May, 2002). There are various ways of communicating such as written, verbal and non-verbal messages to consider when interacting in the educator-student relationship. A significant factor for an effective working relationship is skilled communication between a clinical educator and a student. Megginson (2006) mentioned that gestures, tone of voice, facial expression and verbal content are significant in communication. They relate messages to strengthen or weaken the affective domain of learning. Clinical educators need to listen and act as a sounding board for any anxieties and fears which students may experience during their clinical education. When an effective relationship is fostered and developed, it can have profound positive effects on students' learning (Warren & Denham, 2010). It is important to emphasize the need for belonging and uniting to feel part of the community and where trust and understanding are present in their relationship with the clinical educator, learning will occur. Students will be motivated to feel part of the community of practice (Wenger, 1999).

2.5.2 Learning through Feedback

The clinical educator assesses the students' practices in relation to expected norms according to set learning outcomes and provides relevant feedback. Feedback received from clinical educators is essential for students' learning during clinical education as it offers information on their actual performance (Van De Ridder, Stokking, McGaghie & Ten Cate, 2008). Feedback that highlights both strengths and weaknesses should be given and can be used to guide and motivate students, thereby promoting learning (Molloy & Clarke, 2005). The students are expected to internalize the information received from feedback by reflecting on their performances to transform their future practice.

However, Bucknall (2007) stated that the nature of the feedback process can be challenging as the success of feedback as a learning opportunity will depend on how clinical educators and students position themselves, the message that is generated and the characteristics of the learning context. Higgs, Richardson and Dahlgren, *(*2004) suggest that if clinical educators balance agendas such as safe patient practice, professional standards and students' self-esteem, honest, accurate feedback can become a positive learning opportunity. The social needs of the student in the relationship can be addressed. Although Ende (1983) and Glover (2000) suggested that feedback should be non-judgemental, Ende (1983) acknowledged the danger of a non-judgmental approach which he named "vanishing feedback". This happens when the clinical educator neglects to raise the necessary issues during feedback for fear of a negative emotional response from the student. This type of feedback could impede learning. Glover (2000) and Molloy and Clarke (2005) also reported tension being present in the relationship during formal, face-to-face feedback sessions.

Feedback is an essential part of inter-psychological action (Delany & Molloy, 2009) as feedback forms the basis of the assessment process (Brown, 2004). Formative feedback should be meaningful and comprehensive for students and is therefore seen as crucial. Summative feedback should be clear, should relate to the assessment criteria and be aligned to the learning outcomes (Brown, 2004). Not only do clinical educators play an essential role in students learning by providing positive feedback to students, they can also have a powerful effect on the motivation of students (Ernstzen & Bitzer, 2012).

2.5.3 Learning through Assessment

Assessment is part of the learning process as it provides students with information on the quality of their learning and highlights the importance of sound feedback. Van der Vleuten (1996) stated that assessment should have a positive impact on students' future learning as assessment should drive the direction of learning for students. According to Brown, (2004) effective assessment is the most important thing we need to do to help students to learn. Quality assessment should be aligned with the intended learning outcomes (Epstein, Dannefer, Nofziger, Hansen, Schultz, Jospe, Connard, Meldrum & Henson et, 2004) as it provides opportunities for clinical educators to give feedback to students on current performances. The feedback that students receive will enable them to develop strategies to improve their performances.

Brown (2004) also mentioned that assessment needs to be marked reliably to a defined standard by individual assessors and the criteria need to be clearly understood by all involved. Both students and assessors need to understand what is expected of them. Assessment practices should therefore be refined and reviewed continuously (Wilson & Scalise, 2006). The clinical educator as assessor of learning forms an important part in an effective teaching-learning relationship, but if discrepancies arise, the relationship can be jeopardized which can have a detrimental effect on the atmosphere of learning (Ernstzen & Bitzer, 2012).

2.5.4 Learning through Reflection

Felton, Gilchrist and Darby (2006) defined effective reflection as a process involving the interaction of emotions and cognition in which people intentionally connect experiences with academic learning. For learning to be effective, reflection must include an intention to share and understand the language, assumptions and aspirations of both the student and the clinical educator. Students internalize the information and use it to guide and regulate their own performances. With the support of the clinical educator, students are required to reflect on their thoughts and feelings before, during and after clinical experiences. Reflection as an essential and valuable process, enhancing the quality of learning and fostering students' responsibilities (Ash, Clayton & Atkinson, 2005; Bender, 2007), is incorporated into experiential learning where it prepares physiotherapy students for real-life work settings (Mostert-Wentzel, Frantz & van Rooijen, 2013).

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In the clinical setting, the clinical educator encourages students to reflect on their actions. This will help them to develop their clinical reasoning skills (Brookfield, 1995) and they will develop a deeper understanding of the world of their patients (Hay, 2003) as they focus on the emotional issues (McDrury, 2003). Emotions can have a positive influence on learning (Felton, Gilchrist & Darby, 2006). By focussing on their emotions in the reflection process students become intrinsically motivated. This leads to deep learning (Deci & Ryan, 2000).

Critical reflection can lead to transformative learning which involves the integration of new knowledge into existing knowledge structures and taking action on these insights (Mezirow, 1991). Due to the complex nature of the clinical context, it is important for the clinical educator to facilitate the students to reflect on their experiences.

2.5.5 Learning through Roles and Relationships

Roles and relationships are crucial components in successful clinical education (Strohschein, Hagler & May, 2002). The nature of the interpersonal relationship between a clinical educator and a student is important for learning (Pickering, 1990). The supervisory interaction between clinical educators and students in clinical education is regarded as the strongest element in developing students' expertise, and in forming professional identity (Laitinen-Väänänen, 2008). Students' learning occurs through these relationships among clinical educators and students in the clinical environment. The quality of the teaching-learning relationship between a clinical educator and a student is important as it determines the learning of students. A review of relevant literature on clinical education indicated that the relationship between a clinical educator and a student has the power to affect the student's learning positively or negatively (Fortune & Abramson, 1993; Fortune, Feathers, Rook, Scrimenti, Smollen & Stemerman, 1985). Positive relationships can increase the students' potential to practise effectively in the clinical environment, whereas negative relationships restrict students to routine tasks (Newton, Billet & Ockerby, 2009). A good relationship can result in a positive attitude to the clinical experience and thus leads to a deeper learning level for the student. The findings of a study conducted by Smedley and Morey, (2009) revealed that the development of a positive relationship with the clinical educator is essential in generating the ideal clinical environment.

Vygotsky's principles highlight the important role that relationships between students and clinical educators play in learning. To form a positive relationship between a clinical educator and a student Vygotsky and Cole (1978) suggested that they form a kind of "psychological symbiosis". During this process of inter-psychological functioning between the student and the clinical educators they will be able to communicate with each other and develop a state of deep spiritual, emotional and mental connection which leads to understanding and empathy (Brown, 2002). Trust, respect, understanding, spontaneous conversations and transparency, in which students are willing to reveal their limitations, are essential in the teaching-learning relationship and form key

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components of learning (Hupcey, Penrod, Morse & Mitcham, 2001; Gillespie, 2002; Gillespie, 2005). Ferguson, (2000) and Cross (1995) and Cross (1999) added that a shared responsibility for collaboration is needed for a positive teaching-learning relationship. To understand the learning process in these symbiotic relationships is highly relevant for the students' learning that occurs in the clinical environment.

According to Vygotsky's principles (Vygotsky & Cole, 1978), the learning zone defines the zone of actual development (ZAD) in which students function on a level without assistance where they are active and responsible. Working within this zone, the students have already mastered the skills expected of them during activities in clinical education. The clinical educator can help students to gain new knowledge, from a prior knowledge base, which is appropriate for their level of comprehension.

Another key feature in Vygotsky's principles is known as the zone of proximal development (ZPD) (Vygotsky & Cole, 1978). The ZPD is the area where learning actually takes place. Anything that a student can learn with the assistance and support of the clinical educator in the clinical environment lies within the ZPD. Students interact with clinical educators to accomplish a specific task which could possibly not be completed independently. By identifying the level at which students are functioning, clinical educators can adjust the amount of help they give, depending on the students' progress. This is called "scaffolding". The ZPD works in conjunction with scaffolding. The students' prior experiences, knowledge and skills form the basis of scaffolding for potential development. The clinical educator forms a relationship with students during the supervision sessions and it is within these relationships that the clinical educator scaffolds the learning of the student. Through scaffolding and facilitating the clinical educators may role model behaviours and/or provide verbal instructions for students. Shared experiences and effective communication among participants are essential to implement scaffolding successfully as a learning tool (Vygotsky, 1962). Vygotsky refers to this as co-operative or collaborative dialogue (Vygotskii & Cole, 1978). In this way the students actively participate in communities of practice (Lave & Wenger, 1991).

However, if this psychological symbiosis is not successful the teaching-learning relationship can be negatively influenced since any conflicting situation has the potential to influence the relationship negatively (Power & Bogo, 2003). Ineffective communication results in poor relationships. In studies conducted by Bonello (2001), Lew et al. (2007), Morris (2007) and Anderson, Rich and Seymour, (2011) students reported that the failure of clinical educators to listen to them and negative and humiliating comments made, have negative impacts on their learning and well-being.

2.6 Roles of a Clinical Educator

Clinical educators need to facilitate students to incorporate knowledge and skills during clinical education in the clinical environment. Acquiring skills under the guidance of clinical educators, not only relies on accumulating a body of knowledge and skills that are discipline specific, but also requires the application of this to a range of clinical scenarios and different patients' circumstances in the clinical environment. The clinical environment is thus the ideal setting for the development of the student's deep conceptual learning together with practical experience.

Figure 2.2 illustrates the many roles the clinical educator fulfils, two of which are identified as mentors and assessors of students (Harden & Crosby, 2000; Ernstzen, Bitzer & Grimmer-Somers, 2009).

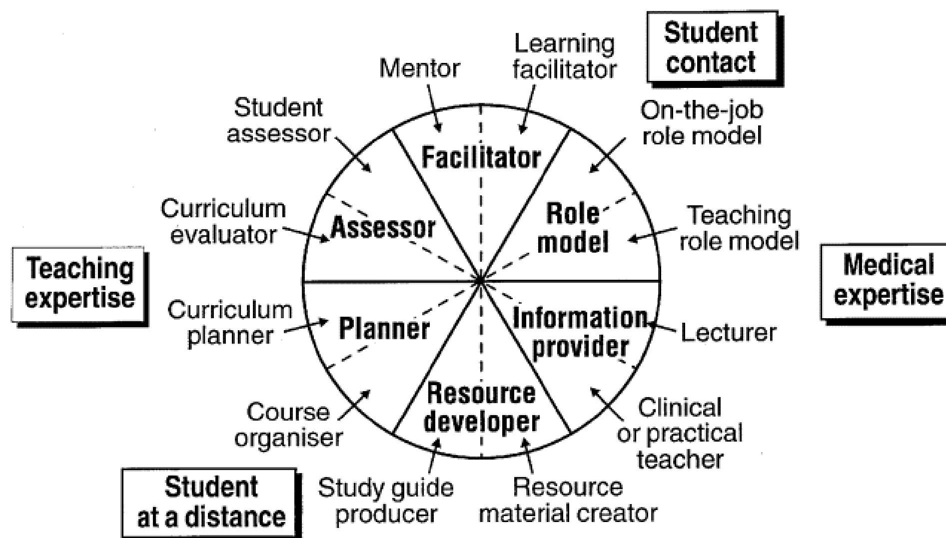

Figure 2.2 : The Twelve Roles of a Clinical Educator (Harden and Crosby, 2000)

2.6.1 Clinical Educator as a Mentor

Lingham and Gupta (1998) described mentoring as a process by which a person acts towards another as a trusted counsellor or guide. It is about helping that person to learn within a supportive relationship. Morton-Cooper and Palmer (2000) outlined a mentor as a clinical educator who assists a student to achieve a set of competencies. A mentoring process can be seen as a critical friend who collaborates in partnership with the students in the learning process. Clinical educators who are in a symbiotic relationship with their students and support the learning of students in the clinical environment can perform the role of mentor as they are naturally close to the students during their clinical educational experiences.

Mentoring, therefore, as a concept and practice, is related to facilitating professional learning in healthcare education. Mentoring students is often described as consisting of three behaviours making up the relationship between a clinical educator and a student. These include career development, psychosocial support and role modelling (Raabe & Beehr, 2003; Richardson, 1999;

Gopee, 2008). Many situations that a student encounters in the clinical environment are not taught at an academic level and can only be learned from a clinical educator, acting as role model. McClure, (n.d.) added that flexibility and responsiveness to the needs of the students' learning are essential qualities needed by a mentor in order to give psychosocial support. These attributes could enable students to achieve their goal of becoming competent practitioners (Gopee, 2008), especially if they are founded on a longer term supportive teaching-learning relationship (van Eps, Cooke, Creedy & Walker, 2006). It is therefore widely recognised that mentorship plays a vital role in supporting learning, and developing and training healthcare professionals (Best & Rose, 2005).

A mentoring relationship can be either formal or informal. A formal mentoring relationship involves a more structured manner of learning between a student and a clinical educator. An informal relationship occurs at informal times when the clinical educator is available to talk to, give advice and to council the student (Bray & Nettleton, 2007). A mentoring relationship between a student and clinical educator is seen as a powerful tool for advancing clinical skills (Ezzat & Maly, 2012).

Furthermore, a clinical educator acting as a mentor is usually a more senior experienced physiotherapist who is willing to invest time and energy, offer support to students and who takes an interest in their students. A mentor will assist students to find their feet and to facilitate them while interacting in the clinical environment. The mentor's role is widely implemented and utilised during clinical education. Slightly different titles and terminologies are used by different healthcare professional groups for this role. Different definitions have been offered over time as research and expert opinions have influenced the forms by which mentoring is currently used. A good mentor should guide the students, share their own experiences with them, give honest feedback and encourage students' self-development. They also provide appropriate knowledge-based information to encourage students to build their confidence and link theory to practice (Morton-Cooper & Palmer, 2000).

2.6.2 Clinical Educator as an Assessor

The assessment of clinical competence forms an important part of clinical education and represents the peak of Miller's pyramid of clinical competence assessment (Miller, 1990; Wass, Van der Vleuten, Scatzer & Jones, 2001). This means that it involves real-life performance-based assessment of what students actually "do" in clinical practice. Students are assessed during their interactions with patients in the clinical environment by the direct observation of a clinical educator. The observation of students' performance occurs over a range of circumstances and across a spectrum of patients and needs from which the clinical educator can determine the students' ability to execute safe and effective decisions regarding their patients' well-being. Monitoring students' performances during clinical education can involve formative and summative assessments. The goal for formative assessment is to enhance learning, particularly by providing opportunities for

feedback from clinical educators to students to improve their performances without the fear of failure.

There is an increasing demand on assessors from internal and external sources in physiotherapy education, to be accountable for their practices. Strohschein, Hagler & May, (2002) mentioned that it is important to critically and appropriately respond to these pressures for professional growth as well as for professional survival. In the physiotherapy practice, students graduate with primary contact practitioner status and it is essential that assessment identifies students as competent across the required spectrum of professional practice (Delany & Molloy, 2009).

An assessor in the physiotherapy context is referred to as a qualified expert who is an experienced professional who has developed the skill of assessing the students' levels of achievement related to physiotherapy's practice competencies (Kilminster, Cotrell, Grant & Jolly, 2007). Consequently, the clinical educator as an assessor takes on the responsibility of being a gatekeeper for the physiotherapy profession and acts particularly as a "sign-off" clinical educator, emphasizing the accountability of safe and competent entry-level practitioners. Assessors should therefore be well prepared, trained, fair, competent, skilful and knowledgeable (Neary, 2000).

According to Kilminster, Cotrell & Grant, (2007), assessment practice should protect the public as well as foster habits of learning, self-reflection and drive institutional change. As an assessor, the clinical educator is therefore professionally accountable to society, professional bodies and to the patients for their judgement when assessing students to be "fit for purpose" (Wass, Van der Vleuten, Shatzer & Jones, 2001).

In changing from a mentor to an assessor, the clinical educator's role changes to that of judge, and involves assessing students' progress on their performances which includes skills, attitudes and behaviours and reporting on them (Price, 2004).

2.6.3 Challenges within the Dual Role

Literature on mentoring and assessing has established that the dual role of the clinical educator, as a mentor and an assessor, comprises many challenges for both students and clinical educators. Several previous studies (Martin, 1996; Chambers, 1998; Neary, 2000; Morgan, 2005; Kneafsey, 2007; Rutkowski, 2007; Cassidy, 2009; Hodges, 2009) elaborated on the challenges and confusion of mentors as assessors and the impact these dual roles could have on the teaching-learning relationship. In a study done by Segers, Nijhuis and Gijselaers (2006) on the impact of assessment on students' learning strategies, the authors argued that the research agenda of the coming decade will be dominated by the search for empirical evidence relating to the ideal conditions for assessment to support learning.

Furthermore, on the one hand the mentor's positive relationship with the students in a community of practice, focuses on trust, guidance, the needs of the students and helping the students to

understand complex situations (McClure, n.d.; Buchel & Edwards, 2005; Hodges, 2009), whereas changing roles, on the other hand, appears to cause confusion which could affect the teaching-learning relationships negatively and restrict learning. Laitinen-Väänänen (2008) stated that the role of mentors should be carefully evaluated as confusion of roles is one of many possible themes that are worth considering for further study. Purposeful learning can be greatly influenced by the teacher-student relationship as it involves the cognitive as well as the affective aspects of learning (Miller, n.d.)

Another challenge which faces clinical educators in the dual role is that as assessors, some of them find it difficult to evaluate students' competence from an objective point of view. Subjectivity may have negative or positive consequences for students. However, Dolan (2003) states that judgements can be subjective and can vary from person to person. Students may experience a feeling of anxiety that may result in a lack of self-confidence as they assume others may judge them. Clinical educators struggle with their dual role of assessor and mentor as a result of the conflict which arises within these responsibilities (Bray & Nettleton, 2007).

There are differences of opinion expressed by Bayley, Chambers & Donovan, (2004) and Chambers (1998) regarding the assessment of students. Bayley, Chambers & Donovan, (2004) suggested that assessing students should not be part of mentoring as this could undermine the teaching-learning relationship and create a conflict of interest. Pressures are not only placed on the clinical educator, but also on the students as they too need to adapt to the changing of roles. On the contrary, Chambers (1998) stated that as the mentor becomes the assessor, the positive relationship developed previously with the student, may help to avoid student's stress and anxiety during the assessment period.

Failing a student is a multi-dimensional problem for mentors acting as assessors. Some clinical educators may feel that a fail mark may reflect their own inability to create an appropriate learning environment to facilitate strategies and to provide appropriate feedback, thus emphasizing their inadequacy as a mentor (Rutkowski, 2007). Duffy, (2003) confirmed this saying that mentors passed students' clinical assessments even when they were doubtful about their performance. This is because failing a student can cause friction and can result in destabilizing relationships. Negative and resentful attitudes can become prevalent and are not conducive to learning. For this reason, some clinical educators do not fail weak students, because they feel it is a reflection on their own quality of guidance during the clinical block.

Likewise, another challenge which could affect the teaching-learning relationship is that students are reluctant to expose their lack of knowledge and inefficiency in skills to the clinical educator, knowing they will be assessed by the same person. The students, therefore, avoid revealing their weaknesses. A study done by Molloy, (2004) mentioned that clinical educators' dual role as mentor and assessor may inhibit the students' honest and active contribution in feedback sessions during

the clinical block. Successful clinical education is dependent on the teaching-learning relationship between the clinical educator and the student as these are crucial components of the clinical learning experiences of the students (Chan 2001; Strochschein, Hagler & May, 2002). It is the quality of the experience that is vital to learning as well as the framework in which the experience is located (Best, Rose & Edwards, 2005). Learning opportunities which constitute change can only occur in an environment when threats to the student are minimised (Spencer, 2003). Authors also stated that there is a need to investigate clinical educational practices in physiotherapy. They maintained that if there is a clearer understanding of the present status of clinical education, if needed, strategies for improving the process should be implemented (Strochschein, Hagler & May, 2002).

2.7 Summary

The literature reviewed in this chapter confirms that it is during clinical education that undergraduate physiotherapy students learn to apply their knowledge, skills and attitudes to real-life patients in a clinical environment. At the heart of clinical education is the teaching-learning relationship between a clinical educator and a student. Considering the controversies that are mentioned in the literature, when a clinical educator changes from a mentor to an assessor, it is necessary to investigate how the dual role affects the teaching-learning relationship and, therefore, the learning of students in the existing physiotherapy practice. The next chapter explains the method followed to investigate this complex relationship.

Chapter 3: Methodology

This chapter presents the methodology of the study designed to explore the students' and clinical educators' perceptions of the dual role of clinical educators and how their perceptions influence the teaching-learning relationship. The techniques used to gather the data and the research procedure are discussed. The data management processes are outlined. Consideration is given to ethical aspects concerning the study.

3.1 Research Question

How does the dual role of the clinical educator as mentor and assessor to undergraduate physiotherapy students at the Division of Physiotherapy SU, influence the teaching-learning relationship?

3.2 Study Objectives

The objectives of the study were:

- to describe the students' perceptions of how the dual role of the clinical educator as a mentor and assessor of students influences the teaching-learning relationship;
- to describe the clinical educators' perceptions of how the dual role as a mentor and assessor of students influences the teaching-learning relationship;
- to describe the students' and clinical educators' perceptions of how the assessment sessions influence the teaching-learning relationship when a clinical educator changes from a mentor to an assessor; and
- to determine what the implications are on the teaching-learning relationship between the clinical educator and the student when a clinical educator is both the mentor and the assessor.

3.3 Research Design

This study followed a qualitative research approach, with an interpretivist paradigm, which was conducted by means of a phenomenological inquiry. In a phenomenological research approach, the philosophy implies an interpretive or subjective approach where the focus is on how individuals experience and understand a particular, natural situation (Maree, 2007). According to Maree (2007), qualitative research focuses on how individuals and groups understand and view the world and construct meaning out of their experiences. By focussing on people's subjective experiences, the interpretivist paradigm is based on the ontological assumption that social reality can only be understood from within (Nieuwenhuis, 2007). It is important to note that within the interpretive field of study, the role of the researcher entailed being an active participant in data generation and interpretation (Maree, 2007).

The researcher sought to provide a holistic understanding of how participants relate to and interact with one another in clinical education and how they construct meaning from and explain their experiences of the phenomenon under investigation (Maree, 2007). These strategies allowed the researcher to move beyond the obvious and understand the complexity of the roles of the participants in their contexts. The investigation was based on the students' and clinical educators' experiences, to determine how the dual role of the clinical educator as mentor and assessor at the Division of Physiotherapy at SU, influenced the teaching-learning relationship positively or negatively.

3.4 The Role of the Researcher

The researcher is currently employed as a clinical educator and coordinator at the Division of Physiotherapy, SU, and consequently fulfils the dual roles as both mentor and assessor for fourth-year medical and surgery undergraduate physiotherapy students. The researcher was also the clinical educator for the third-year orthopaedic clinical rotation in 2012, which means that the current 2013 cohort of fourth-years had prior clinical education experience with her. The researcher, as clinical coordinator, is also involved in giving continuous support to clinical educators at the various placements. The researcher is therefore involved with the participants, their experiences, biases and interests. Consequently, the process of gathering the data was outsourced to an independent and experienced interviewer, currently from the Centre for Health Professional Education at SU in order to enhance the credibility of the study. This was needed to prevent the influence that the principle researcher as clinical educator might have had.

3.5 Instrumentation

Face-to-face, semi-structured, individual interviews were conducted with nine clinical educators as well as with three third-year and four fourth-year undergraduate physiotherapy students. Two semi-structured focus group discussions were organized with undergraduate physiotherapy students. Focus group discussions were included to allow the students to share their experiences and to trigger concepts mentioned by fellow students that might otherwise not have emerged. A focus group provides the opportunity for participants to build upon each other's contributions and for new understanding to further development (Wibeck, 2000). A focus group consisting of clinical educators was impractical for logistical reasons and therefore the researcher increased the number of interviewees. It was anticipated that these interviews would provide rich and in-depth data of the students' and clinical educators' experiences and perceptions regarding the dual role of the clinical educator, during clinical education (DiCicco-Bloom & Crabtree, 2006). Interview discussion schedules, available as Addendum A and B, were developed by the principle researcher and used as guidelines to define the line of enquiry, to assist the interviewer to maintain focus and to ensure coverage of all important issues. The schedules included open-ended questions based on the main objectives as well as aspects from the literature that appeared to have an impact on the teaching-

learning relationship. The researcher and interviewer discussed the interview schedules to ensure the salient use of them. A pilot study was conducted to refine the interview schedules.

3.6 Study Population

The study population included third- and fourth-year undergraduate physiotherapy students at SU who had completed their clinical rotations and assessments at the end of March 2013. The population of the study also included clinical educators who were responsible for the clinical education of third- and fourth-year undergraduate physiotherapy students at that time.

3.6.1 Sampling

Purposive sampling was used during the study, using a sampling framework. Purposive sampling is commonly used in a phenomenological inquiry for the purpose of obtaining and sharing participants' knowledge regarding the phenomenon under investigation (Maree, 2007).

The sampling for individual interviews included two clinical educators who were involved with third-years, six clinical educators involved with fourth-years and one involved with both third- and fourth-year undergraduate physiotherapy students at the Division of Physiotherapy, SU. The sampling framework was informed by factors that were anticipated to generate the richest possible information to be obtained from these participants. The selection of clinical educators was based on those with experience in supervising students during clinical education and, in contrast, those with less experience as identified from the Division of Physiotherapy's database. This was done to ensure a deeper understanding of different perceptions of clinical educators who had more and fewer years of experience in clinical education.

Eight third-year students were selected for the first focus group discussion and eight fourth-year students for the second focus group discussion. The recruitment of the students was based on their clinical assessment results at the end of their first block in March 2013. An equal number of students, who scored in the low, average and high percentages of clinical examination results, were selected. The choice of respondents was made arbitrarily by an administration officer of the Division of Physiotherapy, SU and covered the noted dimensions of diversity regarding their results within the two groups. The dimensions of diversity regarding the results of the students could reveal a wide perspective of their experiences in the teaching-learning relationship.

The researcher invited the selected participants via e-mail at the end of March, 2013. All participants accepted the invitations. Interviews and discussions were scheduled accordingly.

3.7 Data Collection

Data collection was divided into three phases: the preliminary phase (pilot study), a second phase (focus groups with students) and a third phase (individual interviews) Prior to each interview the

aim of the study was explained to the participants and written informed consent was obtained from each interviewee (Addendum D).

During the preliminary phase, a pilot study completed on 18 September 2012, individual in-depth interviews of approximately an hour each were conducted by the researcher with one fourth-year student and one clinical educator from the Division of Physiotherapy SU. The aim of the pilot study was to explore and to determine experiences and perspectives about the research question in order to validate and refine the interview schedules. These interviews were conducted as part of an ethically approved short course in qualitative methodology at the SU and ethical approval was granted as part of the course structure. The interviews were recorded and transcribed, but are not included as data in the current study.

The second phase consisted of two focus group interviews of approximately one hour each with eight third-year and eight fourth-year undergraduate students, respectively. The interviews were recorded on a digital voice recorder and transcribed by an independent assistant.

The third phase took the form of in-depth interviews with different students and clinical educators who agreed to participate. These interviews lasted approximately one hour each, were recorded on a digital voice recorder and transcribed by an independent assistant. The interviews were conducted in Afrikaans and English, according to the languages preferences of the participants. All interviews took place at the Division of Physiotherapy at the Faculty of Medicine and Health Sciences, Tygerberg Campus, SU.

3.8 Data Management

The recorded interviews were downloaded on the researcher’s computer and protected by a password. A unique serial number was allocated to each recording. Thereafter, the recordings were copied to a computer flash disk. The flash disk was handed to an independent assistant to transcribe the recorded interviews. The transcribed interviews were copied and saved on a secured computer for the research period. The transcribed interviews were made available by the researcher for member checking.

3.9 Data Analysis

The data collection from the students were kept separate from those of the clinical educators and analysed separately. A contextualised interpretive content analysis, as defined by Miles and Huberman (1994), was used to analyse the data. The researcher read through the verbatim transcripts and became immersed in the data in order to become familiar with the contents. The researcher coded the data by identifying patterns present. The Microsoft Office OneNote 2007 programme was used to code transcripts, notes and written analytic memoranda. The researcher identified themes from the initially recorded transcripts. The themes and the developing categories were reviewed and refined. The patterns that emerged from the data were arranged into themes

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and entered into a codebook (Addendum C). An iterative process was followed during the course of the study, as the researcher went backwards and forwards between the literature and the research question (Kelly 2009). To add to the validity of the findings, the supervisors of this study checked the themes and categories against the transcriptions of the interviews.

3.10 Quality Criteria

The quality criteria for qualitative research were considered using credibility, transferability, dependability and conformability of the research (Frambach, Van der Vleuten & Fudakowski, 2013) as guiding principles.

3.10.1 Credibility

Credibility is defined as the degree to which the findings of the study are trustworthy and make sense to others (Frambach, Van der Vleuten & Fudakowski, 2013). To ensure the credibility of the study, a number of options were considered. Credibility was established by triangulation of the data as different sources (third and fourth year students and clinical educators) were used from whom the data were collected. Triangulation is a method used by qualitative researchers to check and establish validity, by analyzing a research question from multiple perspectives (Terre Blanche, Durrheim & Painter, 2006). Furthermore, member checking by the participants of the transcribed interviews was done by three clinical educators and four students to add to the validity of the study (Ringsted, Hodges & Scherpbier, 2011).

It was continually necessary to recognise participant bias, role duality, sensitive information obtained about students and colleagues, and values and personal interests regarding the research topic and process. Peer checking, by the supervisors of the study, was conducted during the analysis phase and all transcriptions and interviews were available for verification purposes. However, Unluer (2012) stated that the researcher, who is positioned as an insider in the study, has the advantage of determining the problem, has access to data collection, and has the support of helpful colleagues, all of which add to the Division of Physiotherapy at SU’s benefit of the interpretation of the findings. By presenting the steps in which the data were produced and analysed, transparency was highlighted which helped to establish the credibility of the study.

According to Babbie (2010), objectivity refers to trust and establishing rapport. Objectivity is about generating honest and credible inter-subjectivity. Using the data obtained from the students and the clinical educator, the researcher could check the findings of the study. During the analysis of the data, the researcher established that the data from the variety of sources, pointed to the same conclusion.

3.10.2 Transferability

The aim of transferability is to give the readers enough information to judge, understand the findings and apply them to other settings (Krefting, 1991; Frambach, Van der Vleuten &

Fudakowski, 2013). A detailed explanation of the context of this study is thus provided in chapter one, *Background of the study* and the sampling strategy is clearly explained in the section 3.6.1 of this chapter.

3.10.3 Dependability

Dependability is defined as the degree to which the findings of the study are consistent in relation to the context in which the data were gathered (Frambach, Van der Vleuten & Fudakowski, 2013). Dependability encouraged the researcher to be flexible and open. The data, the methods and the research decisions that were made, were available for external enquiry. Furthermore, the data were collected and analysed until no new themes emerged.

The researcher was actively engaged with the data during the analysis and interpretation thereof. In the interpretivist paradigm, the researcher faced the primary challenge of getting close to the research subject in order to create genuine and candid insider descriptions (Unluer, 2012). However, the interpretivist approach acknowledges that the researcher interpreted the data with some degree of subjectivity, rather than complete objectivity (Mertens, 2010). The filtration of all paradigms by subjective values cannot be entirely value-free as all paradigms are human constructions (Cuba & Lincoln, 1994).

3.10.4 Confirmability

Confirmability is defined as the degree to which the findings are based on the study's participants and context instead of the researcher's bias (Frambach, Van der Vleuten & Fudakowski, 2013). The findings of the data were discussed based on literature evidence, as confirmation. Informal discussions with peers were conducted while analysing the data. In addition, the researcher took a reflexive stance (Mauthner & Doucet, 2003) while analysing the data, taking into account the effects the researcher and the research strategy could have on the findings. The researcher kept a field journal as a strategy for reflexive analysis.

3.11 Ethical Considerations

Ethical approval for the study was obtained on 5 December 2012 from the Human Research and Ethical Committee (HREC), Faculty of Medicine and Health Sciences (FMHS), SU (Protocol number: S12/11/289) and from the Institutional Research and Planning Division (IRP) at SU. The research was conducted according to the Helsinki Declaration of 1972. Written informed consent was obtained from the participants. Permission to conduct the study was obtained from the chairperson of the Division of Physiotherapy's undergraduate programme committee and the Head of the Division of Physiotherapy at SU on 12 November 2012. The following principles of ethical research are highlighted as applicable to the study.

3.11.1 Autonomy

Participation was voluntary and participants had the right to withdraw at any point during the interviews. They were informed that the digital recordings would be destroyed after the study. Written informed consent was obtained from all participants. Information about the topic being investigated was sent to the participants together with the invitations.

3.11.2 Confidentiality

The participants were assured about the confidential handling of the data during the process of peer assessment and editing. No names were included in the transcriptions and interview numbers were used. All participants' information and responses shared during the study were stored electronically in a password protected document folder and the results were presented in an anonymous manner (a numbering system was allocated to the participants) in order to protect the identities of the participants.

3.11.3 Non-maleficence

The research caused no particular harm to the participants. If participants required debriefing after an interview, the necessary referral to a professional, who could provide such service, was made available.

3.11.4 Beneficence

The results of this study will be made available to the Physiotherapy Division's undergraduate committee at SU. The findings of the research study could make positive contributions to the experiences of all the participants within the teaching-learning relationship during clinical education in the Division of Physiotherapy at SU. Refreshments were provided to the participants of the study during the interviews and discussion groups.

3.12 Summary

This chapter elaborated on, outlined and motivated the methodological aspects of the study. The chapter also provides information on how quality was maintained during the research process as well as the adherence to ethical principles. The next chapter will explore the findings of the study.

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Chapter 4: Results

In chapter four, analysis of the data reveals the themes and categories that emerged from the individual interviews and focus group discussions. The findings highlight the key factors in the dual role of the clinical educator that can influence the teaching-learning relationship. The views of the clinical educators and the students are presented.

4.1 General Information Regarding Participants

In-depth, semi-structured, individual interviews were arranged with nine clinical educators, as well as four fourth-year and three third-year undergraduate physiotherapy students. In addition to these, two students' focus groups were conducted, consisting of eight third-years and eight fourth-years, respectively. The students' ages ranged between 21 and 25 years. They were all females.

Of the clinical educators that were interviewed, one was responsible for third-year undergraduate physiotherapy students at more than one clinical block. Six clinical educators for fourth-year students at one clinical placement and two for both third- and fourth-year students clinical educators had diverse experience in educating students in a variety of placements in the clinical environment, ranging from two to twenty-five years, were interviewed. Four clinical educators were employed permanently in academic fulltime posts, one was employed in a permanent part-time clinical post and four educators were appointed in clinical contract posts at SU. They were all females.

4.2 Findings

The data presenting the different views of the clinical educators and students, about the influence of the clinical educator's dual role, were studied and analysed. Key factors in the dual role of the clinical educator that could influence the teaching-learning relationship, by either enhancing or obstructing the learning of students, were identified. Three key themes became prominent, namely, challenges regarding the dual role, expectations of the clinical educators, students and the teaching-learning relationship, and preferences regarding the dual role of the clinical educator. From these themes, significant categories emerged. Each theme was analysed according to the main categories.

4.3 Themes and Categories

The themes and categories that emerged from the data collected are as set out in the table below.

Table 4.1: Themes and Categories that emerged from the Data

Themes	**Challenges**	**Expectations**	**Preferences**
Categories	➢ Inconsistencies ➢ Subjectivity ➢ Conflict • Failing Students • Intimidation • Feedback • Diversity ➢ Limitations	➢ Participants and their Relationship	➢ Roles ➢ Relationship

The findings of the students' and the clinical educators' views were analysed separately, enabling the researcher to identify similarities and differences in their experiences. The students' and clinical educators' views for each theme (challenges, expectations and preferences) are presented accordingly. In the next section, each construct as identified in table 4.1 will be elaborated on and will be supported by verbatim quotations from the participants.

4.3.1 Challenges

The participants identified that there is a role conflict between that of the clinical educator as mentor and assessor. The dual role was perceived as challenging for students and clinical educators within the teaching-learning relationship. Challenges, identified as a theme in this context, were described as a call to contest the learning experiences and outcomes of students. The following categories regarding the challenges are listed below and analysed to determine how these affected the learning process. The categories are:

- inconsistencies
- subjectivity
- conflict, and
- limitations.

Each category will be discussed individually and the sub-categories that emerged will be defined specifically.

4.3.1.1 Inconsistencies in the relationship and process

Inconsistencies are defined as the state of not being the same throughout or not matching set standards. In this context, inconsistencies also refer to students or clinical educators not behaving in the same way throughout. The perceived inconsistencies, identified by students and clinical educators alike, caused a lack of harmony within the teaching-learning relationships as well as in the assessment process. Quotations are presented from both the students' and clinical educators' interviews.

The following inconsistencies were identified.

- Inconsistency in the behaviour of clinical educators as mentors and as assessors,
- inconsistencies between the expectations of different clinical educators, especially during assessment procedures, and
- inconsistency in the behaviour of students during a learning event versus an assessment event.

Students pointed out that there were inconsistencies among clinical educators. Changing from a mentor to an assessor's role, the clinical educator's behaviour and attitudes towards the students were inconsistent. This confused the students as is evident in the quotations below.

Inconsistencies experienced by students when clinical educators change between the roles of mentor and assessor

> [Student (ST) number (10): page 3]: *Sometimes it's just like when the clinical educator is a nice mentor and they're chilled during the block and then all of a sudden your assessment comes and they're like super strict and you don't understand why you're losing marks. They should've been strict the whole time. They should've been consistent … they [CE] also need to be aware of crossing the boundary of an educator… some clinical educators are too friendly and too generous when they mentor and then they truly swop when it comes to assessing. They're strict and then you get two different views of the person.*

> [Focus Group (FG) number (1) student number (3): page 7]: *Don't be our friend and then on our clinical exam turn around 360°. This affects us and our patients, and we wonder what is actually going on now? We are so busy trying to figure out what is wrong with the clinical educator that we lose focus on what we need to do.*

Inconsistencies experienced by students that existed among clinical educators, especially during the assessment process

> [ST 8:4, 6]: *Clinical educators differ. The one feels this about something, the other the absolute opposite. This causes huge confusion among us and students will often feel that my previous clinical educator indicated I had to do it in this way, but then suddenly someone jumps at you and says, no, I expect you to do it this way. There are huge differences between different clinical educators.*

[FG 2 (3):8]: *Clinical educators differ. The one will focus more on this and if you do not do it correctly, you might probably fail, whereas others will focus more on something else.*

[FG 2 (4):10]: *For me the assessment is very inconsistent, you know, because I could get a hundred percent for my technique test and I could get excellent for my whole mock exam, but when I come to the end of my block, I get 60% or 50% and I ask myself how come this is happening, because I thought I was on the right track? So, for me even that kind of system is not as consistent as I think it could be.*

[FG 2 (8): 9]: *They would mark you down for something that they would have done differently, but not necessarily what we've learned. And I think that for me, this is a big problem, because I try and follow what we've been taught and they have done multiple other courses and know different ways to which they've been exposed. So, you get marked down for doing something that they would have done differently and I think sometimes that's a bit unfair.*

Clinical educators' views regarding inconsistencies

Inconsistencies experienced by clinical educators that existed among assessors

[Clinical Educator (CE): number 8 page 6]: *Not all assessors act the same during assessments. Some ask more questions as the assessment continues, while others actually intervene more during the process. I am guilty of this. Especially if you think the student is in the wrong, you chip in too quickly instead of distancing yourself while you observe his performance, allowing the student a chance to show what he is actually capable of doing.*

Some clinical educators also detected inconsistencies among students as students were perceived to be under stress during assessment sessions.

Inconsistencies experienced by clinical educators that existed among students

[CE4:4]: *During clinical assessments, which students often find stressful, they will do the most peculiar things that they would never do during the clinical block.*

4.3.1.2 Subjectivity during clinical assessment

Another major challenge experienced by most students was the subjectivity of clinical educators during assessments. This was also found to be a challenging theme that emerged from the interviews with the majority of clinical educators.

Students' perceptions

[FG 2 (8):9]: *When they're marking, the clinical educators are very subjective instead of being objective.*

[ST9:6]: *Sometimes it's about personal preference when you choose a technique during the assessment which the clinical educator did not want you to do. She prefers you to do something different, but both are correct. They [CE] are marking you during an assessment, so now you would rather be on the look-out what she would expect you to do. So you adapt towards their way of thinking, as they will be assessing you.*

[ST12:6]: *If the clinical educator asked me to focus more on specific techniques, I would make sure I also do it during the assessment as I realized that she would also, during the assessment, want me to focus on these.*

Clinical educators' perceptions

[CE 7:2]: *It is difficult when you supported the students for weeks and you know their potential ability. It is difficult to then be objective and observe and forget about what happened the past few weeks, especially if the student didn't performed well. It is challenging to stay objective.*

[CE 3:9]: *I think every assessment is subjective. I think the possibility of subjectivity is there if a student is very good or perceived to be good on several occasions. It could influence the mark, especially for good students that the halo effect could go through.*

[CE 8:3]: *If you expect a student, who performed well throughout the clinical block, to do well during the clinical assessment, and he doesn't, you are inclined to give him credit, where credit is not really due. And similarly if a student performs badly throughout the block, and he performs very well during the block assessment, you will tend to be more critical towards him. I, myself, am guilty of that. It is very difficult to be really objective if you were the mentor throughout the block.*

[CE 3:2]: *I think you can never get away from the fact that students know you're going to mark them. There's always that undercurrent. I'm not sure it facilitates learning well. I think it facilitates them doing what they think you want them to do.*

4.3.1.3 Conflict

Conflict in this context is seen as a situation in which there is disagreement between participants in the teaching-learning relationship and this is not conducive to students' learning. The following sub-categories emerged from the data:

(a) Failing students
(b) Intimidation
(c) Feedback
(d) Diversity.

(a) Failing students

Students emphasized the way failing a clinical assessment made them feel. Clinical educators considered failing a student to be a huge challenge as it could involve emotional conflict for both of them. Clinical educators specifically mentioned that, in borderline cases, it was difficult to decide whether to pass or fail the student. They found it traumatic and said that it could affect the teaching-learning relationship as they lost their confidence to participate.

Students' emotional reactions to failing

[ST 6:7]: *I felt really, really, terrible after failing my clinical block assessment. I nearly had a breakdown. I also had personal problems… My self-confidence was so low…*

[ST 7:7]: *It was terrifying, especially as it was my first block. I was fearful. I freaked out.*

[ST 11:2]: *I never let it impact the relationship between us, because I think it's not fair to be rude towards her. When she did ask me how I felt about it, I didn't give her an answer, because if I was going to, I was going to be rude. So, I have my respect for her. I mean, she does have a degree. I don't have mine yet. So, yes, I keep things neutral.*

Clinical educators' experience of failing students

[CE 8:10]: *This is always very, very difficult. Firstly, we know what the consequences will be when students fail and that can result in a huge amount of stress. It is usually more difficult to decide which way to go when a student ends up with borderline results. Should I fail her? Or shouldn't I fail her? This can cause sleepless nights. I have learned not to think about it for too long. Nine out of ten times, I would fail a student if I had time to think about it or vice versa, if you've failed her, your soft side appears and you think that you should actually give her credit and benefit of the doubt.*

[CE 3:7]: *The first time I failed a student, it had a big impact on our teaching-learning relationship. She was very angry and I was so upset, because I thought it was my fault. It was a very traumatic experience. It did affect our relationship badly, which upset me a lot.*

(b) Intimidation

Students sometimes perceived clinical educators to be intimidating which made it difficult for students to confide in them about their lack of knowledge. Students therefore felt uncomfortable to ask questions about uncertainties or to reveal their weaknesses to clinical educators. Some clinical educators overpowered the learning sessions without considering students' feelings. Clinical educators confirmed that students could feel intimidated by them. This could prevent students from disclosing their weaknesses and lack of knowledge.

Students' views on feeling intimidated by clinical educators

[ST 10:5]: *Sometimes clinical educators can be quite short or brief or get annoyed with you asking questions or don't like explaining things twice. That makes us nervous to ask questions or feel more stupid for not understanding when they've explained the first time while you just understand a different way of explaining. You're going to set yourself up for failure, disappointment from the educator.*

[ST 8:5, 7]: *Often we are reluctant to ask questions as we feel intimidated and you…hmmm don't want to sound stupid in front of them, because at the end of the day, they're the people that will be assessing you. You are scared that they will remember, while assessing you, that you gave a silly answer, so you don't want to be honest in saying what you think. So I don't feel like telling them what I don't know. During a supervision session, I will choose to do an evaluation on a patient as I feel confident to do this. So we choose the easiest way of interaction as someone is peeping over our shoulders. Then it's not a learning experience, but just to impress the clinical educator.*

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Intimidation due to clinical educators' overpowering learning sessions

> [FG 2 (6):2]: *Then she would come in and suppress you the whole time by asking questions, making you feel that you don't know anything.*

> [FG 2 (5):9]: *During my previous block, it was a new block and we didn't know much about it. My clinical educator interrupted me while I was assessing or treating a patient.*

Clinical educators' views of students feeling intimidated by them

> [CE 6:2]: *Some students can feel intimidated by you. Some students will withdraw. They can either find you intimidating as an assessor or the block assessment intimidating.*

> [CE 7:4]: *I think the students sometimes do not want to reveal their limitations. They tend to distance themselves. I think they don't want you to observe their shortcomings as they know you will be assessing them at the end of the block.*

(c) Feedback

Students sometimes perceived feedback to be inappropriate and insufficient during the clinical block. The lack of sufficient feedback caused confusion and uncertainties about the quality of their clinical practice. Sometimes clinical educators found giving feedback difficult and challenging. Clinical educators also mentioned that it was difficult to give feedback when students did not show any insight into feedback and reacted aggressively towards comments made.

Students' views on receiving feedback

> [FG 2 (6):9]: *If you do an assessment and you do not receive adequate feedback, you don't know where you stand and you don't know how to improve.*

> [FG 2 (8):18]: *We all did our mock assessment. To me, a mock assessment is personal. You do not need to do it in front of other people. We had to perform in front of the whole group. The clinical educator basically stood in front us while she criticized us. She criticized us in front of everybody. One of my friends burst out in tears. She didn't consider you, your personality, if you were sensitive or not. We were only in third year. She just went on demoralizing us with no constructive feedback.*

> [ST 7:5]: *Yes, feedback, it was something I really wanted on my clinical block. Sufficient feedback, it is something I value a lot, but I never received that feedback throughout the block.*

Clinical educators' views on giving difficult feedback

> [CE 8: 10]: *The marking is not as difficult as giving feedback. To give face-to-face verbal feedback, that to me is the difficult part.*

> [CE 6:7]: *It was very difficult to provide them with the feedback of them failing, as it was emotional for both of us. That was challenging to handle.*

> [CE 1:5]: *You can break a student with bad feedback.*

> [CE 5:5]: *The most challenging is when students show aggression and do not understand your comments.*

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(d) Diversity

Some students understood the differences in people. They mentioned that different personalities in a relationship could be challenging. Clinical educators realized that the dimensions of diversity among themselves and students could result in challenging situations which could cause conflict and influence the relationships.

Students' experiences on how diversity presents as a challenge

> [FG 2 (4):4]: *And it's very, very relaxed and I'm a person who likes order, who likes to schedule, who likes to follow a certain theme and some of them pitch up ten minutes late and you know, some of them are really sort of like, " No, you don't have to hand that in. I won't read through this SWOT". It's kind of, let's adapt as we go along. So, for me it's very challenging to have somebody who's very chilled.*

> [ST 8:8]: *Some people with different personalities might clash while others seem ok.*

> [ST6:6]: *I am an introvert and the student, working with me, is an extrovert, so she's like, she knows her work well, so she tends to jump in and answer all the questions. Then I'll feel, ok, just give me a chance.*

Clinical educators' experiences of diversity within the relationship

> [CE 3:3]: *It's just so tricky during the exams. Some students like to talk and if you ask them questions during the exam it helps them to think. Some students go blank and to just kind of get the balance so they are having the best opportunity they can to do well. Sometimes it's not easy, because of the personality differences of the students.*

> [CE 1:7]: *I have learned that they are all different. What can break one, can strengthen another. It is amazing how different they can react to feedback. It is challenging to work with so many different students and to treat them accordingly.*

4.3.1.4 Limitations

Limitations are described as shortcomings of participants which became apparent during the teaching-learning relationship. These could restrict the students' learning. Students identified limitations in some clinical educators' attitudes and responsibilities.

Students' perceptions of limitations in clinical educators' attitudes

> [FG 2 (8):4]: *Sometimes it happened that a clinical educator is somewhat impatient if you don't know the answers. It is not always your fault as you perhaps have not heard it, or learnt it or were not exposed to a similar situation before.*

> [FG 2 (4):5]: *It's so demoralizing when you see a clinical educator who looks like they don't want to be there, who looks like, "Oh, my word, this is just something on my shoulders." So terrible! A clinical educator that isn't passionate and determined.*

Students' perceptions of limitations in clinical educators' guidance and support

> [ST 11:1]: *I think my clinical educator didn't play the role that she needed to play. If I had that type of guidance, I would have passed. I told my clinical educator, but I never got the help I needed. If your mock assessment is so informal, it's not*

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structured, it gives you some idea, but it's nothing in comparison with your exams. It's an overwhelming experience. I really think we needed that guidance, especially for our first block. There wasn't a time where we could say, "Can I please have you to come with me to one of my patients and help me?" There was nothing like that.

[ST 6:3]: *Sometimes clinical educators expect too much and sometimes I do not yet feel ready for this.*

[ST6:8]: *I wish she would talk to me more. We didn't see each other often. I then wanted more feedback regarding my limitations to be able to improve on. I wanted to know what the problem was. Was I lazy, was I …? I had so little confidence at that stage…*

[ST 10:5]: *At the moment during my supervision sessions, there is no structure, there is no guidance. I feel a bit lost. You're not gaining as much as you could. We're confused, because we don't have that structure in the first week, like a schedule for each day. Instead of wasting time…as the amount of supervision time is limited and you want to make use of it as much as you possibly can.*

Students' perceptions of limitations in clinical educators' attitudes showing a lack of patience and approachability

[FG 1 (4):8]: *They're not very approachable. That's the challenge. You can't confide in them like you want to.*

[ST 12:1]: *Then they [CE] can be aggressive by asking:"Why didn't you think about this? Why didn't you think about that?" They need more patience, for us to be willing to ask questions.*

Students' opinions on limitations regarding their perception of educators' unfair assessment

[ST 11:2]: *… the way our clinician pulled her face at us while we were busy with our exam. The other students in the block told me, but it's only supposed to be the supervisor that is supposed to mark you in your end exam, but our clinician and supervisor was with us. But it looked almost as if the supervisor and the clinician… the supervisor… I could see the supervisor didn't agree with what the clinician said, but they had to take the average of the two marks or I don't know how that works. But she … she didn't want to say anything to the clinician. That's how I felt about the facial expressions and body language. That's how it looked. It seems unfair.*

[ST 10:5]: *The clinical educator disrupted the assessment session by talking to the patient, distracting you in the exams. Not focussing on your assessment. Just maybe step back, let the student do the work instead of interrupting the session.*

Some clinical educators revealed the lack of adequate preparations by students before they enter the clinical block.

Clinical educators' perceptions of limitations regarding students' preparation

[CE 4:7]: *The fourth years often reveal a lack of satisfactory basic theoretical knowledge at the commencement of a clinical block. I am uncertain in terms of what is expected from them during the pre-exam which they need to pass before they begin their clinical block. If the students reveal basic knowledge, it can help to enhance the teaching-learning opportunities.*

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[CE 6:1]: *The more challenging part in the learning situation is when students are not well prepared, as well as when they struggle to apply the theory in clinical practice.*

[CE 3:6]: *Sometimes the students would give you the impression that they think we want to fail them, which is totally not the case. I find it challenging when the students are not interested or slap dash or negligent. I find if they have a very negative attitude, I don't enjoy that.*

Clinical educators' perceptions of limitations regarding some clinical educators' minimal understanding of the theoretical curriculum

[CE 6:7]: *Third year clinical educators, the ad hoc personnel, do not necessarily have a good idea of the curriculum. So what happens, the problems in fourth year were the results of limitations in the third year. It is important to address this, to improve the alignment of the curriculum.*

[CE 9:7]: *I can see most students are confused. I don't know where the problem is. Is it at the university? Is it in the methods? I have never attended one of their theory classes. Is it in the way the classes are presented? Or is it the student?*

4.3.2 Expectations

Students and clinical educators expressed their views on what they expected from the participants and their teaching-learning relationship.

4.3.2.1 Expectations of the participants and the teaching-learning relationships

Students' views on the attributes and responsibilities of the participants revealed the necessity for effective relationships where good communication, mutual respect and trust are present. Participants in the relationship should have mutual goals. The relationship should be well structured, comfortable and relaxed, allowing enough space for both to develop and benefit from their interaction on equal levels.

Some clinical educators indicated that the participants had a responsibility to clarify expectations at the commencement of the clinical block. A relaxed atmosphere was an important expectation for a positive teaching-learning relationship. To establish a teaching-learning relationship it was important to ensure open conversations, safe environments and establish comfortable relationships with students, to discuss their weaknesses and strengths as well as to ask questions. Clinical educators agreed with the students that they were expected to be consistent. Trust and respect were qualities needed for an effective teaching-learning relationship. Clinical educators found the teaching-learning relationship satisfying, stimulating and rewarding as students connected theory to practical knowledge and by demonstrating basic knowledge when entering their clinical block. They enjoyed developing the students' clinical reasoning process by experiencing how they integrated theory and skills and how the students fitted all the processes together. The most enjoyable was to stimulate the students' cognitive processes.

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Students' expectations

[ST 7:5]: *I think communication is a big… a big factor in a relationship.*

[ST 9:3, 4]: *Planning and structure from both sides are important. Plan the goals and reciprocal respect to reach the goals. It's asking hard work from both sides, to walk the extra mile.*

[ST 6:4]: *There needs to be mutual respect between the clinical educator and the student and hard work from both sides.*

[ST 8:6]: *… there should be trust and good structure so that you know what to expect during each session.*

[ST 12:3]: *Very relaxed and a simple relationship, to feel comfortable to ask questions. You need to feel comfortable with the person. You should not feel the person is on a different level. You need to be able to trust her. The clinical educator should not look from above onto you. There should be trust and a good understanding between you. We know what to expect from each other.*

[ST 10:5]: *Knowledge on both sides … of knowledge-based and understanding where both parties are coming from … to encourage you to do self learning, mutual understanding, give each other input.*

[FG 2 (4):14]: *So, it was a give and receive, give and receive kind of thing and it was also a role of participation. So, we would all sit down, all interact while analyzing some of these.*

[FG 1 (3):11]: *So, I found that it's very important that you have an open relationship with your clinical educator, they're willing to help and teach you, because if they're not, then it's a very big problem, because you won't learn anything and you would feel so rejected. There's like that barrier which there shouldn't be, because we're all doing the same thing. All going towards the same goal at the end of the day: It's to help the patient.*

[FG 2 (4):14]: *The teaching learning relationship was really, really good, how she inspired you to want you to learn, how he would give you recourses, but allowed you to go further and allowed you to take initiative too.*

[FG 2 (4):22]: *She does not threaten you or make you feel that she's superior. And she comes on to your level. She really helps you.*

Clinical educators' expectations

[CE 5:1]: *I have a comfortable teaching-learning relationship with students. They need to feel comfortable to approach me to ask questions.*

[CE 2:3]: *I think it is necessary to clear expectations right from the start, what you as a clinical educator can expect from the student and what they can expect from you. There should be a contract in place between you.*

[CE 3:5]: *A certain level of trust is needed to show them the right direction.*

[CE 1:9]: *I try to make it as relaxed as possible. They are a bit scared of us, especially at the beginning of the year. I chat to them and I try not for the students to feel stupid. Yes so relaxed.*

[CE 6:9]: *The clinical environment influences the learning of students therefore the environment should be positive, supportive with positive role models. If students are*

anxious and intimidated, or not on standard, then they suffer from this emotional roller coaster effect, that can affect their learning experiences.

[CE 2:4]: *I enjoy the clinical reasoning process. I enjoy the integration of skills and theory and to observe how they fit these together. So, to me, it is the cognitive process, yes, that to me is the most enjoyable, to stimulate that.*

[CE 3:5]: *… an aha experience they go through. There is definitely a reciprocal relationship that goes on. I learn from a teacher's point of view and I think they learn, from learning to be a student's point of view.*

4.3.3 Preferences

During a teaching-learning relationship between the clinical educator and the students, the role of the clinical educator regularly switches between that of a mentor and an assessor. The interchanging of the roles is dependent on various activities and responsibilities during clinical education. Analysis of the data indicated that the clinical educators as well as the students revealed certain preferences regarding the dual role and the model of the teaching-learning relationship.

The following categories were discussed:

- roles and
- relationships.

4.3.3.1 Roles

The majority of students explicitly preferred clinical educators to act as both mentors and assessors as indicated in the quotations below. Students preferred the dual role assigned to the clinical educators as the clinical educator and the students learned to know one another well, even on a personal level. Therefore, both parties knew what was expected of them.

Knowing who the assessors were going to be, the students found that this could be beneficial to them as they could adapt to their assessors' preferences and expectations.

Students' preferences for the clinical educators' dual role

[ST 9:7]: *You adapt towards their way of thinking, as they are assessing you at the end of the block. You observe to see what they prefer, how they expect you to do things and I think it helps during the assessment session. If you know this person prefers a certain way of doing things, then you rather do it accordingly, because she will assess you.*

[FG 1(7):7]: *I think it's quite important that they're the same person, because when they mentor you, you kind of work at what they want and how they want it done and how like…yes, their views around it and so, it's a lot easier. They know about you, they have seen the progress that you've made and now they can put it all together into your final assessment.*

[FG 2 (2):27]: *It is good…as you are more relaxed during the exams. It is not someone unfamiliar that peeps over your shoulder.*

Some students were adamant that external assessors would cause problems for them as they would not know what the assessors' expectations and preferences were and they had no relationship with them. This situation would be very stressful for the students.

Students' perceptions about external assessors

> [ST 12:6]: *If an external examiner assesses you, you will not know what she expects from you. You won't feel comfortable. If my clinical educator told me I should focus on my techniques, then I can expect that she will focus on that during the assessment. An external examiner will cause a lot of stress.*
>
> [FG 2 (7):11]: *If an external examiner arrives, you experience anxiety, as this person doesn't know you. She does not know why you are thinking in a specific way. No-one can treat a patient effectively when they feel anxious.*
>
> [ST 8:9, 10]: *I think the dual role of a clinical educator is a bit of a bad idea. An external examiner, you know, comes with a different view. She doesn't know you at all, so you can expect that there's nothing about the block that she keeps in mind. You have to know your story, but for me it felt like more…hmmm… she's more objective. I feel the system, as it is, seems a bit subjective.*

Students' perceptions of roles that clinical educators should adopt to help prepare students for the assessment session

> [ST 10:9]: *It's a good thing in a way, because then they should mentor you in the way they're going to assess you or have that in the back of their mind of…hmmm educating you with a purpose to get you through an exam. That anybody can mark you and you should be able to pass. So, they should mentor you in that way to give you the knowledge to accomplish that.*
>
> [ST 7:12]: *I think it's positive and negative. Positive, because you're getting an objective person, who has not been with you each day, so, she's new, but negative, because you're not building up a relationship with your clinical educator, so, they know what you're like, what type of person you are.*
>
> [FG 1 (8):20]: *It is very nice to have them there, because you feel comfortable with them. It's not someone you've never met before now sitting in. They don't know you at all and now they are watching you. In that sense it can be really nice knowing it's someone you're comfortable with, but it can also be really a bad experience if they've been friendly and don't worry about anything. Then suddenly they come in, implying, I know you're stupid. I know they don't ever say it like that, but they switch completely.*
>
> [ST 9:8]: *On the one hand you know it can be bad, they have walked with you for six weeks and if you fail…it can be really bad for the clinical educator. She can feel it was her fault.*

Most clinical educators indicated that they felt comfortable in both roles as they had adapted their approaches over the years. However, they preferred the role of mentor to that of assessor and they felt that the dual role could be challenging.

Clinical educators' perceptions of their dual role

> [CE 5:3]: *I do feel comfortable in both roles after sixteen years' experience however it is not always easy, maybe, because of the friendship between me and the student. Sometimes it can be a bit personal. I definitely enjoy the mentor's role more. You have to be able to distance yourself from the mentor role when you assess the student. I think it is difficult to change from mentor to assessor without experience. It takes at least three to four years of experience to feel comfortable without support.*

> [CE 3:6]: *So I have it ... I find it quite difficult and I try to separate the two, although the system as it is at the moment, doesn't allow for that. I can do both roles, but I find it's easier to do one. Either be the marker, or the mentor, then they are separate issues. It's a case of putting on a different hat. Both can mediate each other and be balanced. If you have to move into a different role, it's not difficult to do. It may not be the most comfortable place. I'd rather be in a mentorship role, but it doesn't mean that I don't understand the importance of the professional exit exam …much better and nicer role to be a mentor, but maybe that's my personality. It certainly is easier to be a mentor only or be an assessor only.*

> [CE2:7]: *I think it is necessary to be able to function in both roles, as by facilitating students, you will be able to determine the level of the students' ability and in what area they still need more support. You have to use your facilitation skills in order to assist the students to reach the expected levels.*

Clinical educators' preference of roles

> [CE 2:2]: *I think also caring … that I don't necessarily have, but I do think it is important. This thing about showing empathy, where students are allowed to make mistakes without any interference…This is very difficult for me. It is difficult for me … yes. I know it is necessary and that it is good … Hmmm … to find their own feet and to go through the process. This is difficult for me to do. I have adapted…to allow the students what they need. I think I have also grown over the years, so at this stage, I have adapted … for others to do the holding of the hands of the students next to the bed part. I enjoy facilitating the clinical reasoning process of students. I enjoy the part where students need assistance to integrate theory and practical skills and to stimulate the students' cognitive domain.*

Clinical educators' preference for separating the roles

> [CE 8:11, 13]: *I do think the person that's the mentor, should not be the assessor as well. There can be two persons assessing, to allow a more objective view. I think it is impossible to fulfil both roles and should actually involve two people. The mentor, per se, should be one person and the assessor another.*

> [CE 7:10]: *I think it will improve the students' feeling of approachability. It will improve the ability of self-disclosure of students. Someone else will be more objective.*

4.3.3.2 Relationships

Some students preferred an informal relationship where students are seen as equal partners. Students also indicated that they did not want a relationship where the clinical educator acted as a friend to students.

A few clinical educators mentioned that they preferred to keep their distance by addressing the students in groups, rather than on a one-to-one basis.

Students' preference with regard to the teaching-learning relationship

[FG 2 (7):4]: *So for me, they're seeing me as a colleague, to challenge me to develop. It's like saying, I stand by you, but I'm not in front, nor at the back. I am standing next to you.*

[FG 1 (3):20]: *They [CE] don't know the difference between being a friend and being friendly. So, they just mean to keep the line there and not cross over completely to being a friend and then on the day of the assessment, they switch over completely.*

[FG 1(4):7]: *I think they should stay neutral throughout.*

Clinical educators' preference with regard to the teaching-learning relationship

[CE 3:3]: *I always try to have them in groups of two or more, so that it is never personal.*

[CE 8:9]: *The clinical educator should, however, not become too familiar with the students.*

4.4 Summary

The three themes, namely, challenges, expectations and preferences regarding the dual role of the clinical educator in the teaching-learning relationship, together with the categories and subcategories that emerged from the data, were described in this chapter. In the following chapter the findings will be discussed in relation to existing theories and literature review in order to gain a better understanding of the influences which the dual role of the clinical educator as mentor and assessor could have on the teaching-learning relationship.

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Chapter 5: Discussion

In this chapter the findings from the interviews will be discussed under themes and categories. A coherent model supported by positioning theory was designed and is used as a framework to propose suggestions to reposition participants as equal partners collaborating in a community of practice. This will transform the teaching-learning relationship between the student and the clinical educator which will aid in enhancing learning in the clinical environment.

5.1 Introduction

This qualitative study investigated how the dual role of the clinical educator as mentor and assessor at the Division of Physiotherapy, SU influenced the teaching-learning relationship between students and educators. From the findings of this study, it became apparent that the dual role of the clinical educator influenced the teaching-learning relationship both positively and negatively. The social forces that existed in the teaching-learning relationship had a significant impact on students' learning. Disparities arose when clinical educators acted as both mentors and assessors, which caused disharmony in the teaching-learning relationship and thereby affected the learning of students. These disparities were identified in the following three main themes, namely, challenges, expectations and preferences.

Challenges existed when clinical educators acted as both mentors and assessors during clinical education. These challenges which were present in the teaching-learning relationship were categorized as inconsistencies, subjectivity, conflict and limitations. Both students and clinical educators identified explicit expectations of one another as well as from the teaching-learning relationship. When expectations were met, a positive teaching-learning relationship was present which enhanced the students' learning. However, in the event of expectations not being fulfilled, the teaching-learning relationship, and thus learning, was impeded. Students and clinical educators expressed their preferences with regard to the dual role.

The disparities that were identified within the themes and categories will be discussed. Suggestions to address these disparities will be made after the discussions as a coherent model was used as a framework to illustrate the suggestions presented (figure 5.1).

5.2 Challenges that existed when Clinical Educators acted as both Mentors and Assessors within the Teaching-Learning Relationship

The findings (chapter 4) addressed the views of students as well as clinical educators on the dual role of the clinical educator as mentor and assessor and the performance standards which were expected from both roles. It is important to consider the challenges that both the students and the clinical educators face in order to minimize any negative effects they can have on the students' learning processes. The central phenomena of challenges and the way in which these phenomena

influence the learning of students will be highlighted. Challenges will be discussed under the following categories: *inconsistencies; subjectivity; conflict and limitations*.

5.2.1 Inconsistencies

While a number of challenges were identified from the findings, inconsistencies were considered to be the dominant factor that negatively influenced the teaching-learning relationship. Inconsistencies mainly related to the change from mentor to assessor where students especially perceived a change in behaviour of some clinical educators which was inconsistent with the behaviours when acting as mentor. As mentors they were not consistent in the ways they wanted students to perform. Some clinical educators insisted on students using their suggestions. This illustrated a teacher–centred approach while other clinical educators focused on a student-centred approach (Barr & Tagg, 1995) which is the acceptable approach used by SU (SU, Strategy for Teaching and Learning, 2012:2). These inconsistencies caused confusion, misunderstandings and uncertainty which disturbed the harmony that exists in the teaching-learning relationship.

The assessment process was also an area of concern amongst the participants in this study. Describing the assessment process, students acknowledged that they were sensitive to the fact that their mentors were now acting as their assessors. They were confused as the relationship changed and thus personal dynamics between the two role-players changed. As mentors, the clinical educators were usually friendly and helpful, but as assessors, they changed completely.

What also became clear in the study is that students acted as strategic learners, aiming to please the mentor during the assessment process. Students in the assessment session performed what they thought the mentor as assessor would like, based on their previous experience with the mentor. Inconsistencies arose between what the student perceived that the assessor would “want” and what the particular patient involved in the assessment would “need”. Such phenomena strengthened the notions of inconsistencies in performances by the students.

Clinical educators acknowledged the existence of inconsistencies among themselves during the assessment process. They differed in the way they assessed students. Some clinical educators gave input during the assessment, intervening prematurely during the assessment session, whilst others did not. Inconsistencies influenced the reliability and validity of assessment procedures, as was confirmed by Gravett and Geyser (2004). Dalton, Davidson and Keating (2012) acknowledged that, although there will always be some differences of opinion among assessors it is a challenge to decide what level of disagreement should be tolerated.

5.2.2 Subjectivity

Both clinical educators and students revealed an awareness of subjectivity as a major challenge during the process of assessment. Given the high stakes of summative assessments of clinical performances, the assessment procedure should demonstrate sufficient reliability and validity for

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its purpose (Epstein, Dannefer, Nofziger, Hansen, Schultz, Jospe, Connard, Meldrum & Henson, 2004; Epstein & Hundert, 2002; Baartman, Bastiaens, Kirschner & Van der Vleuten, 2007; Roberts, Newble, Jolly, Reed & Hampton, 2006). The possible lack of efficient objectivity by clinical educators, revealed by some students during their performance assessments, could lead to unreliable and invalid assessment procedures. However, according to Van der Vleuten and Schuwirth (2005), reliability is not subject to objectivity, but rather on the amount of sampling across different contexts and assessors.

Similarly, the findings of the study indicated that biases were perceived in some clinical educators' judgements which could influence the accurate assessment procedure. Clinical educators' biases regarding students were perceived as either negative, called the "devil effect" or positive, the "halo effect" [CE 3:9]. Vernon, (1964) called it the halo and horns effects. The halo effect surfaced when the students showed outstanding attributes during their sessions with the clinical educator as mentor. When the clinical educator allowed the total judgement to be influenced by a positive reaction to these attributes during the assessment session, the halo effect became evident. The devil effect had the opposite response. The impact of the devil effect could be equally profound and could influence the assessment procedure. Gilbert and Malone (1995) as well as Borrell-Carrió and Epstein (2004) stated that bias can lead to inaccurate assumptions being made. Reliability is not an absolute prerequisite during formative assessments as no judgement of levels is made. In summative assessments, however, high reliability is necessary to judge students as the results are used for selection and criteria processes. The subjectivity of assessors can cause problems where assessment using observation, occurs. The ability of some clinical educators to remain objective during the assessment process was perceived to be impeded by the fact that the clinical educator had to function both as mentor and assessor.

Moreover, the findings indicated that the students' perceptions of the subjectivity of clinical educators contributed to students' unwillingness to reveal their own limitations and weaknesses. This aspect is, therefore, counterproductive to achieve learning outcomes and can lead to the inconsistencies described in the above section. For learning to be effective, the zone of actual development (ZAD) of the student needs to be established. Students need to disclose their limitations to the clinical educator for the clinical educator to facilitate students' learning towards the zone of proximal development (ZPD) as this zone is the area where learning actually takes place (Vygotsky, 1962).

5.2.3 Conflict

Conflict that arose between the clinical educator and the student and which was evident during the investigation of the data was classified according to the following sub-categories, namely:

- failing students

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- intimidation
- feedback, and
- diversity.

5.2.3.1 Failing Students

The findings indicated that failing students were perceived to contribute to conflicting behaviours and emotions among clinical educators and students. These affected the teaching-learning relationship negatively. Clinical educators described their experiences, when failing a student, as an "emotional shock" [CE 3:7]; "huge amount of stress" [CE 8:10], "traumatic" [CE 3:7], "confused" [CE9:6], "shattered" [CE 4:6] and an "emotional rollercoaster" [CE 6:5]. Students had similar experiences when they failed a clinical assessment. The findings showed that clinical educators tried to avoid conflict by being hesitant to fail students and giving them the benefit of the doubt. Clinical educators' indecision about whether to pass or fail a student, especially in borderline cases, is of crucial importance for the students as well as for the profession. This could indicate that clinical educators do not approach the task of failing students lightly. Indecisions by clinical educators, as a result of a lack of confidence to fail the student, may lead to false confidence and even unsafe practices by students and later graduates, which in turn will place the students' future patients and the profession at risk. This resonated with findings from previous studies conducted by Duffy and Caledonian (2003) and Hays (2008). Failing a student was a traumatic experience for both the student and the clinical educator as this led to friction and destabilizing of the teaching-learning relationship and was not conducive to the promotion of learning.

5.2.3.2 Intimidation

Findings of the study confirmed that students found the over-powering attitudes of clinical educators intimidating. The students experienced conflict when clinical educators suppressed them. The students tried to maintain the social harmony within the teaching-learning relationship by not causing conflict and this prevented them from expressing their opinions, or asking questions that could reveal their lack of knowledge. This resulted in a lack of trust and transparency. Lee, Cholowski & Williams, (2002) mentioned that educators can claim to be putting the students at the centre of learning in practice, but in reality, they are not. When students felt intimidated, they were unwilling to ask questions. Students withdrew and distanced themselves, hiding their shortcomings and thereby prevented self-disclosure. Intimidation in students contributed to a feeling of alienation which impeded communication. This affected the teaching-learning relationship negatively.

5.2.3.3 Feedback

Some students reported dissatisfaction with the feedback they received. A few clinical educators also reported that they were unsure when and how to give feedback. Delaying feedback might influence clinical educators to adapt the assessment marks. It was often difficult for clinical educators to motivate and explain to students why they had failed. A few students reported that

some clinical educators did not give sufficient, timely, appropriate and constructive feedback. This confirmed the findings of a study conducted by Molloy (2004) regarding students' experiences of feedback sessions. Bloxham and Boyd (2007) mentioned that students need feedback about their performances to improve their future assessments. Clinical educators should therefore be aware of the value of constructive feedback for students' future development.

Students experienced feedback as an asymmetrical process where clinical educators were perceived as "expert diagnosticians" and the students as "attentive listeners". They were both responsible for this situation. Latting (1992) mentioned that clinical educators usually adopt a clinical knowledge paradigm where they assess patients from a diagnostic point of view and provide treatment accordingly. They are then inclined to assess students from the same angle. The one-way interaction of feedback sessions affected the students' self-esteem. The feedback sessions illustrated the power imbalances that existed between some students and clinical educators (Molloy, 2004). These imbalances became potential conflict situations. Students can see their clinical educator as an authoritative figure displaying considerable power in this relationship. They will feel intimidated. This can have a negative effect on the learning process of students (Ratner, 2000).

5.2.3.4 Diversity

The dimensions of diversity were key factors in the teaching-learning relationship as diverse cultural backgrounds, language, learning styles and personalities were present. Students had different needs and expectations and although these were clearly identified, some of these expectations were not always met. Therefore conflict arose which affected the learning process negatively. Wood (2009) claimed that the dimensions of diversity present in a group of students can impede learning, unless the manner in which education is presented is appropriate for everyone.

5.2.4 Limitations

Clinical educators and students reported that the expectations they had of one another were often not fulfilled. This led to limitations in participants' attitudes and behaviours. Some clinical educators expected too much from students. Students reported that clinical educators were sometimes not approachable enough to discuss their problems and often they did not feel comfortable to ask questions. In previous studies, students also consistently reported that they need to feel respected, appreciated and part of a team (Newton, Billett & Ockerby, 2009; Ralph, Walker & Wimmer, 2009; Brown, Williams, McKenna, Palermo, McCall, Roller, Hewitt, Molloy, Baird & Aldabah, 2011; Rodger, Fitzgerald, Davilla & Millar, 2011). Inclusivity will depend on the attitude of the clinical educator who needs to encourage students to become actively involved in a community of practice.

Other limitations regarding the attitudes and behaviours displayed by clinical educators that were described by students within the teaching-learning relationships, were inadequate professionalism, patience and passion. Students sometimes found that clinical educators were not regularly available to see the improvement in the continuity of the patient's treatment. Buchel and Edwards (2005) stated that clinical educators should be readily available when help was required and that they should ensure that a safe, non-judgemental and non-threatening learning environment was established. It is expected that clinical educators should have attributes and behaviours that are conducive to learning.

Furthermore, clinical educators said that students were not always well-prepared or did not have the basic knowledge expected of them prior to the clinical block. The findings supported the results of Cross, (1998) and Chipchase, Buttrum, Dunwoodie, Hill, Mamdrusiak & Moran, (2012) who found that clinical educators expect that students should feel confident to participate in clinical education discourse. This suggests that students should be able and willing to demonstrate and transfer their knowledge in clinical practice by participating in discussions.

In summary, the results revealed a range of challenges in the dual role of clinical educators. These included inconsistencies, incompetence in providing useful feedback, unfair assessment practices, the lack of objectivity of clinical educators, anxiety and confusion of students during assessment processes, biases of clinical educators, disorganization, ineffective communication, emotional overload, expectations that were not met and intimidation of students. These challenges could render clinical educators vulnerable to retreat behind what Borrell-Carrió and Epstein (2004) described as the "low-level decision rules". "There are days when you think, I can't do another judgement. It just drives me mad" [CE 3: 9]. Low-level decisions rules are described as clinical educators' responses influenced by fatigue or overload that render them vulnerable in making hasty decisions regarding students' performances. The low-level decision rules during mentoring and assessing of students could result in less effort by the clinical educator to resolve situations. This could put the clinical educator at risk of making improper, avoidable decisions (Borrell-Carrió and Epstein, 2004).

5.3 Expectations

Looking at the findings of the study, the researcher could determine whether the participants knew what was expected of them in the teaching-learning relationship. All participants revealed what they expected from one another regarding their attributes and responsibilities in the teaching-learning relationship. The responses of the participants substantiated assumptions that ignorance, regarding the roles as a possible cause, influenced the teaching-learning relationship negatively. Findings of the study revealed that students expected to feel inclusive, have good communication skills, share power, and show mutual respect and trust in the teaching-learning relationship. They expected the relationship to be reciprocal, relaxed, comfortable and open, so that the students will

feel comfortable to ask questions. Clinical educators identified support, positive role models, and a relaxed atmosphere as important attributes. The need for trust and respect for one another was also highlighted. They mentioned the necessity to facilitate the clinical reasoning process for students to integrate skills and theory into practice, to clear expectations at the commencement of the clinical block and the use of contracts to set up ground rules between the participants. Clinical educators also expected students to have basic knowledge, skills and be well prepared before entering a clinical block. These findings resonate with findings in previous studies (Oyeyemi, Oyeyemi, Rufai, Maduagwu & Aliyu, 2012; Harden & Crosby, 2000; Buccieri, Pivko & Olzenak, 2013; Cross, 1995; Kilminster, Cotrell, Grant & Jolly, 2007; Strochschein, Hagler & May, 2002; Stalmeijer, Dolmans, Wolfhagen & Scherpbier, 2008; Higgs, 2004; Hughes, 2004; Hodges, 2009). It therefore became apparent if attributes and responsibilities that were expected of both parties were all met, the teaching-learning relationship will be a positive one in which learning will takes place. However, some attributes and responsibilities were not present. Their absence affected the teaching-learning relationship negatively and needed to be addressed.

5.4 Preferences

It was necessary to determine the respondents' preferences regarding the dual role of the clinical educator acting as both a mentor and an assessor, in order to ensure best educational practice and improve the quality of the learning experience of the student.

The majority of the students and the clinical educators preferred that the clinical educator acted both as mentor and assessor in the teaching-learning relationship. Students preferred the dual role assigned to the clinical educators as the clinical educator and the students learned to know one another well, even on a personal level. Researchers have consistently found personalisation from students' perspectives as an important component, indicating the concern students have regarding their own welfare (Brown, Williams, McKenna, Palermo, McCall, Roller, Hewitt, Molloy, Baird & Aldabah, 2011; Smedley & Morey, 2009). The students indicated that, knowing who the assessors were going to be was beneficial to them as they could adapt to their assessors' preferences and expectations. This however, indicated that students adopted a strategic approach to learning and that students preferred the dual role for their own benefit. Several students used strategic learning approaches to gain sufficient pass rates. Such an approach was counter-productive as the students used extrinsic motivation to attain pass marks for the assessment. Intrinsic motivation leads to deep learning (Rose & Best, 2005). According to students, the presence of an external assessor caused stress and made them anxious. Anxiety experienced by students can push students towards a surface approach to learning (Mayya, Krishna Rao & Ramnarayan, 2004).

Most clinical educators admitted that the dual role of acting as an assessor and a mentor was challenging. Some clinical educators preferred the mentor role to that of an assessor. This was confirmed by the findings in a study by Hays (2008) that clinical educators also stated that they

prefer not to have any role in assessment practice as they fear that this may harm their relationship with students. It is suggested that the system should allow the clinical educator some flexibility regarding their preferences. Not everyone feels comfortable to act as mentor and/or assessor. Clinical educators should be able to choose whether to act as either mentors or assessors or both.

The study has demonstrated that the dual role of the clinical educator in the teaching-learning relationship could impact learning both positively and negatively. It is therefore a “Catch-22” [FG 1 (1):19] situation. However, the majority of clinical educators in this study preferred to act as both mentor and assessor to students. Some of them acknowledged that inconsistencies and subjectivity existed among them. Clinical educators, in the dual role, being both a mentor and assessor “can mediate each other” [CE 3:6], and said that “there could be a good balance to be found between the two roles” [CE 3:8], that “you will be able to determine the level of the students’ ability and in what area students still need more support” [CE2:7], that “the dual role is very important for the clinical educators to keep in touch with the students and to be involved in the holistic approach to the students’ learning” [CE 4:10]. Clinical educators also said that “you have to distance yourself from the mentor role when you assess the student” [CE5:3].

The dual role could have a negative influence on the relationship between the clinical educator and the students as the interactions, which occurred between the student and the clinical educator in the clinical environment, could be challenging for both participants. Expectations that were not met highlighted limitations that became evident as has been demonstrated by the findings of the study. However, Tirado & Galvez (2007) believed that when the clinical educator acts as mentor and then assessor, the possibility exists that these challenges, expectations and limitations could be addressed by transforming his/her actions.

It was evident from the findings that challenges, expectations, preferences and limitations were present and solutions had to be found to counteract the negative influence these had on the teaching-learning relationship.

5.5 Suggestions for Change

Considering the implications which the challenges, expectations and limitations had on the learning of students, the researcher designed a coherent model as framework (figure 5.1), reinforced by positioning theory, to suggest ways in which discrepancies could be resolved. These suggestions would help to reposition the participants to transform the relationship. A learning-centred paradigm would be established to ensure effective learning.

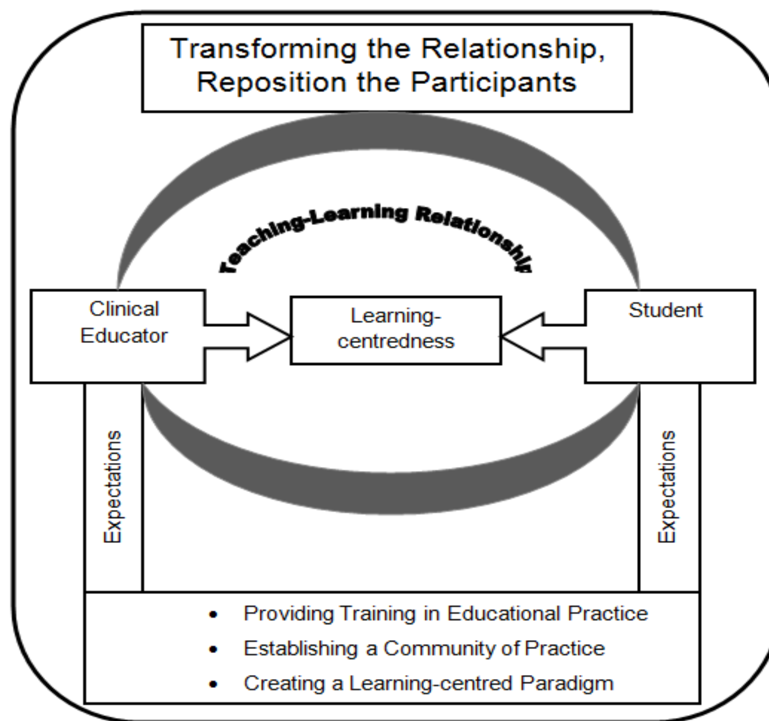

Figure 5.1: A Coherent Model of the Teaching-Learning Relationship During Clinical Educational Practice

In Figure 5.1 the coherent model illustrates a concept of a bridge between the student and the clinical educator to act as an interactive and dynamic connection with a strong foundation to maintain an effective teaching-learning relationship which can enhance learning. The teaching-learning relationship between the clinical educator and the student is upheld by the expectations of both participants. Suggestions supported by the positioning theory are put forward and listed under headings in the foundation block of the coherent model. These suggestions can resolve the conflicting issues such as challenges and expectations that were not met which became apparent during the dual role. If the expectation were met, a positive relationship will focus on a learning-centred approach in clinical education. Honest communication and clearing expectations at the beginning of the clinical rotation are keys to ensure a successful teaching-learning relationship.

The following suggestions are long-term mechanisms which need to be considered by the Division of Physiotherapy, SU, to transform the learning of students. The researcher suggests that the positioning theory be applied to:

- provide further training for clinical educators,
- establish a community of practice, and
- create a learning-centred paradigm.

If these strategies are successful, the likely effect would be a transformed relationship between the clinical educator and the student. Communication would be open and spontaneous, establishing a socio-constructive paradigm and students would be holistically involved in the learning process.

5.5.1 Positioning Theory underpinning the Dual Role

The positioning theory's lens enabled the researcher to critique the positions of students and clinical educators acting as both mentors and assessors and to understand how these relational activities impacted on learning. In order to ensure that the dual role influences the teaching-learning relationship positively, Harre's & van Langenhoven's (1999) positioning theory was applied as a useful tool which helped the researcher to grasp and shed light on how the interactions between the clinical educator and the student could be transformed. This can become a reality if the participants are repositioned as equal partners in a community of practice. By commitment to clinical contracts, both students and clinical educators are responsible for repositioning themselves to ensure an effective teaching-learning relationship.

It is therefore suggested that if clinical educators position themselves in relation to the students, they can act effectively as both mentors and assessors during the teaching-learning relationship. "It is a developing process between the two roles" [CE 7:3]. Through this repositioning, a balance can be found between the two roles. It is a case of "putting on a different hat" [CE 3:6]. Positioning, therefore, can be seen as a means to collaborate and effectively communicate with one another. This will help to establish harmony in the teaching-learning relationship as conflicts can be resolved and stress eliminated (Delany & Molloy, 2009).

5.5.2 Providing Training in Educational Practice

The roles of a mentor and assessor should be seen as specialist roles. Clinical educators need to be "emotionally mature" [CE 3:7] so as to act effectively in both roles. Experience in assessing students is also essential and "as much training as possible" [CE 3:7]. It is suggested that clinical educators should be trained to position themselves in different roles, in order to manage the roles effectively. Educational opportunities will help clinical educators to define, acquire and assess the knowledge, skills and attitudes new graduates need in the process of learning.

Training of assessors is required to ensure consistency (Wass, van der Vleuten, Shatzer & Jones, 2001b), as well as for comparative assessment methods (Downing, 2002). A paper by Boulet, McKinley, Norcini & Whelan (2002) confirmed that a significant number of differences were experienced among assessors when they observed the same performance event of a student. However, Holmboe & Hawkins (2008) have shown that assessors' training can address these issues. Clinical educators need training and experience to develop the ability to determine the level of function of a student as was demonstrated in the following quote: "It took some time for me to develop the ability to determine the level on which the student functioned while adhering to the minimum safety standards which were expected, as well as determining the level of efficiency a student needed. My expectancy levels of the students were initially too high" [CE 2:6]. It is therefore necessary for clinical educators to be knowledgeable regarding the curriculum and the

prior knowledge students are expected to have acquired in order to build on this and develop new knowledge (Vygotsky & Cole, 1978).

Clinical educators are expected to be competent educators (Higgs & Mcallister, 2006). A new culture and set of responsibilities are required when health practitioners move on to become clinical educators. It is essential for the clinical educator to be knowledgeable in order to act efficiently as an assessor and a mentor. Knowledge of the principles of adult learning, appreciation of different learning styles and educational strategies, a comprehensive understanding of the curriculum, and fostering reflective practice are essential attributes necessary to educate students (Irby & Papadakis, 2001).

Clinical educators need to cope with the demanding task of assessing students' performances and giving feedback (Dowling, 2001). They can benefit from structured educational programmes in the assessment practices and procedures and from the philosophy and skills of giving and receiving feedback (Palincsar, 1998; Delany & Molloy, 2009). Higgs and Mcallister (2006) have indicated that high levels of efficiency occurred when clinical educators, who had gained sufficient knowledge and experience, can enjoy and juggle the dual roles of a clinical educator. A highly skilled and experienced clinical educator that could balance, as a tightrope walker, (Higgs & Mcallister, 2006) the demands, qualities and skills needed as mentor and assessor, is described as a "professional artist" (Fish, 1998).

The researcher agrees with Higgs and Mcallister (2006) who suggested that it will be valuable for clinical educators to attend workshop sessions, conferences and courses where they can discuss the challenges which they face within the dual role. Not only will these activities result in a reciprocal relationship between the clinical educator and the students, but also between them and the academic institution, as the key stakeholder, who is responsible for the educational development of both parties (Dornan, Hadfield, Brown, Boshuizen & Scherpbier, 2005). Anderson (2001) stated that it is vital to provide clinical educators with opportunities to attend educational courses and to accept the challenges present in the roles of a clinical educator in order to address inconsistencies.

To minimize subjectivity, the criteria for assessment should be clearly stated so that assessors know exactly what is being assessed and are aware of different levels of achievement. The application of assessment criteria should be consistent and objective. The reliability of assessments is determined by several factors such as the number, format and the assessor, among other things (Wass, Van der Vleuten, 2001; Webb, Endacott, Gray, Jasper, McMullan & Scholes, 2003). These could be addressed by early agreement on the set qualifications of competence of students in clinical education by clinical educators (Delany & Molloy, 2009).

Clinical Educators also need help and guidance when failing students. In a study conducted by Brown, Douglas, Garrity & Shepherd, (2012) it was suggested that clinical educators need guidance and support by institutions in this regard as it is vital that clinical educators have the confidence to fail incompetent students. Patients, society and the profession need protection from unsafe practices.

5.5.2.1 Feedback

During assessment, feedback in physiotherapy educational practice involves information disclosed by clinical educators, to improve students' performances (Molloy, 2004). It is therefore suggested that the clinical educators determine the students' level of knowledge to be able to respond with relevant, constructive feedback on students' performances. Effective education begins at the level of a student's prior knowledge (Wood, 2009).

Theories of critical reflection should support these recommended sessions of feedback to improve students' performances. Therefore, clinical educators should position themselves to provide constructive, supportive and encouraging feedback when acting as mentors, as well as providing judgement on students' performances regarding expected standards when acting as assessors to students. Students should also be equipped with the skills to position themselves in order to receive and accept constructive criticism and feedback (Delany & Molloy, 2009).

A further suggestion is for the positioning theory to be used to highlight the fine-lined, social process of feedback sessions which is present in the mutually constructed roles of the teaching-learning relationship. These interactive communication sessions of feedback need to be planned in the same way the content of the feedback needs to be delivered. Clinical educators have to adapt their position in order to provide feedback to students. Wood (2009) pointed out that students' learning is enhanced by frequent formative feedback sessions. A two-way feedback culture will be established, where students and clinical educators feel comfortable to exchange opinions on students' performances during clinical education. Engaging in discussion, clinical educators should build on a symmetrical conversation with students. This is specifically necessary in the one-way directional nature of feedback sessions. This should occur regularly as it helps participants, in the teaching-learning relationship, to function better (Borrell-Carrió & Epstein, 2004).

5.5.2.2 Self-disclosure

By actively involving students during feedback sessions, clinical educators can ensure that students participate in self-disclosure as members in a practice community. By engaging students as part of a community they will feel comfortable to reveal their lack of knowledge and to ask questions. During this study, students welcomed the self-disclosure of clinical educators. Hargie, (1981) and Brown (1993) recognized that self-disclosure by experts helped to reduce power asymmetry and promote open communication within the teaching-learning relationships. While clinical educators share their knowledge and experiences with students during self-disclosure

sessions and through self-reflection both participants can experience change and growth (Higgs & Mcallister, 2006). Students also develop emotional self-awareness and self-direction while participating in the teaching-learning relationship. The clinical educators' and students' awareness of self includes elements such as self-knowledge, self-identity and self-acceptance (Higgs & Mcallister, 2006). Self-awareness and self-knowledge are dynamic processes that could be enhanced by participating in mentor programmes and assessor courses. These should be planned around communities of practice where participants collaborate, communicate and interact with one another, as well as applying self-reflection to clear disparities.

5.5.2.3 Self-reflection

The importance of self-reflection for students should not be underestimated (Schön, 1995). It is suggested that students be encouraged to reflect on their performances in order to connect their own performances to professional standards and expectations. "If a student has an opportunity to do self-reflection after their assessment, they do not feel so overwhelmed." [CE 2:5] Opportunities for self-reflection will also diffuse negative, emotionally-elicited responses to feedback (Delany & Molloy, 2009). By self-reflection students will be able to identify gaps and address deficiencies to improve the quality of their performances prior to the assessment session, also known as the pre-assessment effect (Boud & Falchikov, 2007). Stiggins (2012) recommended that clinical educators should arrange assessment sessions which will motivate and encourage students to learn. This could contribute to reinforcing the students' intrinsic motivation to learn by self-reflecting and inspire them to set higher standards. The use of portfolios as an objective means to assess students' learning in the clinical environment is suggested.

Clinical educators should also be encouraged to apply self-reflection. As a high-level of competence is expected, it is suggested that clinical educators should position themselves towards a reflexive stance when mentoring and assessing students, to be able to evaluate the needs and goals of specific situations. By taking a reflexive stance, clinical educators will be able to provide alternative decisions regarding their educational practices when alternating between the role of mentor and assessor. Clinical educators should apply problem-solving approaches in areas such as assessment, diagnosis of needs, interactions and outcomes to integrate relevant teaching strategies for professional development, teaching and learning and relationships (Buccieri, Pivko & Olzenak, 2013). Kelly (2007) stated that clinical educators should encourage active learning, reflection and critical reasoning skills in students.

Similarly, the Division of Physiotherapy at SU should apply self-reflection to minimize the noted deficiencies in clinical education. At times clinical educators with no experience or training in clinical education have volunteered to serve as clinical educators. Not all of them are effective in teaching and they often need further training in order to ensure clinical educational competence.

Training should include the development of instructional, interpersonal and assessing skills (Buccieri, Pivko & Olzenak, 2013).

5.5.3 Establishing a Community of Practice

Prideaux and Worley (2007) claimed that students' experiences are greatly influenced by the teaching-learning relationship. It is, therefore, suggested that a community of practice be established in which the clinical educator and the students form a "psychological symbiosis" as was suggested by Vygotskii and Cole (1978). This symbiosis positions the clinical educator to balance the power in the teaching relationship. A level of mutual trust will develop between the parties and maintain harmony within a transformed relationship. According to Laitinen-Väänänen (2008) learning occurs through active engagement with individuals.

Clinical educators engage in leading roles and by means of role modelling they generate effective, collaborative, professional communities of practice (Delany & Molloy, 2009). It is therefore important to ensure that there is a positive relationship in the collaboration between a clinical educator and a student (Hodges, 2009). Collaborating is defined as a process that enables students and clinical educators to engage in social constructivist activities in the clinical environment in which they make sense of their practice through discourse to accomplish pre-set objectives. The learning and professional identities of students are greatly influenced by the psychological positioning in a discourse community.

Clinical educators and students had explicit expectations of one another which needed to be realized in order to transform and strengthen their relationships as equal partners within the community of practice. Inconsistencies and confusing situations can be prevented if clear expectations are set at the commencement of the clinical block and if clinical educators fulfil their obligations by guiding and supporting the students. This can be achieved if clinical educators and students are cognizant of one another's expectations, needs and positions within a specific situation and communication between them becomes spontaneous and open. The success of the implementation of the model of transformation that is suggested depends on effective communication among the participants. A study conducted by Ezzat & Maly (2012), reported that communication on the expectations established by the participants in a relationship is critical to promote deeper learning opportunities. The more the communication between the clinical educator and the student is enhanced, the more likely teaching-learning relationships will function effectively.

In a community of practice clinical educators should welcome and encourage students to take part in discussions allowing them to express their opinions and perspectives in order to develop as professionals. Students, who do not spontaneously join in the discussions, should be drawn in by direct questioning. The more confident the student becomes, the more effective the community of practice will be (Delany & Molloy, 2009).

It is important to acknowledge the dimensions of diversity regarding backgrounds, beliefs, values and expectations that exist among participants in the community of practice (Delany & Molloy, 2009; Lee, Dennis & Campbell, 2007). These dimensions of diversity may influence and direct the actions and comments of the participants. During interpersonal relationships within the community of practice, participants can reach the stage where they enter into communal decisions regarding responsibilities and expectations. Participants can reconstruct their thinking of the learning process, while spending more time on reflection in order to plan concrete future actions. Clinical educators need to be flexible and adapt to students' learning styles, accommodating the dimensions of diversity (Ezzat & Maly, 2012).

5.5.4 Creating a Learning-centred Paradigm

Using the positioning theory to resolve the challenges and expectations that were identified during the analysis of the study, the unfolding of the teaching-learning encounters can be further enhanced if the participants in the relationship reposition themselves towards a learning-centred paradigm, rather than a student-centred or a teacher-centred one. In many aspects, the student-centered approach appears to be directly opposite to the teacher-centered paradigm. However, both are limited by their one-dimensionality. As students' learning should be the focus of clinical educators, the researcher is proposing a synthesis of the two by creating a learning-centered paradigm based on Vygotsky's Zone of Proximal Development (ZPD) Theory (Vygotsky & Cole, 1978) .

The ZPD is created when the learner interacts with the clinical educator in a community of practice. Thus, the clinical educator is brought back into the learning process, without dominating it and the emphasis is on the process of learning. Clinical educators, when acting in both roles as assessors and mentors to students, affect the learning of students, as has been demonstrated by the findings of this study. For clinical educators to position themselves in relation to students towards a learning-orientated, rather than a self-orientated approach, they need to trust and respect one another. These values place clinical educators in a one-to-one relationship, firstly, as supportive mentor and secondly, as a distanced assessor. When an undergraduate physiotherapy student enters the unfamiliar clinical environment, major repositioning from both participants, towards a learning-centred approach, is required and is essential for learning to happen. Clinical education can therefore be seen as a type of repositioning (Delany & Molloy, 2009), based on a learning-centred paradigm.

If the clinical educator and student repositioned themselves as equal partners this transformation of their actions could lead to a transformed relationship in a community of practice, thereby creating a learning-centred paradigm to benefit the learning of students. Harmony in the relationship would be restored.

5.6 Summary

Chapter five discussed the findings according to the themes identified in the previous chapter. The designed coherent model was used as a framework and provided insight into how participants could position themselves as equal partners to transform the teaching-learning relationship. A learning-centred paradigm could be established which could improve the current clinical education towards positive learning experiences. Conclusions regarding the findings, contributions of this study, possible strengths and limitations of this study and future research options and recommendations will be presented in the next chapter.

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Chapter 6: Conclusion

This research paper presents the findings of the realistic experiences of students as well as clinical educators, when clinical educators act as both mentors and assessors to students, during clinical education. The study's main objective was to investigate how the dual role of the clinical educator influences the teaching-learning relationship and how the students' learning in the clinical environment is subsequently affected. The research demonstrates that the dual role of the clinical educator influences the teaching-learning relationship, both positively and negatively.

Several participants acknowledged that the dual role of the clinical educator contributed to a positive relationship in the clinical environment. The findings of this study indicated that the main contributing factors that influenced the teaching-learning relationship negatively, were the challenges that existed in the dual role of the clinical educator. These challenges were identified as inconsistencies, subjectivity, conflict, and when expectations of the participants were not fulfilled. These challenges resulted in confusion among students. Disparities caused students to refrain from disclosing their lack of knowledge and prevented them from asking questions. This was not conducive to the promotion of learning. In these instances a lack of coherence between the actual educational practice at the division, and theoretical knowledge and perspectives on learning, was identified. The findings also indicated that implicit theories about teaching and learning of students were not always recognized, articulated or specified and caused inconsistencies during clinical education. The expectations of the participants and their teaching-learning relationships were clearly identified and expressed. The majority of students and clinical educators preferred the clinical educator to act as both mentor and assessor. However, to address the challenges which inhibited learning, a coherent model was created and used as a framework to reposition the participants in a "psychological symbiosis" relationship in order to balance the power where mutual respect, trust and transparency are key components. When the expectations of both parties are met, these anchors will lead to the transformation of the teaching-learning relationship and a learning-centred paradigm will be established driven by open communication as participants collaborate as equal partners in communities of practice. Disparities within the relationship will be addressed and harmony can be restored.

By drawing on the strengths of the findings and by considering the suggestions offered, the clinical educator could minimize the negative influences on the teaching-learning relationship to enhance the learning of undergraduate physiotherapy students. Support is needed from the Division of Physiotherapy at SU to encourage clinical educators to attend organized workshops, courses and conferences for training in education, and to implement the suggestions. Steinert, Mann, Centeno, Dolmans, Spencer, Gelula & Prideaux, (2006) proposed that it is reasonable for institutions to expect that faculty development will "result in improved teaching performance and better outcomes for students."

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If institutions agree that the on-going growth and development of the profession depends in part on the graduation of physiotherapy professionals who have the habit of deep, critical enquiry into their practice (Hunt, Adamson & Harris, 1998) then they should think about the impact that the relationship between clinical educators and students offer students in their learning development.

To establish good practice which will enhance students' learning it is recommended that a formalised professional development programme be implemented within the Division of Physiotherapy at SU. The goal of this programme should be to facilitate the clinical educator through sessions both prior to and throughout their clinical educational roles. It is necessary to develop qualified and skilled clinical educators, who understand assessment methodology, who know what needs to be assessed and who know how to judge the performance of students (Hays, 2008). By the implementation of the training programme, the Division of Physiotherapy at SU will ensure the quality of their educational practice.

6.1 Contributions

The findings of the study identified the attributes that the clinical educator and students need in a teaching-learning relationship in order to function effectively to enhance the learning experience. The study contributed by identifying new perceptions on how the dual role influenced the relationships between students and educators and how to evoke an increased commitment to educational scholarship investigation to teaching and learning processes. If the learning processes are in place, the learning product will improve. The findings indicated how the division and all those in the faculty who manage, monitor and educate students, could assist clinical educators and students in their development and preparation to transform the teaching-learning relationship to a learning-centred relationship during clinical education. This study may also assist in the selection of future clinical educators in the Division of Physiotherapy at SU.

Some possible strengths of this qualitative research study include the distinct perspectives of both clinical educators' and students' experiences. The study shed light on the experiences of all participants regarding the dual role of the clinical educator and students' learning during the teaching-learning relationship. Findings of the study captured the perceptions of the participants on how the dual role influenced the teaching-learning relationship and further revealed how these could affect the learning of students. The findings could help to improve the quality of the clinical practice in the Division of Physiotherapy at SU, by transforming the teaching-learning relationship to establish a learning-centred paradigm.

6.2 Limitations of the Study

For this study, as with any qualitative research, the findings of this research can only be generalised to similar contexts. Furthermore, all participants in the study were females, a proportion that reflects the current make-up of the physiotherapy profession. Although this

approach is consistent with approaches for qualitative research, the small number of participants could also add to the limitation of generalising the findings.

A further limitation of this study involved the use of interviews as the only source of data collection and analysis (Padgett, 1998). Some of the interviews were conducted in Afrikaans. After analysis of the data, the quotations used were translated and then checked by an editor, to prevent any problems arising from the interpretations.

In addition, the study was designed to focus on the data from the interviews, rather than on encompassing the broader structured context of the clinical environment. Information regarding the clinical environment could be valuable in rendering a more detailed view of potential, important socio-cultural and structural factors that might influence the experience of the teaching-learning relationship.

The fact that the principle researcher is a staff member of the Division of Physiotherapy at SU, as well as a clinical educator of physiotherapy students and consequently fulfils the dual role as a mentor as well as an assessor, might have given rise to a certain degree of bias. The following strategies were adopted to minimize subjectivity:

- using an independent interviewer,
- using a field journal as a reflexive strategy during the analysis of the data, and
- making the transcribed interviews and audiotapes available for the data to be verified.

6.3 Recommendations for Further Research

Further research is necessary to refine the assessment programme of clinical education at the Division of Physiotherapy as a whole, how the assessment programme is integrated in the curriculum and to ensure it conforms to the assessment policy, set by SU.

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Addendum A: Discussion Schedule for Clinical Educator

1. Why did you decide to become a clinical educator?
    - Ad hoc or full time employed
    - Work experience
    - Third- and/or fourth-year students
2. How would you describe the role of a clinical educator as a mentor?
3. How would you describe the role of a clinical educator as an assessor?
4. Do you feel comfortable in these roles? Why or Why not?
5. How would you describe the responsibilities of a clinical educator as a mentor?
6. How would you describe the responsibilities of a clinical educator as an assessor?
7. Describe the qualities a clinical educator needs when mentoring students.
8. Describe the qualities a clinical educator needs when assessing students.
9. Describe which part of being a clinical educator do you enjoy most? Why?
10. Describe which part of being a clinical educator do you find particularly challenging? Why?
11. What do you understand about being professionally accountable when assessing students? Do you find this easy or difficult? Why?
12. Describe the teaching-learning relationships between you and the students.
13. Have you ever failed a student? Why not?
14. Describe this experience.
15. How did this impact on the teaching-learning relationship between you and the student?
16. Have you any suggestions for change to enhance the learning of a student?
17. Describe any other experiences during the clinical educational process which you would like to discuss?
18. In conclusion: Knowing the overall study and question stated, what is your opinion about how the dual role of a clinical educator, being a mentor and an assessor of students, influences the teaching-learning relationship?

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Addendum B: Discussion Schedule for Students

1. In which year of studying are you currently?
2. What in your opinion are the qualities that a clinical educator needs to assist students during their clinical block?
3. Which of these qualities of a clinical educator during a clinical block do you value most?
4. How would you describe the responsibilities of a clinical educator as a mentor?
5. How would you describe the responsibilities of a clinical educator as assessor?
6. How would you describe the roles of a clinical educator as a mentor?
7. How would you describe the roles of a clinical educator as an assessor?
8. Which aspect of having a clinical educator during the clinical block do you find challenging? Why?
9. Describe the teaching- learning relationships between you and your clinical educator.
10. Describe the prerequisites of an effective teaching-learning relationship between you and a clinical educator.
11. Describe what you think can negatively influence this relationship.
12. Describe any positive experiences you have had with your clinical educator during a clinical block. Why?
13. Describe any negative experiences you have had with your clinical educator during a clinical block. Why?
14. Have you ever failed a block test?
15. If so, describe your experience / feelings.
16. How did this impact on the teaching-learning relationship between you and the clinical educator? Why?
17. Have you any suggestions for change to enhance the learning of a student?
18. Describe any other experiences during the clinical educational process which you would like to discuss?
19. In conclusion: Knowing the overall study and question stated, what is your opinion about how the dual role of a clinical educator, being a mentor and an assessor of students, influences the teaching-learning relationship?

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Addendum C

CODEBOOK

Themes	Definitions	Categories	Sub-Categories	Quotes
Challenges	Challenges are factors that contest the positive learning experiences and outcomes of students which cause a lack of harmony within the teaching-learning relationship.	Inconsistencies		[FG 1 (3):7]: *Don't be my friend-friend and then on your clinical exam turn around 360°. This affects us and our patients, and we wonder what is actually going on now? We are so busy trying to figure out what is wrong with the clinical educator that we lose focus on what we need to do.* [CE 8:6]: *Not all assessors act the same during assessments. Some ask more questions as the assessment continuous, while others actually intervene more during the process. I am guilty of this. Especially if you think the student is in the wrong, you chip in too quickly instead of distancing yourself while you observe his performance, allowing the student a chance to show what he is actually capable of doing.*
		Subjectivity		[FG 2 (8):9]: *When they're marking, the clinical educators are very subjective instead of being objective.* [CE 1:5]: *It is a bit of… it is actually very subjective. So I am going to be very honest. I pray before I assess any student, because, you know, I have seen tears in those eyes if they did not do well and sometimes students are doing well during their clinical block, but then they floor it in the assessment and then they feel…that is it that they carry with them.*
		Conflict	Failing Students	[ST 7:7]: *It was terrifying, especially as it was my first block. I was fearful. I freaked out.* [CE 3:7]: *The first time I failed a student, it had a big impact on our teaching-learning relationship. She was very angry and I was so upset, because I thought it was my fault. It was a very traumatic experience. It did affect our relationship badly, which upset me a lot.*
			Intimidation	[ST 12:4]: *You shouldn't feel that the clinical educator belittled you.* [CE 6:2]: *Some students can feel intimidated by you…and they need to expose them at the beginning of the clinical block. Some students will withdraw. They can either find you as an assessor intimidating or the block assessment intimidating.*
			Feedback	[FG 1 (8):18]: *We all did our mock assessment. To me, a mock assessment is personal. You do not need to do it in front of other people. We had to perform in front of the whole group. The clinical educator basically stood in front us while she criticized us. She criticized us in front of everybody. One of my friends burst out in tears. She didn't consider you, your personality, if you were sensitive or not. We were only in 3rd year. She just went on demoralizing us with no constructive feedback.* [CE 6:7]: *It was very difficult to provide them with the feedback of them failing, as it was emotional for both of us. That was challenging to handle.*
			Diversity	[ST 8:8]: *Some people with different personalities might clash while others seem ok.* [CE 8:10]: *There are personality clashes between you and a student…*
		Limitations		[FG 1 (4):8]: *They're not very approachable. That's the challenge. You can't confide in them like you want to.* [CE 6:1]: *The more challenging part in the learning situation is when students are not well prepared, as well as when they struggle to apply the theory in clinical practice.*
Expectations	Expectations are	Mentor		[ST6:3]: *She needs to be able to support you, give advice on aspects for further evidence research*

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	views of participants that are expected from mentors, assessors, students and their teaching-learning relationships that enhance learning.			*practice and provide you with positive and negative feedback, by balancing that, your weaknesses, to improve that. She should allow you a chance to disclose your opinion.* [CE 2:2]: *I think timely, honest feedback is important so that students know on what level they are functioning and if that is acceptable or not.*
		Assessor		[ST 8:4]: *Assessors need to be consistent when assessing students. I think they should gather around a table and decide on a standard beforehand.* [CE 3:5]: *For the students to feel comfortable in the exam situation, so they don't feel threatened. You need to be more objective, possibly more aloof, you've got to be more critical, give informative feedback. So, you do need to distance yourself a bit.*
		Student		[ST 9:3]: *On the one hand it is the student's responsibility to identify gaps and honestly reveal their weaknesses in which they need help. Students play an important role in her their own planning. You have to have a plan. You have to do weekly planning to address stipulated goals. You have to reflect to ensure you reach your goal. You cannot expect the supervisor to come in and assist you if you haven't plan ahead. The student needs to take more responsibility for that.* [CE 5:8]: *I expect students to really be well prepared regarding basic knowledge and skills before entering the clinical block.*
		Relationship		[FG 2 (4):22]: *She does not threaten you or make you feel that she's superior. And she comes on to your level. She really helps you.* [CE 1:9]: *I try to make it as relaxed as possible. They are a bit scared of us, especially at the beginning of the year. I chat to them and I try not for the students to feel stupid. Yes so relaxed.*
Preferences	Preferences are choices that the participants make regarding the dual role and the model of the teaching-learning relationships.	Roles		[ST 6:10]: *I think it's a good idea. During the block, she gets to know you as a person while she is your mentor. On a personal level, she will know your personal state, how you work, as well as what influences it. So she actually gets to know you holistically. She can therefore assess you in a sincere way.* [FG 2 (7):11]: *If an external examiner arrives, you experience anxiety, as this person doesn't know you. She does not know why you are thinking in a specific way. No-one can treat a patient effectively when they feel anxious.* [ST 8:9, 10]: *I think the dual role of a clinical educator is a bit of a bad idea. An external examiner, you know, comes with a different view. She doesn't know you at all, so you can expect that there's nothing about the block that she keeps in mind. You have to know your story, but for me it felt like more...hmmm... she's more objective. I feel the system, as it is, seems a bit subjective.* [CE2:7]: *I think it is necessary to be able to function in both roles, as by facilitating students, you will be able to determine the level of the students' ability and in what area they still need more support. You have to use your facilitation skills in order to assist the students to reach the expected levels.* [CE 1:11]: *... I hate it to assess ... [I] enjoy the mentorship much more then the assessor's role. It is a huge responsibility. However, I am usually a person that sees it as it is. Now I just work within the structure. It is a difficult balance. I think, if you approach it correctly, then it can influence the students positively. It is more difficult for a student to be assessed by someone unknown. The dual role is part of the*

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				package, so you can make it work if you approach it correctly. [CE 7:10]: *I think it will improve the students' feeling of approachability. It will improve the ability of self-disclosure of students. Someone else will be more objective.* [CE 5:3]: *I do feel comfortable in both roles after sixteen years experience however it is not always easy, maybe, because of the friendship between me and the student. Sometimes it can be a bit personal. I definitely enjoy the mentor's role more. You have to be able to distance yourself from the mentor role when you assess the student. I think it is difficult to change from mentor to assessor without experience. It takes at least three to four years of experience to feel comfortable without support.*
		Relationship		[ST 8 :2]: *They have to balance that fine line* [FG 2 (7):4]: *So for me, they're seeing me as a colleague, to challenge me to develop. It's like saying, I stand by you, but I'm not in front, nor at the back. I am standing next to you.* [CE 8:9]: *The clinical educator should, however not become too familiar with the students.*

Code: [Focus Groups (FG) Number 1 = 3rd years, Number 2 = 4th years, student's number: Page number]

[Student (ST) Number: Page number]

[Clinical Educator (CE) Number: Page number]

Red: Focus groups and students' quotes

Black: Clinical Educators quotes

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Addendum D: Participant Information Leaflet and Consent Form

Reference Number____________ **Participant no.**_______

INFORMED CONSENT FORM FOR PARTICIPANT IN A RESEARCH STUDY

Research Project Title: The Clinical Educator's Dual role as Mentor and Assessor: Influence on the Teaching-Learning Relationship.

Investigators: Mrs I.S. Meyer

University of Stellenbosch: Division of Physiotherapy, Department of Interdisciplinary Health Sciences, Faculty of Medicine and Health Sciences, University of Stellenbosch.

1. Introduction

You are being asked to voluntarily take part in the research project described below. Please take your time making a decision and feel free to discuss it. Before agreeing to take part in this research study, it is important that you read the consent form that describes the study. Please ask the study researcher to explain any words or information that you do not clearly understand.

2. Why is this study being done?

The purpose of this study is to understand students' and clinical educators' perceptions of their experiences on the dual role of the clinical educator acting as both a mentor and assessor and what implications this dual role has for both on the students' learning, the learning relationship between the educator and the student.

Research Question

How does the dual role of the clinical educator as mentor and assessor at the Division of Physiotherapy SU, influence the teaching-learning relationship?

Aims

The aims are:

- to explore the students' and clinical educators' perceptions on the dual role of clinical educators as mentors and assessors of students, and
- to explore how the perceptions of both parties may influence their teaching-learning relationships.

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Objectives

The objectives of this research are:

- to describe the students' perceptions of how the dual role of the clinical educator as a mentor and assessor of students influences the teaching-learning relationship,
- to describe the clinical educators' perceptions of how the dual role as a mentor and assessor of students influences the teaching-learning relationship,
- to ascertain the students' and clinical educators' perceptions of the assessment sessions, and
- to determine what the implications are on the teaching-learning relationship between the clinical educator and the student when a clinical educator is both the mentor and the assessor.

The results of this study will provide the Division of Physiotherapy with information which could lead to changes regarding the clinical platform.

This study will potentially be published in an accredited medical/allied health/educational journal.

This study is being conducted on third and fourth year physiotherapy students as well as on clinical educators who facilitate students. As a third or fourth year student currently registered in the Physiotherapy programme of the Division of Physiotherapy at the University of Stellenbosch, you were asked to be part of this study. As a clinical educator employed by the Division of Physiotherapy at the University of Stellenbosch, you were asked to be in this study.

3. What is involved in the study?

If you agree to take part in this study, the researcher will:

- ask you questions during approximately one hour long interview that will be held at the Division of Physiotherapy at Stellenbosch,
- the questions will be about your perceptions and views on your experiences of the research topic, and
- the interview will be recorded.

4. What are the risks and discomforts of the study?

There are no known risks associated with this research. You may choose not to answer or to skip a question. You may also choose to stop your participation in the study completely. Your will in no way be affected by your participation in this research study.

5. What are the benefits of this research study?

This research may help us to understand how we can further develop the clinical environment to optimize the learning of students during their clinical education.

6. What other options are there?

You have the option not to take part in this study. There will be no penalties involved if you choose not to take part in this study.

7. Who is paying for this study?

Internal Funding
Funding for this study is provided by the researcher.

8. Will I be paid to participate in this study?

You will not be paid for taking part in this research study.

9. What if I want to withdraw, or am asked to withdraw from this study?

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you do not take part in the study, there will be no penalty.

If you choose to take part, you have the right to stop at any time. However, we encourage you to talk to the researchers so that they know why you are leaving the study. If there are any new findings during the study that may affect whether you want to continue taking part, you will be told about them.

The researcher may decide to stop your participation without your permission, if they think that being in the study may cause you harm.

10. Who do I call if I have questions or problems?

You may ask any questions you have now. If you have questions later, you may contact
Mrs I.S. Meyer (021) 9389300

If you have questions or concerns about your participation as a research subject, please contact the University of Stellenbosch Health Research Ethics Committee 2.

Mertrude Davids at 021 938 9207 or mertrude@sun.ac.za

11. What about confidentiality?

Your part in this study is confidential. None of the final data analysis will identify you by name. All records containing your name will be erased from the documentation prior to the researcher sharing the data with the statistician, study supervisor, and / or any other interested parties within the University. The collected data will be stored on computer file that will be protected by a password known only to the researcher. All records will be destroyed after the completion of the research project. Anonymity of all participants will be maintained.

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12. Authorization Statement

I have read each page of this paper about the study (or it was read to me). I know that being in this study is voluntary and I choose to be in this study. I know I can stop being in this study without being penalized. I will get a copy of this consent form now and can get information on results of the study later if I wish.

Participant's Name: ____ Date:____________________

Participant's Signature: ____ Date:____________________

Gender: Male ☐ Female ☐

Consent form explained/witnessed by: ____

Signature

Printed Name: ____

Date:______________________________ Time:____________________

All research conducted for this project is in accordance with the guidelines set out by the Declaration of Helsinki and the MRC for ethical guidelines in medical research.

14. Informed consent for the taping of the interview

The purpose of the digital-recording for this interview and the use, storage and final destruction of the tapes has been explained to me and I understand the explanation. I have been offered to answer any of my questions concerning the procedures involved in the recording of the interview and I have been given a copy of this consent form.

____ ______________________________

Participant's Name (printed) Date of Birth

____ ______________________________

Signature of Participant Date