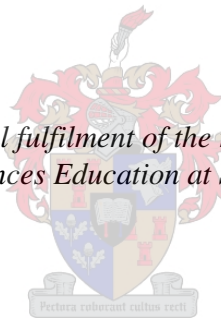


Clinical Occupational Therapists’ experience of their role as clinical educators during the fieldwork experience of occupational therapy students

by
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Declaration

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Abstract

Fieldwork is an essential part of the occupational therapy student's education, and optimal learning is dependent on effective facilitation by a clinical Occupational Therapist. This study explored the lived experience of the clinical Occupational Therapists in their role as clinical educators by means of a phenomenological inquiry. Ten semi-structured interviews were conducted with clinical Occupational Therapists involved in clinical education. The data was analysed by using thematic content analysis, and was discussed according to the *Lived Experience of a Clinical Educator Model*. The results indicated that the clinical OTs' sense of self, which revealed strong humanistic values, acted as the core element influencing the way in which they related to others and were able to juggle many roles in order to perform their role as clinical educator. It furthermore influenced the ways in which they managed balance and harmony in the workplace, as well as the process of growth and development. Incongruence during the performance of their roles as clinical educators was mainly caused by insufficient collaboration between the clinical educators and the university, the prescriptive nature of the fieldwork curriculum, workload pressures, the students' attitudes and their lack of knowledge, as well as insufficient training of new clinical educators. The results may be helpful in fostering a collaborative relationship between the university and the clinical Occupational Therapists, as well as renewed attention to growth and development, all of which will benefit the students' education.

Abstrak

Kliniese werk vorm 'n essensiële deel van die arbeidsterapie-student se opleiding en dit is noodsaaklik dat die leerproses effektief gefasiliteer word deur 'n bekwame kliniese Arbeidsterapeut. Hierdie studie het die Arbeidsterapeute se belewing van hul rol as kliniese opvoeders nagevors deur middel van 'n fenomenologiese ondersoek. Tien semi-gestruktureerde onderhoude is met kliniese Arbeidsterapeute, tans betrokke by kliniese opleiding, gevoer. Die data is verwerk deur middel van tematiese inhouds-analise en is bespreek aan die hand van die *Lived Experience of a Clinical Educator Model*. Die resultate het aangedui dat die kliniese terapeute se bewustheid van hulself ('sense of self') die kern element vorm wat hul verhoudings, sowel as die wyse waarop hulle al hul onderskeie rolle en take behartig, beïnvloed. Sterk humanistiese waardes kom voor in hierdie kern element. Dit is verder bepaalend in die wyse waarop die Arbeidsterapeute balans en harmonie in hul werkplek verseker, sowel as hul professionele groei en ontwikkeling. Inkongruensie tydens die rolvulling word veroorsaak deur onvoldoende samewerking tussen die universiteit en kliniese opvoeders, 'n voorskriftelike kurrikulum, werksdruk, studente se negatiewe houding en gebrek aan kennis, sowel as onvoldoende opleiding van die terapeute wat nuut begin met kliniese opleiding. Die resultate mag in die toekoms behulpsaam wees in die totstandkoming van 'n samewerkende verhouding tussen die universiteit en kliniese terapeute, met genoegsame aandag wat geskenk word aan professionele groei en ontwikkeling. Dit kan tot voordeel van die studente se leerproses aangewend word.

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Chapter 1 - Introduction

1.1 Background and problem statement

'Fieldwork education, the practical component of the curriculum, is an integral part of the education of occupational therapy students and is instrumental in developing professional behaviour.' (Bonello, 2001, p93).

The South African Professional Board for Occupational Therapists, Medical Orthotics/Prosthetics and Arts Therapy has set out the *Minimum Standards for the Training of Occupational Therapists* (HPCSA, 2009) in accordance with the *World Federation of Occupational Therapists (WFOT) Minimum Standards for the Education of Occupational Therapy students* (2002). According to these standards, each student is expected to complete a minimum of 1 000 hours of fieldwork prior to obtaining the occupational therapy degree and registration with the Health Professions Council of South Africa (HPCSA). Students in their first, second and third years of study have to perform fieldwork under the direct supervision of a registered Occupational Therapist (OT), but students in their fourth-year of study may work under the guidance of a registered health professional in the absence of a registered OT, although access to a registered OT should be provided for guidance on an ongoing basis. It is also required that the students should be exposed to a range of different fieldwork placements to gain a broad scope of experience. The Professional Board evaluates each university's Occupational Therapy department every five years to ensure that all teaching programmes comply with the Minimum Standards.

Each university designs its own fieldwork and educational programme to comply with the above mentioned requirements. There is no recipe for the ideal format of a fieldwork programme, but it is expected to reflect the current context and trends of health and community care (Duncan & Alsop, 2006; Aiken, Menaker & Barsky, 2001). The fieldwork experience provides opportunities for real-life experiences which allow the students to integrate theoretical and practical learning, and assists in the development of their clinical reasoning, problem-solving and judgement skills. It also promotes professional competence, confidence and identity, and facilitates multi-professional collaboration (Bonello, 2001; Alsop & Ryan, 1996). The supervisory process has been identified as the most critical element in the quality of this experience (Steele-Smith & Armstrong, 2001; Christie, Joyce & Moeller, 1985), and the clinical therapist plays an important

role in the transfer of clinical knowledge, skills and attitudes from teacher to student using strategies that directly involve a patient (Daggett, Cassie & Collins, 1979 cited in Edwards & Baptiste, 1987, p250).

Limited professional resources, under-resourced infrastructures and rapid de-hospitalization and de-institutionalization are some of the factors which currently influence the implementation and management of fieldwork education in South Africa (SA) (Duncan & Alsop, 2006). It is therefore regularly required of clinical OTs to deal with big caseloads in workplaces that are often not well resourced in terms of the staff and/or equipment needed for therapy. All of these factors may have a negative influence in the context of an increased demand for quality fieldwork placements (for students) that meet the required minimum standards. Meeting these standards within the current SA health system has therefore become a challenge, and there is a constant need for the development of more and/or alternative placement areas (Duncan & McMillan, 2006). The Department of Health currently has no legislation on the subject of clinical teaching performed by their staff.

Students at Stellenbosch University Occupational Therapy Division (SU OTD) perform fieldwork at a variety of placement areas during their third and fourth years of study. The periods of fieldwork are generally five to seven weeks in duration. Most of the placement areas are situated in state-operated institutions, for instance hospitals and schools, but there are also some placement areas in private hospitals, old age homes and non-governmental organizations (NGOs). SU OTD annually supplies all students, clinical occupational therapists and lecturers with a revised copy of the *Guide for Clinical Work* (Division of OT, 2011), which identifies the expected generic outcomes for clinical work and interdisciplinary teaching and learning during a clinical block. It also provides regulations for the amount and format of written work that must be presented by students for evaluation, as well as the different clinical assessments and feedback sessions that have to take place.

The clinical OTs are responsible for teaching clinical and professional skills to the students, as well as supervising the students' treatment of their patients. The supervising SU lecturer is responsible for marking all the students' reports and case studies, and together the OT and the lecturer award marks to the student. No formal performance appraisals of the work done by the clinical OTs in their role as clinical educators are currently done. They perform the clinical education on a voluntary basis, and receive no remuneration for it, but are rewarded by SU OTD in a few different ways. The HPCSA (2010) stipulates that the clinical OTs may all receive two

Continuing Professional Development (CPD) points per student that they supervise – up to a maximum of sixteen points per annum. All OTs are legally obliged to collect 30 CPD points per annum in order to stay registered with the HPCSA. Educational activities, which are usually CPD accredited, are also provided for professional enrichment. The latter are usually free of charge for attending clinical OTs who supervise SU students.

During recent years SU OTD has become concerned about certain aspects of the fieldwork experience which directly involve the clinical OTs and which may impact negatively on the fieldwork learning experience of students if they are not addressed timeously. These concerns include the following:

- The demand for fieldwork placements is expected to increase in the future. According to the National Plan for Higher Education (Ministry of Education, 2001), all Higher Education institutions are expected to increase their student numbers and graduate output in the next few years, in order to meet the demand for high-level skills. Placement areas also have to be negotiated annually with the OT Divisions of the University of Cape Town (UCT) and the University of the Western Cape (UWC), as clinical placement areas are limited. Resistance from the OTs in supplying additional fieldwork placements is currently experienced due to their high workload, the inexperience of novice OTs, and the fact that student training does not form part of their job description.
- Students have reported that in some fieldwork areas the clinical OTs are mainly involved in indirect service provision, and that the students do not observe frequent patient treatment from which to learn.
- Not all the involved OTs are equally positive about the fieldwork education process, which can lead to sub-optimal student training.
- Complaints from OTs regarding their professional relationship with the SU OTD, and the fact that their input is not always sufficiently valued, are voiced.
- Inconsistent, divergent and unmet expectations between the clinical OTs and SU OTD do sometimes exist, which can indirectly have a negative impact on the learning experience.
- Educational opportunities provided for the clinical OTs are generally not well attended.

SU OTD strives to provide excellent education to its students, including quality fieldwork experiences. In the light of the concerns described above, as well as the Division's new programme for comprehensive quality assurance management in clinical fieldwork, it was

considered important to explore all factors that may influence student education. This research study therefore focused on the role of clinical OTs in the clinical training of OT students during fieldwork, in order to identify the factors that may impact on the quality of the fieldwork experience.

1.2 Purpose of the study

It is accepted that clinical OTs are important partners in the fieldwork education of the SU OT students. However, the abovementioned concerns may impact negatively on the quality of students' fieldwork experiences if they are left unattended. The purpose of this study was, accordingly, to discover, from the clinical OTs' perspective, how they experience their role in facilitating learning of the OT students, and to identify any factors that might concomitantly influence their optimal fulfilment of this role and the fieldwork experience of SU students.

The objectives were:

- to determine how the clinical OTs interpret and experience their role as clinical educators during fieldwork;
- to determine how the clinical OTs value their role as clinical educators during fieldwork; and
- to determine any factors that might have a beneficial or detrimental effect on their role as clinical educators during fieldwork and that could influence the quality thereof.

The results gained from the study were considered to be important in that they provide a foundation for the concerns mentioned, clarify assumptions, and possibly furnish solutions thereto. The implementation of these possible solutions is likely to improve the quality of the fieldwork experience for students and to benefit the partnership between SU and clinical OTs in the long run.

1.3 Problem formulation

In order for the researcher to investigate the possible factors that might facilitate and/or prevent the clinical OT from providing a quality fieldwork experience to OT students at SU, the proposed study addressed the following research question: ***How do clinical Occupational Therapists experience and value their role as clinical educators during the fieldwork experience of occupational therapy students?***

1.4 Terminology

'In the literature the words fieldwork education, clinical education, professional fieldwork experience and clinical practice are all terms used to describe that special part of the professional educational programme in which students gain hands on experience of working with clients under the supervision of a qualified practitioner' (Alsop & Ryan, 1996, p4). The words *'fieldwork educator'*, *'clinical occupational therapist'* and *'clinical supervisor'* therefore all refer to the practising OT under whose guidance a student will work during a fieldwork placement.

In this study the following terminology is used:

Clinical Occupational Therapist (OT) refers to the practising OT who is involved in the training of OT students in his/her area.

Clinical educator refers to the person performing the specific role that the clinical OT performs when he/she is involved in the training of OT students in his/her area of work.

Direct supervision refers to the supervision supplied by a clinical OT who is able to supervise an OT student on an ongoing and full-time basis during the fieldwork experience.

Formal supervision refers to the supervision supplied by a clinical OT on a full-time or part-time basis, where he/she is involved in evaluating the student's clinical performance.

Informal supervision refers to the supervision that can be supplied by team members other than the clinical OT in those instances where the OT does not work in the placement area on a full-time basis. No marks are allocated under these circumstances.

1.5 Delineation of the study

This study focused only on obtaining data from clinical OTs who are currently involved in the fieldwork education of third- and fourth-year OT students at SU.

1.6 Chapter overview

In order to ascertain the degree to which the objectives of the study were met, and the research question answered, the following chapters will provide information regarding the relevant literature (chapter 2), specific methodology used (chapter 3) and the results obtained (chapter 4). The results obtained are discussed in relation to the existing literature, to provide insight and

understanding of the lived experiences of the clinical educators, and the degree to which the findings are underscored by the literature (chapter 5). This is done in order to draw a conclusion and make relevant, applicable recommendations that will benefit the future fieldwork experiences of OT students at SU (chapter 6).

Chapter 2 - Literature review

2.1 Introduction

Fieldwork has been a valued component of occupational therapy education since 1923, and is relied upon to '*acculturate occupational therapy students to the profession*' (Cohn & Crist, 1995, p103). However, the research undertaken on this topic was minimal until the late 1980s (Bonello, 2001). In order to contextualise the research study, the body of existing literature assisted in highlighting issues and also indicated some factors likely to influence clinical experience.

The literature study focused on the rationale and perceptions of fieldwork, the design and implementation of the fieldwork experience, and the specific role of the clinical supervisor, in partnership with the university, during these processes. An in-depth study of all these factors shed light on these specific phenomena and formed a basis for reference in the interpretation of the data obtained from the research study.

2.2 Rationale for fieldwork

Fieldwork is described as '*the essential bridge from classroom to service delivery*' (Cohn & Crist, 1995, p105) which provides students with opportunities for observation and active participation in patient treatment (Alsop & Ryan, 1996; Kautzman, 1987). It promotes the integration of theory and practice, consolidates previous learning, facilitates new learning, and promotes clinical reasoning and judgement (Mulholland & Derald, 2007; Unsworth, 2001; Banks, Bell & Smits, 2000), as well as critical thinking (Vogel, Geelhoed, Grice & Murphy, 2009; Lederer, 2007; Velde, Wittman & Vos, 2006). Fieldwork, and especially service learning in the community, also contributes to the appreciation of students' civic responsibility, and it facilitates the development of cultural competence amongst them (Hoppes, Bender & DeGrace, 2005; Ekelman, Deal Bello-Haas, Bazyk & Bazyk, 2003; Barrett, 2002), which is, according to Murden, Norman, Ross, Sturdivant, Kedia and Shah (2008) and Odawara (2005), crucial for the effective planning and execution of OT intervention.

Through the fieldwork experience an increased understanding of the role of occupational therapy and confirmation of the correct career choice is facilitated (Mulholland & Derald, 2007), and it has the greatest impact on the development of students' preference for a clinical practice area after qualification (Crowe & Mackenzie, 2002; McKenna, Scholtes, Fleming & Gilbert,

2001; Christie, et al., 1985a). Professional competence, confidence and identity, as well as multi-professional collaboration, is promoted (Mulholland & Derald, 2007; Hoppes, et al., 2005; Alsop & Ryan, 1996) through contact with a variety of patients and team members from other disciplines.

All the above factors indicate the importance of the fieldwork experience in the education of OT students and in the facilitation of their knowledge, skills and attitudes. It can, therefore, be extrapolated that the quality of this experience determines the quality of the workforce in the future. Educational institutions have to design and implement fieldwork programs that will ensure quality education and an efficient future workforce.

2.3 Designing a fieldwork programme

Each university designs its own fieldwork and educational programme to comply with the requirements of its professional board, as previously described (see 1.1). There is no recipe for the ideal format of a fieldwork programme, but it is expected to reflect the current context and trends of health and community care (Duncan & Alsop, 2006; Aiken, et al., 2001; Bonello, 2001; Cohn & Crist, 1995).

Historically occupational therapy clinical education took place in traditional settings where one student worked and learned under the supervision of a qualified OT. Changes in the health care environment, as well as increased student numbers, have necessitated the need for additional and/or alternative placements (Overton, Clark & Thomas, 2009; Fisher & Savin-Baden, 2002a; Bonello, 2001; Cohn & Crist, 1995). The findings of various studies identified staffing issues, limited resources, workload pressures and multiple expectations on clinicians as the main barriers to providing fieldwork placements for students (Thomas, Dickson, Broadbridge, Hopper, Hawkins, Edwards & McBryde, 2007; Bradley, Jaffe & Lee, 2003; Fisher & Savin-Baden, 2002a; Casares). Limited professional resources, under-resourced infrastructures and rapid de-hospitalization, as well as de-institutionalization, are factors that have been found to influence the implementation and management of clinical education in SA (Duncan & Alsop, 2006). These problematic, limiting factors require the constant development of more and/or alternative placement areas in order to meet the necessary minimum standards within the current SA health system (Duncan & McMillan, 2006).

Exploration of alternatives to the one-to-one (1:1) model of supervision has given rise to a number of non-traditional placements (Alsop & Ryan, 1996), which include the following:

- The 2:1 (collaborative) model, where two students are supervised by one clinical educator (Blakely, Rigg, Joynson & Oldfield, 2009; Bartholomai & Fitzgerald, 2007; Martin, Morris, Moore, Sadlo & Crouch, 2004);
- The 3:1 model, or group model, where three students are supervised by one clinical educator (Martin, et al., 2004; Farrow, Gaipman & Rudman, 2000; Aiken, et al., 2001);
- The role-emerging model where students are placed in settings where OT services are not routinely provided. A member of staff at the workplace provides informal supervision. Formal supervision and evaluations are performed by an OT (Overton, et al., 2009; Bossers, Cook, Polatajko & Laine, 1997);
- Project placements where students are required to manage a project within a health/welfare organisation under the guidance of an OT (Overton, et al., 2009; Fortune, Farnworth & McKinstry, 2006);
- Risk assessment programmes during which students perform workplace risk assessments for local business organisations under the guidance of academic staff members (James & Prigg, 2004);
- The interagency model whereby an OT collaborates with therapists and agencies from the independent and voluntary health sectors, in order to share the responsibility for student learning (Fisher & Savin-Baden, 2002b);
- Community projects where there are no OTs and no well-defined roles. Supervision is performed by an OT who provides guidance and support (Mulholland & Derald, 2005; Friedland, Polatajko & Gage, 2001);
- Service learning which integrates academic learning and service to the community, according to needs identified by the community (Pretorius & Bester, 2009; Hoppes, et al., 2005).

Findings from a literature review by Overton, et al. (2009, p300) indicate that, even though non-traditional placements have been used for more than twenty years, a perception still exists that these types of placement are inferior to the more traditional placements. However, they provide a *'unique opportunity to take the profession into new territories and, in turn, map the future for occupational therapy practice'*.

The benefits of non-traditional placements include a stronger emphasis on client-student interaction (Mulholland & Derald, 2005; Bossers, et al., 1997), self-directed learning that facilitates the development of clinical reasoning skills (James & Prigg, 2004; Fisher & Savin-Baden, 2002b; Bossers, et al., 1997), the development of a strong professional identity

(Bossers, et al., 1997), a more varied experience of roles (Fisher & Savin-Baden, 2002b) and the development of additional occupational therapy practice settings (Martin, et al., 2004). The limitations include limited access to a clinical educator (Martin, et al., 2004; Fisher & Savin-Baden, 2002b), assessment tools that do not adequately reflect learning (Friedland, et al., 2001) and lack of knowledge regarding the OT role in explaining it to others (Thomas, et al., 2005; Friedland, et al., 2001). Adequate preparation prior to placement, clear expectations regarding the students' role and support options are deemed necessary to ensure the success of non-traditional placements (James & Prigg, 2004; Martin, et al., 2004; Bossers, et al., 1997).

In a major study undertaken by Christie, et al. (1985a), the findings highlight the importance of the fieldwork experience, and, supplementary to that, the supervisory process is identified as the most critical element of the experience. This has been confirmed by the more recent studies of *inter alia* Mulholland & Derald (2007) and Steele-Smith & Armstrong (2001). Various authors recommend that clinical OTs should have input in the design of the fieldwork programme, and that there should be a culture of appreciation and acknowledgement for the work done by them. It is furthermore recommended that Universities should respond to controversy and/or the requirements of the clinical educators, as closer collaboration will have positive implications for practice and education, and will fuel fieldwork excellence (Kirke, Layton & Sim, 2007; Casares, et al., 2003).

Duncan and Lorenzo (2006) are of the opinion that a prescriptive approach to learning requirements is counter-productive as it limits access to potential learning opportunities and restricts the creativity of all the role players in a constantly changing environment. They also deem it necessary to negotiate a *'flexible, practical yet academically well-grounded curriculum pitched at the appropriate level for the student's stage of professional development'* (Duncan & Lorenzo, 2006, p56) prior to the start of each placement. This will ensure that all parties gain as the expectations and anticipated outcomes are mutually agreed upon, the fieldwork curriculum is responsive to the needs and goals from the site and the client, and a wider range of fieldwork opportunities may be developed. The GRACE fieldwork program (Rosenwax, Gribble & Margaria, 2010), which was designed with all stakeholders as integral and valued partners in the clinical education process, prove that this approach can be successful and can culminate in an oversupply of placements for OT students.

From the literature it is evident that the design of a fieldwork programme is influenced by various factors which can influence the success thereof. The clinical OT is viewed as an important role-

player in the design and subsequent implementation of the programme, and universities should collaborate with them and value their input in this regard, to improve clinical teaching and ultimately the quality of students' fieldwork experiences.

2.4 Implementing a fieldwork programme

Alsop and Ryan (1996) describe the fieldwork experience as a partnership between the university, the clinical educators and the students, where each of the partners has both expectations and responsibilities. They all have an important role to play in the successful implementation of the fieldwork programme.

2.4.1 The role of the University

The university is expected to be well organized with its fieldwork arrangements, to communicate regularly and efficiently, and to deal with students who experience problems in fieldwork (Kirke, et al., 2007; Alsop & Ryan, 1996). Fieldwork placements must provide a good range of practice experience for the students, and should be of adequate length to maximise student learning (Kirke, et al., 2007). Findings from studies by Overton, et al. (2009) and Mulholland & Derald (2007) indicate a need for increased academic preparation and knowledge before students commence clinical work, clear placement objectives and expectations, and modification to the assignments during placement.

According to Higgs and McAllister (2005), research into the lived experience of a clinical educator, according to the *Lived Experience of Being a Clinical Educator Model*, offers valuable insight into the role of the clinical educator and furthermore allows the researcher to consider strategies and implications for the preparation, support and development of the clinical educator. Findings from various studies recommend that programmes to prepare clinical educators for their tasks should be presented, as well as sufficient opportunities given for continued professional development and the maintenance of practitioner competence. Furthermore, support should be provided and regular and effective communication from the university should inform the clinical educators about curriculum developments (Pereira, 2008; Kirke, et al., 2007; Thomas, et al., 2007; Johnson, Koenig, Verrier Piersol, Santalucia & Wachter-Schultz, 2006; Fone, 2006; Hook & Lawson-Porter, 2003; MacKenzie, Zakrewski, Walker & McCluskey, 2001; Bonnelo, 2001). Some countries, for example the United Kingdom, follow a programme of accreditation to prepare OTs as clinical educators, which is deemed

essential for effective student education (Duncan & Alsop, 2006; Duncan & Lorenzo, 2006; Alsop & Ryan, 1996). No such formal programme exists in South Africa.

Steele-Smith and Armstrong (2001) state that the clinical educator who experiences student supervision as positive and rewarding is more likely to be a provider of additional clinical placements. Financial rewards/incentives, additional resources, the availability of local training, reduced caseloads (Fisher and Savin-Baden, 2002a) and appropriate acknowledgement by the profession, universities and host organisations (Thomas, et al., 2007) are all recommended to assist in the increased availability of placements and in the satisfaction experienced during the supervisory process.

2.4.2 The role of the student

Students view the role of the clinical educator as important and valuable during their fieldwork experience (Mulholland & Durdall, 2007; Johnson, et al., 2006; McKenna, et al., 2001; Christie, et al., 1985b). They expect their supervisors to have good interpersonal and communication skills, especially as far as feedback to the student is concerned. The supervisor must also be competent as a clinician and educator, and a good role model to the students (Mulholland & Durdall, 2007; Alsop & Ryan, 1996). Other important aspects are the benefits offered by the setting, the availability of resources, and opportunities for learning and exposure to diversity (Mulholland & Durdall, 2007).

Clinical educators describe the preferred learning characteristics of a successful student as active experimentation and doing, flexibility, adaptability and good teamwork (Herzberg, 1994). They must show an interest in what they are learning, be receptive to feedback, act professionally, apply effective communication skills, and be organised and enthusiastic (Kirke, et al., 2007).

2.4.3 The role of the clinical educator

Universities expect that a clinical OT, with relevant experience, will take responsibility for their students' supervision and that he/she will understand the programme of study and the assessment procedures to be followed. His/her tasks include the following (Duncan & Lorenzo, 2006; Mulholland & Durdall, 2005; McAllister, Lincoln, McLeod & Maloney, 1997; Alsop & Ryan, 1996):

- to practise as a competent clinician;

- to manage themselves and students in the workplace;
- to support students during the placement;
- to facilitate learning by the students; and
- to evaluate students' performance and their competence to practise.

Each of these tasks will be briefly explained.

2.4.3.1 Practise as a competent clinician

The clinical OT has to perform the dual roles of clinician and clinical educator. The challenge of balancing multiple workload demands may sometimes cause tension and stress. However, it is essential that professional conduct is modelled at all times, as students learn mostly by observing the actions and reasoning processes of the educator (Kirke, et al., 2007; Jung & Tryssenaar, 1998; McAllister, et al., 1997).

Alsop & Ryan (1996) state that, apart from possessing the necessary knowledge, skills and expertise in their own field, the clinical educator should also be committed to the education of students. The decision to become involved in student education should be made freely, to prevent any uncomfortable feelings about it which may lead to tension in the relationship with the students. Adequate support for their added responsibilities must be supplied (Kirke, et al., 2007).

2.4.3.2 Manage themselves and students in the workplace

Clinical educators are expected to manage their caseload and administrative duties in the workplace, as well as the students' placement. The latter requires liaison with the university, orientating the students to the specific area, planning the students' programmes, monitoring progress, and finally managing the effective withdrawal from the placement (Kirke, et al., 2007; McAllister, et al., 1997; Alsop & Ryan, 1996).

Clinical educators identified the benefits associated with fieldwork supervision in terms of the potential it provides for future recruitment, students' help in finishing projects or developing resources, and their contribution to the development of the OT profession (Thomas, et al., 2007).

2.4.3.3 Support students during the placement

It may sometimes be necessary for clinical educators to provide extra support to students on matters related to their learning or their personal life, in an effort to prevent this from having an adverse effect on their performance. It is important to identify and handle problems correctly, and the clinical educator can involve the academic coordinator if necessary (Kramer & Stern, 1995). However, it is important for the OT to recognize the limits of his/her abilities, and to know when to refer a student to another source for help (Alsop & Ryan, 1996).

Johnson, et al. (2006) and Kautzmann (1987) state that the students' primary objectives in Level 1 fieldwork (comparable to third-year at SU) are to practice their clinical skills and receive feedback on them, as well as to observe the clinical OT in action. In a study by Kemp (2000), the problem of the clinical OTs not demonstrating treatment of their patients to the students was identified as the second biggest cause of stress to SU students during their fieldwork experience. Mitchell & Kampfe (1993) found that a clinical supervisor who fosters open communication in the learning environment and transmits a feeling of support during planned discussions and feedback sessions can be instrumental in stress reduction, greater satisfaction and fewer emotional problems. The skilful use of reflection, confrontation and empathy can provide an atmosphere which is conducive to learning and personal growth.

2.4.3.4 Facilitate learning by students

The clinical educator is responsible for facilitating the acquisition of clinical knowledge, skills and attitudes by the students through relevant real life experience (Duncan & Lorenzo, 2006; Mulholland & Derald, 2005; Alsop & Ryan, 1996). McAllister, et al. (1997, p17) suggest that '*adult learning theory provides a strong theoretical foundation for clinical education*' as the characteristics of adult learners, principles of adult learning, characteristics of effective facilitators and the goals of adult learning are all present and/or applied during clinical education.

Knowles, Holton and Swanson (1998) base their model of andragogy on the following assumptions about adult learners:

- they need to know the reason why they need to learn something;
- they become more self-directed, although they may still be dependent on the teacher in some circumstances;

- they accumulate experiences that become a rich resource of learning and they tend to learn better through experiential learning;
- their learning needs are related to their life roles and/or tasks at the time, or their need to learn;
- their learning becomes more effective when it can be applied in real-life circumstances;
- internal motivation to keep growing and developing is present in normal adults, but it can be blocked by different factors, such as a negative self-concept, the inaccessibility of opportunities or resources, and time constraints.

Findings from a study by Whitcombe (2001) indicate a positive attitude by clinical educators and students towards andragogical learning. Mulholland and Derald (2007) relate the above assumptions to occupational therapy fieldwork, in that the nature and expectations of fieldwork require a degree of self-directedness that increases in subsequent fieldwork experiences. The experience that students accumulate during fieldwork is a resource and frame of reference that they can take back with them to the classroom and use during subsequent learning. The assumptions also relate to the realities of practice and of being professional during the fieldwork experience, as well as some real life problems that this poses. These different learning experiences make the students' subsequent learning more relevant and real.

Merriam & Caffarella (1999) state that Kolb's' model of experiential learning (1984), or an adaptation thereof, is most often used in practice, as the cyclical nature thereof allows for continued change and growth. According to Mulholland and Derald (2007), the assumptions about the adult learner mesh with the concept of experiential learning and relate well to OT students' fieldwork. The authors state that the students encounter many concrete experiences during fieldwork on which they are able to reflect in follow-up courses and fieldwork assignments. This enables them to conceptualize what could have been done differently, and they can actively experiment in subsequent courses and placements.

Experiential learning is a manifestation of the constructivist orientation to learning (Merriam & Caffarella, 1999). Gravett (2005) states that constructivism is not a single theory, but a cluster of related views of theorists such as Dewey, Piaget, Lave and Vygotsky. It rests on the assumption that learning takes place, and knowledge is actively constructed, when students make meaning of their own experiences. This happens through an internal cognitive activity, and the process is dependent on the students' previous and current knowledge structures. New information is therefore understood and learned via the students' existing knowledge framework. By linking

new information and facts with existing knowledge, more integrated knowledge structures are actively constructed. Meaningful learning takes place during this process. Well organised and connected knowledge can be retrieved more effectively when needed, as in the case of experts, in a certain discipline, who have developed more interconnections between concepts than novices in the same discipline. Conceptual change occurs in students when meaningful interconnections are constructed and existing conceptions are revised or enriched.

Findings from a study by Unsworth (2001) on the differences in clinical reasoning of expert and novice OTs indicate that, due to their experience, expert clinicians are able to draw on a larger bank of knowledge to plan client intervention more efficiently and to anticipate the clients' performance, which can then quickly be adjusted or changed as needed. It is therefore essential that the students should be provided with an adequate variety of patients in different clinical settings to develop their clinical reasoning skills (Holmes, et al., 2010; Overton, et al., 2009; Velde, et al., 2006; Banks, et al., 2000).

Situated learning is one of the core premises of constructivism (Schunk, 2004). It refers to the fact that learning is not just a cognitive activity, but involves relations between a person and a situation, and addresses the notion that many processes interact to produce learning. Mann (2004) states that situated learning is relevant to medical education, as individuals learn from each other through conversations and participation in work and practices in the community. New learners start on the periphery of the community of practice, but as they learn and move towards the centre of the community, they become more involved and responsible, and will contribute to knowledge building. Findings by Jenkins (1994, cited in Bonello, 2001, p96) confirm that learning happens, and new knowledge is created, when OTs work in the real situation of practice. The author also advocates that the context in which learning occurs must always be considered during assessments.

Ramsden (2003) and Prosser and Trigwell (2000) state that the variation in students' previous learning and teaching experiences, as well as their perceptions of their new learning and teaching context and their situation within this context, influence their approach to learning. According to them a deep approach to learning is associated with good teaching, clear goals, and an emphasis on independence. A surface approach to learning, on the other hand, is associated with a high workload and inappropriate assessment that is perceived to measure rote-learned material. Students tend to prefer a learning approach that will relate to their perception of their learning situation. This may vary amongst different students, depending on

how they perceive their situation within the context in which they are learning. Their learning approaches are also fundamentally related to their learning outcomes, with a higher quality outcome amongst students who adopt a deep approach toward learning.

A constructivist learning environment should create rich experiences that encourage learning through proper construction of the learning environment and the application of student-centred principles. The contextual factor (organization and structure of the learning environment) is one of the aspects of motivation that is especially relevant to constructivism, the other two being implicit theories (students' beliefs regarding their own abilities) and teachers' expectations (teacher actions and students' achievement outcome) (Schunk, 2004). The ideal state of mind for learning is when students are moved beyond their comfort zones, experience a low degree of threat, and feel a sense of well-being. The brain should be challenged by the learning activity to create new synapses, or follow relatively unused synaptic pathways (Gravett, 2005).

The learning environment plays an important role in contributing to students' abilities to integrate theory and practice (Banks, et al., 2000). It must be psychologically safe, should encourage risk-taking, and be conducive to learning. It should evoke positive emotions such as interest, enthusiasm and enjoyment. Negative emotions obstruct learning, and students find it hard to focus when they feel threatened, as the brain is then less able to engage in complex intellectual tasks, and rote learning may be encouraged (Gravett, 2005). Alsop & Ryan (1996) list the specific skills and positive attitudes a good clinical educator needs in order to facilitate optimal learning by students. These attributes were confirmed in a later study by Kirke, et al. (2007). Students who experience negative attitudes from their clinical educator will become complacent, less motivated, and will not experience optimal learning during the fieldwork experience (Alsop & Ryan, 1996).

The literature suggests that student-centred learning emphasizes students' responsibility for, and active participation in, learning, with the teacher as a guide, mentor and facilitator. There is a higher focus on cooperative learning, and a greater flexibility in learning, teaching and assessment. However, some adult learners regard their role as learners as passive recipients of information due to their previous educational experience, and they expect to be taught by a teacher. If these expectations are then not met, the learners often express hostile behaviour towards a teacher, or students may become dependent on their teachers (Gravett, 2005; Cannon and Newble, 2000). Vermunt and Verloop (1999) state that the teacher-regulation strategies towards learning functions can be strong, loose or shared. These strategies can lead

to destructive friction, constructive friction or congruence, depending on the degree of student-regulation of learning, and will as such influence the cognitive, affective and metacognitive learning activities of the students. Findings from a study by Whitcombe (2001, p557) indicate that a learning contract is a *'useful tool in fostering independent learning and the skills of self-evaluation'*. It is, however, time consuming, and demands good communication and facilitation from the clinical educator.

2.4.3.5 Evaluate students' performance and their competence to practise

Fieldwork supervisors are described as the *'gatekeepers who maintain the quality standards of the profession'* (Herzberg, 1994, p817), and they are expected to perform objective evaluations of the students' performance during formative and summative assessments. (McAllister, et al., 1997). The assessment tool must reflect the learning experienced at the placement setting (Overton, et al., 2009), and should therefore be valid and reliable (Cannon & Newble, 2000). The clinical educator needs the necessary skills to judge competent performance, be conversant with the assessments, and take responsibility for failing a student (Alsop & Ryan, 1996). He/she must be equipped for these tasks through preparatory programs supplied by his/her respective university (Pereira, 2008; Kirke, et al., 2007; MacKenzie, et al., 2001).

Feedback is an essential component of effective formative assessment, and can enable deep learning (Rushton, 2005). Students value feedback, and learn from it when it is based on their performance and goals (Hewson & Little, 1998). Feedback must be given shortly after the assessment, negative and positive feedback should be balanced, and students must know where they can improve (Cannon & Newble, 2000). Feedback should also be constructive and must not overload or overwhelm the student (Edwards & Baptiste, 1987).

The literature indicates that the clinical OT, in his/her partnership with the university and the students, plays an integral role in the effective implementation of a fieldwork programme, as well as in the facilitation and evaluation of learning by the students. These tasks have to be performed over and above all the other roles and tasks expected of the clinical OT in his/her daily work. Adequate preparation and support from the university is deemed essential to ensure that the students have a successful fieldwork experience, and that optimal learning takes place.

2.5 Conclusion

It is during the fieldwork experience that OT students learn the integrated knowledge, skills and attitudes required for their profession after graduation. The literature indicates that the role of the clinical educator is crucial during the design and implementation of the process, and that it can influence the context of learning, the method of facilitation and the motivation of the student towards a certain approach to learning. Many factors influence the execution of this role, which, if not handled correctly, may have a detrimental effect on students' learning.

It was therefore deemed necessary, in the SU context, to investigate how the clinical OTs experience their role as clinical educators, with the aim of identifying possible factors that influence it in a positive and/or negative way. It is only by gaining this knowledge, and acting on it appropriately, that an excellent standard of clinical education can be provided and maintained for the SU OT students.

Chapter 3 – Methodology

3.1 Introduction

In order to discover how the clinical OTs experienced their role as clinical educators during the fieldwork experience of the SU OT students, it was necessary to focus on how they viewed and understood their specific world, and how they constructed meaning from their experiences. Qualitative research was deemed the most appropriate way of investigating the specific phenomena, as it is a process whereby rich descriptive data can be collected to gain more insight and understanding of what is being observed. These types of studies are usually conducted by interacting with, and observing, the participants, and the focus is on their meanings and interpretations. The emphasis is on the quality and depth of information, and not on the scope and breadth of information as provided by quantitative research (Nieuwenhuis, 2007a).

The detail regarding the specific design of the study, the instruments used, data collected, quality assurance and ethical considerations is accordingly discussed in order to provide a solid foundation for findings which will be able to withstand rigorous future peer reviews.

3.2 Research design

The study followed an **interpretivist** paradigm with a **qualitative** approach which was conducted by means of a **phenomenological inquiry**.

The interpretivist perspective is based on the ontological assumption that social reality can only be understood from within (internal reality), by focusing on people's subjective experiences (Nieuwenhuis, 2007a). The social world does not exist independently of the human mind and is not predetermined by some independent law of nature (Nieuwenhuis, 2007a). This perspective is furthermore based on the epistemological assumption that there is an interactive relationship between the researcher and the participants, as well as between the participants and their own experiences (Nieuwenhuis, 2007a). The researcher is empathetic and accepts the participants' experiences, beliefs and narratives as true for those who have lived through them (Nieuwenhuis, 2007a).

During the study the researcher interacted closely with the participants to explore the richness, depth and complexity of their role in facilitating learning during the fieldwork process of SU

students, as perceived from the clinical OT's perspective. Although subjective, the researcher accepted their personal experiences as true for the OTs who lived through them. Each situation was unique, and was analysed accordingly. The researcher did not decide what counted as knowledge, but what the clinical OTs viewed as knowledge from their frame of reference. The data from the study assisted the researcher in developing a sense of understanding and improved insight into the factors which were beneficial or problematic for quality fieldwork experiences. Although the researcher was not able to generalise the findings, they provided greater clarity on the question of how the clinical OTs made meaning of the fieldwork phenomena and therefore furnished greater understanding of, and insight into, their experiences.

The phenomenological inquiry investigates subjective phenomena in the belief that essential truths about reality are grounded in the lived experience (Streubert & Carpenter, 1995). The *experience* is important, and not what anyone else may think about it (Streubert & Carpenter, 1995). A holistic perspective and the study of the lived experiences, serve as foundations for such an investigation (Streubert & Carpenter, 1995). The research process was conducted according to the core steps central to a phenomenological investigation as described by Spiegelberg (1965, 1975, cited in Streubert & Carpenter, 1995). These steps included *intuiting*, during which the researcher became totally immersed in the phenomenon and acted as the tool for data collection; *analyzing*, which involved the immersion of the researcher in the data to find common themes or essences, and, *describing*, whereby the researcher communicated the distinct critical elements of the phenomenon by means of a written description. These critical elements were described individually, but also in their relationship to one another and in relation to the world, with reference to appropriate literature.

Reductive phenomenology (Streubert & Carpenter, 1995) occurred concomitantly with the investigation as this process was critical for the preservation of objectivity. The researcher has been involved in fieldwork supervision for at least twenty years, and it was therefore necessary for her to put aside any bias, presuppositions or beliefs that might have been formed in order to obtain the purest description of the phenomena.

3.3 Instruments: Semi-structured interviews

Face-to-face, semi-structured, individual interviews were conducted with clinical OTs, because it was anticipated that this would provide rich and in-depth information about their experiences of facilitating students' learning during fieldwork (DiCicco-Bloom & Crabtree, 2006). An interview

schedule with pre-determined, open-ended questions was used to define the line of enquiry. The questions were determined on strength of their capacity to assist in achieving the objectives of the study, as set out in 1.2. The initial seven questions considered for the interview were as follows:

1. Tell me about your experiences of being a clinical educator to OT students.
2. Tell me about your current experience in your role as clinical educator of SU OT students during their fieldwork experience in your area.
3. How do you interpret and understand your role as a clinical educator of SU OT students during their fieldwork experience?
4. How do you value your role as clinical educator of SU OT students during their fieldwork experience?
5. Describe the factors that have a positive and beneficial effect on your role as clinical educator and subsequently on the fieldwork experience of the students.
6. Describe the factors that have a negative and detrimental effect on your role as clinical educator and subsequently on the fieldwork experience of the students.
7. Explain whether you are of the opinion that the SU OTD provides enough support in terms of education to enable you to perform your role as clinical educator optimally.

After the first interview another question was added, as the clinical OT had stated that she was of the opinion that the clinical OTs should be consulted regarding the fieldwork curriculum in order to ensure that it is realistic and in keeping with current trends in the field. Question eight (8) was formulated as follow: *'Do you think the clinical OT should be able to furnish input into the design of the fieldwork curriculum for OT students?'*. Rich and valuable information was gained from this.

The interviews were conducted in either Afrikaans or English, in accordance with the interviewee's preference. The researcher was attentive to the responses and to any new emerging lines of information, which were then also explored and probed. Caution was applied not to get sidetracked by trivial aspects not related to the study, for instance when the interviewees started to compare the different universities that placed students with them and to describe positive and/or negative aspects thereof. Whenever this happened, the interviewee was guided back to the focus of the interview (Nieuwenhuis, 2007b).

To ensure the success of the interviews, the researcher strived to adopt good interviewing techniques by being a non-judgmental listener. DiCicco-Bloom and Crabtree (2006) advise on

the necessity of establishing a rapport early on in the interview. This was done by showing trust and respect for the interviewee and the information she shared, as well as by providing a safe and comfortable environment for sharing the experiences. Non-verbal communication, for instance eye contact and posture, was observed throughout the interview, to establish whether the interviewee felt comfortable and secure enough to share her perceptions with the interviewer (Nieuwenhuis, 2007b). On the whole, this was not perceived as a problem as information was offered freely - and elaborated on when requested. The first question to the interviewee was always broad, open-ended and non-threatening, and was repeated when necessary. Further clarification of responses was done without leading the interviewee. Prompts, such as repeating the words used by the interviewee, were used when necessary.

A digital recorder was used to record the participants' experiences in an effective and accurate way. This allowed for the interview to proceed naturally, and the information was not filtered or interpreted by the researcher. The researcher was able to give her full attention to the conversation, and made supplementary field notes as needed (Stanton, 2000). Verbatim transcriptions of the recordings were made by the researcher herself, and included non-verbal clues. The transcriptions were made as soon as possible after the interview to allow the researcher to fill in any gaps resulting from indistinct or unclear words, as the conversation was then still fresh in her memory. Copies of all data were stored in the SU OTD.

3.4 Data collection

The data was collected by means of the recorded interviews and field notes as described. The specifications regarding these data sources are discussed below together with the specific way in which the data was analysed and reported.

Selected clinical OTs, who were willing to participate in the study, were contacted before the interview to prepare them for the actual interview, and the researcher briefly explained the research that was conducted. Any preliminary questions were answered. The location for the interview was agreed upon by both parties, but it was ensured that it suited the OT.

3.5 Target population and sampling

'Purposeful sampling is used most commonly in phenomenological inquiry. This method of sampling selects individuals for study participation based on their particular knowledge of a phenomenon for the purpose of sharing that knowledge' (Streubert & Carpenter, 1995, p43).

In the study a sample of information-rich participants was selected (purposeful sampling) from the group of clinical OTs involved in fieldwork teaching of SU OT students. There were five fields of placements where students gained fieldwork experiences: physical field; psycho-social field; educational settings; community projects; work rehabilitation.

According to Patton (1990), there are no rules for sample size in qualitative research, and the size of a sample will depend on what the researcher wants to know, the purpose of the study, how the information will be used, and the resources available. For the purposes of this research study a sample of twelve clinical OTs was initially selected for interviews by means of proportional stratified purposeful sampling, whereby the population was divided into different strata according to the areas in which clinical education takes place. The sample sizes were allocated proportionally (Maree & Pietersen, 2007). Table 1 indicates how the clinical OTs were selected from each of the five fieldwork areas mentioned before, to ensure that the sample was representative of the group. The criteria for selecting the therapists from each field were as follows:

- a minimum of two years' experience in clinical training;
- the clinical therapist had to be currently involved in clinical education; and
- a fair distribution of third- and fourth-year placement areas, as there may have been differences in the problems experienced within these two groups.

Fieldwork areas	Physical	Psycho-social	Educational settings	Community	Work rehabilitation	Total
Fieldwork areas with fulltime or consulting OTs	10	10	4	2	3	29
Initial sample of OTs selected from each area	4	4	2	1	1	12
Final sample of OTs selected for interviews	3	3	2	1	1	10

Table 1: Sample selection from fieldwork areas

The selected sample was flexible, and data was collected up to a point of saturation when no further new information or themes emerge from the data collection process (Nieuwenhuis, 2007b). The point of data saturation was reached after ten interviews, and therefore two OTs from the initial sample were not interviewed (see Table 1). They worked in the physical and psychosocial fields respectively, which meant that all fields were still represented effectively.

3.6 Analysis and reporting

Qualitative data analysis is usually based on interpretative philosophy and tries to establish how participants make meaning of a specific phenomenon. This is best achieved through a process of inductive analysis, whereby findings emerge from dominant themes inherent in the raw data (Nieuwenhuis, 2007c).

The process of data analysis began when data collection commenced, to allow the researcher to discover additional questions or descriptions which were needed, as well as to decide when the point of saturation had been (DiCicco-Bloom & Crabtree, 2006; Streubert & Carpenter, 1995). The data was organised in a systematic manner whereby different data sets were kept separate and data sources were well marked for easy identification (Nieuwenhuis, 2007c).

The method of thematic content analysis was guided by the stages as described by Burnard, Gill, Stewart, Treasure and Chadwick (2008) and Burnard (1991). The analysis included the following:

1. Notes, regarding the topics discussed during the interview, were made directly after the interview. During the research project the researcher also wrote down ideas about ways of categorizing the data which helped to assist during analysis of the data.
2. The researcher became immersed in the data and read through the verbatim transcripts. Notes of words, theories or short phrases that summed up what was being said in the text were made in the margins. This is also known as open coding, and the aim was to offer a summary statement or word for each element that was discussed in the transcript. Off-the-topic material, also known as 'dross', was left uncoded.
3. The process of open coding was repeated to ensure that all emerging themes were identified.
4. Microsoft Office OneNote 2007 was used to organize and file the words and phrases. The number of categories was reduced by putting similar ones into broader categories or higher-order headings.

5. The new list of categories and sub-headings was worked through, and over-lapping or similar headings were removed to produce a final list.
6. A colleague was invited to generate category systems, and the lists were then discussed. The necessary adjustments were made in an attempt to enhance validity.
7. Transcripts were re-read alongside the finally agreed list of categories, to establish the degree to which it covered all aspects of the interview. The necessary adjustments were made.
8. All the data was stored on a flash disk.
9. Copies of the complete interview, as well as the original tape recordings, were also kept at hand during the writing-up process.
10. The writing-up process began. In each section the various examples were linked by commentary offered by the researcher.
11. The researcher reported the key findings and accompanied it with a section in which the findings were interpreted according to the *Lived Experience of Being a Clinical Educator Model* (McAllister, 2001) and, furthermore, discussed in relation to other existing literature.

The findings were reported in form of a research assignment. The researcher plans to follow it up with an article to be published in a peer-reviewed journal, for example the *South African of Occupational Therapy*. A proposal will also be sent to a relevant congress, for example the SU Scholarship of Teaching and Learning Conference (SoTL), which will be held in May 2012. Feedback regarding the research study will also be given to the clinical OTs and to SU academic staff at a quarterly clinical supervisors' meeting during 2012.

3.7 Quality assurance

Krefting (1991) states that every qualitative research proposal and report must establish its trustworthiness on grounds of its credibility (truth value), transferability (applicability), dependability (consistency) and confirmability (neutrality), as this is critical to the evaluation of the worth of research. Certain strategies, as described by Krefting (1991), were implemented to enhance the trustworthiness of the study.

There were no time limits attached to the interviews, which ensured that the researcher could adequately submerge in the research setting, and participants were able to volunteer more sensitive information as they felt more comfortable. This subsequently enhances the credibility of the study. The interviews were kept internally consistent by using a schedule of questions as

previously described (see 3.3). A pilot interview with a previous clinical OT, who was not a participant in the study, was performed before the study commenced. The interview was analysed, and the feedback was applied in the subsequent interviews with participants.

A field journal was kept as a strategy for reflexive analysis. This tool was used by the researcher to assess the influence of her own background, perceptions and interests on the qualitative research process. It included a daily schedule and logistics of the study which are important for audit ability. There was also a section where the researcher wrote down her own subjective thoughts, feelings and ideas, through which she could become aware of biases and preconceived ideas. Ways of collecting data or approaches could then be altered to enhance credibility.

The researcher made use of peer examination to ensure credibility. Peer examination occurred by means of assistance from an impartial colleague in checking categories during the analysis process, as well as by discussing the research process and the findings with her. Member checking was not deemed appropriate or necessary to expand or qualify the original data obtained from the interviewees, as the interview processes as a whole revealed no need for this.

Triangulation was also not deemed appropriate as the data represented the OTs' own accounts of their lived experiences. There was accordingly no need to use different sources to check the findings,

In her final report the researcher provided an adequate database of the sample selected for the study, to allow transferability judgments to be made by others. The exact methods of data gathering, analysis and interpretation used during the study were described in the final report, to allow other researchers to follow the decision trail clearly.

3.8 Ethical considerations

Ethical considerations were applied and observed in order to ensure that the research study was valid in all material aspects.

Ethical approval was obtained from the internal Ethical Committee of SU before commencement of the study.

At the time of the interviews, consent and permission to record the interviews was obtained from the participants (Streubert & Carpenter, 1995). There was an understanding between the

researcher and the participants that all information shared during the research process would be kept confidential and private, and that the findings would be presented in an anonymous manner in order to protect the identities of the participants. During the process of peer examination, as well as editing, the identities of the interviewees were kept confidential and they were referred to by means of their interview number. The data will be stored for three years in the OT Division at SU, and will thereafter be destroyed. Transcriptions and list of names will not be stored together.

The researcher continuously conducted the research according to the highest professional ethics whereby no data was fabricated or falsified, and ethical publishing practices will be followed in the future (Mouton, 2001).

3.9 Limitations of the study

The following limitations could possibly impact on the study:

- The fact that the researcher is a part-time lecturer at SU might have influenced the responses of the participants, and her involvement in clinical education at SU for more than twenty years might have given rise to a certain degree of bias and preconceived ideas. In order to promote objectivity, the following measures were put into place: (1) a pilot interview with an experienced interviewer took place prior to the start of the research project; (2) a field journal was kept during all the interviews, to act as a reflexive strategy, to be aware of any bias or preconceived ideas; (3) peer checking during analysis; (4) all the audiotapes and field notes were available afterwards for verification of the data. An impartial third-party (co-interviewer) taking notes was not deemed suitable, as this could have undermined the interviewee's frankness, openness and spontaneity, jeopardise confidentiality, or the perception of confidentiality, and act as a passive clog to the obtaining of data. These negatives were considered to outweigh any possible advantages of having a third party monitor the interviews.
- The findings may not be transferable to other universities due to the specific sample selection.
- The method of data gathering was limited to semi-structured interviews only. For this particular study I was interested in every OTs in-depth account of her experience of her role as a clinical educator. If focus groups had been used to gather the data, the possibility would have existed that some of the quiet and shy OTs might have been intimidated and overshadowed by their more verbal colleagues.

- The majority of interviews were performed in Afrikaans and translated when used for referencing purposes. This could potentially have caused problems with regard to interpretations, so in order to prevent this, the translations were checked by an experienced editor.

3.10 Conclusion

The methods followed during the research process were deemed the most appropriate in fulfilling the purpose of the study and in providing an answer to the research question. By means of a phenomenological study it was possible to become immersed in the phenomena and to obtain rich and in-depth information that provides a better understanding of the way in which the clinical OTs experience their role as clinical educators. The subsequent findings indicated the factors that impacted on this role and of which cognisance should be taken to ensure optimal educational and fieldwork experiences for OT students.

Chapter 4 – Results

4.1 Introduction

The results of the study were collected from ten female participants who obtained their basic degree in OT during the period stretching from 1979 - 2005. None of them had completed post-graduate studies. They had qualified at different universities, namely SU (n=5), UCT (n=1), UWC (n=2) and University of the Free State (n=2). On average they had been involved in the clinical training of OT students at different educational institutions for 11.9 years, and more specifically with SU students for 8.7 years. Four of the OTs were exclusively involved in the training of fourth-year students, another three exclusively in the training of third-year students, while the final three were involved in the training of both third- and fourth-year students. One person from the latter group was also involved in the clinical training of first- and second-year students. Three of the participants had a dual role, i.e. they acted as clinical OTs in their areas, but were also appointed as part-time supervising lecturers by SU.

Four themes emerged from the analysis of the data collected during the study, as illustrated in Table 2 below. Each theme is discussed individually in accordance with the main categories.

THEMES	Tasks of the clinical educators	Motivators	Influencing factors	Recommendations made by the clinical educators
CATEGORIES	<ul style="list-style-type: none"> • Demonstration • Feedback • Training programme • Support • Evaluation 	<ul style="list-style-type: none"> • Professional responsibility • Personal benefit 	<ul style="list-style-type: none"> • Personal factors • Factors in the workplace • Students • Relationship with SU • Fieldwork curriculum • Education of clinical educators 	<ul style="list-style-type: none"> • Education of clinical educators • Relationship with SU • Training of students

Table 2: Themes and categories that emerged from the results

4.2 Tasks of the clinical educators

This theme refers to the specific tasks the clinical OTs had to perform while training OT students during their fieldwork experience in their areas of practice. These tasks were performed over and above the other roles that the OTs had to perform, for instance as clinicians or administrators.

The coding categories under this theme were as follows:

- Demonstration
- Feedback
- Training programme
- Support
- Evaluation

Each one of these categories is discussed individually with specific mention of the sub-categories that emerged from them.

4.2.1 Demonstration

This category refers to the OTs' demonstration of patient treatment to the students, as well as the demonstration of professional conduct towards patients, team members, staff, and the general public.

Four sub-categories emerged from this category:

- role model;
- effective way of teaching;
- student feedback on demonstration; and
- student responsibility to observe treatment.

4.2.1.1 Role model

The OTs unanimously identified their task as role model as being important. According to them it provides the students with a frame of reference that they can apply in their studies and future practical work.

I think my biggest role is actually that of being a role model to them. This is how it is supposed to happen or look.. and that they can physically see it.... (Interview 1, lines 49-51)

I think I try to give them an idea of what it is that they are actually going to be one day, so actually moulding them into the therapists that they need to be. (Interview 6, lines 279-281)

4.2.1.2 Effective way of teaching

Demonstration of patient treatment and professional conduct was perceived as essential and the most effective way of teaching by all the clinical OTs. It was used to teach the students certain basic or specific skills needed during the clinical block, assist in integrating theory and practice and facilitate the learning of new information that can then be applied in the future.

But hands-on is in the end what they need, because they arrive here and some of them are afraid to handle a disabled child, so I have to show them that the child will not be injured. (Interview 8, lines 138-140)

If they do not see it, it takes even longer to integrate theory and practice. (Interview 3, line 37)

So that they can observe your behaviour, how you handle yourself and how you treat your patient. (Interview 10, lines 33–34)

.... the demonstration itself is very, very important so that they can see exactly and understand, becauseit is actually me really teaching them the whole different way of being able to analyzeand a...a different type of activity or an assessment over here. (Interview 5, lines 110-113)

4.2.1.3 Student feedback on demonstration

It was the OTs' perception that students learned most when they observed the clinical OT in her treatment of patients and her interaction with other team members.

The feedback I receive from the students indicates that they learn more from what they see me doing than from any verbal lectures that I may give them. (Interview 4, lines 68-70)

Many of them will say that, for once, it is so good to see how it should be done and not only to hear how it should be done. (Interview 1, lines 61-62)

4.2.1.4 Student responsibility to observe treatment

The OTs took responsibility for the demonstration of treatment at the start of the clinical block, but expected students to take responsibility for observing them in treatment later during the block. According to them some students unfortunately did not take the responsibility to follow this through.

I make it their responsibility to shadow me if and when they want to....(Interview 4, lines 72-73)

(You told them do observe your sessions. Do they do it?) No, not actually. (Interview 8, lines 26-27)

4.2.2 Feedback

This category refers to the feedback that the clinical OTs gave to students during or after their patient treatment, or with regard to other tasks that were related to the students' professional behaviour.

Five sub-categories emerged from this category:

- facilitation of clinical reasoning;
- constructive feedback;
- assist student in optimal treatment of patients;
- formal and informal feedback; and
- identify learning styles.

4.2.2.1 Facilitation of clinical reasoning and learning

Feedback from the clinical OT to the student was perceived to be an important tool in the facilitation of clinical reasoning. Discussion and the use of guided questions were used during this task.

... ..but the clinical reasoning, I think...then you need to guide them...it is not just giving them the answers (Interview 6, lines 307-308)

After the home visit we will discuss it. What will you now treat? Did you see what the stove looked like? (Interview 4, lines 140-142)

Some of the clinical OTs commented on how students struggle to integrate knowledge and theory during their clinical blocks. Limited knowledge, as well as a lack of confidence in their knowledge and skills, was identified as possible reasons for this problem.

It is usually when students have an insufficient knowledge base or when they struggle with the integration of theory and practice (Interview 1, lines 17-18)

You find academically strong students who can usually explain to you how to do something, but they are not always capable of doing it themselves. I think that confidence often plays a role....it is the first time that they are confronted with it.....(Interview 3, lines 49-51)

4.2.2.2 Constructive feedback

Feedback was constructive in nature, to motivate students and to facilitate learning.

I focus a lot on positive feedback to reinforce those aspects that they are good at. (Interview 2, lines 100-101)

4.2.2.3 Assist student in optimal treatment of patients

The feedback sessions were important in assisting the students in their selection of appropriate activities for optimal assessment and treatment of their patients.

And then we discuss the findings from their assessments and what their treatment will entail...(Interview 4, lines100-101)

...giving the student feedback of what works in the area, what doesn't...this is the technique ...specifically on techniques, especially with pressure garments and splintingI think that's important...(Interview 6, lines 275-277)

Specific expectations regarding adequate planning were set for the students to ensure that their patients received optimal treatment. This helped them to improve their management and planning abilities.

So I think the students' ability to organise and plan their work also develops in this specific area..... Through the need for planning..... (Interview 2, lines 217-220)

4.2.2.4 Formal and informal feedback

Feedback was given on a formal basis during pre-arranged meetings between the clinical educator and the student, as well as on an informal basis when feedback was given on the spot. This was described as time-consuming by some of the therapists.

...the only negative thing is that the verbal feedback that I give to them after their treatment sessions just adds to my workload (Interview 2, lines 151-153)

...the most valuable learning opportunity is the informal one where I can see what she is doing...I come in and see that the transfer is not correct... or I walk past and indicate that she must just let the patient move forward a bit...It is more valuable because they are under less pressure.(Interview 3, lines 204-207)

4.2.2.5 Identify learning styles

During the discussion and interaction with the students the OTs gained insight into their level of knowledge and the way in which they learn. This assisted them in knowing how to facilitate learning with specific students.

Some students talk a lot and I find it easy to figure out their thought processes. Others are more quiet and will maybe just sit and observe and not be talkative....then it takes longer to figure out how they learn and on which level they function. (Interview 4, lines 217-220)

...just need to kind of like feel them through, because each student is also different. They learn differently and they experience things differently. So the way that I handle each student... I might be a little more firm on this one, because my expectation might be more. (Interview 5, lines 26-29)

4.2.3 Training programme

This category refers to the specific programme of training designed and implemented by the clinical OTs to facilitate learning during the students' fieldwork experiences.

Five sub-categories emerged from this category:

- planning of programme;
- orientation of students;
- grading of expectations;
- strategies in developing student independence; and
- feedback regarding patient progress.

4.2.3.1 Planning of programme

Good planning and preparation was essential to ensure that the training programme ran smoothly, and that it produced an optimal learning experience for the students.

I think you must just plan well....to keep up with everything and keep priorities in mind. What is important in the day? (Interview 2 , lines 207-208)

....and to prepare before the students arrive is a huge task. The planning must be efficient, otherwise it will be unfair to them, as the learning opportunity will not be optimal.... (Interview 4, lines 15-17)

4.2.3.2 Orientation of students

Some of the OTs identified the necessity for orientation to the fieldwork area, to inform students regarding the area, available materials and area tasks, in order to foster a good understanding and set out the expectations.

I receive them and then orientate them to the hospital and the different areas. Then we do the administrative planning and they receive their assignment for indirect services. (Interview 3, lines 6-8)

So in terms of guidance I first give them lots of orientation to the area that we have, so that they have a good...understanding about what happens here. (Interview 5, lines 84-86)

4.2.3.3 Grading of expectations

A graded programme of teaching was followed by the OTs. In some of the areas the students shadowed the OT for the first week and observed different treatment sessions. In the weeks following progressively less guidance was provided, as the students progressed and became

more independent. However, in some areas time constraints did not allow for this to happen and students had to work more independently from an earlier stage in the block.

So I think it is a growth process for them...from a relatively easy, quiet week of orientation to the end of the block when they have to do everything independently. (Interview 2, lines 92-93)

...I feel that in the learning environment nurturing is most probably the best way to go, but also give them enough leeway where they can actually go out and go and learn and become independent on their own. (Interview 5, lines 7-9)

Some students are thrown in at the deep end....sometimes there is just not enough time, but I have to tell you that approximately 75% of them usually observe the assessment of a Neuro patient first. (Interview 3, lines 30-31)

4.2.3.4 Strategies in developing student independence

The clinical OTs made use of different strategies to assist the students in becoming more independent, for instance working in conjunction with another student, or they observed the students from another room.

So what I tend to do is thatI tend to observe them via my window, but not in the sense that they know that I am busy observing them. (Interview 5, lines 217-218)

With the large session I will allow the students to be co-therapists. And I try to help and support them to grow in their abilities...and then later I am in my office finishing reports and I just listen to them....(Interview 2, lines 81-85)

4.2.3.5 Feedback regarding patient progress

The clinical OTs expected the students to provide feedback regarding the treatment and progress of patients, as the OTs were still primarily responsible for the patients treated by students.

... I allow them to experience, but I say to them it is very important that...it's still my client so I need to know what is happening, and you need to keep me updated....and it is not that I try to pry.... but I need to be there to know what is happening. (Interview 5, lines 237-239)

I expect the students to provide me with feedback regarding their treatment sessions....verbal, but also written feedback in their SOAP notes. (Interview 2, lines 88-90)

4.2.4 Support

This category refers to the support the OTs provided to the students during their fieldwork experiences.

Two sub-categories emerged from this category:

- reasons for providing support; and

- amount of support provided.

4.2.4.1 Reasons for providing support

The clinical OTs provided support to students who struggled with personal problems or who experienced stress due to academic expectations. In these circumstances the OTs found it necessary to discuss the problems with the students to prevent obstruction of learning.

...and sometimes you can see that the student is struggling. So it may be that they have personal problems and they are not working as expected. (Interview 10, lines 60-62)

...a lot of Stellenbosch students that I have seen... and that I have worked with....they are very stressed when they come here. Excessively...(Interview 5, lines 156-157)

Another form of support provided was the guidance that the students received with regard to their clinical work and the way in which the teaching programme was graded.

I think also as a support system for the students...just as a...to provide guidance..... (Interview 6, lines 277-278)

...the method of teaching that I apply is to show them how one should do it. It is too much to expect of them to be able to do it independently at that stage....they cannot do it. (Interview 4, lines 147-149)

4.2.4.2 Amount of support provided

It was necessary for the clinical OTs to use their own judgment and to distinguish between those students who needed more support and those who needed a firm hand.

And you kind of like feel them through when they start the... block here... so you know which one you can push a little bit more, which one you have to give more emotional support....and that type of thing. It is not that you want to pre-judge them, but you kind of like just get a feeling of...of who you...who needs a little bit more of your time. (Interview 5, lines 29-31)

4.2.5 Evaluation

This category refers to the tasks during which the OTs were involved in evaluating the student's practical or written work.

Three sub-categories emerged from this category:

- excessively strict marking by some lecturers;
- time consuming; and
- unrealistic expectations.

4.2.5.1 Excessively strict marking by some lecturers

Some of the clinical OTs commented on their task of acting on behalf of students when the university lecturers tended to be too harsh during clinical examinations. Senior lecturers were sometimes experienced as intimidating due to their senior position at the university, and in these cases the OTs found it difficult to express their point of view regarding the allocated marks.

...I believe that a good student must get the marks she deserves and I will take the clinical staff on that point. (Interview 9, lines 73-74)

So you tend to feel a bit intimidated as well, because you know that they have been so long in the business, or that they are...you know whoever they are by name....so....ja, you tend not to always....I won't say challenge...., but your challenge then will be a bit just....ja, you don't want to push....push the boundaries (Interview 5, lines 289-292)

4.2.5.2 Time-consuming

Evaluations were experienced as time-consuming. It interfered with the normal treatment of patients, and additional arrangements had to be made to allow for this.

And another difficulty is all the feedback, for instance the mid-prac and that sort of thing....it always happens during a child's treatment time...so you actually steal a bit of their time to be able to perform these tasks. (Interview 8, lines 290-293)

....the (work)load itself.....I think, you know, we are often sitting there thinkingoh, I have so much to do ...so your mind is somewhere else, but you're sitting in that students exam thinkingI need to get going, I need to get going...there are patients that need to be seen..... (Interview 6, lines 176-179)

4.2.5.3 Unrealistic expectations

The fieldwork expectations from SU were sometimes perceived as unrealistic and not in line with current developments in the health system. The way in which SU expected students to perform clinical examinations was not deemed suitable for certain areas where patients only stayed for short periods. This caused stress to the students.

I think Stellenbosch curriculum is not in line with what is happening in the state at the moment. I think...that the way their..... exams are set up in terms of...you know that they must have a patient, they need to do their first case study and....you know....then they do their exam and then the patient is gone, because the patients do not stayyou know, in those days we would have a patient stay for two weeks so you.... the student could assess and treat and do the whole rigmarole in two weeks, and it doesn't accommodate for that any more.. (Interview 6, lines 199-204)

4.3 Motivators

This theme refers to all those aspects which motivated the OTs to become involved, and stay involved, in clinical training of OT students.

The coding categories under this theme are as follows:

- professional responsibility; and
- personal benefit.

Each of these categories is discussed individually with specific mention of the sub-categories that emerged from them.

4.3.1 Professional responsibility

This category refers to motivating aspects that are directly linked to the OTs' profession and their feelings of responsibility in the promotion thereof, as well as to ensure that the OTs of the future are adequately trained to successfully perform their tasks after qualification.

Three sub-categories emerged from this category:

- pride in the profession;
- loyalty to the profession; and
- contribution to the OT profession.

4.3.1.1 Pride in the profession

Clinical OTs felt responsible to act as ambassadors for the profession, and to teach students the importance of the OT's contribution to health care. They also wanted to reassure the students about their choice of profession.

..... I can play a small part in the students' lives...to teach them about OT and to show them how amazing the profession is.... (Interview 2, lines 108-110)

I do not want them to go away from here thinking that OT is not a good profession, or that they will go away confused. So you want to reassure them and inform them....so that they can see how interesting a profession it is. (Interview 10, lines 49-52)

4.3.1.2 Loyalty to the profession

Loyalty and a need to re-invest in the profession motivated OTs to get involved in clinical training.

I do it because I want to give something back (Interview 6, line 294)

I feel that I give something back to the profession. I have had my opportunities....and this is a way to give something back...yes, I think this is certainly my biggest motivator... (Interview 1, lines 195-197)

4.3.1.3 Contribution to the OT profession

A sense of duty towards the profession motivated clinical OTs to be involved in clinical training. They wanted to ensure that the OTs of the future receive quality training that is of a high standard and that would ensure that they were able to fulfil their tasks optimally after qualification.

Then the students that you train....they are going to be the future OTs so you want to make a good impression on them, you want to train them properly, you don't want to do a half-hearted job....(Interview 6, lines 120-122)

It is important to me, because you feel that they are the future. You want to train them so that they can cope in any place the land up in. (Interview 8, lines 147-148)

4.3.2 Personal benefit

This category refers to the benefits that the OTs derived from their involvement in clinical training, which also played a role in motivating the OTs to stay involved in this role.

Five sub-categories emerged from this category:

- professional development and learning;
- enjoyment & satisfaction;
- student development;
- sharing of patient loads; and
- financial rewards.

4.3.2.1 Professional development and learning

The clinical OTs' professional development and growth was stimulated through their involvement in clinical training. They found it necessary to stay abreast of the most recent developments in the OT field. Explaining facts to students also assisted their own understanding thereof.

It is also nice to have students, because it keeps you up to date a little bit, you know, you are forced to read up with what are the common trends, and the protocols, the new regimes (Interview 6, lines 170-171)

...I think another advantage is that it keeps me on my toes with regard to knowledge and what is happening in the OT profession. (Interview 2, 144-145)

I literally grow when they are here....my brain works overtime to try and explain things....four years of explaining things to them have helped me to understand it better. (Interview 4, lines 368-370)

The OTs learned from stimulating interaction with the students, who often arrived with new and fresh ideas that the OTs had not considered before.

I actually feel that I have really learnt a lot from students.... (Interview 5, line 395)

I think that they are also often a source of enthusiasm and energy. We sometimes think that something can only be done in one way, but there are smart students that can show you it can be done in another way, even if you have been doing it in the same way for 10 years or longer. (Interview 1, lines 264-267)

During their interaction with the students the OTs had to reconsider their assumptions and beliefs regarding the treatment of their patients. This assisted in the confidence with which they could then relay the knowledge to their students.

....this is quite a challenge, because I am actually confronted and challenged to think about my reasons for doing certain things. (Interview 3, lines 160-162)

4.3.2.2 Enjoyment & satisfaction

The majority of OTs stated that they enjoyed working with the students and experienced satisfaction from doing it.

...to me it is a very important part of my work, because I enjoy it and I get satisfaction from it. (Interview 4, lines 166-167)

...I really do enjoy having students. (Interview 5, line 394)

4.3.2.3 Student development

The clinical OTs experienced a feeling of accomplishment when the students enjoyed the area and experienced professional growth.

....it is very satisfactory to see how the students develop and grow and when they appreciate the learning process they are going through...(Interview 4, lines 162-164)

....a lot of the times the students come and they let me know....Thank you very much...that is what they...that is the general response. Thank you very much...I have learnt quite a lot here. So it is not that...it's not that I need the affirmation, but the affirmation is very nice, because it tells you that what you are doing is right. (Interview 5, lines 118-122)

4.3.2.4 Sharing of patient loads

The more senior students contributed to the sharing of the workload.

...it is a fine balance, because the fourth-year students ...from the second affiliation can help you and save time. So they can treat your patients and make enough progress that you feel....you spent time with them, but, in return, they help you by treating patients (Interview 4, lines 46-49)

4.3.2.5 Financial rewards

The OTs indicated that financial rewards did not make a difference to them and that it was not viewed as a motivator for doing the work as a clinical educator.

To be honest, I think for me personally...if I had to get extra money for it, it isn't going to make a difference. (Interview 6, lines 113-114)

...there is a bit of payment, but that is not why I am doing it. (Interview 2, lines 15-16)

4.4 Influencing factors

This theme refers to all the factors that influenced the OTs in the performance of their role as clinical educators. These factors were either perceived as beneficial to the role or, otherwise, as detrimental to the role.

The coding categories under this theme are as follows:

- personal factors;
- factors in the workplace;
- students;
- relationship with SU;
- SU fieldwork curriculum; and
- education of clinical educators.

Each one of these categories is discussed individually with specific mention to the sub-categories (positive and/or negative factors) which emerged from them.

4.4.1 Personal factors

This category refers to those factors, inherent to the OTs, that can either be beneficial or detrimental to their role as clinical educator. The following sub-categories emerged from this category:

Positive Factors	Negative factors
<ul style="list-style-type: none"> • personality of the OT • experience in work and clinical training • OT studies 	<ul style="list-style-type: none"> • language • experience in work and clinical training • age

4.4.1.1 Personality of the OT

The clinical OTs identified a positive attitude, good interpersonal skills, a passion for teaching, and the ability to allow students to learn at their own pace as factors that contributed to the success of their role as clinical educator.

...you need to be somebody that is open to be able to teach. OK and also to allow learners to learn on their own...(Interview 5, lines140-141)

I think I am an easy person to get along with. I am not really a difficult person. I generally enjoy people and have good interpersonal relationships.....any age group. I think I am by nature an optimist....(Interview 7, 68-71)

4.4.1.2 Experience in work and clinical training

OTs found that their experience in clinical training has assisted them in knowing how to handle students and that it has taught them patience. They could also assist students in setting more realistic goals for their patients. However, for the new clinical educator, the lack of experience made them feel insecure.

I think the fact that one has experience makes it easier to work with students. I think it will be difficult for someone who is new in an area to immediately start with students....it helps if you have some experience. (Interview 2, lines 247-351)

I think a person is more realistic. The longer and more experience you have, the more realistic you become with regard to aims for a situation (patient treatment) (Interview 8, lines 161-162)

I was new and at times felt a bit scared, because I had students that I had to provide guidance for. (Interview 10, lines 44-46)

4.4.1.3 OT studies

OTs that qualified at a university other than SU had a different frame of reference which they could apply to the students' advantage. However, the unfamiliar system initially caused discomfort for the OT.

...my background and where I have studied as well. In the sense thatyes, UWC is termed as being the....the ...community-based ...OT area... but I think that has also given me the ease that I have with which to work....because the manner in which I would tackle a specific activity would be different to (Interview 5, lines146-149)

I was a bit scared in the sense...that maybe the knowledge that I have would not be sufficient, although we're all on the same basis. (Interview 5, lines45-46)

4.4.1.4 Language

The inability of some of the OTs to address a student in his /her first language, and/or to mark reports in that language, was problematic and not to the student's benefit.

If you get a Xhosa student then we are lost, because we don't have any... Xhosa-speaking therapists in the department. So I think that does make it a little bit harder....so it is difficult to provide good supervision in terms of that...the languages, definitely. (Interview 6, lines 340-343)

4.4.1.5 Age

Age was identified by one OT as a factor that sometimes influenced her motivation for work and her patience negatively.

...we are all getting older. I think as I become older, I experience a negative factor in that some days I do not feel motivated to treat patients. And that can be a problem if I have students with me....they will quickly pick it up. (Interview 7, lines 81-83)

4.4.2 Factors in the workplace

This category refers to factors in the workplace of the clinical OT that could either be beneficial or detrimental to the role. The following sub-categories emerged from this category:

Positive Factors	Negative factors
<ul style="list-style-type: none"> • learning environment • support among own staff 	<ul style="list-style-type: none"> • time constraints • suitable patients • staff turnover

4.4.2.1 Learning environment

A learning environment where the students found it comfortable and pleasant to work, and where the personnel had a positive attitude towards them, was conducive to the learning experience of the students. The patients also benefitted from the treatment provided.

....and then to create an atmosphere that will be conducive to interaction with the students, that they feel comfortable to share things with you and vice versa. (Interview 10, lines 141-143)

... the one thing is that you don't want them to feel uncomfortable, you don't want them to feel as if it is not a learning environment, because the important thing is that they need to come here and come and learn and experience what the area is about. (Interview 5, lines 34-37)

4.4.2.2 Support among own staff

The clinical OTs valued the support, in terms of student training, that they received from other staff members in their own departments. Support included the sharing of knowledge, guidance for therapists who were unfamiliar with the SU supervision process, and sharing the supervision of one student among a few OTs.

...so I think that helps, in terms of training that we are here to support each other, to help each other, especially in areas that we are not so strong in... (Interview 6, lines 364-365)

(Initially at start of supervision) but luckily I had K here. So K could guide me along (Interview 5, line 338)

....we ensure that we each have a client with each student so that one person is not solely responsible for one student. (Interview 8, lines 180-181)

4.4.2.3 Time constraints

All the participants identified time constraints, and the fact that it rendered them unable to spend enough time with the students, as a big problem during clinical training. The time constraints were mainly due to their workload.

.....sometimes it is a pity that the workload leaves one with so little time available to spend with the students. (Interview 9, lines 24-25)

Oh, it (workload) definitely has a huge impact, because....if we look at just a student demonstration....if you're sitting in on an exam....that could easily take an hour and a half and how many patients could we not have seen in that time (Interview 6, lines 163-165)

4.4.2.4 Suitable patients

The clinical OTs did not have any control over the type of patients available for referral to the students. The severity of the disabilities of these patients sometimes caused difficulties for the students.

...the type of diagnoses and the severity of the injury of a patient that I cannot control sometimes has a negative effect. (Interview 3, lines 219-220)

...our children function at a lower level. So it is not so easy to find suitable children for the students any more....(Interview 8, lines 256-257)

4.4.2.5 Staff turnover

Staff turnover and unfilled OT posts resulted in an increase in workloads. It was therefore often expected of young inexperienced OTs to supervise students. These factors impacted negatively on student training.

...you get now young therapists coming inthey are supervising the students, but they also don't have that much experience. They are just settling in themselves... (Interview 6, lines 189-191)

When we experience personnel shortages, you have your workload and the students become an extra workload which sometimes means that you do not have enough time to spend with them. (Interview 10, lines 168-170)

4.4.3 Students

This category refers to all the factors related to students which the OTs perceived to be either beneficial or detrimental to their role as clinical educators. The following sub-categories emerged from this category:

Positive Factors	Negative factors
<ul style="list-style-type: none"> • preparation 	<ul style="list-style-type: none"> • preparation • lack of responsibility • negative attitude • students with special needs

4.4.3.1 Preparation

Students who were prepared for their clinical blocks, and were eager to learn, benefited from their learning experiences. However, students who were unprepared at the start of the clinical block did not experience optimal learning, and their progress were slower.

When they come here, they know where they are coming to....so they have researched their block already...they know exactly what and what type of work they will be doing. They need a bit of guidance here and there, as...because each area is different and how you are going to approach it is going to be different, but... I feel they are very well prepared when they get here... (Interview 5, lines 50-54)

I feel it is the lack of preparation before the start of the block and they only start to find their feet in the fourth or fifth week of a six-week block. (Interview 8, lines 93-95)

4.4.3.2 Lack of responsibility

Students who did not take responsibility for their patient's treatment and/or did not hand in their written work timeously acted as a source of frustration to the OTs.

And now it is with the students....you know you have to keep reminding them...I need your work, I need....you know, and you missed the deadline (Interview 6, lines 79-80)

And for them (students), everything revolves around marks, but for us it does not revolve around marks....we want what is best for the patient. (Interview 4, lines 210-211)

I do not think that...the students think that they....yes, they are here to learn, but it is as though the patients are doing them a favour andand I think that mentality needs to change. (Interview 6, lines 212-214)

4.4.3.3 Negative attitude

The clinical OTs found it frustrating when students displayed a negative attitude towards learning. Although in the minority, these students did not appear motivated to learn and did not apply the feedback they received from their clinical OT.

I think a lot of it has to do with students who are not necessarily ready to learn...they do not want to learn....their attitude. Some of them just do not want to do it. It happens minimally, but for me it is one of the biggest frustrations. (Interview 4, lines 193-195)

I think I've been here long enough to say that the....the calibre of students has ... changed. I think now we are finding we have to spoon-feed a lot more....I don't know if it is the attitude of the students that is changing. (Interview 6, lines 67-69)

I often experience frustration when I feel that I have really tried to tell and demonstrate it.....see if you can now do it by yourself. (Interview 7, lines 12-14)

4.4.3.4 Students with special needs

The clinical OTs would have preferred to know before commencement of a clinical block whether any of the students in their area had special needs that had to be attended to. The absence of this knowledge was a source of stress and worry to them.

So I think for my own peace of mind it would have been nice to have heard that they were still 100% able to present groups.....that they had good skills. (Interview 2, lines 254-256)

....I endured 5 sleepless nights about this student who was unable to learn, but it was actually her problem. If I had known that before, I would have handled her differently and would have helped her, and then this block would have been more valuable to her. (Interview 3, lines 100-103)

4.4.4 Relationship with SU

This category refers to the factors regarding the relationship between the clinical OTs and the staff of SU OTD that were beneficial and/or detrimental to the role of the clinical educators. The following sub-categories emerged from this category.

Positive Factors	Negative factors
<ul style="list-style-type: none"> • cooperation • support from lecturer • communication 	<ul style="list-style-type: none"> • response to feedback • inexperienced lecturers • communication

4.4.4.1 Cooperation

Good cooperation between the clinical OTs and lecturers benefited the student's training. Problems were discussed and solutions made to suit all parties.

B usually come and does the case studies with me. When she is here we communicate well and I tell her about the problems. Or she will make suggestions....as in the case of the patient load that was decreased. (Interview 2, lines 193-195)

..... I experienced it better this year when the lecturer took more responsibility for the marking of the reports. We discussed the issues that we were unsure about, but it was not primarily my responsibility anymore and it helped to relieve some stress. (Interview 9, lines 169-173)

4.4.4.2 Support from lecturer

Some of the lecturers acted as a source of support and information to the clinical OTs.

The support and the fact that I can ask any questions.....the relationship with the university is very important. I would not have enjoyed doing student training without them. (Interview 4, lines 258-260)

4.4.4.3 Communication

Some of the clinical OTs commented positively on the fact that they found it easy to make contact and communicate with lecturers at SU. However, others were more negative with regard to communication from SU, especially regarding information that did not always reach the clinical OTs on time.

I feel comfortable about making contact. I just feel that communication from their side (SU) does not always come through to me. (Interview 3, lines 83-84)

....It is more the frustrations regarding logistical arrangements. (Interview 3, lines 96-97)

I think communication is actually quite lacking..... (Interview 6, line 391)

.....this year (2011) they have gone to more trouble to arrange meetings and to communicate with us. It is more positive. It also makes one more positive towards the students, because you know what is going on. (Interview 9, lines 146-148)

4.4.4.4 Response to feedback

Various clinical OTs commented on the fact that SU was slow to react to their feedback regarding the fieldwork experience of students. It was their perception that the feedback was not always well received and/or considered important.

They have requestedcommentsand so that they can take the feedback forward....and I think just in our dealings with Stellenbosch University....I think we have been too....we are trying to make too much a change, and I do not know how well that is being received (Interview 6, lines 247-250)

.....but I do not think that they are always so keen to receive feedback from the therapists. (Interview 10, line 250)

It really takes time before they realise what the problem is and to address it. I do not know whether they sometimes, from their side, feel that it is not important enough to address. (Interview 7, lines 141-143)

Feedback that was ignored might also have led to a loss of clinical placements.

Within this department, I think, a lot of the therapists feel like, you know they've said it, they are telling the university the students aren't coping, the curriculum isn't in line, but nothing is happening. And I...and I think that feeling.....you know what, we rather than don't want the

students... because we end up sitting with the problem....with students who aren't coping. (Interview 6, lines 264-267)

...when therapists give feedback regarding the clinical work, and when they ask ...change this or adapt this or let us see if it cannot work this way....and these things do not happen....then at the end of the day the therapists will withdraw from clinical training. When they feel they are not listened to. (Interview 7, lines 158-161)

4.4.4.5 Inexperienced lecturers

One clinical OT indicated that a lecturer, who is inexperienced in the area where he/she supervises, is an added burden to their workload, as they have to train the lecturer as well as the student.

...if you get a supervisor that's inexperienced in that area.....say you put somebody in hands and they've never actually done hands....then that makes it a lot harder....it puts a lot more pressure on us as clinicians, you know, to actually train, because you are giving your advice, but they are also lacking now from the theory side of it....(Interview 6, lines 48-51)

4.4.5 Fieldwork curriculum

This category refers to the fieldwork curriculum as specified in the *Guide for Clinical Work (2011)*, as well as the students' theoretical education in preparation for fieldwork, that may be beneficial or detrimental to the role of the clinical educator. The following sub-categories emerged from this category.

Positive Factors	Negative factors
<ul style="list-style-type: none"> • guide for clinical work • case studies 	<ul style="list-style-type: none"> • guide for clinical work • case studies • planning of clinical blocks • insufficient knowledge regarding certain subjects

4.4.5.1 Guide for Clinical Work

The *Guide for Clinical Work* was described as a helpful tool for the clinical OTs insofar as it provided clear guidelines with regard to what exactly is expected from the student. However, it was also perceived to be cumbersome, took time to get used to, and had many prescriptive rules and regulations that were not always followed by the students.

It is very structured, very cumbersome, but it does help, because I think it does give yougives me a guideline as to.... (Interview 6, lines 29-30)

It took me a while to get used to the green book and the type of routine, because of the fact that I did not qualify at Stellenbosch. (Interview 10, lines 89-91)

And in spite of the green book....the students do not follow it. Do all these things really have to look the same? (Interview 1, lines 226-227)

4.4.5.2 Case study

Although the OTs agreed that the case study had a place in training, they had different opinions on the format thereof. Some of them had adapted the format to suit their areas. Permission from SU in this regard was not considered to be necessary by all. Marking these case studies was time consuming.

So the case studies are so, so important, because it gives them that whole holistic view of the client. (5UWC4)

Marking the case study is time consuming. (Interview 2, line 158)

I do not know whether I am allowed to, but I have adapted the written work in my department. I have not been reprimanded about it, but if I have to do everything as it is set out in the green book I will never get to my patients. So I selected those most important to me....(Interview 3, lines 295-298)

Some of the things have been adapted for the area, because it is not practical and will not work in this area....(Interview 1, lines 233-234)

4.4.5.3 Planning of clinical blocks

Clinical blocks that included frequent public holidays and lectures on campus had a negative impact on the students' learning and productivity, especially in an acute physical area.

In the acute area it was an absolutely useless week for the students....they did not learn anything and did not see any progress. (Interview 3, lines 128-130)

4.4.5.4 Insufficient knowledge regarding certain aspects of OT

The students' knowledge regarding neurology, and the techniques used for treatment thereof, had lately been found lacking. This problem caused extra work for the OTs as they had to teach the basic principles to the students.

What I have now realised is the fact that they find it difficult to integrate their knowledge regarding neurological diagnoses here. Their foundation is not very solid. (Interview 3, lines 69-71)

I think they really struggle with the NDT techniques. (Interview 7, line 33)

.....they do not always have the background knowledge needed when they come to our area....specifically regarding neuro and the CP child. They do not really have the knowledge to handle the children. (Interview 8, lines 47-50)

And in the end it happened that we have to firstly train them how to evaluate a child. (Interview 8, lines 108-109)

4.4.6 Education and support of clinical educators

This category refers to the education and support that SU supplied to the clinical OTs and the beneficial and/or detrimental effect that this aspect had on their role as clinical educators. The following sub-categories emerged from this category.

Positive Factors	Negative factors
<ul style="list-style-type: none"> • short course for Clinical Supervisors • clinical supervisor’s meeting 	<ul style="list-style-type: none"> • insufficient initial education • clinical supervisor’s meeting

4.4.6.1 Short course for Clinical Supervisors

The clinical OTs who attended the *Short course for Clinical Supervisors* agreed that it was a valuable course in terms of learning new techniques, and also to confirm whether their approaches to student training were correct.

...and that course...50% of it taught methods which we could practice, but the other 50% confirmed that what I was doing was correct. (Interview 4, lines 266-268)

The clinical supervisors’ course that I attended was incredibly informative. I think I learnt a lot from it. (Interview 7, lines 108-109)

4.4.6.2 Clinical supervisor’s meeting

Some of the clinical OTs were of the opinion that the clinical supervisor’s meeting provided an opportunity for the sharing of knowledge, learning and networking. However, other OTs did not view it in such a positive light, and were of the opinion that the time of the meeting was inconvenient and that it did not really deal with the problems they experienced in student training. Some of the younger OTs also felt intimidated by the more experienced senior lecturers.

It helps to sort out certain things that might have bothered or that you were unsure about, but also provides an opportunity to talk to other therapists and to network....(Interview 10, lines 108-110)

...I am in a room full of Stellenbosch... people...so ja... I suppose at the end of the day it is my own confidence...and me not wanting to just speak up in a room with all you type of a thing... (Interview 5, lines 365-367)

I think that the actual nitty-gritty, the problems that are actually happening per placement, are not dealt with. (Interview 6, lines 398-400)

4.4.6.3 Insufficient initial education

The clinical OTs were of the opinion that their initial preparation and education by SU was insufficient and that they would have preferred more formal education to prepare them for their role as clinical educators.

But I think I would have preferred to receive some information regarding the role of the clinical educator when I started. Maybe with another person or a group of people.. (Interview 4, lines 287-290)

....I would have definitely liked....like a little course just on what Stellenbosch really requires form clinical therapists....and what my role is... (Interview 5, lines 349-350)

4.5 Recommendations made by the clinical educators

This theme refers to the recommendations made by the clinical educators. All of these recommendations were aimed at enhancing the learning experience of the students and the OTs' experience of their role as clinical educators.

The coding categories under this theme are as follows:

- education of clinical educators;
- relationship between SU and clinical educators; and
- training of students.

Each one of these categories is discussed according to recommendations made by the clinical educators.

4.5.1 Education of clinical educators

A formal course should be designed to inform the new clinical educator about his/her duties and to explain the SU system of clinical training.

...definitely like a little lecture or a discussion, where it is a more formal basis and say this is what we would like. Dit is nou in die boekie in, (It is in the book) but... more so...on a one-to-one kind of like a basis... where you can actually ask questions and...and have that structure in place. (Interview 5, lines 356-358)

I think it is important that they understand the reason behind all the documents... (Interview 4, lines 298-299)

Attendance of the clinical supervisor's meeting should become compulsory.

.....you learn so much, but now only 5 of us attend and the rest miss out on the opportunity to learn. And the people that attend get frustrated, because the ones who do not attend sometimes do the wrong things in clinical training. So maybe the only thing is to make it compulsory. (Interview 4, lines 302-305)

Workshops on specific topics related to clinical training and the *Guide for Clinical Work* should be arranged.

I think maybe...to have like a workshop session...to actually say, OK....with the third-year student this is what is expected ...actually go...go through that green hand....guideline? (Interview 6, lines 421-422)

Psychodynamics. A workshop would help....(Interview 7, line 126)

It is incredibly important to have continuous education....bits and bobs....that you have the opportunity to ask about things that you are uncertain about... (Interview 4, lines 323-325)

4.5.2 Relationship with SU

Lecturers and clinical educators from specific clinical areas should meet on a regular basis to discuss the fieldwork experience of students in that area. Problems can then be solved timeously.

It would actually be nice for the university to come, like maybe on one day and say....look here is our clinical therapist or the lecturers or whatever....let's have a session together, let's have a feedback session. What are you all finding difficult? What about paed's is not appropriate for our students? You know, rather have the session like that, and then the therapist actually feels heard. (Interview 6, lines 385-389)

Formal feedback, in the form of questionnaires, can be obtained from all the clinical areas in order to adapt the *Guide for Clinical Work* and to make it more applicable.

The Guide for Clinical Work can be adapted in terms of its expectations by using feedback from all the clinical therapists in the fieldwork areas. The information can be obtained by means of a questionnaire, or even a more simplistic tick sheet, which they have to complete and return to the university. (Interview 3, lines 375-378)

More social events should be organised where the clinical educators can become better acquainted with the SU lecturers.

....maybe a better way to do that would probably be more socials in a way.... (Interview 5, line 322)

4.5.3 Training of students

Clinical educators would prefer to have more autonomy in order to adjust documents and the training requirements according to their specific areas.

.....but one does not want to phone and ask them if you may change every small little thing. (Interview 1, lines 249-250)

Lecturers and clinical educators should be more lenient and flexible with their marking of students and should allocate good and excellent marks when they are deserved.

....sometimes I think Stellenbosch lecturers tend to be too hard on their students. (Interview 5, line 295)

I really feel that other lecturers.....lecturers from other faculties will more easily give a student a good mark and it definitely influences their self-image. I can see it with my own children. I really think this is the one area that we need to work on. (Interview 9, lines 90-93)

Clinical educators would prefer to receive copies of the students' notes in order for them to know exactly what the students have been taught by SU.

So we are actually trying to get the universities to say ...this is the notes that were covered...so that the students can't chance it and say....No, we didn't cover it, because if they miss the lecture, then that is not our problem. (Interview 6, lines 95-97)

Clinical educators should preferably have one student-free block during which they can take leave, otherwise the pressure on them becomes too much.

....at least keep one block open throughout the year where you don't take on students so you have a little breather, but then that's the time that the therapist wants to take leave and go away, because we also need a break (Interview 6, lines 167-169)

Clinical educators must be informed well in advance of students with special needs to allow enough time for preparation.

.....maybe if they could just inform me beforehand regarding any specific requests or any medication that the students take. (Interview 2, lines 332-334)

Yes, it does not have to be in writing. It can be a telephone call or an email....(Interview 3, lines 112-113)

The coordinating lecturer must take public holidays into account during his/her planning of the clinical blocks, so that it does not affect the students' learning experience negatively.

I know the planning of the programme is difficult with all the lectures as well, but I think they must keep these things in mind. (Interview 3, lines 131-134)

4.6 Conclusion

Four themes emerged from the data collected by the study. It included the (1) tasks of the clinical educators, (2) motivators, (3) influencing factors, and (4) recommendations made by the clinical educators. The different themes, together with their coding categories and sub-categories were described in this chapter. In the following chapter the results will be discussed in relation to existing theory in order to gain a better understanding of the clinical OTs' experience of their role as clinical educators.

Chapter 5 - Discussion

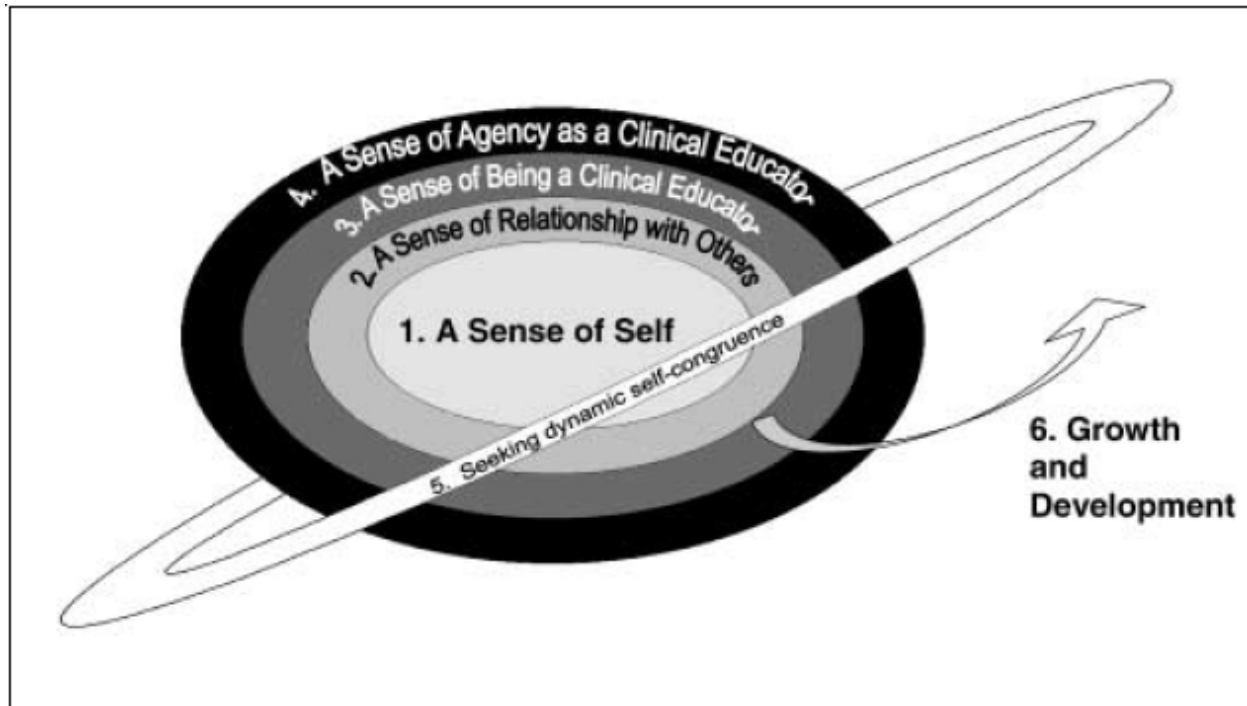
5.1 Introduction

The results from the research study indicated that four main themes emerged from it, regarding (1) the tasks of the clinical educators, (2) the motivators for that role, (3) the factors that influence the role performance, and (4) the recommendations made by the clinical educators to try and improve their role performance in the future.

In order to answer the research question, namely, *how do clinical OTs experience and value their role as clinical educators during the fieldwork experience of occupational therapy students?*, the results were discussed according to the *Lived Experience of Being a Clinical Educator Model* (McAllister, 2001), as the use of a model allowed the researcher to arrive at explanations regarding the results by means of an existing theory (Reed, 1984). Moreover, recommendations – underpinned by reference to additional literature – were made by way of extrapolation from this discussion.

The *Lived Experience of Being a Clinical Educator Model* (McAllister, 2001) was derived from research into the lived experience of the clinical educator, and was therefore entirely congruent with the present study. In a later publication the authors (Higgs & McAllister, 2007) state that, although the original model was relevant to the clinical education of speech pathology students, it could benefit other health science disciplines as well. De Sales (1996) states that clinical educators usually discuss the same topics, but the relative importance thereof may vary. These topics, when put together, constitute their lived experience and the whole of the phenomenon which was explored. Taking all of these factors into account, the *Lived Experience of Being a Clinical Educator Model* was deemed the most applicable and relevant choice of framework for discussion.

Figure 1: The Lived Experience of Being a Clinical Educator Model (From: Higgs & McAllister, 2005, p166)



The *Lived Experience of Being a Clinical Educator Model* (McAllister, 2001; Higgs and McAllister, 2005), as illustrated in Figure 1 above, represents the experience of the clinical educator as having six major interactive and dynamic dimensions:

- a sense of self;
- a sense of relationship with others;
- a sense of being a clinical educator;
- a sense of agency as a clinical educator;
- seeking dynamic self-congruence ; and
- growth and development.

The sense of the self forms the core of this model for successful clinical education. It influences all the other senses and is taken into each relationship and work situation (personal dimensions). The overarching ring (self-congruence) and growth arrow indicate the inevitable and ongoing need for professional growth and development in the role (Higgs and McAllister, 2005).

Each of the six dimensions is discussed individually in order to articulate the component factors of the clinical OTs' experience of their role as clinical educators.

5.2 A sense of self

A sense of self is described as the core phenomenon of the *Lived Experience of Being a Clinical Educator Model* as it influences how the clinical educator relates to others, approaches his/her role performance, and takes action in the workplace. This sense of self includes elements such as self-awareness, self-knowledge, self-acceptance, self-identity, and the extent to which clinical educators choose a level of control and become lifelong learners (Higgs & McAllister, 2007; Higgs & McAllister, 2005; McAllister, 2001).

The participants in this study indicated self-awareness and self-knowledge by commenting on their respective personalities and life-experiences. According to Eraut (1994 cited in McAllister, 2001, p106), insight into these concepts is important for controlling one's own behaviour. The clinical OTs professed a positive, caring and student-orientated attitude that was applied in their training of students. They enjoyed working with the students and their good inter-personal relationships and open communication assisted them in getting along with the students as well as the SU staff. These feelings of unconditional positive regard and empathetic understanding of others are congruent with the humanistic psychology and humanistic values of Rogers and Maslow which contributed to the andragogical model of learning (Merriam & Caffarella, 1999; Knowles, et al., 1998).

The clinical OTs were aware of the feelings that the different aspects of clinical training evoked in them. They expressed an awareness of frustration caused by students and the SU relationship. Inexperienced OTs also related how they felt insecure at the initial thought of clinical supervision and of not being confident in their own knowledge base, or that they felt intimidated by senior staff from SU. These feelings were acknowledged by them, but through experience and valuing themselves, the OTs expressed improved self-acceptance at later stages. Hunt and Kennedy-Jones (2010) state that it is important for novice clinical educators to realise that they are not expected to know everything in clinical practice, and that the university should support these clinicians in developing skills to undertake clinical supervision.

Self-identity is defined as '*being aware of the identity or identities that comprise the sense one has of oneself, and the values, goals and abilities which are part of one's identity*' (McAllister, 2001). The participants unanimously agreed that the professional role they portray, and how

students perceive them as role models, was an important part of their identity as a clinical educator. The profession was important to them and they valued the role they played in training the future OTs as well as the recommendations they were able to make to SU regarding the fieldwork curriculum, based on their knowledge and practical experience in their respective areas. Different frames of reference, which resulted from their basic OT studies, formed part of their identities and influenced what they had to offer in the training process. The OTs further valued quality treatment of their patients, as well as the important role they play in a multi-disciplinary team concerned with patient treatment. Findings from studies by Rodger, et al. (2011) and Mulholland, et al. (2006) state that students value the wide range of skills that the clinical OT models in his/her work and interaction with a variety of people.

Maintaining a level of control in the fieldwork situation was managed by means of expectations which were set for students with regard to their professional conduct, patient treatment and work habits. In this respect the clinical OTs were all strict and expected students to adhere to the rules. The use of graded programmes of training allowed for gradual increases of autonomy for the students as far as patient treatment was concerned, but even there measures were put in place to allow the OT to always be aware of what is happening with their patients. Feelings of frustration were experienced when these measures of control were unsuccessful. This could refer to the work of Vermunt and Verloop (1999) who found that the learning strategies of students and the teaching strategies of the lecturers are not always compatible. Congruence occurs when the strategies are compatible, and friction occurs when they are not. The shared-control strategy, in this case illustrated by the graded programme, is best suited to students who have already acquired some skill, but need further skill development.

The clinical OTs' own continuous professional development in terms of their own practice as well as student training was viewed as important to them. They valued the fact that they were able to learn from workshops, courses and meetings on relevant topics, but also from students who often arrived with new and fresh ideas. Their interaction with the students resulted in them thinking about, and reconsidering, their assumptions about the way they were performing their work in order to adapt it to facilitate the learning process more optimally. Various authors (Pereira, 2008; Thomas, et al., 2007; Kirke, et al., 2007; Johnson, et al., 2006; Fone, 2006; Hook & Lawson-Porter, 2003; MacKenzie, et al., 2001; Bonnelo, 2001) support the creation of opportunities for continuing professional development and the maintenance of practitioner competence which, in turn, benefit the students' learning.

The analysis of the sense of self of the clinical OTs in this study indicates that they had identified the different elements comprising the sense of self that they brought to the learning experience. McAllister (2001, p118) states that *'who we are as people influences what we value, pay attention to and do as educators'* and it is therefore important to remember that this sense of self, as indicated by the clinical OTs, influences the way they relate to students and perform their work.

5.3 A sense of relationship with others

A sense of relationship with others relates to the awareness that one exists in relationship to others. The elements included in this dimension are being people-orientated, perceiving others as they are, holding humanistic values, and seeking to implement those values and perceptions in one's relationships with others (Higgs & McAllister 2007; McAllister, 2001).

The clinical OTs identified a positive attitude, effective inter-personal skills, support when needed, and the ability to allow students to learn at their own pace, as conducive to the learning process. This included students from diverse cultures and those with special needs, for example visual or hearing disabilities. Not being able to optimally assist these latter groups was a cause of stress and frustration to the OTs. Frustration was also caused by students who did not honour open, honest communication or mutual respect, as well as those who did not take responsibility for patient treatment or effective work habits, and wanted to be *'spoon-fed'* by their clinical OTs.

The clinical OTs, due to their sense of self, held humanistic values, by using a student-centred approach to teaching (Knowles, et al., 1998). Rodger, Fitzgerald, Davila, Millar and Allison (2011) state that students value supervisors with experience and skill in constructing relationships that are conducive to quality student learning. These types of relationships are open and honest, are characterised by clear communication, mutual respect and an understanding of different learning styles, and allow for a balance between supervision and autonomy for the student. This finding was consistent with the findings of Mulholland and Derald (2007), Kirke, et al. (2007) and Mulholland, Derald and Roy (2006), who found that effective communication and rapport supported student learning. Incompatible learning and teaching strategies (Vermunt & Verloop, 1999) cause destructive friction which might have been responsible for the frustration experienced by the clinical OTs in the situations described above.

Reed (1994 cited in Paul, p207) states that a successful match between a disabled student and teacher depends on the teacher's attitude towards students with disabilities as well as his/her knowledge regarding the disability and experience in teaching this type of student. Cannon and Newble (2000) urge teachers to ensure that they are aware of the university's policies and support arrangements with regard to disabled students. They advise the use of strategies, for example good assessment procedures and flexible assignment deadlines.

In their relationship with SU, the clinical OTs valued open communication and their cooperation with the respective SU lecturers to foster their own learning and professional development, as well as to optimise student learning. As a result of the knowledge and experience accumulated as clinical educators, the OTs also felt committed to making a contribution with regard to the fieldwork curriculum and how it could be adapted to suit the requirements of the current health system more effectively. Frustration was experienced in instances where this feedback was not acted upon and/or did not seem to be perceived as important by SU personnel. In some instances some of the more senior SU personnel were found to be intimidating to novice clinical OTs, but due to their sense of self-awareness and self-acceptance they were able to resolve these problems. Findings from various studies (Rosenwax, et al., 2010; Kirke, et al., 2007; Casares, et al., 2003) indicate the need for the university to respond to controversy and/or requirements by the clinical educators and for their inclusion in the design of the fieldwork programme to facilitate fieldwork excellence.

The results indicate that the clinical OTs preferred to act in a people-orientated way. In their interaction with students they tended to perceive them as persons with individual styles and needs, and believed that open and honest relationships with humanistic values are beneficial to optimal learning. Good communication and cooperation was also valued in their relationships with SU, although the latter were sometimes influenced by the fact that input from the OTs was not perceived to be important enough to act upon. Frustration was therefore caused when clinical OTs felt that they were not treated according to the people-orientated, humanistic values that they regard as important. The positive and negative aspects experienced in their sense of relationship informed and influenced the next dimension, namely a sense of being a clinical educator.

5.4 A sense of being a clinical educator

A sense of being a clinical educator relates to the actual performance of the role as clinical educator and how the sense of self and of relationships to others influences it. The elements included in this dimension are the motivations for becoming a clinical educator, an understanding of the role, the desired approach to clinical supervision and the affective aspects of being a clinical educator (Higgs & McAllister, 2005).

The OTs' professional responsibility, together with the personal benefit they gain from their role, were identified as the main motivators in their acceptance of the external role demands and in remaining involved in the clinical training of SU students for an average of 8.7 years. Their pride in their profession, as well as their loyalty to it, invoked in them a sense of responsibility to become involved in clinical training and to ensure that the future workforce is properly trained and of a high standard. They exhibited a positive and caring attitude towards student training, and experienced joy and satisfaction in the course thereof. Financial rewards were not deemed important at all. The clinical OTs benefitted in terms of a workload that was sometimes shared, as well as in their own professional development as they were able to learn from workshops, courses and meetings, but also from the students who often arrived with new and fresh ideas.

These positive and rewarding values and attitudes, most of which relate to the clinical OT's sense of self, are viewed as indicative of providers of fieldwork experiences (Steele-Smith & Armstrong, 2001; Jung and Tryssenaar, 1998). The sharing of knowledge and skills, personal development, honour, recognition and satisfaction in observing student growth can all act as motivators to offer and provide fieldwork experiences. Thomas, et al. (2007) support the view that financial reward is not a primary motivation for supervising students, although findings from a study by Fisher and Savin-Baden (2002a) indicate the opposite.

The expectations with regard to the students' fieldwork curriculum were conveyed to the OTs by means of the *Guidelines for Clinical Work* (2011), and this was generally described as a helpful tool which provided clear guidelines regarding the SU expectations. A few of the OTs received help from colleagues or a university lecturer in interpreting and understanding the rules and procedures. However, some of the OTs perceived the guide as prescriptive, with rules that were not always followed by the students, and as taking time to read and become accustomed with. This must be seen in the light of the work of Duncan and Lorenzo (2006), who warn against a prescriptive approach to learning on the basis that it may be counter-productive, limit potential learning opportunities and restrict creativity.

The OTs unanimously agreed on the importance of acting as a competent role model during the demonstration of patient treatment and professional conduct, in order to facilitate learning by the students. Findings from various studies (Rodger, et al., 2011; Kirke, et al., 2007; Mulholland, et al., 2006) indicate the importance of demonstrating treatment and professional conduct to the students, as well as the explicit demonstration of clinical reasoning. This skill is highly regarded by the students during their learning experience, and facilitates the integration of practice and theory. Frequent opportunities for observation by the students are therefore advised.

Individual teaching styles were found in this regard, for example some of the OTs followed a more graded programme of training, while others expected more independence from the students from the outset. This could possibly relate to the levels of control preferred in the sense of self of the OTs. Vermunt and Verloop (1999) warn that a loose-control strategy, with a lesser degree of teacher regulation, may lead to destructive friction which will not be conducive to optimal learning. It can therefore be extrapolated that students who experience less control from their OTs in the initial stages of the clinical block may experience problems due to the fact that their skills are not well developed at that stage.

Constructive feedback and the OTs' use of guided questions and discussions were considered necessary to facilitate clinical reasoning and learning. Once again, this is indicative of the sense of relationship as described above, and through the use of effective interpersonal skills learning is facilitated according to the student's learning style and tempo. This was consistent with the findings of various authors (Rodger, et al., 2011; Mulholland and Derald, 2007; Kirke, et al., 2007; Mulholland, et al., 2006) who found that constructive, timely and balanced feedback is viewed as an important teaching strategy and critical for effective learning.

The OTs found that it was often necessary to provide support to students due to personal or academic problems which caused tension and stress to them. Due to their belief in humanistic values, for example caring, empathy and sensitivity, they were able to identify the students' need for support, as well as to judge how much support should be given. This finding is supported by Kramer and Stern (1995), who found that it is sometimes necessary for the clinical educator to provide support to the students on matters relating to their personal life and learning, to prevent them from having an adverse effect on the learning experience. Mitchell and Kampfe (1993) state that students can also experience support from a supervisor who fosters open communication during discussions and feedback sessions.

The evaluation of students was influenced by unrealistic expectations regarding the format of the practical examination, as well as time constraints which forced therapists to make alternative arrangements for their patients' treatment while they were engaged in student evaluation. The participants furthermore commented on the skill needed to act on behalf of students when certain university lecturers tended to be too harsh during student evaluations. In this regard the younger, less experienced clinical OT experienced the university lecturer as more intimidating than his/her older, more experienced colleague. Overton, et al. (2009) state that evaluations should reflect the learning experienced at the placement setting, and should therefore be adapted accordingly. The clinical OTs were of the opinion that the university lecturers should be more lenient and flexible when they award marks, and that high marks should be awarded when deserved. Findings from studies indicate that evaluations should be objective and adequately reflect learning (Friedland, et al., 2001; McAllister, et al., 1997), and that the clinical educator should be equipped for the task through preparatory programmes (Pereira, 2008; Kirke et al., 2007; MacKenzie, et al., 2001; Alsop & Ryan, 1996). This would facilitate everyone using the same criteria during student evaluation.

A high value was placed on a student-centred approach and the principles of adult learning theory during the fieldwork experience, which is congruent with the sense of self. The OTs provided students with appropriate guidance and support, but expected them to be active, motivated partners during the learning process and to act in a professional manner, providing optimal treatment for their patients. It was found that the facilitation of learning was negatively influenced by students who did not adequately prepare for the clinical block, or who appeared to display either a negative attitude towards learning or a lack of responsibility towards their patients. In some physical placement areas the learning process was influenced by the students' lack of basic knowledge regarding neurology and techniques used for the treatment thereof.

Findings from studies by Mulholland and Derald (2007), Whitcombe (2007) and Kautzman (1990) support the notion that fieldwork supervisors place a high value on andragogical learning (Knowles, et al., 1998). This type of learning is deemed appropriate because it provides students with a frame of reference that can be applied in future placements and after qualification. The knowledge accumulated by the students during these real-life learning experiences assists in expanding their bank of knowledge, which will in turn develop their clinical reasoning skills and treatment interventions (Holmes, et al., 2010; Overton, et al., 2009; Velde, Wittman & Vos, 2006; Banks, et al., 2000). The description of the students'

responsibilities during the learning process is consistent with findings by Kirke, et al. (2007) and Sladyk (2002 cited in Evenson, 2009, p257), who found that students must show an interest in what they are learning, demonstrate concern for the patient's needs and issues, be receptive to feedback, act professionally, and apply effective communication skills. They also have to be organised, stick to timelines and due dates, and show enthusiasm for what they are doing. Findings by Rodger, et al. (2011), Overton, et al. (2009) and Mulholland and Derald (2007), support the view that students should receive the necessary knowledge and preparation before they commence fieldwork.

The clinical OTs commented on positive and negative emotions experienced in the performance of their roles as clinical educators. All the participants enjoyed the student training and commented on the satisfaction experienced when professional growth is observed. However, in contrast to this, frustration and uncertainty were experienced when the SU demands differed from the OTs' expectancies, for example lack of information regarding students with special needs that cause worry and stress to the OTs, a fieldwork curriculum that was not perceived to be aligned to the current health system, and tiredness that set in due to the multiple demands of the OTs' work. These findings are supported by the *Model of Occupational Role Acquisition* (Heard, 1977), which indicates that conflict and uncertainty develop when the internal and external expectancies of a role differ. This gives rise to bargaining to try and lessen the differences. The need for ongoing support for supervisors to enable them to perform their roles effectively, is indicated (Hunt & Kennedy-Jones, 2010; Kirke, et al. 2007; MacKenzie, et al., 2001)

The clinical OTs' sense of being clinical educators, with the accompanying competing tasks it entailed was supported by various findings in the literature. Their sense of self and sense of relationship was evident in the way they influenced their motivation for becoming clinical educators, the many tasks they performed, the approaches followed, and the emotions experienced.

5.5. A sense of agency as a clinical educator

A sense of agency refers to the way in which clinical educators manage to juggle their multiple tasks within their environment, and how empowered and competent they feel in doing it. The elements in this dimension relate to the perceptions and competence to act as clinical educator, creating and maintaining facilitative learning environments, designing, maintaining and

evaluating students' learning programmes, and managing self and others (Higgs & McAllister, 2005).

In general the OTs felt competent regarding their skill as clinical educators in their day-to-day contact with students and in the facilitation of learning. The more experienced OTs also felt empowered to act and to make changes to external expectancies when they perceived it as not beneficial to the learning process. In some cases these changes were made with permission from SU and in other cases without it. Jung and Tryssenaar (1998) found that supervisors consistently question whether they possess the knowledge, skills and characteristics required by an effective supervisor. McAllister (2001) state that the more experienced clinical educator is more competent, confident and empowered to take action and make changes. This explains why the more experienced clinical educators felt more competent and empowered to perform their role and to make changes as deemed necessary.

A few of the OTs commented on feelings of limited confidence and unease when they started to supervise SU students in clinical work. These feelings were more prevalent among OTs who did not qualify at SU, and therefore were not familiar with the SU expectations regarding student training. Insufficient training for the role was also cited as a problem. Feelings of insecurity and low confidence in meetings with more senior staff also kept OTs from participating and from optimal learning. The need for preparatory programmes to prepare new OTs for their role as clinical educators has been widely discussed and recommended (Hunt & Kennedy-Jones, 2010; Pereira, 2008; Fone, 2006; Hook & Lawson-porter, 2003). It is envisaged that these programmes will equip the OT with the necessary skills to fulfil his/her role competently.

The participants commented on the need to create a welcoming and supportive learning environment to enhance students' learning processes. It was important to them that the students felt welcome and sufficiently at ease to share information with them. They also provided the necessary resources and a comfortable area to relax when appropriate. This attitude is indicative of their strong student-centred and humanistic approach to education. Rodger, et al. (2011) and Mulholland, et al. (2006) state that welcoming learning environments with a student-friendly culture, in which they feel respected and are able to enjoy their fieldwork placement, contribute to students' learning experiences.

Clinical OTs found the possession of organizational skills essential. The participants commented on the need for effective planning before the start of a clinical block, as well as planning and implementing an orientation programme and a graded programme of training.

This had to coincide with the OT's own planning for patient treatment and other tasks, in order to manage her workload within the available time. Frustration was experienced when the OTs were not able to spend sufficient time with a student due to an excessive workload, sometimes caused by staff shortages. Findings from studies by Rodger, et al. (2011) and Kirke, et al. (2007) support the need for planning before the commencement of student fieldwork to ensure a quality experience. Furthermore, various authors (Thomas et al., 2007; Casares, et al., 2003; Fisher & Savin-Baden, 2002a) identified staffing issues, limited resources, workload pressures and multiple expectations of clinicians as problematic and the main barriers to the provision fieldwork placements for students.

Overall, clinical OTs ensured that orientation was done to give students a good understanding of the area and expectations, and the graded programme allowed for progressive independence by the students. The OTs also agreed that programmes with graded expectations should be used to guide students towards independence. Different strategies were used, for instance working in conjunction with another student or observation from another area. Feedback regarding patients' progress was always expected from the students. Findings from various studies (Rodger, et al., 2011; Kirke, et al., 2007; Mulholland, et al., 2006) support this finding and state that an organised, well-planned orientation programme assists in clarifying expectations and reducing student anxiety. It is furthermore deemed important and conducive to learning, and is essential for guiding students towards increased independence. These programmes should also allow opportunities for adequate facilitation of learning through different teaching methods and timely feedback.

Although the majority of OTs seemed to plan and implement their training programmes effectively, factors were identified that made them feel less empowered than they would have liked to be. These were the fact that the fieldwork roster did not always take public holidays into account, which left the clinical OTs in acute areas with insufficient time for training. In addition to this was the prescriptive nature of fieldwork expectations which were not always appropriate for their areas of work. Feelings of frustration were accordingly caused by the fact that the OTs were not empowered to make the necessary changes. Kirke, et al. (2007) and Casares, et al. (2003) state that it is important for the university and the clinical educators to collaborate on matters that cause controversy in order to find solutions that will be beneficial to the students' fieldwork experiences.

The analysis of the sense of agency as a clinical educator indicated that the more senior, experienced OTs felt more competent and empowered to take action and make changes where necessary. However, this was not always possible, and in these instances this acted as a source of frustration to them. The OTs were able to manage their multiple roles through good management, creation of a supportive and welcoming learning environment, orientation of students, and the planning of a graded training programme. This was also indicative of their strong student-centred and humanistic approach inherent to their sense of self. Frustration was experienced when the focus of the sense of agency shifts due to factors such as staff shortages resulting in excessive workloads and feelings of incongruence.

5.6 Seeking dynamic self-congruence

Seeking dynamic self-congruence refers to the clinical educators' goal to achieve a balance between living out their sense of self through their actions and relationships within their own environment, with all its dynamics, constraints and unpredictability (Higgs & McAllister, 2005). The elements of this dimension relate to the meta-cognitive monitoring of what one is doing, thinking and feeling to draw the selves together. It involves being aware of incongruence and utilising strategies to promote harmony between these dimensions.

According to McAllister (2001), the clinician can become aware of incongruence through emotional awareness, whereby a 'gut-feeling' or intuition senses the incongruence, and through cognitive awareness, which involves thoughts and the thinking process (reflection-in-action and reflection-on-action). Factors that influence the level of awareness are experience, reflective skill, fatigue, anxiety and the complexity of the task. Marrow, Macauley and Crumbie (1997) argue that reflection-in-action and reflection-on-action underpin the process of supervision, and assist the clinician in fostering a logical order to thoughts and feelings relating to personnel and clients. They can assist in problem-solving, resolving internal conflict or frustration, and in establishing a more clear vision of specific learning needs.

The participants in this study mentioned different strategies used to deal with problems and frustrations they had become aware of, in order to promote harmony in their workplace.

Strategies to deal with frustrations caused by students, due to their negative attitude and lack of responsibility towards patients, included discussing the problems, re-emphasizing the expectations, and referring them back to theory where limited knowledge seemed to be a

problem. These measures were not always successful and were a source of worry, as the clinicians were not always sure how to handle these problems.

Reflective practice, whereby judgment is based on experience and prior knowledge (Merriam & Caffarella, 1999), was evident in the way the students' written work was adapted by three of the more senior and experienced clinical educators, who reflected on the use and format of the written work expected of students. Changes were deemed necessary because some of the reports required were not applicable for their area of work. Marking the reports was also time-consuming, a luxury they could not afford. One of these OTs discussed a new, shorter version of the case study that she was busy compiling for acute areas, as the current format of case study was not deemed appropriate. Reflection in and on action was furthermore evident in implementing strategies to deal with practical problems at work, for example using support from staff at work when necessary. McAllister (2001) states that cognitive awareness is more often used by the experienced educator, which was evident in the way that these clinicians handled the problems as described above.

The participants in this study indicated that a certain amount of incongruence was also caused by the relationship with SU – especially with regard to the fact that feedback from the OTs was not acted upon. Strategies to deal with this incongruence included adapting certain expectations in their areas, with or without the consent of SU. Unfortunately this did not always solve the problem, and clinicians were left with the feeling that their input was not acknowledged or appreciated. Some of the participants indicated that they had to consider whether it was feasible to stay involved in clinical education in the future if the situation did not change. Findings from various studies (Kirke, et al., 2007; Casares, et al., 2003; Jung & Tryssenaar, 1998) stress the importance of recognition and appreciation for the work done by the clinical educators, and that universities should respond to their requirements. Thomas, et al. (2007) argue that acknowledgement and recognition are essential to maintain and increase the OTs' willingness to provide fieldwork supervision, which, in the case of the current study may be under threat.

Incongruence due to personal relationships between less experienced clinical educators and senior SU staff were successfully dealt with through reflective practice. More social activities to further improve relationships have been recommended by the OTs.

The clinical OTs developed different strategies to seek dynamic self-congruence and to promote harmony in the workplace. Not all of the strategies proved to be equally successful, due to

different factors – some of which the OTs were able to change and others not – with possible implications for future clinical placements.

5.7 Growth and development

Growth and development refer to the growth and development from novice to expert as experienced by the clinical educators as well as their awareness and active choice in this process (McAllister, 2001).

The younger, more inexperienced OTs described their feelings of incompetence and uncertainty at the start of their career as clinical educators. They identified a lack of sufficient initial training by SU as a contributing factor. They expressed a need for a formal, short course to inform the new clinical educator about the SU system of clinical training, and exactly what is expected of the clinical educator. Bonello (2001) describes the training of new clinical educators as a neglected area. Workshops to prepare them for their role have been recommended in order to solve this problem (Hunt & Kennedy-Jones, 2010; Kirke, et al., 2007; Hook & Lawson-Porter, 2003).

The clinical OTs had varied reactions regarding their attendance at meetings, workshops and courses to promote growth and development. They all agreed that lifelong learning was important, but were not in agreement concerning the purpose of some of the events provided by SU.

All of the OTs who had attended the *Short Course for Clinical Supervisors* agreed that it added value to their roles as clinical educators and that it was to be recommended. Only a few of the OTs commented on the benefit of attending the clinical supervisors' meeting. They were of the opinion that it provided an opportunity for sharing of knowledge, learning and networking. However, although they could see the need for the meeting, the majority of clinical OTs did not attend the meeting due to time constraints and the fact that they did not perceive it to address the problems experienced with student training during fieldwork. The participants commented positively on the workshops organised by SU and recommended some further topics, for example a discussion about the *Guide for Clinical Work*.

Findings from the literature indicate that workshops and courses are valued by clinical educators and that they can facilitate improvement in the clinical educators' skills, for example the construction of relationships that facilitate quality learning for students (Rodger, et al., 2011),

knowledge and skill development regarding time management (Jung & Tryssenaar, 1998), and professional development in fieldwork supervision (Hunt & Kennedy-Jones, 2010).

The clinical OTs' commitment to lifelong learning was evident in their sense of self, though this did not always reflect in their attendance at workshops or meetings due to time constraints and discussion topics that did not seem relevant to them, or did not address fieldwork problems. However, the OTs who regularly attended these sessions found it beneficial to their professional growth and development. The preparation of new clinical educators was another issue which needed to be addressed, as the current preparation seemed to be lacking in this regard.

5.8 Conclusion

In this chapter the results of the study were discussed according to the *Lived Experience of Being a Clinical Educator Model* (McAllister, 2001). It provided insight into the role of the clinical educators and their experience thereof. Conclusions regarding the findings will be drawn in the following chapter, to inform the researcher regarding the contribution of this study to the body of knowledge in OT, and possible future research. Appropriate recommendations will be made where necessary.

Chapter 6 - Conclusions

6.1 Summary of findings

The *Lived Experience of Being a Clinical Educator Model* (McAllister, 2001) provided an appropriate and valuable framework for discussion of the results as there was a notable congruence between them. The clinical OTs' sense of self revealed their humanistic values, an improved self-acceptance through dealing with feelings and emotions, pride and loyalty in their profession, and a passion for training future OTs. They furthermore made use of different levels of control during fieldwork and were dedicated to lifelong learning, albeit at varying degrees. The sense of self proved to be the core element influencing the way in which they related to others and were able to juggle many roles in order to perform their role as clinical educator. This influence was evident in their relationships with students and the OT staff from SU, as well as their organisation and performance of the tasks demanded by their roles as clinical educators. Differences were observed between the novices and the experts in the field.

The clinical OTs' sense of self furthermore influenced their striving for balance and harmony in the workplace, as well as their awareness and choice in the process of growth and development. Incongruence during the performance of their roles as clinical educators was mainly caused by insufficient collaboration between the clinical educators and SU regarding problems experienced during fieldwork, the prescriptive nature of the fieldwork curriculum, and insufficient preparation of students regarding certain basic knowledge. Factors that further added to the incongruence were students with negative attitudes towards learning, or insufficient communication from SU regarding students with special needs and/or diverse cultures, workload pressures, and limited knowledge and experience regarding clinical education. The professional development and growth of the clinical educators was negatively influenced by insufficient training of the new clinical educators and/or educational activities which were not always deemed relevant.

In spite of all these factors, the OTs' experience of their role as clinical educators remained largely positive and they were motivated to be part of the students' learning experience. This is indicative of the important influence of the sense of self and the elements thereof which influenced their motivation for involvement in clinical work.

6.2 Conclusions

This study provides a contemporary view of the clinical Occupational Therapists' appreciation and experience of their role as clinical educators of OT students at Stellenbosch University (SU) from their own perspective and within the context of their professional work.

The findings from the study indicate that the clinical OT's experience of her role as a clinical educator is influenced by her sense of self, which acts as the core phenomenon that informs all the dimensions and aspects of her role performance. This confirms McAllister's (2001) finding in this regard. The elements present in the OTs' sense of self, as well as all their other senses, were also aligned to those described by McAllister (2001) and supported by findings from various literature sources. The *Lived Experience of Being a Clinical Educator Model* (McAllister, 2001) is therefore proved to be a relevant tool for the analysis and discussion of findings regarding clinical education in OT.

The importance of the sense of self is further demonstrated by the way it assists the OTs in staying positive regarding their role, and actively involved in performing their tasks, in spite of factors that may influence their self-congruence negatively. These factors are mainly related to their relationship with SU, negative attitudes of students, workload pressures, insufficient training for the role, and their own insecurities. It is postulated that the high regard for humanistic values, the OTs' sense of professional responsibility and the value they attach to their role are all major contributors in this regard. Nevertheless, the negative factors should still be addressed in order to assist the OTs to reach greater self-congruence and to provide optimal learning opportunities for the students.

Improved collaboration between SU and the clinical educators is deemed essential in order to provide an optimal learning experience for the students, as well as to ensure that placement areas are not lost. The feedback from the clinical areas must be taken into account and acted upon to ensure that the students' fieldwork experiences reflect the current context and trends in health and community care. Support and acknowledgement should be supplied to the clinical educators and SU should be sensitive to OTs' requests regarding the placement roster in order to prevent sub-optimal learning experiences for the students. These proposed actions are aligned with findings from research which have identified collaboration between the university and clinical educator (Kirke, et al., 2007; Casares, et al., 2003), as well as recognition and acknowledgement of the latter's' role (Rodger, et al., 2011; Thomas, et al., 2007; Kirke, et al., 2007), as important factors facilitating an optimal fieldwork experience.

Professional development and training of new clinical educators have been found necessary. Workshops, courses and meetings should therefore be arranged to discuss problems which might exist in the areas, and to provide training to new clinical educators as well as continuous professional training to all the clinical OTs. The topics should address their needs and prepare them to handle the issues which cause problems in the clinical field, for example handling students with negative attitudes and dealing with their own insecurities.

This study set out to give the clinical educators a voice to tell their own story concerning their experiences as clinical educators. The resulting findings can now assist in the future planning of quality fieldwork and improved clinical education.

6.3 Contributions

The findings of this study confirm the importance of collaboration between the universities and clinical educators in the design and implementation of a fieldwork curriculum. It is only through this collaboration that an optimal learning experience that is aligned with the current health system can be ensured. The clinical OTs' valuable experience gained from their work and clinical training should therefore be acknowledged and implemented by SUOTD.

The findings furthermore contribute to the body of knowledge by demonstrating the sense of self as the core phenomenon that influences the role performance of the clinical OT. This concept has not been widely discussed in the OT literature thus far. *The Lived Experience of Being a Clinical Educator Model* (McAllister, 2001), is now proved to be relevant for use by OTs in the SU setting, and can be used as a tool for personal reflection on the role of clinical educators and how they experience it. It can also provide a basis for the training and professional development of clinical educators (Higgs & McAllister, 2007).

6.4 Suggestions for further research

Future research as to the skills required of OTs in the current health system in South Africa (SA) is needed to ensure that the students' training is aligned to these requirements. There is currently no published literature available on this topic. However, information in this regard was obtained by the South African Professional Board for Occupational Therapists, Medical Orthotics/Prosthetics and Arts Therapy. The OTs who qualified in 2004 and 2005 were requested to complete questionnaires regarding the skills needed in their year of community practice. This was done in order to find out which skills were needed and whether the students' training was aligned to the community requirements. The results were not published, but were

used during the compilation of the *Minimum Standards for the Training of Occupational Therapists* (2009). Research is therefore needed to assess whether the situation has changed since the last survey and what the minimum standards are that are currently needed. The findings should be published and would provide a useful baseline for OT training in SA.

It may be that the research embodied in this study could act as a springboard for further research in the quest for optimal fieldwork training for students – which may, in turn, enrich the professional lives of clinical OTs, resulting in a win-win situation for all concerned.

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Addendum A : PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

Clinical Occupational Therapists' experience of their role as clinical educators during the fieldwork experience of occupational therapy students.

REFERENCE NUMBER: N11/03/075

PRINCIPAL INVESTIGATOR: Brenda Emslie

ADDRESS: 21 Feldhausen Ave, CLAREMONT, 7708

CONTACT NUMBER: 083 458 3823 or 021 683 9935

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask Brenda Emslie any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

Up to twelve (12) Occupational Therapists (OTs), currently involved in the clinical training of OT students from Stellenbosch University (SU), will be selected for face-to-face, semi-structured interviews.

The aim of the study is to gain more insight, from your perspective, in your role as clinical educator during the fieldwork experience of the SU OT students. The information gained will assist in a better understanding of, and insight in, your interpretation, experience and value of this role, as well as any factors that might influence your fulfilment of this role.

The results from the study will assist the SU OT division in addressing any identified factors that may influence the quality of the students' fieldwork experience and/or the partnership between SU and the clinical OTs in their strive to ultimately provide excellent education to the students.

Why have you been invited to participate?

You are an experienced clinical educator with a wealth of information on the topic. Your experience is valuable and through sharing it, I will gain more insight into your role as clinical educator, as well as the specific factors that influence your fulfillment of this role.

What will your responsibilities be?

You are requested to take part in an interview that will be conducted by me. The interview will last approximately 45 minutes and will be audio-taped.

Will you benefit from taking part in this research?

No, you will not benefit directly, however, from the information gained the SU OT division may be able to facilitate better student training.

Are there risks involved in your taking part in this research?

There are no physical risks involved in taking part in this research project. The information shared during the research process will be kept confidential and private and the findings will be presented in an anonymous manner in order to protect the identities of the participants. The data will be stored in the OT division at SU and will be destroyed after three years

If you do not agree to take part, what alternatives do you have?

You are welcome to contact the Head of the OT Division directly with any feedback regarding the fieldwork experiences of SU OT students in your area.

Who will have access to your medical records?

Not applicable.

What will happen in the unlikely event of some form of injury occurring as a direct result of your taking part in this research study?

Not applicable.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study. A convenient setting for the interview will be chosen to limit any transport costs that you may have. Refreshments will be provided.

Is there anything else that you should know or do?

- You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study doctor.
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I agree to take part in a research study entitled ***Clinical Occupational Therapists' experience of their role as clinical educators during the fieldwork experience of occupational therapy students.***

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 2011.

.....
Signature of participant

.....
Signature of witness

Declaration by investigator

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If a interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) on (*date*) 2011.

.....
Signature of investigator

.....
Signature of witness

Addendum B : Persoonlike informasie/Personal information

1. Aan watter universiteit het jy gekwalifiseer? / *At which university did you qualify?*

.....

2. Lys asb jou akademiese kwalifikasie(s) asook die jaar wat dit verwerf is / *Please list your academic qualifications, as well as the year it was obtained.*

.....

.....

.....

3. Dui asb. die area aan waar jy huidiglik werk / *Please indicate your current area of work:*

- a) Fisies / *Physical*
- b) Psigo-sosiaal / *Psycho-social*
- c) Werk rehabilitasie / *Work rehabilitation*
- d) Skole / *Schools*
- e) Gemeenskap / *Community*

4. Hoe lank is jy al betrokke by die kliniese opleiding van AT student? / *How long have you been involved in the clinical training of OT students?*

.....

5. Hoe lank is jy al betrokke by die kliniese opleiding van US AT student? / *How long have you been involved in the clinical training of SU OT students?*

.....

6. Watter van die volgende US studente verrig kliniese werk in jou area? / *Which of the following SU students perform fieldwork in your area?*

- a) B. Arbeidsterapie I / *B. Occupational Therapy I*
- b) B. Arbeidsterapie II / *B. Occupational Therapy II*
- c) B. Arbeidsterapie III / *B. Occupational Therapy III*
- d) B. Arbeidsterapie IV / *B. Occupational Therapy IV*