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the experiences of occupational therapy clinicians as educators: the community college context

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**The experiences of occupational therapy clinicians as educators:
The community college context**

by

Nichelle Lea Cline

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of
DOCTOR OF PHILOSOPHY

Major: Education (Educational Leadership)

Program of Study Committee:

Larry Ebbers, Major Professor
Sharon Drake
Carol Heaverlo
Marisa Rivera
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Iowa State University

Ames, Iowa

2012

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DEDICATION

To my husband, Jerry

Your constant support and unshakable faith mean the world to me

I love you

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ABSTRACT

The purpose of this qualitative study was to explore the clinical fieldwork educator role in the community college from the perspective of the clinician. While there are numerous fieldwork studies from the perspectives of the students and the academic institutions, there is a paucity of literature regarding the meaning that fieldwork educators make of their role (Thomas et al., 2007). The participants in the study were four occupational therapists and two occupational therapy assistants who volunteer to supervise occupational therapy assistant students in the clinical setting prior to graduation from their academic program. All of the clinical educators lived within the Midwest United States. Data were gathered through semistructured interviews, participant self-assessment and reflection, and student evaluation of the fieldwork experience. The data gathered were analyzed for themes in order to construct meaning that might inform practice, policy, and further research in fieldwork education.

EPIGRAPH

Teaching comes
 As grand discovery
 Emerges after time away, placed teaching
 Like suspended animation
 Away from you heart,
 As the urgency of other matters
 Took precedent
 And then the blessedness
 The challenge and joy
 Of teaching others teaching
 Of teaching teachers to be learners
 Of learning and teaching yourself:
 Such Freedom to learn
 Can never be taken for granted.
 Such Freedom to teach and learn
 Ceases to be given
 When those learning
 And those teaching are not the same.
 Forging a kind of synchronicity
 Communicating:
 Listening, hearing, learning, sharing
 Thoughts made real in voice;
 Creating spatial awareness of the room
 To think and be and soar
 And share new thoughts
 And being oneself.
 Not creating pre-fab students
 Like paper houses, consumed in
 Acts of God, of nature:
 Learners and teachers making things new
 Inspiring, empowering,
 Shifting, stretching, growing, interpreting
 Collaborating, embracing knowledge.
 A joyous celebration
 Suspending judgment,
 Being, knowing, thinking, doing
 Understanding and engagement
 Building confidence, bold risks taken:
 Student-centered reality:
 Questions fueling our sensibilities
 Moving the staid from the center

Maximizing learning
An ideal of artistic clarity and transformation.

—Cheryl Kirk-Duggan, “Suspended Moments”

CHAPTER 1

INTRODUCTION

The development of the community college occupational therapy assistant clinical educator and those educators' perceptions of that role was the focus of my research. While I conclude my dissertation with a reflexivity statement, I intend to set the context for this study by revealing my developmental journey to researcher of the role of clinical educator in the community college system.

The terminology used for clinical education and clinical educators varies among academic institutions and the varying clinical locations within the profession of occupational therapy. The community college occupational therapy assisting programs most often refer to the experience as fieldwork; however, it is also sometimes referred to as a clinical experience. The clinical educator is a clinician in occupational therapy practice. The clinician may also be referred to as an occupational therapist, occupational therapy assistant, or occupational therapy practitioner. The clinician may also assume the role of clinical educator. The clinical educator may also be described as a supervisor, fieldwork supervisor, or clinical fieldwork educator.

I completed my educational experiences as an occupational therapy student in a traditional classroom in December of 1994. I had attended two universities and was in the process of completing my third undergraduate degree. I understood traditional classroom culture and forged traditional relationships with my faculty. Many I respected, some challenged me, and others were less inspiring. Always, though, I understood the relationship. I understood the role of teacher and student. The model employed by both colleges was similar to my classroom experiences in previous college coursework as well as childhood and

adolescent classroom experiences. I understood that in the role of student I had an obligation to prepare and participate to receive the information that my instructor had the obligation to prepare and deliver to the student. I intuitively trusted that the instructor knew the material, knew how to best deliver the material to me, and knew how to assess my ability.

The final 6 months of my formal occupational therapy education required a full-time field experience in a facility that delivered occupational therapy services. I was assigned a different fieldwork supervisor for each of my 3-month experiences. Both clinicians were full-time practicing occupational therapists. They had full patient caseloads and were expected to maintain their typical workload while supervising me in the field. For the first time in my academic career I was uncertain how to define my role or the role of my supervisor or “teacher.” I was not yet a graduated occupational therapist or practitioner. Yet, this was not a traditional classroom setting, although I was expected to learn and develop my skills. I knew that this was the culminating learning experience of my occupational therapy education and would best prepare me for practice. While I had great learning experiences at both facilities, I sometimes felt like I was an unpaid employee left to my own devices to learn as I went along. My supervisors seemed very busy and devoted to their practice. While they were skilled clinicians and cared about my success, I was unsure if they were teaching me, mentoring me, facilitating my learning, or expected me to know more than I did. Although it was implicit in the process that they were participants in my education at the college, I did not know how connected they were to the college or how they perceived their role in my education. I was not sure why they volunteered to supervise a student. Nevertheless, I passed both of my fieldwork rotations with excellent recommendations from my supervisors and became a registered occupational therapist.

One year after beginning practice, I was asked to be a fieldwork supervisor by both occupational therapy and occupational therapy assistant programs across the country. It was regulated by accreditation that a practitioner have one year of full-time experience before supervising fieldwork students. While I had not initiated the process or volunteered myself for the position, I had always had an interest in being an educator and agreed to supervise fieldwork students. The experience did not go as I expected. I quickly realized after my first student arrived that I was very busy as a practitioner. In addition, I had no formal training as an educator, or more specifically, a clinical educator. I had never attended a community college and had very little awareness of the academic preparation of the occupational therapy assistant (OTA) student. I had not anticipated that students would come with varying intellectual abilities, attitudes, and performance skills. No one had explained the idea of learning styles, mentoring, and progressing a fieldwork student. I had performance evaluations to complete on each student, but I had no frame of reference for completing them accurately. Finally, I had no real connection with the academic institutions that were sending me students. I rarely met with any of the faculty. I did not know the college or even program mission for most of the schools. The most contact I typically had with the school was the initial phone call or letter requesting I take a fieldwork student and the very rare phone call or visit from the academic fieldwork coordinator once the student arrived. While I very much wanted to be an excellent clinical educator, I wondered if some of my students felt like unpaid employees left to their own devices as well.

When I accepted the position of program director for an OTA program, I also assumed the duties of supervising the academic fieldwork coordinator and the fieldwork program. Each year we send out approximately 150 fieldwork placement requests for the

next academic year. We typically receive approximately 60 affirmative responses. We then attempt to place the students according to performance abilities, facility requirements, and supervisor/student personality fit. As educators, we have assessment data, personal experience, and anecdotal information that allow us to identify strong clinical educators and excellent clinical educating facilities. However, while the number of excellent clinicians is large, the number of clinicians who understand and enjoy the role of educator is fewer. Regulatory requirements as well as our own program mission and philosophy have required us to be more proactive in including our clinical educators in the education process of our OTA students. We educate the clinical educators about the philosophy and mission of the college, make attempts to connect directly with each one while they are supervising students, offer workshops on progressing and evaluating a student, and provide counseling and feedback for all student issues. We are definitely more proactive than the programs were when I was a clinical educator 15 years ago. However, there continues to be a disconnect between the clinician and the college. I frequently feel like I do not know how the clinical educators perceive themselves in relationship to the college and the role of educating the student.

Statement of the Problem

The Accrediting Council for Occupational Therapy Education (ACOTE) sets explicit standards for the fieldwork component of the academic program (Costa, 2007). The number of hours students spend in the clinical setting is equal to or more than the number of hours spent in the classroom portion of the curriculum (Crist, 2010). This would indicate that clinical educators have a large role in preparing the future practitioners. Given that they are clinicians first and volunteer educators second, it is important to understand what motivates

them to volunteer to educate fieldwork students and what makes a good fieldwork supervisor. The majority have no training or experience as an educator. It is up to each academic institution to ensure that the clinician is competent at student supervision (Costa, 2007).

The term *fieldwork crisis* has been employed in much of the fieldwork literature. This is a result of the global shortage of quality fieldwork placements due to the current difficult economic trends, growth in the number of academic programs, and shortage of qualified practitioners to supervise placements (Kirke, Layton, & Sim, 2007). Occupational therapy is a reimbursable allied health profession. Therefore, practitioners are often required to meet productivity requirements, which may be limited if the practitioner elects to supervise a fieldwork student.

One of the biggest concerns in the United States is the number of available qualified practitioners with interest in the role of clinical educator. Growth in the number of educational programs continues to put a strain on the number of qualified fieldwork supervisors in any given fieldwork cycle. At the American Occupational Therapy Association's (AOTA's) annual spring program directors' meeting, AOTA reported that since 2007, 74 OTA programs have started or completed the accreditation process, for a 51% growth in the number of OTA programs across the country (Harvison, 2012). In addition, since 2007, 14 occupational therapist (OT) programs have started or completed the accreditation process, for a 9% growth in the number of programs (Harvison, 2012). These numbers do not include the developing programs that are still in the process of application to accreditation. The state in which the following research occurred is experiencing the same growing pains. There is one established OTA program and one recently accredited OTA program as well as two developing OTA programs. In addition, there is one OT applicant

program (AOTA, 2012) and an expectation that another university within the state will apply for developing status within the next 2 years. Therefore, due to the number of fieldwork students expected, the state will require approximately twice as many willing and qualified clinical educators within the next 3-4 years if all programs gain accreditation. This will put greater strain on the already limited resource of quality fieldwork educators.

ACOTE (2008) offers a definition of supervision and regulatory standards that define the process of fieldwork education, and academic faculty have significantly reviewed fieldwork from the institutional and theoretical perspective. However, there is a paucity of available literature regarding how clinical educators view their role in the educational process of the community college OTA student. In addition, it has not been thoroughly explored as to how to identify good clinical educators or how to provide formal or informal professional development opportunities to promote quality educators. Finally, there is a lack of research as to why clinicians continue to maintain the volunteer role of clinical educator over time.

Purpose of the Study

The purpose of this study was to contribute to the existing research in the field of occupational therapy fieldwork supervision specifically relating to the role of the clinical supervisor as educator of community college students. The goal was to construct meaning from the clinicians' perspective regarding their motivation to become a clinical educator of community college students, experiences as an educator, growth in their supervisory and education skills, and the processes they use to be effective in educating the clinical student.

Research Questions

The following are the research questions that guided this study:

1. How do occupational therapy clinicians describe the factors that influenced their decision to become clinical supervisors of students enrolled in a community college OTA program?
2. How do occupational therapy clinicians describe their role as educators in a community college context?
3. How do clinical educators describe their journey to becoming clinical educators of community college students?

Significance of the Study

The perspective of the clinical educator has long been ignored in fieldwork education. There is a paucity of literature regarding the perspective of the occupational therapy clinical supervisor in his or her role as educator, especially in the community college context. There is more research from the academic educator and student perspectives regarding their preferred type of supervision and favorable clinical education experiences (Hanson, 2011). My intention with this study was to give voice to the clinician as supervisor in a community college educational role, as well as propagate further research from the clinical fieldwork perspective. In addition, I hope that the influence of clinicians can assist with the development of more rigorous academic coursework and effective fieldwork administration at the community college. Finally, the collaboration of clinicians, educators, and administrators can influence the educational process and healthcare delivery of occupational therapy practice. The clinician has a unique perspective regarding the place where formal education is completed and professional practice begins. Ideally, the transition would be less disruptive to the clinician and more beneficial to the student.

Theoretical Perspectives

Crotty (1998) described epistemology as “concerned with providing a philosophical ground for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate” (p. 8). The epistemology of this study was constructionist as it intended to make meaning of the clinician’s role as educator of community college students. Crotty also stated that in the constructionist view, meaning is “constructed by human beings as they engage with the world they are interpreting” (p. 43). My goal was to construct meaning surrounding the clinical fieldwork educator’s perception of the supervisor role and what meaning that has in the education process of the OTA student. No human can make meaning in isolation from another object or human (Crotty, 1998). Therefore, it was important to examine the supervisor and supervisee within the context of the supervisory educational experience.

The theoretical perspective is the philosophical position that informs the methodology (Jones, 2002). The theoretical perspective of this study was interpretivist. And, since the goal was to understand and construct meaning situated historically and culturally, the theoretical perspective was specifically one of basic interpretivism (Crotty, 1998). Historically, fieldwork supervision has been implemented in a specific way. However, the approach may vary depending on culture or context. Therefore, basic interpretivism framed this study.

The methodology for this study was phenomenological. In this methodology, the goal is to construct meaning (Crotty, 1998). The focus in this study was on the lived experience of the clinical supervisor. The research created meaning around the everyday experiences of the occupational therapy practitioner who decides to become a clinical

supervisor and who completes that position in a positive and effective manner. According to Merriam (2002), a person and his or her world are interrelated. Therefore, the supervisor cannot exist without the supervisee experience. The research focused on the interaction of the supervisor with the experience (Merriam, 2002).

Theoretical Models

The theoretical framework of occupational therapy practice is broad and incorporates many theoretical perspectives. The profession is historically founded in social work and mental health treatment (Hussey, Sabonis-Chafee, & O'Brien, 2007). Therefore, many of the occupational therapy practice processes and models are based on similar models used in social work and mental health. The occupational therapy education models are no exception. Of the many different theoretical perspectives from which the profession and its educational system draw, the developmental models were most relevant to this study. The developmental theory that is most relevant to all settings is the Ronnestad and Skovholt (2003) model. The Ronnestad and Skovholt developmental model places a strong emphasis on lifelong learning and professional development. In many fields, taking on a supervisee is considered a key step (Davys & Beddoe, 2000). Occupational therapy curricula standards encourage this, and it is required by the ACOTE standards that lifelong learning and giving back to the profession is taught in each program. This is considered a step toward achieving expert practitioner status (Costa, 2007). By using the developmental model of Ronnestad and Skovholt to frame my study, I explored the developmental process from student to practitioner to clinician.

Definitions of Terms

Occupation: Activity in which one engages that is meaningful and central to one's identity (Hussey et al., 2007).

Occupational therapy: Goal-directed profession that promotes independence in function; the practice of using meaningful and purposeful occupations (Hussey et al., 2007).

Occupational therapist (OT): Allied health professional who uses occupation to work with clients who have been born with or acquired illness, injury, or disability (Hussey et al., 2007).

Occupational therapy assistant (OTA): Allied health paraprofessional who, under the direction of the OT, uses occupation to work with clients who have been born with or acquired illness, injury, or disability (Hussey et al., 2007).

Occupational therapy practitioner: Can refer to either an OT or an OTA (Hussey et al., 2007). This person may also be referred to in the literature as a clinician.

Fieldwork: Practical experience applying classroom knowledge to a clinical setting. May be categorized as Level I (observational with direct supervision) or Level II (development of entry-level skills; Hussey et al., 2007).

Program director: Administers program, provides faculty support in didactic coursework, oversight of fieldwork program (ACOTE, 2008).

Academic fieldwork educator (AFWE): Administers and facilitates the fieldwork program in collaboration with the program director, provides faculty support in didactic coursework including fieldwork seminar, provides on-site supervision in collaborative model fieldwork delivery (Costa, 2007).

Academic program faculty: Provide instruction in didactic coursework, assist academic fieldwork coordinator with collaborative model fieldwork delivery (Costa, 2007).

Clinical fieldwork educator: An occupational therapy practitioner who also provides traditional fieldwork supervision in settings (Costa, 2007). This person may also be referred to as a clinical instructor, fieldwork supervisor, or clinical educator.

Site supervisor: Provides administrative and educational support to academic fieldwork supervisor in collaborative delivery setting where an OT or OTA is not present (ACOTE, 2008).

Summary

This study informs the educational practices of community college OTA programs and occupational therapy practitioners regarding the motivation, development, and professional identity of clinical educators. Chapter 2 provides a literature review of regulatory requirements for clinical education, current practices in supervision, development of practitioners/educators, and the professional identity of clinicians. Chapter 3 describes the methodology, research design, and methods for this study. Chapter 4 analyzes the data with thematic interpretation. Findings and conclusions related to the analysis of the data are included in Chapter 5.

CHAPTER 2

REVIEW OF LITERATURE

The review of literature provides a framework for establishing a study. There is a scarcity of literature regarding fieldwork education from the clinical educator's perspective. This literature review situates the study within a larger body of research surrounding clinical fieldwork education in general. According to Creswell (2009), due to the exploratory nature of a phenomenological qualitative study, the literature review is not prescriptive in nature. Therefore, when studying clinical fieldwork education, the literature review provides foundational information by exploring the historical development of the role of clinical educator and the current practice models in clinical education. Chapter 2 is divided into three sections. It first establishes fieldwork historically within the profession, including regulatory requirements. Second, supervision readiness, student fieldwork supervision process, and teaching and learning models are explored. Finally, it addresses the effectiveness of fieldwork supervision.

Fieldwork Delivery in Occupational Therapy

Traditional fieldwork delivery in the occupational therapy profession relies on the clinician-as-educator model. Students complete the classroom portion of the coursework on campus with traditional faculty in lecture and laboratory formats. They also complete multiple fieldwork experiences in different clinical and school settings with a clinical supervisor who is a practicing occupational therapist (OT) or occupational therapy assistant (OTA). The clinical supervisor is called a clinical fieldwork educator. This person is a practitioner who currently treats patients or clients and most often bills a third-party payer for services. Therefore, patient care often takes priority over the education of the student. The

clinical supervisor is not paid by the college to supervise the student but volunteers to train the next generation of practitioners. Typically this is completed with a ratio of one clinical supervisor to one student for a distinct period of time. Students complete both Level I fieldwork and Level II fieldwork experiences. The Level I experiences are 1- to 5-day experiences with significant supervision and instruction by the clinical educator. The Level II experiences are full-time clinical appointments, which, by completion, should have produced an entry-level practitioner. The student is under the supervision of the clinical educator for a full-time work week, often in excess of 40 hours per week. The fieldwork process, qualifications of clinical educators, and Level I and Level II requirements are highly regulated by accreditation.

History of Fieldwork and Clinical Fieldwork Supervision

Occupational therapy, as a relatively young profession, modeled many of its educational practices and processes after the medical, mental health, and social work models. Historically, those professions used the learned professionals to train the next generation of healers and care providers. The word *supervisor* was used to describe these professionals, although the role encompassed teaching, mentorship, leadership, and evaluation (Costa, 2007). The word *supervisor* is still often used in the literature when describing the clinical educator.

In 1924, the American Occupational Therapy Association (AOTA) published its first standards for clinical supervision. Initially, the standards were highly managerial and assessment oriented. However, over the next 70 years the standards became more explicit and more descriptive. For example, in 1977 the revisions indicated that the fieldwork supervisor's role was to facilitate the development of the professional identity of the student,

establish a dynamic teaching and learning relationship, and provide an experiential learning environment. In the 1980s, the importance of the relationship between supervisor and student was added. In 1991, AOTA Press published a guided instruction manual for clinical educators. It listed the four functions of the fieldwork supervisor. The four functions were described as follows: The clinical educator as administrator facilitates the fulfillment of student fieldwork objectives. The clinical educator as teacher facilitates student learning. The clinical educator as consultant promotes student confidence. And finally, the clinical educator as evaluator assesses students' development and performance to meet entry-level professional skills (Costa, 2007).

AOTA's Representative Assembly adopted the "Role Competencies for the Fieldwork Educator" document created by the Commission on Education (2006). These competencies have been established based on the "Standards for Continuing Competence" (AOTA, 2005). These competencies are statements that describe the typical values, knowledge, skills, and responsibilities that will contribute to a competent and successful educator of fieldwork students. There are five standards attributed to a competent fieldwork supervisor. They include knowledge, critical reasoning, performance skills, interpersonal skills, and ethical reasoning.

Definition of Supervision and Regulatory Standards

Clinical educators are often referred to as supervisors. There are many references in the literature to definitions for supervision in educational settings. According to Costa (2007), the following definition by Bernard and Goodyear (2004) is one that contains all of the elements necessary for clinical supervision:

Supervision is an intervention provided by a more senior member of the profession to a more junior member of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of the professional services offered to the clients that he, she, or they see, and serving as a gatekeeper for those who are about to enter that particular profession. (p. 6)

Costa (2007) explained that although the authors of this definition are education and counseling professors, the definition also relates to clinical supervision in occupational therapy. Supervision is an intervention by clinical educators as they are the senior members of the profession and intend to define the body of knowledge. It is their intent to assist the junior members (students) in the determination of best clinical practice according to setting and situation. This experience occurs over time with the clinical educator evaluating the progress of the student throughout. Finally, as the last stop prior to independent practice, the clinical educator serves as the final educational and evaluative experience for the student. The fieldwork experience is a place where the clinical educator can determine whether or not the student is ready for entry-level practice.

The previous definition of supervision serves as a philosophical guide to the practice of clinical education or supervision. There are also regulatory standards in which the Accrediting Council for Occupational Therapy Education (ACOTE) requires the educational institution to provide and create fieldwork that meets specific guidelines. Some of those guidelines refer specifically to the qualifications necessary for the clinician to be an educator. The following are the standards related directly to the role of the clinical educator as well as the role of the academic institution in developing clinical educators according to the ACOTE Accreditation Standards (AOTA, 2009a):

OTA-Level .B.10.14: Ensure that the fieldwork experience is designed to promote clinical reasoning appropriate to the occupational therapy assistant role, to transmit

the values and beliefs that enable ethical practice, and to develop professionalism and competence in career responsibilities. (p. 9)

This standard addresses the learning outcome expected from the experience. The person responsible for facilitating that learning is the clinical educator in the practice area assigned. It is not prescriptive but implied in this standard that the academic program will ensure the clinician comprehends the learning outcomes required of the student.

Doctoral; Masters and OTA-Level Standard B.10.17: Ensure that the student is supervised by a currently licensed or credentialed occupational therapist (for OT); or occupational therapist assistant (for OTA only) who has a minimum of 1 year of practice experience subsequent to initial certification, and is adequately prepared to serve as a fieldwork educator. The supervising therapist may be engaged by the fieldwork site or by the educational program. (AOTA, 2009a, p. 10)

This standard is more regulatory in nature. Again, the only prescription is that the clinician be in practice one full year. What constitutes “adequately prepared” is subjective and left to the academic institution to determine qualification and level of preparation.

Doctoral; Masters and OTA-Level Standard B.10.18: Document a mechanism for evaluating the effectiveness of supervision (e.g., student evaluation of fieldwork) and for providing resources for enhancing supervision (e.g., materials on supervisory skills, continuing education opportunities, articles on theory and practice). (AOTA, 2009a, p. 10)

ACOTE is more explicit in this standard, requiring that the academic institution take responsibility for the professional development of the clinical educator.

Doctoral; Masters and OTA-Level Standard B.10.19: Ensure that supervision provides protection of consumers and opportunities for appropriate role modeling of occupational therapy practice. Initially, supervision should be direct and then decrease to less direct supervision as is appropriate for the setting, the severity of the client’s condition, and the ability of the student. (AOTA, 2009a, p. 11)

This standard speaks to the institution as well as the clinician. Again, it requires the institution to monitor the clinician and prescribes the level of independence required by the end of the rotation.

These standards address the logistics of fieldwork education and regulate the process by which academic institutions are to be held accountable. However, there is little in the standards to guide the development and direction for a clinical supervisor. It is important to note the difference between training and supervision. Training is the passing along of a skill set, most often technical skills. It is often mechanistic and does not vary from person to person. Supervision is more organic. It is relational and contextualized to the individual supervisor and the individual supervisee. The clinical supervision process is holistic and developmental (Bernard & Goodyear, 2004; Cornforth & Claiborne, 2008). Therefore, the next section explores literature that contributes to the development of clinical supervisors as educators.

Theoretical Models of Supervision

There are many theories and models of supervision defined in the literature. Only the models that are relevant to the supervision of students and the practice of supervising occupational therapy students are described here. The profession of occupational therapy is historically founded in psychosocial practices such as social work and mental health treatment. Therefore, many of its processes and models are based on similar models used in these professions and their research. Costa (2007) presented three categories of such models as well as a fourth miscellaneous category. The three areas of psychosocial-based supervision models she discussed were the supervision models in psychodynamic theory, developmental models of supervision, and social role models of supervision. These are the models discussed here.

The following models of supervision are psychotherapy based. While there are many psychotherapy theories, only those that have clearly delineated supervision theory are

included here. The first of these is the psychodynamic model of Sigmund Freud. According to Goodyear and Bernard (1998), clinical supervision in mental health began over a century ago. In addition, the supervision of future practitioners of psychotherapy became a specific component in the development of professional identity as a psychotherapist. The authors stated, “Freud reported that it began in 1902 with a number of young doctors gathered around me with the express intention of learning, practicing, and spreading the knowledge of psychoanalysis” (Goodyear & Bernard, 1998, p. 6). The goal of the supervisor in this model is to promote personal growth in the supervisee while he or she acquires clinical expertise. The supervisor/supervisee process may feel more like therapy than an educational experience. This experience is referred to as the therapeutic triad. The supervisor identifies with a patient or client and then elicits that same emotion with the student (Cara, 2005).

A second psychotherapy model is the person-centered model, which came from the work of Carl Rogers. The major goal of the supervisor in this model is to assist the student to develop self-confidence and understanding of self. In this model, the students should experience the same relationship with their supervisors that the client-centered therapists cultivate with their patients/clients. The students should explore any patient/client concerns with the supervisors to provide insight into self and the therapeutic process (Bernard & Goodyear, 2004).

A third psychotherapy model is generated out of the cognitive-behavioral theory. This is a more procedural approach that emphasizes role modeling and coaching by the supervisor while the supervisee sets goals in behavioral terms. Supervisors use the Socratic method of questioning their supervisees. Boyd (as cited in Costa, 2007) identified four propositions central to cognitive-behavioral supervision:

1. Proficient therapist performance is more a function of learned skills than a “personality fit”. The purpose of supervision is to teach appropriate therapist behaviors and extinguish inappropriate behavior.
2. The therapist’s professional role consists of identifiable tasks; each one requires specific skills. Training and supervision should assist the trainee in developing these skills, applying and refining them.
3. Therapy skills are behaviorally definable and are responsive to learning theory, just as there are other behaviors.
4. Supervision should employ the principles of learning theory within its procedures. (p. 31)

Systems theory has also been used as an approach to supervision. It is most often used when supervisors/supervisees are working with families but may also be used to address cultural issues in treatment. This involves diagnosing the system rather than the symptom. The supervisee is encouraged by the supervisor to see himself or herself as part of the treatment system and to view therapy in a more contextual way. The supervisor encourages the supervisee to see that they each belong to different systems and exist in different contexts but are existing together in the one specific context of the supervisory relationship (Montgomery, Hendricks, & Bradley, 2001).

Constructivist theory originates from both a philosophical and psychotherapeutic perspective. Constructivist theorists believe that knowledge and truth are the result of perspective (Crotty, 1998). Therefore, it is a supervisory process that focuses on the meaning one makes out of life experiences. There are two models to consider under this theory. The first is the narrative approach to supervision. Occupational therapy students are in the process of creating their professional life story. It is the role of the supervisor to facilitate the professional identity development of the students (Bernard & Goodyear, 2004). The second model under the constructionist theory is the solution-focused model. In this model, the supervisor focuses specifically on what the student has done correctly or done well. The

supervisor will work with the successes and facilitate growth based on past success, avoiding focus on shortcomings. The underlying assumption is that the supervisee can identify “solutions” from within and the supervisor facilitates that process (Costa, 2007).

Developmental models are probably the most prevalent and most recognized in the occupational therapy profession. The most well known developmental model is the integrated development model developed by Cal Stoltenberg. It identifies eight domains of professional competencies that supervisees must have mastered upon completion of field experience. These domains include (a) intervention skills, (b) assessment techniques, (c) interpersonal assessment, (d) client conceptualization, (e) individual differences, (f) theoretical orientation, (g) treatment plans and goals, and (h) professional ethics. Throughout the field experience, the supervisee will move through the same four stages in each of the eight domains. Those stages start with self–other awareness then move through motivation and on to levels of autonomy (Costa, 2007). In Level I, the supervisee is highly motivated but also highly anxious and is therefore heavily reliant upon the supervisor. The supervisor’s role is to provide structure and help the supervisee manage anxiety. The supervisor should facilitate the link between classroom theory and practice. Level II supervisees move from dependency to imitation of their supervisor. They alternate between confidence and confusion. The supervisor should progressively decrease the amount of structure and formal teaching. By Level III, supervisees are developing a clearer view of self and better understand their role. Motivation is more consistent and the supervisee is no longer consumed with doubt. The supervisor emphasizes personal/professional integration and assists with the career decision making. The final stage is Level IIIi, meaning integrated.

The supervisee is able to identify strengths and weaknesses and has met entry-level competency (Stoltenberg & McNeill, 1997).

A second developmental model is the Ronnestad and Skovholt model. This theory employs the lifelong learning model and encompasses the career of the supervisee from prior to entry into an educational program through the senior professional stage. Ronnestad and Skovholt identified six phases, starting with lay helper or observer/volunteer in the first phase. Phase 2 is the initial stage of a student's career. The advanced student, Phase 3, is the stage of didactic completion with intention to move into the Level II fieldwork. Phases 4 through 6 occur after program completion and encompass the novice, experienced, and senior practitioner (Ronnestad & Skovholt, 2003). Ronnestad and Skovholt also identified 14 themes related to the professional development of a therapist:

1. Professional development involves an increasing higher-order integration of the professional self and personal self.
 2. The focus shifts dramatically over time, from internal to external to internal.
 3. Continuous reflection is a pre-requisite for optimal learning and professional development at all levels of experience.
 4. An intense commitment to learn propels the developmental process.
 5. The cognitive map changes: Beginning practitioners rely on external expertise, and seasoned practitioners rely on internal expertise.
 6. Professional development is a long, slow process.
 7. Many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most.
 8. Clients serve as a major source of influence and serve as primary teachers.
 9. Personal life influences professional functioning and development throughout the professional life span.
 10. Interpersonal sources of influence propel professional development more than "impersonal" sources of influence.
 11. Professional development is a life-long process.
 12. New members of the field view professional elders and graduate training with strong affective reactions.
 13. Extensive experience with suffering contributes to heightened recognition, acceptance, and appreciation of human variability.
 14. For the practitioner there is a realignment from Self as Hero to Client as Hero.
- (p. 90)

These themes are important because they represent the need for lifelong learning and the necessity of formal coursework for those who intend to supervise fieldwork students (Costa, 2007).

According to Costa (2007), the model that is probably most familiar to occupational therapy practitioners is Loganbill, Hardy, and Delworth's model. Their model describes how supervisees view the world, themselves, and their supervisors. Supervisees move through three stages. The first stage is stagnation, which is a time of fear and inability to proceed. The role of the supervisor is to reassure the student that he/she knows more than he/she thinks he/she does and to encourage the student to begin the learning experience (Cara, 2005). Stage 2 is a time of confusion when the student moves randomly, practicing trial and error. The student may become less trustful of the supervisor as "expert." The role of the supervisor is to facilitate progress through the developmental tasks and to not personalize the student response. Stage 3 is integration. The student is now able to navigate complex situations and better tolerate change. The student has a more realistic view of the supervisor and transitions into a peer relationship. Loganbill, Hardy, and Delworth (1982) also identified eight basic issues that supervisors should address with the student: (a) competence, (b) emotional awareness, (c) purpose and direction, (d) autonomy, (e) respect for individual differences, (f) professional ethics, (g) motivation, and (h) identity. Each of these eight issues should be assessed at each of the three stages previously mentioned. Finally, they also identified interventions to assist the student or supervisee in transitioning through the three stages. The supervisor has a toolkit that includes facilitative, confrontive, prescriptive, conceptual, or catalytic methods. Depending on the needs of the supervisee, the supervisor

can use these tools to assist the supervisee through difficulties in any of the three stages.

Social role models of clinical supervision are developed with the idea that while supervision includes skills similar to teaching, therapy, or counseling, it is a higher order role because it involves the skill sets of all three (Costa, 2007).

The discrimination model of clinical supervision was developed by Bernard in 1979. The model includes the multiple roles the supervisor assumes when supervising a student—that of teacher, consultant, and counselor. This model employs the concept of therapeutic use of self, which requires the supervisor to adjust to the needs of the supervisee similar to how one adjusts to the needs of the client. The supervisor may teach by assigning, questioning, assessing, and demonstrating; consult by identifying alternatives for the supervisee; or counsel as the supervisee needs guidance and direction. The role the supervisor adopts depends on the needs of the supervisee (Bernard & Goodyear, 2004). The goal of this model is for supervisors to be purposeful in their interactions with their supervisees and to be discriminant in selecting which of the three roles should be utilized. In addition, while many theoretical models require the role of supervisor to use logic and reasoning, this model allows supervisors to use creativity in their supervisory approach when it may be useful. This encourages the development of intuition and perceptual skills in addition to the critical reasoning skills encouraged by more traditional approaches (Koltz, 2008).

Hawkins and Shohet (2000) described a model of supervision that is referred to as a double matrix or seven-eyed model. They described the four principles in any treatment session and then overlaid the many contexts in which the principles exist. The principles are

the supervisor, supervisee, patient, and work context. Those four principles then exist under seven modes of focus. Those modes of focus are as follows:

- Mode 1: the content of the occupational therapy session
- Mode 2: the strategies and intervention provided
- Mode 3: the therapy relationship between the supervisee and the client
- Mode 4: the supervisee's internal process
- Mode 5: the supervisory relationship
- Mode 6: the supervisor's own process
- Mode 7: the wider context of the professional community in which the supervisor and supervisee practice (Costa, 2007, p. 40)

There are also six factors that assist the supervisor in selecting the choice of focus. The supervisor must consider the nature of work the student is completing, the style of the student's therapy, the student's personality and learning style, the degree of trust within the supervisory relationship, the insight into self the student possesses, and the student's cultural background (Hawkins & Shohet, 2000).

The Holloway systems model was developed by Elizabeth Holloway in 1995. This model focuses on the tasks, or the "what," of supervision and the process, or the "how," of supervision (Costa, 2007). The supervisor utilizes the tasks of student supervision, which include evaluating, advising, modeling, consulting, and supporting, to facilitate the supervisee's move through the processes of acquiring counseling skills, conceptualization, assuming a professional role, emotional awareness, and self-evaluation (Costa, 2007). This model is similar to Bernard and Goodyear's (2004) discrimination model.

The following models are derived from eclectic areas of literature but are also relevant to the supervisory process. The Schwartz ego model is another theory discussed in relation to occupational therapy fieldwork education. This model is based on Loevinger's developmental theory of the nine stages of ego development. The stages of this theory that

particularly would be relevant to the supervisee are Levels 3, 3 through 4, and 4. Students at Level 3 are in what is called the conscientious stage. They are conformists and reliant on their supervisors. As they progress from a Level 3 to Level 4, they are considered explorers and begin to make some decisions independently. Finally, in Level 4 students are able to independently practice, self-evaluate performance, and are more tolerant of ambiguity in treatment approaches and supervisory styles (Costa, 2007).

The following theories were not identified by Costa (2007) but are located in other clinical education and occupational therapy research.

Attachment theory may also apply to student supervision. According to Bennett (2008), “Attachment theory is broadly accepted as one of the most comprehensive and widely-studied theories today in terms of understanding human development, close relationships, and interpersonal behaviour” (p. 104). The nature of the supervisor–supervisee relationship lends itself well to a practice model rooted in attachment theory. The two variables identified that may influence the supervisory relationship are stage of student development and attachment. The attachment theories of Bowlby and Ainsworth, which hypothesize that infants are born with a biological need for physical closeness to a caregiver, are generalized to the supervisor–supervisee relationship (Bennett & Holtz Deal, 2009). The nature of the supervisor–supervisee relationship may activate an adult attachment system. The supervisee is dependent on the supervisor to develop and grow as a practitioner. Just as the previously described developmental supervision theories move students through developmental stages similar to those of human development, attachment traits may also be analogous to the beginning and ending of the supervisor–supervisee relationship (Bennett & Holtz Deal, 2009). In this model,

It is the supervisor's responsibility to provide a "secure base" for the student's learning, and in such an environment, the student becomes free to explore the professional world. Likewise, in a secure environment, the student is comfortable to return to the safe haven of supervision for repair of the inevitable ruptures that occur during the field experience. (Bennett & Vitale Saks, 2006, p. 671)

Maslow's hierarchy of needs is another theory often used in the occupational therapy field. As his theory indicates, all people have needs, which would mean that all supervisees and supervisors have needs as well. A supervisor would need to address the most basic physiological and safety needs of the student first. The supervisee would need to be physiologically comfortable and feel safe in the environment. The next level of need is love and belonging. This would address the relational aspect of the field experience. The supervisor must help the student feel accepted. The final two levels of need may be achieved as the supervisee gains skills and builds self-esteem regarding his or her role as practitioner. This model also suggests the human desire for mastery of the environment. The supervisor and supervisee are both attempting to master their disparate roles of teacher and apprentice (Early, 2009).

A model of practice frequently used to ground occupational therapy in theory is the model of human occupation developed by Gary Kielhofner (2008). Applied to the occupation of supervisor, the model would take into account the volition, habituation, and performance of the role, all of which exist in a specific context or environment. The supervisor would first address his or her own volition (motivation) for assuming the supervisory role, as well as facilitate the supervisee's understanding of his or her own volition in pursuing field experience. The next step is to self-examine patterns, roles, habits, and behaviors that the supervisor or supervisee uses often, unconsciously, to complete his or her daily occupations. Then the ability to perform the physical, cognitive, and emotional tasks of the field experience

is assessed. If a student experiences difficulty, a supervisor would examine all of these areas within the context of the treatment setting to determine whether it is a motivational issue, an issue of habituation, or a deficit in cognitive, physical, or emotional capability. Likewise, when examining opportunities for development, the supervisor looks to all three areas in context to facilitate growth of the supervisee (Kielhofner, 2008).

Teaching and Learning

Clinical education is an essential bridge from the theoretical and classroom instruction to independent practice. According to Delany and Bragge (2009), it is essential to learning in the health professions as it facilitates socialization in the practice community, develops professional identity and commitment to lifelong learning, promotes adaptability, and provides skills in collaboration with other professionals. The clinical educator must strike a balance between supervision and maintenance of the process and facilitation and promotion of the student's learning (Davys & Beddoe, 2000).

The majority of clinical educators enter clinical fieldwork supervision without any formal training. They bring their life experiences as students and the experience of having a fieldwork supervisor during their educational experience but do not typically have the theoretical background in teaching and learning necessary to educate a student. Many are selected due to the fact that they are expert clinicians. This, however, does not always translate into a skilled teacher. "Teaching is not a natural byproduct of clinical expertise, but requires a skill set of its own" (Cangelosi, Crocker, & Sorrell, 2009, p. 369). It is the responsibility of the academic institution to prepare the fieldwork supervisor. According to Higgs and McAllister (2007a),

Clinical educators lack an explicit theoretical and philosophical framework for their educational activities, myths about clinical education are pervasive, integration of academic and clinical curriculum suffers, and there is a mismatch between the theory and the practice of clinical education. (p. 156)

It is the responsibility of the supervisors to require of themselves the same commitment to learning that they expect from the students whom they agree to supervise. Lichtman et al. (2003) noted,

As we strive to stay ahead of their learning about how to provide quality health services to [patients], we must also pay attention to our need to learn how to be a good or better teacher. Techniques for sharing knowledge, coaching, and supporting others in their learning and allowing the time needed for learning are all vital elements of good teaching. (p. 458)

Clinical education in occupational therapy is primarily a form of experiential learning. Learning occurs through real day-to-day experiences rather than formal classroom education. Clinical educators are required to facilitate students' learning from classroom theory and knowledge to application and critical thinking in clinical practice (Costa, 2007).

Adult students may learn differently than their supervisor. Therefore, it is important for the supervisor to understand learning styles. A clinical student's learning style will be based on many things, including personality type, formal educational training, developmental and chronological age, and intellectual and cognitive abilities. It is important for clinical educators to understand the learning styles in order to design learning activities that speak to the individual style of the student. The clinical educator must be able to grade or scaffold the learning so the student can move from beginning student to the level of independent practitioner by the end of the fieldwork experience (Costa, 2007). Costa (2008) referred to this as the "just-right" clinical challenge. A supervisor implements this through the pace at which information is delivered, the environment or context of the institution, the number of

clients assigned, and the level of complexity of the patient care needs. Patient treatment sessions are in essence learning sessions. Due to the complexity and multidimensionality of individualized treatment sessions, it is the role of the supervisor to plan the learning session prior to the treatment session. It is beneficial to include the student in the planning of the treatment/learning session in order to promote critical thinking and self-directedness. In addition, following the treatment session, the supervisor should debrief the session with the student and allow the student to reflect on the learning (Laitinen-Vaananen, Talvitie, & Luukka, 2007).

Effective Supervision

According to Costa (2007), “Learning to become a clinical supervisor is both an art and a science” (p. 166). Given the complexity of the role of clinical fieldwork supervisor, the outcomes of the experience for the clinician, student, and academic institution are understandably varied (Atkinson & Woods, 2007). Many fieldwork supervisors report feeling underprepared and unqualified to be effective in student supervision (Mackenzie, Zakrewski, Walker, & McCluskey, 2001).

The first step in creating an effective fieldwork experience with a successful clinical supervisor is to determine readiness. Regulatory requirements set minimum experience requirements for new clinical supervisors, but this does not necessarily indicate preparedness for the role. The academic institution should be supportive in the development of these dimensions as well as assist with the clinician’s assessment of his or her ability to be successful in the role of educator (Costa, 2004). Following the determination that the clinical practitioner is ready for the role of clinical educator, the clinician, with the assistance of the academic institution, must continually assess his or her effectiveness in the role of educator.

One method to assess effectiveness is to use a formal assessment instrument. One such instrument is the Fieldwork Experience Assessment Tool (FEAT). It was developed in a project funded by the American Occupational Therapy Foundation (AOTF) and the AOTA Education Special Interest Section in 1998 and revised in 2001 (Atler et al., 2001). The FEAT assesses what it terms the “dynamic triad of interaction” (Atler et al., 2001, p. 1). The three key components to fieldwork are the environment, the fieldwork educator, and the student. This instrument is designed to be used while the student is in the fieldwork setting. It should be completed by both the educator and the student. This assessment tool includes a discussion section with questions designed to facilitate communication and problem solving between the educator and student (Atler et al., 2001).

A second formal assessment instrument for the clinical educator to self-assess is the Self-Assessment Tool for Fieldwork Educator Competency. This tool was designed by a task force within AOTA (2009a). This assessment tool was used in the data gathering for this research. It is described in more detail in Chapters 3 and 4 and is included in its entirety in Appendix B.

A third measure of formal assessment is the Student Evaluation of Fieldwork Experience (SEFWE). This assessment is completed by the student following each Level II fieldwork placement. This instrument was also used in the data gathering for this research. It is also described more thoroughly in Chapters 3 and 4. It is included in its entirety in Appendix C.

Beyond formal assessments, Costa (2007) also recommended informal methods. It is important to examine whether students are meeting the performance standards and expectations of the clinical site as well as the academic institution. In addition, Costa

recommended peer review. She cited three ways to peer review as a clinical educator. First, a clinical educator could agree to jointly supervise a student with a more experienced clinical educator. With this method, it is important to establish roles and responsibilities for each supervisor prior to the beginning of the student placement. Videotaping of supervisor–student interactions is a second way to receive feedback from peers. The student must be made aware of and agree to the videotaping. This will allow the supervisor to see what others see when he or she is supervising as well as gain feedback and direction from a more experienced peer. Finally, peer review can be accomplished by forming a supervision group of clinical educator colleagues to give each other feedback and brainstorm issues and concerns.

The literature is consistent in describing what makes an effective clinical educator. In a study completed by Christie, Joyce, and Moeller (1985), 90% of students and 85% of supervisors cited interpersonal and communication skills as the most important quality of fieldwork supervisors. This included skills like active listening; open and honest communication; flexibility; the ability to adapt to the needs of the student; and providing feedback that is timely, constructive, consistent, and promotes growth. Other characteristics listed by both groups included having time to spend with the student, competency as a clinician and educator, and role modeling professional behavior. In addition, the supervisors named organizational skills and the ability to teach as important characteristics of a good supervisor.

Knight (2001) also found that effective clinical supervision requires the supervisor to facilitate and manage a positive supervisor–student relationship. In addition, she found that the supervisor must be able to assist the student in integrating classroom theory with practice.

Severinsson and Sand (2010) stated that the most important factor in the professional development of the student is to have a supervisor who facilitates a supporting yet challenging relationship. This includes finding time for the student, exemplifying excellent communication skills, and teaching practical skills. The authors explained, “Growth potential is infinite if students have a skilled supervisor who is motivated, active and authentic” (Severinsson & Sand, 2010, p. 674).

Bennett (2003), a physiotherapist and researcher of physical therapy clinical education supervisors, identified five categories encompassing the abilities/qualities of effective clinical instructors. The participants in Bennett’s study were experienced clinical educators who self-identified the top three abilities/qualities required to be an effective clinical educator. The following categories resulted:

1. “Teaching and learning: Approach.” The three abilities/qualities most frequently identified were approachability, enthusiasm, and desire to facilitate learning. Others included being inspirational, motivational, patient, and having a sense of humor.
2. “Management/organisation of placement.” The abilities/qualities identified for this category can be summarized as the ability to manage time, the workplace, and the process.
3. “Continuing professional development in teaching and learning.” The ability/quality reported under this category with significant frequency was being a good communicator. Others included the ability to communicate with peers and a strong knowledge base in practice areas.
4. “Facilitation of learning.” The ability/quality most frequently identified was sharing knowledge with the learner. Others included asking questions to enhance learning and creating a learning environment.

5. “Teaching and learning: Process.” The three most frequently identified abilities/qualities under teaching and learning were to give honest and constructive feedback, set learning objectives, and skill in providing learning opportunities (Bennett, 2003, p. 434).

Hummel (1997) described supervisor efficacy from the perspective of the student. Her study found that students’ perceptions of a fieldwork supervisor’s efficacy were primarily based on the interpersonal skills of the supervisor. A supervisor who allowed questions and demonstrated empathy toward student anxiety was considered to be most effective. In addition, the students preferred supervisors who were collaborators and facilitators of clinical experiences. Skill at varying teaching based on a student’s learning style was also cited as evidence of supervisor efficacy. One additional finding of this study was that students perceived that the environmental constraints of being a practicing clinician and an educator took the supervisor’s time away from the student.

Given the complexity of the role and the level of skill required to be effective, Hummel (1997) suggested fieldwork supervisor training that is a collaborative effort between the academic institution’s faculty, the clinician, and the administration of the practice setting.

Higgs and McAllister (2007b) conducted a study from the perspective of speech pathology clinical educators. The following six themes emerged in their research. They used the metaphor of Russian dolls to describe the first four, with the final two as “overarching and transcendent of the previous four” (Higgs & McAllister, 2007b, p. 194).

The themes they identified are as follows:

1. Sense of self, of self-identity . . .
2. Sense of relationship with others . . .
3. Sense of being a clinical educator . . .
4. Sense of agency . . .

5. Seeking dynamic self-congruence [the ability to balance and coordinate the first four] . . .
6. Experience of growth and change. (Higgs & McAllister, 2007b, pp. 194-197)

Summary

Historically, occupational therapy clinical education has been modeled after clinical education provided for other professions. The fieldwork process is highly regulated by the profession and managed by the academic institution. Academic institutions have developed models and theories surrounding clinician readiness, clinician process, and clinician effectiveness. However, the clinician's perspective has been noticeably absent in the occupational therapy research regarding the role of clinical educator. The goal of this study was to determine how the clinician identifies as an educator.

CHAPTER 3

METHODOLOGY

The literature review in the previous chapter described the many aspects of clinical fieldwork education or supervision. This chapter outlines the research methodology that was used to discover the constructed meaning that the clinical fieldwork educators make of their role.

This study explored how six occupational therapy practitioners from mid- to large-size hospitals in the Midwest make meaning of their role as educators in a community college context. This chapter begins with a discussion of the qualitative approach to research. The remainder of the chapter includes the philosophical assumptions, methodology, and methods used in the research design. Finally, it describes the measures used to ensure valid and ethical research.

Methodological Approach

According to Merriam (2002), “The key to understanding qualitative research lies with the idea that meaning is socially constructed by individuals in interaction with their world” (p. 3). Denzin and Lincoln (2000) claimed that qualitative research involves an interpretive and naturalistic approach: “This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them” (p. 3).

There were three reasons I chose the qualitative approach for this study. First, as evidenced by the literature review, there are multiple regulatory standards that state what a clinical fieldwork educator is required to be and do. These could be measured and assessed in a quantitative study. However, they do not address the social experience of being an

educator and living the role. I wanted to discover the meaning the clinical fieldwork educators make regarding their role as an educator of community college students. Shank (2002) defined qualitative research as “a form of systematic empirical inquiry into meaning” (p. 5). Inquiry into meaning suggests researchers try to understand how others make sense of their experience (Shank, 2002). I wanted to know how clinical fieldwork educators came to the role, why they continue, and what the role means to them.

Second, I wanted to explore the clinical fieldwork educator role from the perspectives of the clinical fieldwork educators themselves. As Merriam (2002) stated, I wished to learn “how individuals experience and interact with their social world, the meaning it has for them” (p. 4).

Finally, I desired to explore deeper the fieldwork educator experience. I wanted to explore the words that describe the role in context. As stated by Merriam (2002), the product of qualitative research should be “richly descriptive.” According to Shank (2002), this type of inquiry is grounded in the world of experience.

Philosophical Assumptions

Crotty (1998) described epistemology as “concerned with providing a philosophical ground for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate” (p. 8). Crotty also stated that in the constructionist view, meaning is “constructed by human beings as they engage with the world they are interpreting” (p. 43). My goal was to construct meaning surrounding the lived experiences of occupational therapy practitioners in the role of educator of the community college student based upon the perceptions of the interviewees and observation of the environment.

Therefore, my epistemology was constructionist.

Epistemology is also that which informs the theoretical perspective (Crotty, 1998). The theoretical perspective is the philosophical position that informs the methodology (Jones, 2002). My theoretical perspective was interpretivist. And, since I attempted to understand and construct meaning situated historically and culturally, my theoretical perspective was specifically one of basic interpretivism (Crotty, 1998).

Research Approach

According to Merriam (2002), “A phenomenological study seeks to understand the *essence or structure* of phenomenon” (p. 93). The phenomenon in this study was the experience of the occupational therapy clinician in the role of educator of community college students. The goal of this study was to explore the meaning that occupational therapy practitioners make of the experience of educating community college students. Therefore, a phenomenological approach to this research was utilized. Creswell (2007) stated,

The type of problem best suited for this form of research is one in which it is important to understand several individuals’ common or shared experiences of a phenomenon. It would be important to understand these common experiences in order to develop practices or policies, or to develop a deeper understanding about the features of this phenomenon. (p. 60)

As the profession of occupational therapy and the community college occupational therapy assistant (OTA) programs attempt to create the ideal educational experience for students, it is important to study the meaning that the practitioners make of the education experience. This will help academic educators develop better partnerships and support systems for the clinical educators and better experiences for the students. The phenomenon of practitioner as educator can only be studied from the perspective of those who have lived it (Merriam, 2002).

A phenomenological study also contributed to a deeper understanding of the experiences of the practitioner/educator. The concept of intentionality is an indication of the relationship between human beings and their world. The subjective consciousness and the objective object give meaning to each other (Crotty, 1998). Crotty further stated, “Consciousness is always consciousness of something. An object is always an object for someone. The object, in other words, cannot be adequately described apart from the subject, nor can the subject be adequately described apart from the object” (p. 79). There are regulatory and academic descriptions of the role of the fieldwork educator that include requisite learning objectives, behavior expectations, and outcome assessments. However, the “object” of fieldwork does not occur without the interaction with the “subject,” the practitioner/educator. This is what Pollio, Henley, and Thompson, (1997) called “the situatedness of human experience” (p. 15). They stated that the human experience “requires us to emphasize not only that there is a situation but the situation is significant only in the unique way it is experienced by the person” (Pollio et al., 1997, p. 15).

It is important when conducting a phenomenological study for the investigator to forego preconceived and encultured ideas regarding the experience. This is called bracketing or epoche. There were two broad areas that were bracketed prior to conducting the study. First, it was important not to subject the findings to objective science or authoritative sources, and second, not to impose the criteria of validity to the meaning of the experiences. Fieldwork education has been subject to quantitative data and outcome studies for decades. It is important that the experiences of the practitioners/educators are not subjected to preconceived measures for successful or effective student experiences (Merriam, 2002).

Methods

Participant Selection

The participants for this study were selected from a pool of clinical educators who have volunteered to supervise students from a Midwest community college. Initially, I used typical case sampling to provide a list of persons with the shared experience of being a practitioner/educator (Merriam, 2002). This was achieved by locating a database of clinical educators for a Midwest community college. According to regulatory requirements, all of these clinical educators had at least one year of clinical experience and volunteered to educate a fieldwork student at least one time in the past 10 years. I used purposeful sampling to narrow down that list in order to find information-rich cases (Merriam, 2002). The practitioners/educators selected for this study had volunteered for at least two different fieldwork rotations, and two of these occurred within the past 3 years. These criteria were used to ensure that the clinical educators had recent experience with a community college student and had more than one experience from which to draw conclusions. In addition, given the number of community college and graduate-level students seeking fieldwork experiences, it was necessary and beneficial to explore why the clinical educators had chosen to work with the community college students.

Eight practitioners were selected based on the preceding criteria. All eight initially agreed to participate. However, when contacted to begin interviews, one declined the first interview and one opted out of the study due to a conflicting time commitment. The remaining six practitioners/educators ranged in age from 26 to 50 years old. The six participants comprised four occupational therapists (OTs) and two OTAs. After conducting the first interviews, I learned that two of the OTs had initially been trained as OTAs. The

participants all completed occupational therapy or OTA programs at institutions in the Midwest. Participants were selected for diversity of years of clinical experience and level of occupational therapy education. Five of the participants were White females. One participant was a White male. I attempted to include two more males and one person of color from the database, but all declined to be interviewed. The lack of diversity regarding persons of color and male participants is reflective of the population from which the database was drawn.

Data Collection

Interviews. I gathered data from the participants over a 3-month period from December 2011 through February 2012. As my methodology was phenomenological, my main form of data collection was participant interviews with document analysis. Since I used developmental theory as a conceptual framework, I used a modified version of Seidman's (2006) technique of a series of three interviews. I did not conduct three separate interviews but rather two interviews. However, Seidman's three-interview sequence seems to reflect developmental theory, so I imitated the construction and sequence of the interview form but not the three-interview process. Rather than conducting a third interview, I chose to have the participants complete a self-assessment and written reflection between the first and second interviews.

I initially contacted the participants by phone and e-mail to request a face-to-face meeting. The first interview was conducted in person and was the longer of the two interviews. First, I gathered background and contextual information from the participants to gain a foundation for their role identification. The second part of the face-to-face interview focused on the responsibilities and actions of being a fieldwork educator. This included their

motivation to supervise students, their process for working with students, and the implications it had for them professionally and personally. The final part of the face-to-face interview was a summation of the questions and an attempt for the participants to make meaning regarding the process of clinical education (Seidman, 2006). After this first interview, participants completed a written self-assessment (Appendix B) and reflective writing assignment (described in Chapter 4) related to their philosophy of teaching and perception of their role in the community college OTA students' education. I used this assessment as a self-reflective tool for the interviewees after our first interview and to inform the final interview.

The second interview was conducted over the telephone. It was a summative open-ended question-and-answer session regarding the first interview findings and reflections upon the self-assessment and reflective writing assignment completed by the participants. The participants were also asked one final time to apply meaning to the role of clinical educator of community college OTA students.

The interviews were semistructured or in-depth interviews. According to Esterberg (2002), semistructured interviews allow a more open and explorative format for the research topic. In this format, I had a general interview guide with open-ended questions. However, the participant responses guided the direction of the interviews. I conducted a set of trial interviews using the interview guide with three academic clinical fieldwork coordinators to determine if the structure, content, and language of the questions were clear and nondirective. While conducting the interviews, I used audio recording and took field notes. These notes were later transcribed for analysis. (See Appendix A for the interview guide.)

Written documents. At the end of the first interview, I asked each participant to complete the American Occupational Therapy Association's (AOTA's) Self-Assessment Tool for Fieldwork Educator Competency (see Appendix B). This self-assessment tool supports the development of skills necessary to be an effective clinical fieldwork educator. This tool was designed by AOTA to provide a structure for fieldwork educators to assess their own level of competence and to identify areas for further development and improvement of their skills. The tool asked the clinical educators to self-assess in the areas of clinical practice, facility development, and educational skills. The participants ranked themselves on a Likert scale from 1 to 5. A score of 1 indicated the participant felt least proficient at a skill and 5 indicated most proficient. Each item on the self-assessment also required comment on the topic. I used the participants' self-scored competencies and the open-ended comments section to assist in developing insight into the clinicians' post-interview perspective as to their role as educator. Each participant also completed a series of philosophy statements regarding clinical education in a free-writing assignment also given to them at the end of the first interview.

In addition to the self-assessment and self-reflection documents the clinical educators completed, I also analyzed the Student Evaluation of Fieldwork Experience (SEFWE) forms completed by students on their fieldwork experiences at the participating clinical educators' sites (see Appendix C).

Data Analysis

Data analysis in qualitative research is a creative rather than mechanical process. The job of the researcher is to create meaning from the data (Esterberg, 2002). Prior to analyzing the data, it was essential to bracket my personal experiences and previous scientific

knowledge from the analysis of the experience. This is called epoche. Next, all of the writings and transcripts were read in a process called “open reading.” This is referred to as reading for the sense of the whole (Wertz, McMullen, Josselson, Anderson, & McSpadden, 2011). The first step in analyzing the data was to analyze all of the data for significant statements (Merriam, 2002). All of the statements were treated with equal value.

Phenomenological researchers refer to this as horizontalization (Creswell, 2007). In addition, while analyzing the data, I continually returned to the essence of the experience. This is called phenomenological reduction. Finally, after examining the data from different frames of reference, I constructed a synthesis describing the phenomenon (Merriam, 2002).

My process for analyzing the data is summarized in the following six steps taken from Creswell (2007) and modified for my study:

1. Describe personal experiences with the phenomenon. This I completed under the reflexivity statement. I have experienced fieldwork as a student, a clinician, and an academic coordinator. I had to bracket that experience and approach my research from the perspective of my participants. It was important for me to construct new meaning based on their perspectives.
2. Horizontalization: Develop a list of significant statements or open coding. After reading the document for a sense of a holistic viewpoint, I used open coding for both the transcriptions of the interviews and the documents. According to Esterberg (2002), open coding requires working through the data line by line to identify themes or areas of interest.
3. Group statements into themes.

4. Use verbatim examples to describe the “what” of the experience of the fieldwork educator. I used direct quotations from the interviews and the clinicians’ words to demonstrate thematic interpretation. I also used student comments from the student evaluation forms to support the emerging themes.
5. Use the themes and verbatim statements to do focused coding. Once the themes started to emerge, I returned to the transcripts and documents and completed content analysis for the emergent themes (Esterberg, 2002).
6. Complete a synthesis describing the phenomenon. Finally, I analyzed the themes to construct meaning of the lived experience of clinician as educator.

Goodness and Trustworthiness

As qualitative researchers evaluate their work for goodness and trustworthiness, there is an open relationship with the participants. Interpretations are fluid and temporal. They can be reinterpreted by researcher and participant based on context. Rather than objectivity in establishing facts, there is a dependability and conformability in establishing the research process (Creswell, 2007). Merriam (2002) described it as

- (1) craftsmanship in which the researcher adopts a critical outlook during data analysis, (2) communication where validity is determined in dialogue with others, and (3) pragmatic validity, which goes beyond an argument’s persuasiveness to assess validity in terms of real-world changes brought about as a result of the research. (p. 24)

Creswell (2007) listed five questions he would ask to assess a phenomenological study in particular:

1. Does the author convey an understanding of the philosophical tenets of phenomenology?
2. Does the author have a clear “phenomenon” to study that is articulated in a concise way?

3. Does the author use procedures of data analysis in phenomenology, such as the procedure recommended by Moustakas (1994)?
4. Does the author convey the overall essence of the experience of the participants? Does this essence include a description of the experience and the context in which it occurred?
5. Is the author reflexive throughout the study? (pp. 215-216)

Merriam (2002) listed several criteria for determining goodness and trustworthiness in qualitative research. “Goodness” in research usually means that the study was conducted in a rigorous, systematic, and ethical way so that the results can be “trustworthy.” Possible methods include triangulation, member checks, peer review, positionality, and reflexivity. The researcher can also saturate data, vary the participant sample, complete an audit trail, and use thick, rich description when contextualizing the study. In relaying the themes, I attempted to use thick, rich description to construct meaning from the participants’ words.

The following strategies were utilized to promote goodness and trustworthiness in my study. The first is reflexivity and positionality. Merriam (2002) stated that the researcher must critically self-reflect and ask two questions: First, what have I brought with me to this process in terms of background, values, experiences, and so forth? And second, how have I responded to what I am learning? These two questions were examined throughout the research process. I introduced my research with my personal experiences. I have also included my reflexivity and positional statements.

Triangulation involves using different sources, methods, investigators, or theories to corroborate evidence (Creswell, 2007). For this study, I interviewed multiple sources with maximum variability. I used participants’ written self-assessments and reflections in document analysis. In addition, I analyzed the student perspective by reviewing student fieldwork assessments of each participant’s facility.

I conducted member checks with each participant. This process involved bringing data, analyses, interpretations, and conclusions back to the participants. They were then asked to determine accuracy and credibility (Creswell, 2007). Each participant was provided the transcript of the interview, my insights into meaning and themes, and the opportunity for clarification of statements or disagreement with thematic interpretation.

Maximum variation is the process of purposefully identifying a sample of participants in order to allow a greater range for application of findings (Merriam, 2002). I purposefully selected participants of varying age, level of academic preparation, number of years in practice, and size and location of their respective medical facilities.

This study was conducted using human participants. The necessary documentation was in place with the Institutional Review Board prior to beginning the final participant selection and data collection (see Appendix D).

Finally, I have kept and continue to keep an audit trail of my research process. This is a detailed account of the decisions I made throughout the process, including methods, procedures, and decision points (Merriam, 2002).

Reflexivity Statement and Role of the Researcher

According to Creswell (2007), “How we write is a reflection of our own interpretation based on the culture, social, gender, class, and personal politics that we bring to research” (p. 179). Qualitative researchers must be forthcoming and acknowledge subtexts and positionality in their writing. Writing is co-constructed and an interactive process between the researcher and the researched (Creswell, 2007). Denzin and Lincoln (2000) stated that the researcher’s history, logistics, personal biases, and interests should be disclosed in order to situate the work.

I was born and raised in a small town in the Midwest. I now live in a small city also in the Midwest where I am employed at a community college. I attended an occupational therapy program in the state in which I currently live. Upon graduation, I worked as a clinician for 3 years before becoming a program director for an OTA program. I have been a program director for 14 years. Part of my job description requires that I either manage or supervise the academic fieldwork program. I have experienced fieldwork as a student learning from a clinical educator, as a clinical educator, and as an academic educator. I have had negative and positive experiences with clinical educators in all of these areas. In addition, I am invested in this research as I want to understand the needs of the practitioners/educators in order to support them and provide the best learning experience for the students. It was important as I conducted this study to bracket that information and those preconceived notions in order to gain depth of understanding of the participants' lived experiences as clinical educators.

In addition, due to my experiences in the field of occupational therapy and, in particular, my role as an academic educator, my study participants had experience working with me in that capacity. I presented myself as a graduate student and researcher and took measures to bracket those work experiences in order to gain an understanding of the experiences of the practitioners/educators.

Delimitations

This study was delimited to six fieldwork clinical supervisors of OTA students attending a community college in the Midwest. The participants were chosen from a pool of fieldwork supervisors who had completed at least one year of OTA student supervision and

indicated via self-evaluation that they would continue to pursue the role of clinical supervisor as educator.

Limitations

The possible limitations to the study are as follows. I was known to the participants due to my experiences in the profession and role as an academic educator. The role of clinical educator is voluntary, as was the decision to participate in the study. The study was completed using a participant pool from one institution, and all of the participants lived in the Midwest. Therefore, participant selection could not be restricted to type of practice setting.

Summary

The goal of this study was to make meaning of the lived experience of clinical education from the perspective of the clinical educator. Through my methodological approaches described in this chapter, I hope to inform and shape the future of fieldwork for OTA community college students and the practitioners who educate them. The voice of the practitioner has not been heard in the fieldwork discussions that take place in academic circles. This has led to a disconnect between what the academic programs wish for the fieldwork experience to be and what it often is when the student arrives. Giving voice to the clinical educator will shape a new fieldwork experience that includes all persons involved in the process. This chapter also included the limitations and delimitations of my study and how I maintained goodness and trustworthiness.

CHAPTER 4

RESULTS AND ANALYSIS

Background

Six occupational therapy practitioners participated in this study. All of the participants actively engaged in accepting clinical students from multiple community colleges and universities. Each indicated the desire to continue in student supervision. Four occupational therapists (OTs) and two occupational therapy assistants (OTAs) were interviewed and completed self-assessment and self-reflection documents. All of the participants were given pseudonyms to protect their identities. In addition, names of clinical sites and academic institutions have been omitted.

Two of the OTs (Sharon and John) were initially prepared in Master of Occupational Therapy programs. Both had been in practice as clinicians for 20 years. Both had been supervising students for 19 years. Both were employed in midsize rehabilitation hospitals in the Midwest. Both had the additional supervisory duties within their respective departments.

Two of the OTs (Linda and Laura) had been previously educated as OTAs and, after practicing at the assistant level, chose to go back to school to earn a degree in occupational therapy. Each of them completed bachelor's-degree programs in occupational therapy. Laura had 35 years of experience in practice. She worked at a midsize acute-care center in the Midwest. She also had additional supervisory duties within her department. Linda had 25 years of experience and at the time of this study worked for contract companies in the long-term-care setting. She also lived and worked in the Midwest. Neither, Linda nor Laura could remember the exact year they started supervising students, but both stated they had been supervising students for more than 20 years.

The final two participants (Karen and Cathy) were educated in community colleges to be OTAs. They each completed an Associate of Applied Science degree. Karen had been in practice for 11 years and had been taking students for 10 years. She worked in a large research hospital in the Midwest. Cathy had been in practice for 6 years and had been taking students for over 4 years. At the time of this study, she worked in a small rural hospital.

Four of the interviews (Karen, John, Laura, and Cathy) were conducted at the place of employment of the interviewees. Two of the interviews (Linda and Sharon) were conducted in the individuals' homes.

The interviews were conducted developmentally as the participants described their journey to the role of clinical educator of community college students. Therefore, the themes were drawn from participant comments related to every stage of that journey.

Phenomenological Analysis

Phenomenology is a descriptive, qualitative study of human experience. The goal is to conceptualize the processes and structures of an experience, that is, to examine a meaningfully lived experience through the expressions of those who have lived it (Wertz et al., 2011). The participants in this study were asked to express their lived experience of being a clinical educator of community college students.

When using a phenomenological methodology, it is necessary to focus on the lived experiences of a specific population. Therefore, it was necessary for me to implement two procedures essential to carrying out this type of research. The practice of epoche or abstention from prior knowledge about the subject as well as abstention from the natural attitude was required (Wertz et al., 2011). While there is a large body of literature related to occupational therapy fieldwork education and supervision in general, there is a paucity of

literature in the area of fieldwork education from the clinician's perspective, so it was not difficult to abstain from acquiring that knowledge. However, I have personal experience with fieldwork supervision, so it was necessary for me to bracket that experience prior to conducting the interviews and while completing my analysis. While conducting this research, I had to continually go back to the experiences themselves and abstain from adding to or detracting from the experiences as expressed by the participants through the interviews and the written documents. Wertz et al. (2011) stated,

The phenomenological attitude is reflective. It selectively turns from the existence of objects to the processes and meanings through which they are subjectively given. Although this attitudinal focus is called a "reduction," the field of investigation is not narrowed but rather is opened up and expanded to encompass all the complexities and intricacies of psychological life that come into view. (p. 127)

The phenomenological method uses intentional and eidetic analysis. According to Wertz et al. (2011), intentional analysis is "how experiential processes proceed and what is experienced through them" (p. 128). The clinical educators in this study were asked to describe how they became clinical educators and how they conducted clinical education. In addition, they were asked to reflect on and describe clinical education as an experience. Each participant's experience was examined as a whole to determine how that clinical educator made meaning of the experience. Then, through the process of eidetic analysis, the participants' descriptions were compared and examined for themes that were present in all of their described experiences. According to Wertz et al., "Eidetic analysis does not diminish or simplify its subject matter but opens up and highlights its vast richness and complexity" (p. 129). The resulting themes from my phenomenological analysis are described in this chapter.

Themes and Analysis

Interview Analysis

The digitally audio-recorded interviews were initially replayed with key words or phrases identified. The recordings were then transcribed by a professional transcription service. The transcription of each participant interview was then studied for meaning as a whole. Next, line-by-line analysis of the transcripts produced meaning units for each interview. The meaning units from each interview were then grouped together. A list of possible themes was generated with similar meaning units from each interview. The meaning units were initially obtained for each area of clinical educator development, from student to practitioner to clinical educator. However, as the themes began to materialize, it became evident that meaning units from each of the developmental stages reemerged in all areas of the developmental process. Therefore, the themes were identified across the developmental process. Consequently, participant quotes supporting each theme may have been identified from practitioner experiences as students or clinical fieldwork educators. Finally, four key themes emerged: Theme I: Clinical educators are relationship centered and student focused, Theme II: Clinical educators are devoted to teaching and learning, Theme III: Clinical educators have a high degree of self-efficacy, and Theme IV: Clinical educators are strong advocates for the profession.

Theme I: Clinical educators are relationship centered and student focused. This theme emerged from the interviews due to the participants' expressed desire to learn and work in settings that were relational in nature; the continued expression of concerns for the needs of the students to be included, supported, and respected; and the desire to repeat positive learning experiences and avoid repeating negative learning experiences. In addition,

all interviewees expressed the satisfaction they felt as a supervisor when they realized the student had grown. Unsworth, Turner, Williams, and Piccin-Houle (2010) described the relational context of the supervisory relationship as an interpersonal climate with ongoing interactions. They also characterized it as a communal relationship requiring both affective- and cognitive-based trust. A research study conducted on the topic of quality fieldwork asked students to describe the most important aspect of the clinical supervision experience. The most common response was that it needed to be an open, honest relationship. The students preferred supervisors who were friendly, approachable, and valued the student (Rodger, Fitzgerald, Davila, Millar, & Allison, 2011). Vestal and Seidner (1992) also found that clinical supervisors indicated a strong desire for open communication, positive interactions, and mutual respect.

The desire to learn and work in relational settings. When discussing their formative years, the interview participants made several references to the desire for relationships and community. Linda stated the following:

I grew up in a small town in [the Midwest]. Was very involved with sports, 4-H, everything in the community, church . . . so high community involvement. . . . [My high school experiences were] very positive. Very supportive teachers, principals . . . everyone knew you by name . . . you knew the entire high school.

When asked to describe her childhood as part of a small community, Karen replied, “It is in your upbringing. You help your neighbors in times of need . . . so there is this kind of caring . . . compassionate . . . community I grew up with in small-town life, in farm life.”

Linda was raised in a family of six children and also lived on a farm near a farming community. She stated,

I would say I loved high school; my brothers and sisters did too. It gave us a good chance for socialization. It gave us a chance to get off the isolation of the farm and meet and play with other kids.

When asked to describe how they selected occupational therapy as a career as well as how they chose their school, the participants also indicated a desire for relationships. Sharon made the following statement regarding her discovery of her desire for relationships in her chosen vocation:

With my biology major, I was taking things like chemistry and then looking at the prospect of organic chemistry, and like, I know I want to work with people and now what? . . . This seems pretty far removed from people. So, that's where I really started looking at other types of classes and other directions I could go that would fulfill that.

When pressed as to why she specifically chose occupational therapy, Sharon stated, "The combination of the science aspect of it, but also the psychosocial interactions with people. And the hands-on part of it, feeling like it could really make a difference. That kind of thing." She went on to describe the reason for her choice of academic occupational therapy program by stating,

I knew I wanted to stay generally in the Midwest to be somewhat close to family. I chose [a Midwestern university] because at that time it was just a little bit smaller program, and we were in even smaller buildings. So again, you kind of got that real family atmosphere feel to the program.

Laura also noted that her choice of occupational therapy was related to the fact that she would be able to work with all types of people. When asked why she chose this field, she stated that while researching different professions, the description of the field of occupational therapy stood out to her. She was drawn to the interaction with people from all age groups. She stated,

I always was involved with crafts, and it said that you would be involved with all types of people. I have always taken care of the elderly, all through high school. I

mowed lawns and babysat. I was always involved with people . . . always taking care of them. So, when I saw in that book that they do crafts, but they can do them with all age groups, that is what really intrigued me.

Participant experience with being the fieldwork student. When questioned about their own education and fieldwork experiences, the participants conveyed a desire to emulate positive fieldwork experiences and avoid repeating their own negative experiences with their former fieldwork supervisors when supervising their current fieldwork students. A study by Dowie (2008) reflected this same theme as interview participants who provided fieldwork education desired to provide supportive learning environments for their current students due to negative and unsupportive learning experiences they had as students.

The participants mostly defined positive educational and fieldwork experiences by describing positive characteristics directly related to their instructor or supervisor. Supervisors who were motivating yet supportive seemed to have provided the more positive fieldwork experiences for the interview participants. Linda described one supervisor as follows: “She challenged you, but then not in a demeaning way. She challenged you, but then made you proud of seeking out the answer. She really built self-esteem by making you do the work to get there.” Laura described a teacher who influenced how she interacts with students and staff now. She stated,

What I loved about him is he taught me to reach out and be positive reinforcement. I try to be really positive and give them words of encouragement and ask them to do projects that make them feel special. That, “You know, I chose you because I know you could do a good job at this. Would you help me do this?”

While they appreciated the challenge and motivation, the participants responded strongly to clinical supervisors who were inclusive, open, and supportive. Linda described a

positive fieldwork experience where the supervisors were excited about their profession but also open to working with students. She stated,

The first [rotation] the clinicians really embraced us. They would always ask my opinion so I felt like a valued person . . . and then always give insight into other ways. . . . I think part of it is that the therapists were there for the right reason. They weren't there just because it was a job. They truly were invested in what they were doing, and that just showed in all of the aspects.

John had a similar sentiment when describing a positive experience:

I think the second clinical . . . it was much more supportive. And, I would say again . . . I would just say available. You know, somebody who was there if you needed the support or needed to ask questions, and was open to those questions.

The participants also described their desire to feel like an important part of the daily lives of their supervisors and the clinical setting. Laura described a desire to feel like part of the team:

The supervisor treated me more as an equal, you know, they would ask my suggestions: "What do you know? What do you think that you would do in this situation or that?" So, I thought, "I am really an integral part of the team." That I felt I was important to the team. And I felt so much more validated and valued as a student.

The need for personal connection and time with supervisors was shared by several participants. Cathy described two of her experiences as follows:

The second one, I think it was uplifting. . . . I think they were really willing to educate me. The third one I felt like we were just a big therapy family. I think I felt we all got along. I really enjoyed it. And both my second and third places, I still talk to them, and then we still get together. They are just an all-around good group.

Sharon discussed the need for a personal connection with her supervisor:

The second one was—it was a much different pace for one thing at this setting. And so she had more time to share about her life and her family, and even just the nature of the groups we led. . . . I got to know her a lot better personally.

Karen desired a personal connection but also expanded on the need for time with the supervisor:

The second was very professional . . . but I think a bit more intimate in the sense that it was just her and I. So, I felt like I got more time. And it was just a little bit slower pace so I got to do more . . . learning from her. . . . We just had a lot of time to talk about individualized plans of care and diagnoses and things. I felt like I just learned a lot more from her because it was just her and I. . . . I really looked up to and respected my clinical instructor, and really appreciated the time and efforts she took with me . . . helping me learn things. That helped propel me into taking students.

Just as positive experiences with fieldwork supervisors impacted the participants' current supervisory role, the negative experiences also shaped their idea of how to supervise students. In some instances, the negative experiences had a larger impact on their current practice than the positive experiences. Several participants described supervisors who were not capable or did not want to supervise students. John described a particularly difficult fieldwork supervisor who greatly impacted his current practice and how he directs his staff when working with students:

She was a very difficult person to work with. It was not necessarily the best interaction in terms of how we did. I will tell you this, and I oftentimes talk to students about this as well . . . I almost didn't pass that clinical. . . . What was probably the most interesting for me was at the end of the clinical when I was doing my checkout with the . . . clinical coordinator . . . this person said to me about this individual, and I quote, "She can be a little Hitler." And so I always remember that though because it taught me a lot about what I never wanted to be. . . . I am working with students then also coordinating with some of the student pieces trying to make sure [the clinical instructors] are very supportive of students. You recognize the positives or the strengths and weaknesses of staff . . . so that you have people who really want to take students and that can take students.

Laura had an experience where she felt unprepared for the setting and was given little direction or supervision:

It was a psychiatric place, and I actually got stabbed. . . . I didn't feel like I had the support, plus I was so unknowledgeable. You know, I did not have the knowledge to actually know what was safe, and so [I] was stabbed by a patient who had dementia.

I think there needed to be more security and safety . . . that people really need to embrace their students versus just . . . you are now just going to do their job for them. . . . I think I was just being used to fulfill her time. I just felt . . . that my supervisor truly wanted me just to take over. I don't even know if there was respect for her patients, and that's a big thing with me . . . is respect.

Cathy also reported a fieldwork rotation where she felt left to her own devices without direction:

At first I didn't know what I was doing, and so there was really no guidance . . . I felt . . . to what I was supposed to do . . . so I think we just butted heads a lot. Someone always critiqued me, and it was . . . I couldn't ask questions.

Student focused. The participants all indicated a high level of awareness of the needs of the student. They desired a positive fieldwork experience for the student, one that is relational, supportive, and informative. Sharon described an experience where even though the student struggled at her facility, she was able to work with him to find his place in the occupational therapy world:

The students that you've had in the past can go do such a variety of different types of OT and be successful. Sometimes the student that even struggles a little bit when they are with us . . . when they get in their right niche just totally expand out and become so much more.

Laura also described the experience of helping a student find the right fit within the profession:

I think as young people, not necessary young people but young in the career, they sometimes don't know exactly what they want to do yet. They don't have a niche. Just like me when I thought for sure I wanted to be in psych. But, when you get into the real world, you think, "Now I don't even like this." But I really love this.

The participants also identified communication as an essential component in fieldwork supervision. Many of them described communication failure or success as an indicator of a positive or negative fieldwork experience. Knowing this, they intentionally attempt to provide functional communication within their own supervision practice. Cathy,

who had described an experience where she was not encouraged to ask questions, conducts her own fieldwork supervision differently:

I try to be as outgoing as I can with them. If they have any questions, I want them to feel like they can come to me, ask me questions about anything. And if I instruct them to do something, I'll tell them this is how I would have done it. You know, not just say . . . do some research and then get mad because they didn't do it as you wanted them to. So, I really try to instruct them as best I can. I just want to make sure that the student and I are on the same page.

The participants also indicated the necessity to let the students know expectations and encourage the students to take responsibility for their experience. John described how he does this:

I've always said to the students, "It's your clinical, it's not my clinical. You're going to get what you want out of it, but you have to make sure you're letting me know what you need and are communicating along the way. Because in absence of communication I have to make the assumption that you know what you are not asking me."

Laura communicates the same responsibility to the students but with a slightly different approach:

I . . . ask them, "What can I do to make this successful for you? What can I do to make this better for you?" And I ask them all the time . . . "You let me know what I can do differently to help you learn."

When asked what the most gratifying aspect of fieldwork was, the participants had the following responses. Karen stated,

I think it's when I hear back from the student they feel they really learned a lot. I think one of the most gratifying things is watching one of my students and having them come up with something on their own, but knowing that by teaching them and giving them that confidence, I helped lead the way.

Linda described how seeing the students' gratification contributed to her own gratification with the role of supervisor:

I think when we see the lights going on . . . they are excited about something they had done . . . which resulted in a positive outcome with a resident. So . . . they have seen what OT can do. So they have seen fulfillment . . . not so much what I have done there but what I see in them . . . that they have really integrated what they have learned in school and now it is reality. And there is truly a look when they know it's worked.

The participants' responses identified that the role of clinical educator is focused on the relationship with the student. They described lifelong experiences of enjoying and developing relationships. The need for the clinical educator to establish rapport with students and the importance of the reciprocity of the clinical educator–student relationship were emphasized.

Theme II: Clinical educators are devoted to teaching and learning. This theme emerged from the interviews due to participant responses indicating a love of learning and a desire for lifelong learning, an awareness that they learn from their students, the expressed preference for experiential learning, and their willingness to support OT and OTA programs through volunteerism, guest lecturing, and participating in research. All participants mentioned that they self-assess to determine if they are genuinely improving as a clinician and as an educator. Given the nature of supervision and the continually changing healthcare and education environments, as well as the diversity of the student population, fieldwork supervision requires the continued growth of the supervisor. Zorga (2002) stated, “The supervision process could be seen as one of the possible processes of life-long professional learning and professional development” (p. 265).

Lifelong learners. The participants voiced the impact students had on their own learning as well as their professional development. Laura stated this very simply while discussing the benefits of being a clinical supervisor: “The benefit is that I sure learn a lot

that I have forgotten or never learned. Because things change, new diseases come. I have learned from students . . . new techniques. . . . I have learned a lot.” John offered the following regarding clinical supervisors learning from students:

I think they also have to be open to listening to their students, but also open to look at things in different ways . . . recognizing that there is not always one way to get to the end product. There can be different ways, and so you have to analyze this—are we getting to the same end product? I think you also have to have a little bit of internal drive as well to stay up on research and be a good clinician, because students will push you. As students learn, they are going to learn things that we don’t know, and we have to be prepared . . . to be aware of maybe that which is changing.

Sharon indicated that students cause her to reflect on and justify why she practices occupational therapy the way she does:

I like to have them spend some time with me and observe different treatments. . . . The first time you have a student, you always question everything you do . . . like, “Why do I do that?” And I think it is good for a therapist to have to explain that and to be able to explain why. Other than that, I mean I feel like I learn every time I have a student.

Cathy discussed similar sentiments and then went even further to include self-reflection regarding learning from failure:

I think as a therapist we kind of learn from the students. I think as clinical instructor you are always learning . . . you always want to try and find out new information . . . make sure it’s up-to-date when instructing your student on whatever techniques . . . that is, just trying to learn as much as you can over the years. My first [fieldwork] experience . . . it wasn’t a good experience. I felt it kind of led me into [being] the fieldwork supervisor I am today. I had a lot of difficulties there. I ended up not passing, which was quite stressful, but still today . . . I still think it made me the person I am.

The participants also indicated a need to continue to develop their clinical supervision skills by communicating with the academic institutions and doing their own independent learning. Laura described her experiences in the following way:

[The community college] offers some courses to prepare you for clinical supervision. And I would never hesitate to contact the school . . . if I did have some kind of

problem. And also, . . . you can get online. You can pull up tons of resources that just weren't available years ago.

Karen added to this:

Over the years [the community college] has offered more education, both on-site and online . . . and that has helped definitely build my confidence. Also, by talking to other occupational therapists and assistants when they have students. Talking through different scenarios, different issues that may arise. Just talking to them has really built my confidence and my skills also.

John summed up the concept of clinical educator as lifelong learner nicely by stating the following about working with students:

Hopefully we have the ability to help motivate them to be continual learners and to recognize how to grow professionally. Because when your clinical is done, your learning is never done. It's never going to stop. And so, I think that is one of our unique roles . . . is to try to show that to the students.

Love of teaching. Each of the participants at some point in the interview process indicated a love of teaching and described believing strongly in the educational process of the therapist. OTs teach on a daily basis. Although not recognized as a major job responsibility, clinicians routinely instruct patients and clients in any number of tasks (Provident, Leibold, Dolhi, & Jeffcoat, 2009). Sharon and Linda had both served as adjunct faculty at some point in their careers. Sharon, John, and Linda each reported guest lecturing at local community colleges and several Midwestern universities to both occupational therapy and OTA students. Sharon and John had also guest lectured to speech pathology and physical therapy students. Karen and Laura had both guest lectured at several different community colleges. In addition, Sharon, John, Linda, Karen, and Laura had all served on occupational therapy and OTA advisory boards of local community colleges and Midwestern universities. The participants indicated a desire to remain clinicians while helping in the education of the next

generation of therapists. John stated the following when questioned as to why he continues to be so involved in the education of occupational therapy practitioners:

Because I love to teach. And I love the interaction, and I think there is nothing more valuable than that. I think that is our responsibility. I think it's part of our role as clinicians . . . is that payback and how are we going to help educate the next group of people that come along.

When asked why she is so involved in the education of practitioners, Sharon described how teaching, service, and practice all contribute to her professional identity:

I feel pretty strongly about education. So, I enjoy serving on the advisory boards at [Midwestern community college] and [Midwestern community college]. I was on the advisory board at [Midwestern university] for a while too. . . . I think I just really like to teach. I really like to just see somebody learn new techniques, new things that they can take with them, and so it's my chance to be that teacher and still be a clinician. And maybe, that is, probably for me personally, that's kind of the best of both worlds.

Experiential learners and teachers. All of the participants described their preference to learn experientially and to teach in the same way. They all used the term *hands-on* to describe their preferred teaching and learning style. When describing her own positive fieldwork experiences as a student, Linda made the following statement: "They [fieldwork supervisors] both gave me lots of opportunities to work with different types of patients . . . to become more independent . . . to get hands-on treatment with different things . . . to observe different treatments by other professionals as well." Karen also indicated that experiential learning contributed to a positive fieldwork experience: "My second rotation was actually a little bit different in the sense that there was only one occupational therapist in the entire hospital . . . that gave me much more one-on-one and a lot more, I feel . . . hands-on training."

In addition to experiential learning as a preferred learning style, the participants also indicated that experiential learning was their preferred teaching style. When discussing

teaching style, the participants all responded in a similar manner. Laura indicated that hearing or reading about a task was not enough:

I always have the student . . . do the activity themselves . . . hands-on. Because that's the only way I learn. . . . You can tell me and tell me and tell me and even show me in a book. But unless I actually do it physically, I will forget it.

Cathy described her instructional process as follows:

First I will instruct them, and then do hands-on. And then, maybe, have them try and do it. Like today, I taught a student how to do E-stim. She had seen it and thought she felt confident. So, I gave her a couple of steps, but not every student hears what the instructor is saying. Do they get it or not? So, I think hands-on is really good. They have to demonstrate it to me.

Karen also identified herself as a hands-on learner and described how her teaching style imitated the way she learned:

My first approach is definitely hands-on. I mean, I want the student to know the basics of the diagnoses or to ask me. I like to do verbal education bedside to discuss our process. Then I will definitely do some hands-on with the patient and turn it over to the student . . . let the student put their hands on the patient. I feel like the hands-on learning gives . . . a much better understanding of what the individual patient is going through . . . to feel like some of our patients . . . in order to understand a stroke . . . or hypertrophic scarring.

Laura contributed similar thoughts when asked about her teaching style:

Hands-on . . . I want them to come over and feel it, because you can't learn that in a book. I definitely want to show people. When you try to explain something like neurons . . . you can't explain that kind of stuff . . . you need to show people . . . this is upper motor neuron, this is lower motor neuron. Does that make sense? . . . Hands-on.

All of the participants described a love of teaching and learning. They continued to participate in learning experiences in their own lives while also indicating a desire to teach others. This love of teaching and learning was evident in their student experiences and expanded beyond their current roles as clinical educators.

Theme III: Clinical educators have a high degree of self-efficacy. This theme emerged from the interviews due to participants' expressed confidence in their clinical skills, their ability to organize their time around patient needs and student needs, the knowledge of the importance of their role as a gatekeeper of sorts to the profession, and also their ability to assess, progress, and pass/fail a student as necessary. Higgs and McAllister (2007a) referred to this as a sense of self-agency. The clinician has a perceived competency and ability to act as an educator. The clinician is competent in clinical skills and is skilled in managing self and others.

When asked to describe the characteristics of a successful clinical educator, Karen described them as follows:

Definitely organization. If you have somebody who is very absent-minded, tardy, flustered, it's not going to work. The students are coming to you very nervous. They need to know roughly what to expect. The clinical instructor needs to be organized, confident, and approachable, but also disciplined. I feel like the student will flounder if the clinical instructor is too easygoing. You hold yourself to a higher ground . . . this is how we behave in a setting like this. The student should see you be looked upon in a good light by your coworkers.

Linda considered the following as necessary for success as a clinical educator: "A person should be diligent, patient, a good listener, organized . . . and I think well rounded. You need to be well rounded in all areas of OT."

Each of the participants had an organized process for training students, dealing with difficult students, progressing students, and, if necessary, removing a student from the rotation. In addition, they expressed confidence in their ability to handle those difficult situations. Laura offered the following when discussing her process for dealing with student behavior issues:

Part of it is just reiterating what the expectations are . . . if the behavior is jeopardizing the clinical setting, I will let them know I won't accept those behaviors and I will act on it. If they remediate, then I have given them that opportunity . . . sometimes they just don't know the expectations. But I will act on them.

Sharon also characterized her process for student concerns in the following manner:

Initially, just a one to one with the student. Sometimes they are just not aware of them [expectations]. And if I really had difficulty, we will take the next step of calling in our manager. And the student will have a lot more interaction with human resources. And . . . my manager can say, "Okay, if this person were an employee, these are the steps that we would be taking, so we need to implement similar steps with the student. You are helping them learn. You may get away with this for a while as a student but as an employee it has to stop. And, here are the implications."

John mentioned a slightly different approach when working with a student who is not performing as expected:

I think you just have to change the system. I mean, I think all students are different, and that's one of those things . . . we have to always be focused on . . . every student is going to learn at a different pace . . . so we need to identify that and then sit down and develop goals and strategies to get to the end product. You know at the end of the day it's all about end product and how we get there. It's not necessarily always about the steps to get there because all of those may be different. I always said that we can help people be good clinicians if that's what you want to be. We just have to figure out how to get there.

The participants identified specific clinical site processes for the education of the student and ways of measuring student success. The following is the process at Sharon's site:

Well, we have expectations set out initially . . . as far as how many patients they can handle, what documentation they are responsible for . . . we have it loosely mapped out. But if a student is not keeping up . . . and we can usually identify that fairly early on . . . we try to meet weekly with the student to identify those things early on.

When asked if she had moments of feeling less than competent, Karen mentioned that early on in her clinical supervision experiences she struggled with the progression of the student but now has a specific process that directs the student experience:

Within the last couple of years, especially being here in a new setting, I felt like I just needed to present a more structured outline to the students. So, I developed a more structured routine typed out for me and the students . . . that really helped me focus in on . . . week number one . . . these are things I would really like to accomplish. Then we have the Friday conversation. . . . Do I feel like they are doing it, is it time to progress or not? I just needed a more detailed outline so I can look back and say, “We’ve already done this. It’s time to progress to this.”

Time. One of the most frequently discussed topics was the issue of time. Clinicians who supervise students are expected to maintain full productivity as clinicians. They receive no reduction in patient caseload. Therefore, to fully dedicate themselves to their patients as well as to their students, clinicians have to appropriately manage time.

Laura discussed how time management is stressful when agreeing to supervise students. When asked the most difficult aspect of being a fieldwork educator, she responded, “Time management. Surprise, surprise.” When asked to elaborate on time management and how it affected her and the student, she went on to say,

I always spend time with them at the end of the day, and sometimes the beginning of the day and lunch as well. For me, I want to make sure I give them the best opportunity, so I want to make sure their day is full. So, sometimes I put myself out. There are days and times when you just need to stop, focus, reorganize. I have to keep everything organized. I want them to get everything out of it. . . . I have to spend so much extra time to make sure their time is used wisely. My days are longer when I take students. I have to work a lot harder. And I don’t get any extra pay for it.

When asked about any negative impacts from supervising fieldwork students, John mentioned institutional demands for productivity, but he added that there is hope that by the end of the rotation, the student can actually help meet productivity requirements:

When we look at things like productivity and efficiency . . . because as a therapist who takes a student, we know I am going to be less productive upfront because of the time we take in training. So, there is a negative there. But you hope towards the end you have students who are able to be more independent and have a little more autonomy. The benefit is being engaged in the process, education, and training . . . the reward that you get institutionally . . . it’s sort of . . . hopefully . . . a wash.

When asked if she ever had moments of not feeling confident as a clinical supervisor, Cathy mentioned her only issue was time:

I don't know if I have ever not felt confident. I have felt that I probably didn't have enough time to prepare for a student, even when they were already here. I probably didn't take enough time to prepare for the next day's patients. That is probably more of an issue than not being competent.

Gatekeeper to the profession. The participants in this study expressed an acute awareness of their role as gatekeeper to practice. As the last stop in a student's academic program, a fieldwork rotation can essentially derail the student's plan to become an occupational therapy practitioner. The interviewees struggled with a certain duality in that gatekeeper role. They wanted their students to be successful. And as therapists, they have a strong belief system grounded in the idea that they should never give up on a person. However, as will be described in my final theme, these supervisors are passionate about the profession and desire to protect its integrity as well as the safety of future consumers of occupational therapy. Bernard and Goodyear (2004) used the term *gatekeeper* in their definition of supervision. Costa (2007) expanded on the role of gatekeeper to the profession by defining what it means to occupational therapy. The role of gatekeeper is necessary as classroom knowledge is not a good indicator of clinical performance. The profession relies on fieldwork educators to ensure that future practitioners "conform to the spirit and intent of the profession" (Costa, 2007, p. 9).

The struggle to separate the roles of clinician and educator as well as understand the differences between patient and student was articulated by the interviewees. Karen described the difficulty of keeping the line between student and patient a clear one:

Like I said, we all, as OTs, want our students to achieve their goals . . . because you know how important it is to them. Sometimes I feel that overshadows my judgment as an instructor. The [academic] fieldwork instructor at the college says . . . “Remember, you don’t have to have the negative feelings afterwards if you feel they are not ready. Don’t pass them.” That’s how I . . . remove myself a little bit as far as staying in that instructor role, rather than the therapist role. It’s sometimes hard to keep that line separate. I have to remember the student is not my patient.

Sharon’s experiences with failing students were similar:

Those are the toughest parts. Because, as a therapist, we are trained to set goals for people and have them succeed. It is really, really hard to have a student not pass. That goes against everything that we know. But then if you look at it from the perspective of, “Well, can I trust that person to be a therapist? And treat a family member of mine?” You know you have to separate yourself from that. But that is really, really rough to tell the student . . . I don’t think you have skills to make it . . . so that is the point of separating being a clinician from being an educator.

When asked to describe the difference between students and patients, Laura offered the following:

Being a clinician, you just treat the patients, and a lot of things come naturally. But when you are an educator, there are just so many more things that come into play. I guess when you are working with a patient, you expect some noncompliance. They are not always a willing audience. Whereas a student, I guess you pretty much expect that they want to learn. I guess they don’t necessarily have to be interested, but for them there would be consequences.

The interview participants were in agreement that fieldwork is a vital piece of the educational process and the professional development of the therapist in general. When the participants were asked how important they thought the role of clinical educator was in the life of the student and to the profession in general, Sharon responded,

I think without fieldwork, you don’t have opportunity to problem solve with real-world patients. How do you know how to progress a patient if you haven’t seen it or worked through it? . . . I guess we are a very important piece in promoting OT and maintaining the profession, and preparing quality students for the profession . . . helping to build OTs and OTAs who can be an asset to any team they join.

Karen added this sentiment:

I think one of the benefits I have is knowing that a quality person is out there taking care of patients. I have had wonderful students. And then hearing back from them . . . I got a job here . . . and it's all going well. I think that is the most gratifying, knowing that I helped to put quality people in occupational therapy. Hopefully, they continue to deliver occupational therapy with a high standard.

John discussed the role of the clinical educator and how that role relates back to the academic program:

You know at some level we are not here to pass or fail. We are here to determine whether they have the skill set necessary to work within the environment they are in today. That doesn't mean they may not have the skill set to work in a different environment and be completely successful. And that's our responsibility, to get that back to the schools. . . . The academic parts I think are well beyond our scope of influence. Our influence is more in the actual practice piece once they are out of school, which . . . is a really big role because that is where people are going when it's all said and done.

All of the participants identified the need to be excellent managers of time and resources. They described the importance of defining boundaries between clinical practitioner and clinical educator. They were effective in their roles as clinicians and identified strategies implemented when working with students as opposed to patients/clients. The participants took seriously the role of protecting the profession and acknowledged the fact that they were the final step in the preparation of new clinicians.

Theme IV: Clinical educators are strong advocates for the profession. This theme emerged from the interviews due to participant responses regarding volunteerism. They indicated a desire to give back to the profession by volunteering to supervise students. In addition, they exemplify the occupational therapy trademarked motto: "Live life to its fullest." All of the participants fully engage in all aspects of their lives as evidenced by their activities in early life and the many roles they have now.

The participants' activities indicate a balanced life with a strong emphasis on promoting occupational therapy in all areas of life, even outside of their current practice setting. Participants reported childhood and adolescent activities surrounding sports, music, and community/church-based activities. During their college years, many of them selected experiences that shaped their current role as occupational therapist and educator.

Sharon described her college volunteer experiences and how they impact her now:

When I was in college, I worked at camps every summer; particularly, I worked at camp Sunnyside. And that gave me a real appreciation for people of all different abilities. Also, an appreciation for what can be done. If you can get someone who has quadriplegia in a canoe, what is so hard about getting them out of bed?

Cathy also mentioned selecting occupational therapy as a career because of her experiences.

She stated,

I was at [Midwestern community college] and didn't know what I wanted to major in. Then I found out about the occupational therapy program. I did a lot of that stuff when I worked at the Christian Opportunity Center. I was working with mentally and physically disabled people.

When asked specifically why they had chosen the profession of occupational therapy, the participants' responses were reminiscent of a calling to a vocation. Laura replied,

I was introduced to an OT and she was just the coolest lady. She had a psych background and did crafts with her patients. And I just thought, "Oh my gosh, people actually get paid to do this? This is going to be the most fun job. I can't believe I'm going to get paid for this."

Karen described a similar experience:

I had friends who had been in car accidents, so I knew I wanted to help others. I started off observing a physical therapist, and I happened to see occupational therapy across the gym. I asked, "What is that?" And they replied, "Well, that's occupational therapy." And I just knew from watching them and seeing what they did. I just knew that is what I wanted to do.

She went on to say, “Academics in college were easier then, because I was so much more interested in it. I really excelled in college because I liked it so much.”

Participants also indicated a desire to advocate for the profession and the persons it serves. Cathy volunteers for a Children’s Research Center. Laura is part of a citywide coalition group that helps build wheelchair ramps in the community. She is also a Big Sister. Linda volunteers in her church as the contact to provide assistance for persons with disabilities. She is also involved in her neighborhood watch group and the block-to-block rebuilding effort for flood recovery in her city. Karen volunteers in her worship center by supervising the nursery. She also serves on a corporate committee. Finally, Sharon is part of clown ministry and serves as the parish educator and youth group leader in her place of worship.

As previously mentioned, all of the participants volunteered in many different roles in support of occupational therapy education. They indicated a strong desire to advocate for the profession. Sharon said it most simply: “A good clinical educator must be passionate about OT.” Linda stated, regarding her role as clinical educator,

I don’t think of myself as a volunteer in that light. I guess I more think of it as part of my job. I went to [community college]. It has given me so many things. . . . I really like to mentor others. I like that feeling of sharing my knowledge. And, you know, I am a huge OT advocate and long for our profession to be as positive and excellent as it can be. So, I just think that the more occupational therapy students learn . . . and how good they are . . . is just a good reflection on the profession.

Laura summarized the impact the clinical educator can have in the life of the student as well as the impact on the profession:

You can make them be so enthusiastic and reap the benefits . . . if you do your job right. You can find a reward in patients’ behaviors, words, and relationships. That is I think what it is all about. It’s the patient–clinician relationship. And that is why I think most people come to work every day is that it is fun. You get to see and meet

so many different people . . . and you get to ease their burden . . . you're just the one person that can make their day. And I try to instill that in the student. That it is kind of like . . . your mission in life. That's the way I always look at it. It's what I was put on earth for, to make people's life better, and you live your mission every day. It . . . may not be a life changing event, but if you did it right . . . and you started doing this from the beginning, it can be. I mean, it's your whole life.

Intentionally participating in life is a guiding principle in the art and science of occupational therapy. The participants' report of activities throughout their lives indicated a strong desire to participate and live life to its fullest. This includes educating the next generation of occupational therapy practitioners in an enthusiastic and holistic manner.

Analysis of Participant Self-Assessment, Self-Reflection, and Student Evaluation of Fieldwork Experience

Three different artifacts were analyzed for contribution to themes and triangulation of data. Each interview participant completed the American Occupational Therapy Association's (AOTA's) Self-Assessment Tool for Fieldwork Educator Competency. In addition, each participant was asked to describe in writing his or her philosophy of clinical education given five starter statements. Finally, the Student Evaluation of Fieldwork Experience (SEFWE) form was reviewed for each of the participants. This form is completed by students at the end of each fieldwork rotation. One portion of the SEFWE focuses specifically on the fieldwork supervisor role.

The AOTA Self-Assessment Tool for Fieldwork Educator Competency asks clinical educators to assess themselves in five global areas: professional practice, education, supervision, evaluation, and administration. Each global area has from 9 to 16 individual competencies. The participants were asked to rank themselves on a Likert scale from 1 (low proficiency) to 5 (high proficiency) for each competency. In addition, each competency has a section for comments. Some competencies were more applicable to participants than

others. There was a possibility of variance based on years of practice, level of education, and the participants' current practice role. Due to that fact, as well as it being a self-assessment tool, the participant responses were analyzed similarly to the interview transcripts.

Individual assessments were analyzed for meaning units and then compared to the themes that emerged from the interviews. This tool was used for this study specifically to provide data from which I could find some consistency in support of the interview themes. A table with the individual scores for each practice area is included in Appendix E. One participant did not return the self-assessment.

The self-assessments supported the following themes. First, relative to their years of experience and current role, the participants scored themselves highest in professional practice, evaluation, and administration. This would support the theme of self-efficacy. The scores indicated confidence in ability to practice occupational therapy and an effective process for doing so. The participants collectively scored themselves lowest in education. Further analysis of the education competencies revealed that the lowest rated competency for all five participants was ability to incorporate multiple learning styles and use a variety of instructional strategies. This would support the theme of hands-on learning. While all participants indicated a love of learning and teaching, all but one indicated that they preferred to learn and teach using a hands-on approach. In addition, under the supervision area, the competency most often scored lower was ability to use supervision models and theory to facilitate student performance. This would again indicate that the participants prefer experiential teaching and learning and are not as inclined to seek out additional theoretical supervision models.

The participants were also asked to reflect on their clinical education experiences and complete a written statement regarding their philosophy of clinical education of the OTA student. One participant did not respond. The participants were given the same five starter statements to assist in crafting their statement:

1. I teach/taught OTA students because . . .
2. The goal of clinical education is . . .
3. The purpose of clinical education for the student is . . .
4. The role(s) of the clinic educator is/are . . .
5. My role at the community college is . . .

Several insights were gained from these statements, which contributed to the support of emergent themes. First, several of the philosophy statements supported the theme of advocacy for occupational therapy as well as the theme of self-efficacy, especially the passion for the profession and the need to be gatekeeper. Cathy wrote, “I teach OTA students because I understand the value of teaching and making sure there are quality professionals working . . . and promoting OT.” Sharon described her love of the profession but further supported the theme of love of teaching:

I enjoy teaching. I feel that OT is a very valuable component of the rehabilitation process and I want to promote OT. The goal would be that upon completion of clinical education the student is prepared with the needed critical thinking skills to enter the OT profession.

The participant responses also supported the theme that clinical educators are relationship centered and person focused. Rather than write a philosophy statement in narrative, most of the participants responded in phrases or words. The following words were identified multiple times in the statements regarding the role of educator: mentor, encourager,

listener, guide, helper, role model, and advisor. Linda, however, did write a narrative, which I believe identified the person-centered focus of the clinical educator as well as illuminated the theme of advocacy for occupational therapy by passion for the profession and being a gatekeeper. She wrote,

I teach OTA students because I enjoy mentoring and sharing knowledge with others, whether it is my peers, students, or patients. I enjoy occupational therapy so much; it excited me to have others feel that same excitement and learn techniques to assist others to become as independent as possible. I thrive on developing relationships with my patients and I feel that's the key to a successful therapist, to first develop a relationship and then teach that patient whatever they need to learn to improve their health.

To further support my themes, I also analyzed the SEFWE assessments. The SEFWE is an assessment provided by the AOTA. The form is designed for OTA programs to gather information on their fieldwork sites. The form is completed by students at the end of each Level II fieldwork rotation. The students complete the form following their final evaluation and then share the responses with their individual supervisors before returning the form to the academic program. The SEFWE assesses the following areas: orientation to the site, student caseload and population, occupational therapy process at the facility, facility model of practice or theoretical frame of reference, fieldwork assignments, aspects of the environment (refers to milieu), supervision, level of academic preparation for the site, summary of the experience, and an evaluation of the fieldwork supervisor. I struggled with how to use these data, as I believed they were valuable but was unsure how to make meaning from the students' statements as the evaluation was focused on multiple factors. In addition, I had multiple SEFWEs related to three of the participants and their facilities, while I only had a few for two others. One facility and interviewee had no SEFWEs on file. This is not uncommon as some facilities can host more students than others. In addition, the academic

program is reliant upon the student to turn these materials in at the end of the program. For the purpose of this research, I only analyzed the sections pertaining to supervision and evaluation of fieldwork supervisor. I took into consideration that students are required to share this information in a face-to-face meeting with their supervisor prior to leaving the clinic. When analyzing student responses, I considered the fact that the assessment is not anonymous and the student has almost always already passed the fieldwork when he or she completes the assessment. In addition, since students sometimes refer to multiple supervisors in one evaluation, it is difficult to identify to whom they are referring when making evaluative statements. I chose to analyze the student statements as they related to fieldwork education/supervision rather than their evaluation of a particular supervisor. In doing so, I hoped to find agreement in the student statements regarding the meaning of the role of clinical educator.

The themes that emerged were that students should have a perception of the efficacy of the supervisor particularly related to the supervisory process and how the student and supervisor communicated. One student wrote,

She was wonderful. She made me feel comfortable. She was an excellent instructor who taught me about the role of OTAs at [this facility]. She encouraged me to use clinical reasoning, interact with other health care clinicians, and to voice my opinion. She provided positive feedback and gave me excellent suggestions. She made me feel comfortable to go ask questions, and gave me prompt answers.

The following student supported the same theme by describing a negative experience:

We only met once a week. . . . The experience could be improved . . . for the supervisor to provide more feedback both positive and negative in regards to student overall performance . . . including [joint] treatment sessions with patients more frequently.

Another student reinforced this theme while emphasizing how her supervisors took the time to work with her:

I had the opportunity to speak with my supervisor multiple times throughout the day. Her feedback was always constructive and positive. I think the supervision was excellent. I had the opportunity to interact with many different COTA's and OTR's—all of which made sure I was supervised as required and never hesitated to answer questions and guide me through treatment that I asked for help on.

This particular student statement supports the theme of time spent with the supervisor but also the theme of the supervisor's advocacy for the profession: "I worked side by side [with my] supervisor daily. She is fantastic and I have to say thanks to her for helping me appreciate the positive effects of occupational therapy."

The student statements also supported the theme that a clinical educator is person or relationship centered. A student stated,

[She] was an awesome supervisor. She knew I felt comfortable and asked me when I was unsure about something . . . if she could help. I felt welcome and part of the team from the first week. She gave me feedback when I needed it.

This student probably stated it most simply but effectively by writing "thank you for your patience" in the general comment section of the evaluation.

Additional Finding

There was one additional smaller theme or subtheme that seemed to emerge as I completed this research. I was not able to directly relate it to my research questions, and it was not explicit in each interview but occurred with enough frequency that I thought to mention it. In addition, it was supported in the literature. The subtheme is this: Fieldwork supervision is a recruitment tool for clinical sites. Hanson (2011) found that when asked to rate the benefits of fieldwork supervision, 70% to 74% of respondents rated assessing students for future employment as moderately or very beneficial. Thomas et al. (2007)

conducted a study in Australia regarding the benefits and challenges of supervising fieldwork students; 56% of their respondents stated that they played a role in the hiring of new employees, and 56% indicated they had hired previous students. In a study conducted by Kirke et al. (2007), employee recruitment was stated as an extrinsic reward for taking on the role of fieldwork supervisor. In particular, the Level II experience, which mostly simulates actual practice, seems to be a strong indicator of where a student will eventually practice (Simhoni & Andersen, 2002).

Laura and John were explicit in stating that one of the benefits of being a fieldwork educator is the ability to hire successful fieldwork students. When asked about the benefits of being a fieldwork educator, Laura responded, “That’s where we find our stellar employees. We have good knowledge [of them] based on what kind of student they were . . . and if we have a really good student, we will try to get that student to be an employee.”

When asked how she knew she was effective as an educator, Sharon responded that she knew she was good because she hired many of her students. Sharon’s response is less explicit but does speak to the practice of hiring students. Karen also mentioned that one of her current coworkers was a previous student. She described the student as “an awesome student.” She then said,

It has been a pleasure being able to work with her. Going from that clinician–student role to coworker has been great, and it has been really nice to have that. I had never had that happen before . . . becoming a coworker to a former student, so that’s been a very positive, wonderful experience.

Ronnestad and Skovholt’s Developmental Model of Supervision

Ronnestad and Skovholt’s developmental model was introduced in Chapter 1 as a theoretical lens through which to view the design and analysis of this study. Ronnestad and

Skovholt (2003) identified six phases in the professional development of the supervisor. The first phase starts with lay helper or observer/volunteer. Each participant in this study described experiences with being a lay helper, volunteerism, and observation. This was directly evident in the experiences of all of the clinical educators. Karen described observing occupational therapy for the first time as a high school student. Sharon discussed her volunteerism in college, working at camps for persons with different levels of functional abilities. Each participant described interaction with occupational therapy personnel prior to making the decision to apply to occupational therapy school.

Phase 2 is the initial stage of a student's career, including the first fieldwork or clinic experience, but prior to Level II fieldwork. According to Ronnestad and Skovholt (2003), students in this stage are excited to begin coursework yet anxious about clinical skills. Students may struggle with self-confidence. The participants in this study described this experience as well. All of them described occupational therapy coursework as being more interesting than previous coursework unrelated to occupational therapy. They described their ability to focus because the work related to their interests, yet they also mentioned struggles with fear of failure. Karen described the experience as "intense."

The advanced student, Phase 3, is the stage of didactic completion with intention to move into the Level II fieldwork (Ronnstad & Skovholt, 2003). This phase is characterized by anxiety and self-induced pressure to perform in the unknown. Students are most successful if their supervisor is skilled at being supportive and directive in the initial phases of this level. Cathy described how she felt she could not ask questions and did not know how to proceed in her first fieldwork experience. She was ultimately unsuccessful at that fieldwork but described her next experience as supportive. All of the participants described

at least one negative experience in Level II fieldwork, and all were related to noncommunicative and unsupportive supervision.

Phases 4 through 6 occur after program completion and encompass the novice, experienced, and senior practitioner (Ronnestad & Skovholt, 2003). Novice practitioners are new to the profession and typically excited to begin their careers. They are strongly encouraged to find mentors to assist in their professional development as they begin to create their own style of practice. All of the participants in this study had passed the novice phase. Most of them described their mentors as favored fieldwork supervisors and professors from their college experiences. They also mentioned looking to coworkers for support. After one year of clinical practice, a clinician can become a fieldwork supervisor. Five of the six clinical educators who participated in this study mentioned taking their first student immediately after that first year. The sixth participant waited several years due to the nature of her facility. Just as it is suggested that the novice clinician seek mentorship, it is also suggested that the novice clinical educator find mentorship in the novice phase of clinical education. All of the participants indicated that they looked to their supervisors or peers for support as well as the faculty from the student's institution to guide them through this process.

Phase 5 is the experienced professional phase. This would be the ideal phase for beginning supervision. All of the participants in this study had reached or surpassed this phase. This is the phase where clinicians have come into themselves and are comfortable with how they practice. They typically have a high level of motivation to continue to develop their clinical skills as well as their supervisory skills. It is at this phase that they begin to realize they are learning from their clients and students as much as they are helping

or teaching. All participants indicated that they learned from their students as well as their patients. Karen and Sharon even indicated that they sometimes used the patients to educate the students on the therapy they were receiving. Given their years of practice and variety of experiences, Cathy and Karen were in this phase at time of the study.

Sharon, John, Laura, and Linda each had more than 20 years of experience and had many clinical experiences, including supervisory or administrative roles. This would place them in Phase 6. They each had individualized styles of practice and were confident in their service delivery. It is in this phase that typically one of two things happens. Either the clinician becomes a wise master and shares that knowledge in many different ways, or the clinician may burn out and retire or shift careers. All four of the participants in this phase appeared to be wise masters. They were actively engaged in the profession in many different capacities, including student supervision and advocacy for the profession.

Ronnestad and Skovholt's developmental model of supervision helped me structure my interviews and put my study into context. The path to clinical educator is a developmental process, and the meaning ascribed to clinical education is developed over the career of the clinician.

Summary

Chapter 4 described my participant group and the phenomenological approach I used for analysis and the identification of themes. In addition, I used the theoretical lens of the Ronnestad and Skovholt developmental model of supervision to structure and contextualize my research. Chapter 5 includes my summary, findings, and recommendations.

CHAPTER 5

SUMMARY, FINDINGS, AND RECOMMENDATIONS

Summary

The purpose of this study was to contribute to the existing research in the field of occupational therapy fieldwork supervision specifically relating to the role of the clinical supervisor as educator of community college students. The goal was to construct meaning from the clinicians' perspective regarding their motivation to become a clinical educator of community college students, experiences as an educator, growth in their supervisory and education skills, and the processes they use to be effective in educating the clinical student.

Six clinical educators with varying levels of education in occupational therapy and varying years of practice were chosen to participate. The participants were employed in a variety of settings. All were located within the Midwest. Data were gathered via face-to-face interviews, telephone follow-up interviews, field notes, document analysis of participant self-evaluation and reflection, document analysis of student perceptions of clinical education, and member checking.

The study drew from a phenomenological approach with a developmental theoretical lens. The overarching question was, "What does it mean to be a clinical educator of community college students?" The following are the research questions that guided this study:

1. How do occupational therapy clinicians describe the factors that influenced their decision to become clinical supervisors of students enrolled in a community college OTA program?

2. How do occupational therapy clinicians describe their role as educators in a community college context?
3. How do clinical educators describe their journey to becoming clinical educators of community college students?

Findings

In an attempt to construct meaning to answer the overarching question, I will first respond to each of the research questions.

Research Question 1

How do occupational therapy clinicians describe the factors that influenced their decision to become clinical supervisors of students enrolled in a community college OTA program?

My findings related to this question required me to divide the question into two parts as the participants were varied in how they responded. I will first discuss why the participants chose to become clinical supervisors of either occupational therapy or occupational therapy assistant (OTA) students. Then I will elaborate on why they chose to supervise OTA students specifically.

The responses to my interview questions regarding the decision to become a clinical educator surprised me. Not one of the participants responded that they chose to do it because they wanted to or because they thought they would enjoy it. Rather, it seemed to be more of a sense of duty or a required element at their facility. John and Linda indicated that it was expected of them at their facilities. Linda indicated, "It was my turn." Sharon stated, "I thought that was what was next. I had my year of practice. Now I am going to be a clinical educator. It was somewhat expected." Both Karen and Cathy decided to become clinical

educators because someone from the academic institution asked them to assume the role. They did not initiate the process but accepted the opportunity. While none of them had an urgent desire to take on the role, they all continue to do it and have some degree of success with it.

As I reflected on my thematic analysis, it did appear that all of the participants were developing those skills early on in their formative years given the devotion to lifelong learning they all described. Each of them described positive and negative experiences with educators while they were fieldwork students. The desire to model their teaching after their positive experiences may have contributed to their skill set. Learners' perceptions of what constitutes good teaching may affect how they teach (McLean, Cilliers, & Van Wyk, 2008). It may not have been a conscious decision, but the participants each had a developed skill set that contributed to their success. In addition, being relationship centered has undoubtedly contributed to their success in the role of supervisor/educator. Higgs and McAllister (2007a) stated that a humanistic approach is a fundamental requirement of an effective relationship when facilitating learning.

Regarding the question of willingness to supervise students from the community college, the participants provided significantly varied responses. It is important to revisit the description of the participant pool to assist with illustrating why this may be. Two participants were OTAs and attended the community college. Two participants were bachelor's-prepared occupational therapists (OTs) but had previously attended community college and initially practiced as OTAs. In addition, one OT was master's prepared, but her partner was an OTA and had attended community college. The final participant was a master's prepared OT and had never attended community college. This background

information is important to note because I believe it shaped how and why participants agreed to take students from a community college.

The two OTAs both stated they take students only from the school they graduated from because of their loyalty to the school. They had good experiences with the school and believe in giving back to that school. The two bachelor's-prepared OTs both indicated that because they had previously practiced as OTAs, they had great respect for the role and wanted to continue to support those students. Both also indicated that their community college experiences were enjoyable and formative in their development. They, however, were not loyal to any one school in particular. They were willing to take students from any community college. The master's-prepared OT agreed to work with community college students for two reasons. First, she sees incredible value in the role, so much so that she encouraged her partner to return to school to get an OTA degree from a community college. Second, she believes in OTA education and supports several OTA programs by taking fieldwork students, guest lecturing, and serving in an advisory capacity. The master's-prepared OT with no community college experience believes in supporting OT and OTA education as a means of giving back to the profession. He is willing to take students from any community college if his facility has the capacity. All of the participants indicated they were strong advocates for the profession, so their responses to this question were unified under that theme.

Research Question 2

How do occupational therapy clinicians describe their role as educators in a community college context?

The short answer to the above question is they do not. I asked several interview questions regarding the participants' role at the community college. In addition, one of the starter statements of the reflective philosophy of teaching assignment was, "My role at the community college is" Not one of the clinical educators considered themselves a part of the educational process as defined by the career of the student.

A student's career begins with career exploration, admission to an education program, didactic coursework, and then finally fieldwork. As previously mentioned, approximately 50% of a student's face time in that career is with faculty in the didactic portion of the program. The other 50% of the student's face time is with clinical educators in Level II fieldwork (Crist, 2010). Yet, not one of the participants perceived themselves as being part of the process. They saw the role of the academic fieldwork coordinator as the "educator" and their role as something else entirely. They very clearly stated they were clinicians first. Supervising students was one of many hats they wore in their job as clinician. They described themselves as the transition. The idea of being the gatekeeper to the profession was evident in each participant's response. It seems that the role of gatekeeper is conflicting if they are also part of the academic institution. Costa (2007) defined the significance of the role of the gatekeeper:

Although no one enjoys terminating or failing a student, it is a professional responsibility to ensure that occupational therapy professionals conform to the spirit and the intent of the profession. Serving as a gatekeeper for occupational therapy means allowing only those students who have demonstrated entry-level competency in a particular practice setting to pass fieldwork. (p. 9)

Thematic analysis identified that the participants used teaching techniques and assessed student performance, but they viewed this as an extension of their role as clinician rather than a separate role. In addition, they were partial to hands-on learning as opposed to

other models of teaching and learning. As also was indicated in thematic analysis, they struggle with separation of patient versus student and being the clinician versus being an educator. When asked specifically what their role was at the community college, they listed words like advocate, support, advisor, and partner.

Research Question 3

How do clinical educators describe their journey to becoming clinical educators of community college students?

As was revealed in the themes, the clinical educators are passionate about occupational therapy and desirous to assist in the developmental journeys of occupational therapy students. The participants indicated the joy they received from watching students learn and grow. They relayed how the success of the student directly impacted their own sense of efficacy and competence. Karen stated that she felt let down and personally responsible if a student was unsuccessful. As a group, the participants were invested in protecting the profession and ensuring that competent practitioners were entering the workforce.

While demonstrating a high degree of self-efficacy, both in practice and education, the participants identified the areas that are a specific challenge to them in their role as clinical educator. First, they identified time as a major conflict in working with the student. This was also identified in the thematic analysis. Due to being person centered and supportive of student success, the participants felt the responsibility to do much preparation prior to the students' arrival in order to provide a good experience. They felt the need to be available to the students as the students needed them, and as excellent clinicians, they still expected to provide good patient care. This finding is consistent with Jensen's (1992) study

of fieldwork educators, which indicated the main reason facilities did not accept Level II students was due to time and staffing constrictions. The second area of difficulty was students with attitudinal issues. The aforementioned themes of self-efficacy and professional advocacy make it very difficult for this group to work with disinterested or unprofessional students. The final area of difficulty mentioned was the ability to work with students of varying ages. Karen mentioned that younger students were more interested in technology and communicated differently than when she was a student. Laura and Linda noted that more of the younger students have a different level of commitment or work ethic, while Sharon and Cathy mentioned that sometimes working with nontraditional or older students is most difficult because they are set in their ways and sometimes think they already know everything about the profession. It is interesting that the characteristics identified by the participants could be applied to either traditional or nontraditional students. It may be that the true difficulty is in managing learning styles, generational awareness, and the ability to adjust one's teaching style to the needs of the student. "A major function of faculty development should therefore be about making teachers aware of aligning their teaching to the needs of the student" (McLean et al., 2008, p. 565). As was discussed in the teaching and learning theme, all of the participants indicated that they preferred to learn and teach in a hands-on manner. Gale and Jackson (1997) stated that it is the responsibility of the teacher (supervisor) to assist the student with the integration of theory and practice. They added,

Yet, [students and supervisors] often imply that the practical is relevant, useful and intrinsically valuable while the theoretical is distant, irrelevant and inaccessible. However, a teacher's theory is evident in the framework of beliefs, understandings, values and assumptions under which he/she operates; it is the thoughtfulness that gives meaning and direction to experience. (Gale & Jackson, 1997, p. 182)

From my review of the data, ultimately the meaning made by the lived experiences of these six clinical educators is that being a clinical educator means that a clinician is, first and foremost, person centered and relationship focused. In addition, a clinician has a passion for learning and teaching real-world knowledge. He or she has a high degree of self-efficacy regarding his or her clinical skills and ability to supervise students. And finally, a clinician is an advocate for his or her profession and passionate about growing its reputation.

These findings are consistent with previous research conducted on the phenomenon of being a clinical educator in other professions. Ferguson (1996) found that nursing clinical educators

talk about the challenges of shaping students and preparing them for their future roles, encouraging them to accept a commitment to lifelong learning, developing clinical excellence in their students, and fostering in them a deep sense of purpose and commitment to the profession. (p. 835)

In other research conducted by Higgs and McAllister (2007b) on clinical educators of speech pathology students in Australia, the researchers noted that the role of clinical educator is complex as these educators navigate balancing the needs of the patient and the student while being responsive to their own administration as well as the academic institution. Similar themes in my study include that clinical educators have knowledge of self and confidence in varied life roles. They demonstrate an awareness of others and are people oriented. They are lifelong learners and desire to practice and teach. They demonstrate confidence in their skill set and their ability to practice and educate.

Reflections on the Journey to Clinical Educator

Pollio et al. (1997) described the use of metaphor for the human experience of development as a stream of words and images over time as follows:

Experience is organized and flowing, with some parts clear and with other parts serving to provide momentary contexts to support and define the clear central focus. The central events of experience regularly change and we experience new organizations without ever losing track of the unity provided by the flow between successive figural events. The rate of change has a personal tempo, although it sometimes changes at a rate faster and sometimes slower than that tempo . . . sometimes I even require the presence of another person to help me make sense of my experience as my own personal perspective prevents me from experiencing something seen only by the other. (pp. 26-27)

I introduced my research with a poem by Cheryl Kirk-Duggan (1999). She entitled the poem “Suspended Moments.” Admittedly, I am not sure why she chose that title. I came across the poem during my research and it immediately spoke to me as a creative way of expressing the journey or the road to becoming a clinical educator—the living stream of experiences that shape the clinical educator. Each of my participants began a journey and continues to travel it. One could view the process of becoming a clinical educator as a developmental journey with a definite beginning and end, with expected stops along the way. However, as is true for human growth and development, the development into the role of clinical educator is a dynamic and living thing. Kirk-Duggan referred to it as emerging and being a discovery. It is a challenge and a joy as a recursive process where one strays between the worlds of student learner and wise teacher. Each teacher is unique in his or her style, as is each student, even while ultimately hoping to achieve the same goal. It is an interactive process. Just as humans do not develop in a vacuum, nor does clinical education occur without context. It is an individual style with a collaborative spirit. Transcendence of the process is the final goal. The ability to view the experience with “artistic clarity and transformation” is the product of the journey (Kirk-Duggan, 1999, line 43).

Recommendations for Practice

The recommendations for practice are based on the themes generated by the participants' responses. Participants indicated a love of teaching and learning. Therefore, the first recommendation is to make professional development for the clinician in the area of fieldwork education more accessible, both in manner of delivery and financially. McAllister, Higgs, and Smith (2008) reported that clinical educators struggle when working with marginal or failing students. This was also indicated in the participant interviews. Professional development related to learning styles, teaching delivery methods, and generational expectations of students might provide the clinicians with more tools for success, which may translate into more clinicians willing to supervise students.

In addition to professional development, the community college faculty must have more of a presence at the clinical educator's facility. The participants indicated that they were relational and embraced community. The clinical educators view the academic fieldwork coordinator as their connection to the college. Kirke et al. (2007) summed up the previous two recommendations for good college/educator partnerships:

A university running a good fieldwork program would ensure regular visits to student on fieldwork placement and provide the necessary support for students with difficulties. In addition, the importance of providing cost-free fieldwork educator development is particularly crucial for new graduates who themselves have struggled with their new roles. (p. S18)

Finally, the community colleges and professional organizations should include clinicians in the discussions surrounding fieldwork education and research. The American Occupational Therapy Association (AOTA) hosts a fieldwork symposium in the fall as part of the academic program directors' annual meeting. Academic fieldwork educators are invited to attend along with current and prospective program directors. However,

historically, clinical educators have not participated in this meeting. The participants in this study clearly indicated they do not feel they have a specific role at the college but are more ancillary. They believe they have a role in the transition from college to practice. Therefore, that is a distinct role that should have a distinct voice.

Recommendations for Policy

AOTA must work harder to define the role of clinical educator. The profession has a role definition of clinician, academic fieldwork coordinator, academic faculty, and academic program director. However, the definition of clinical educator has not been clearly delineated. AOTA had a clearly defined role competency document that described the competencies for fieldwork educator as recently as 2006 (AOTA, 2005). However, this document is no longer listed as an official document by AOTA, and no explicit role document has been approved in its place.

Community colleges and clinical sites that employ occupational therapy practitioners must develop a better system for assisting the volunteer educator with the workload associated with supervising a student. This may mean the academic institution provides some paid faculty position that assists with supervision or the facilities recognizing the clinician will have a reduced productivity load. The paid faculty member as preceptor model is already used in many allied health programs as well as nursing. Academic institutions would need to assess the viability of the OTA program if additional faculty were to be hired to supervise fieldwork students in a more collaborative model. Given the current demands of occupational therapy existing as a reimbursement-driven profession, it will be difficult for facilities to lower productivity and maintain viability.

Due to the growing number of programs and expected growth in the profession, the number of fieldwork educators needed is expected to increase (Hanson, 2012). It may be necessary to do further research into alternative delivery models for fieldwork supervision. AOTA has done some research into alternative delivery models. The following are alternative delivery methods currently being used in some occupational therapy settings. These have met the accreditation standards put forth by the Accrediting Council for Occupational Therapy Education (ACOTE).

The first method is to change the ratio of supervisors to supervisees. Traditionally, the ratio is 1:1. However, some institutions have adjusted the ratio. This can be done by increasing the number of supervisors for each student. Typically that would mean two OT practitioners as supervisors to one student. However, teams of individuals that include members of other institutional practices can also supervise. This would also provide an opportunity for a form of peer review to improve clinical educator effectiveness (Costa, 2007).

The ratio can also be adjusted to create a second alternative delivery method. One supervisor could take many students. This is often referred to as the collaborative group model. Teams of students are assigned to a site with one supervisor. The students work within peer groups to build learning and mentoring while deferring to the supervisor as lead mentor and facilitator (Mason, 1998). Typically this type of collaborative model would be seen in a community-based and nonbillable setting. It has been implemented consistently in a rehabilitation setting, but only in countries with government-funded health care (Bartholomai & Fitzgerald, 2007).

A specific consideration for the collaborative model is that often it is up to the academic institution to hire the person responsible for team-lead fieldwork supervision. Community-based services often have no OT practitioner on site. Therefore, those sites do not meet accreditation standards unless an OT is present for a specified number of hours per week. The academic institution must offer the supervision or that site does not meet the standards. This is often not a problem for Level I fieldwork as the number of hours are considerably less. However, there are a significant number of hours required for Level II fieldwork supervision (Costa, 2007).

A third alternative delivery method for Level II fieldwork would be to send the students to multiple settings. Students are required to complete Level II fieldwork at a minimum of two different settings. Typically this equates to an equal number of weeks spent at two different clinical or community settings with different patient or community populations. However, a student could be placed at any number of appropriate settings, as long as the number of weeks meets accreditation requirements and the student is able to meet the required learning outcomes (Mulholland & Derald, 2005). This would, however, require more training by the academic institution faculty to ensure that all clinical educators are aware of the mission, curriculum, and learning outcomes of the institution. The diversity of facility placements and practice areas would make any one model difficult to employ across the profession.

Finally, accreditation should include standards that require the teaching of fieldwork students as part of the occupational therapy curriculum. The participants of this study all indicated a desire to give back to the profession and a love of teaching and learning. However, they also agreed that they lacked any formal training in clinical education. It

would be of value to the profession if ACOTE would require that the clinical education process be a regulated part of occupational therapy curricula. However, as already stated in the recommendations for practice, this would require that a clinical education model be developed for each of the diverse therapy settings.

Recommendations for Future Research

AOTA identified a fieldwork research agenda at its 2009 joint meeting of academic fieldwork educators and program directors in Atlanta. The following items were identified as goals for future research in education (AOTA, 2009b):

- **Student-Centered FW Research**
 - This includes research on topics such as influences on student performance; predictors of success in FW; professional behavior; perceptions of students about FW, supervisors, patients, etc; development of clinical reasoning; how/what students learn/experience; transitioning from student to clinician; students as agents of change; etc.
- **Supervisor-Centered FW Research**
 - This includes research on topics such as the supervisory process; motivators to take FW students; teaching tools/methodologies; perceptions of supervisors; how supervisors respond to challenging situations; etc.
- **Site-Centered FW Research**
 - This includes research on topics such as costs-benefits analysis for taking FW students; effectiveness of various models of FW; international FW; diversity issues in FW; FW in emerging practice settings; innovative FW experiences; etc.
- **Campus-Centered FW Research**
 - Program Evaluation of integration of curriculum design and integration of FW into the curriculum; Role of AFWC; Graduates NBCOT Cert Exam performance and performance on Level II FW
- **FW Overarching Topics**
 - This includes research on topics such as the Fieldwork Performance Evaluation (FWPE); best practices in FW; impact of length of FW; development of evaluation tools; etc. (p. 7)

Although the 2009 AOTA research agenda clearly identified supervisor-centered research, the majority of the research agenda did not specify that the clinical educator

perspective be included. In addition, there was no reference to community college research of the OTA clinical educator experience specifically.

At the 2012 AOTA national conference, the Commission on Education updated and expanded on its fieldwork research goals. One of the identified models for further exploration is interprofessional education. Nursing and several other medical and allied health fields have been researching this model formally since 2009. According to the World Health Organization (as cited in Carson et al., 2012), “Interprofessional education [and practice (IPEP)] occurs when two or more professions [collaborate to] learn about, from and with each other” (p. 7). The goal is to improve healthcare outcomes by working together. Policymakers in the United States have made IPEP a priority, and the OT profession must get involved to continue to be eligible for funding and reimbursement (Carson et al., 2012).

My research was conducted on a small group of clinical educators who all live in the Midwest. It would be beneficial to conduct a study on a larger, more diverse group of educators. In addition, the participants in this study varied in years of practice, level of education, and type of facility. A study from the perspectives of only OTs or OTAs might provide more insight into the community college context.

In addition, while there are many other delivery models for fieldwork, internship, clinical, and practicum in other professions, more research is needed on how they would benefit clinical educators in the community college context. Some of these have been explored by the occupational therapy profession but currently do not meet accreditation standards (Hanson, 2012). More research is needed on the following emergent delivery models as it pertains to clinical education of community college occupational therapy students.

The first method that must be explored is remote supervision or telemedicine. Some rural and less populated areas have examined the use of technology to supervise students, including online discussion boards, web-based communication systems, and telemedicine. The majority of these are currently only used as a supplement to traditional supervision but are being seriously evaluated for future practice (McLeod & Barbara, 2005).

A second delivery method frequently discussed surrounds the emergent role setting. The profession of occupational therapy has several emerging practice areas that evolve as the healthcare and sociological systems evolve. Some schools provide self-directed fieldwork sites where the students actually develop the role of the OT at the site (Carole & Prigg, 2004). This type of fieldwork is often done in community-based settings where the role of the OT practitioner is still being defined (Fisher & Savin-Badin, 2002). This would not be a likely option for the OTA student due to the lack of OTs as supervisors at the facility. This is another instance where it would be up to the community college and faculty to develop the OTA role and agree to be the supervising OT for the site. This would also indicate a need for further research into the role delineation of OTAs in different areas of practice.

A final area of research is one that would include paid internships or cooperatives within the academic programs similar to the medical school model for internship education. This would allow the academic institutions to maintain relationships with sites and monitor student progress while allowing the site more autonomy and selection of students. The clinical site would then pay a student a stipend for clinical rotation (AOTA, 2009a). A similar option is the model used by the speech therapy profession. Students in this profession complete their didactic coursework and graduate with practicum experience but not clinical experience. The clinical fellows must then seek out their own clinical experience. Their first

year of practice is called a clinical fellowship year (CFY). They must have a supervisor with a Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) who agrees to mentor and periodically evaluate them. They are eligible to complete the certification process after they complete the CFY (American Speech-Language-Hearing Association [ASHA], 2012).

Any of these delivery methods would require accreditation standards changes, regulatory and reimbursement changes, and significant consumer and community education. However, given the current trends and issues in fieldwork, they must be evaluated for benefit to the profession over time. This would then also become a policy issue.

The occupational therapy profession has different providers with different levels of training and different roles. The students educated as OTAs typically receive an Associate of Applied Science in Occupational Therapy Assisting degree. The OTA is legally regulated and ethically required to practice under the supervision of the OT. Therefore, any of the emergent models would require that an OT be present to supervise the OTA student. Any permanent employee role for OTAs that may be created in an emergent area would also require the hiring of a supervising OT. The majority of community delivery models have been implemented in countries that currently have socialized medicine, which allows for more latitude as they are not limited by reimbursement issues that affect those practicing in the United States. These types of community delivery systems are described as interagency model fieldwork (Fisher & Savin-Badin, 2002). The United States is also the only country that offers the associate's degree and assistant position. These options should be explored within the limits of the current reimbursement and regulatory issues of the practitioners in the United States as well as for future reference given the proposed federal and state regulations

for government health care. It may require the profession to look at supervision requirements of both the OTA and the occupational therapy and OTA student. It would also require ACOTE to revise the fieldwork standards. With any of these models, it is imperative that the clinical and/or community educators be present in the program planning, development, implementation, and assessment of learning outcomes.

Finally, it is clear from the lack of supervisor-centered research that more research must be conducted from the clinician's perspective. In addition to the paucity of literature regarding the clinical educator perspective, there is no inclusion of research related to the OTA students specifically. Given the differences in the level of education and supervisor responsibilities, it would be beneficial to conduct more research on the OTA fieldwork experience and the OTA fieldwork supervisor exclusively.

Some suggested areas to consider as a result of this study are the following:

- supervisory process or model,
- motivators to taking students,
- effectiveness of alternative delivery models,
- teaching tools/methodologies, and
- responding to difficult students.

This study gave voice to six volunteer clinical educators of OTA students. More research is needed on the perception of the role of clinician as educator as well as the clinician's perceived role in the community college.

Reflexivity

I opened my dissertation with a reflexivity statement regarding my journey to community college clinical education research. It was written early in my research journey,

and I wrote this closing statement after I finished conducting my research. Strangely, this was one of the harder sections of my dissertation to write. I suppose it was because it was the final section. It was exciting, yet I was anxious. Could it really be possible that I was this close to finishing the journey I started 3 years ago? Just as my participants were on individual journeys in their pursuit of the role of clinical educator to community college students, I was on a similar journey. Mine started much the same as theirs in terms of education, practice, and clinical education. I also became a community college faculty member and program administrator. Now, I have also experienced research of community college clinical education. As a lifelong learner myself, I know that time and context will require me to continue to grow and change in my life and professional roles. My journey will continue.

While conducting this study, I encountered some obstacles. A clinician's first love is always his or her patients. This often results in difficult communication in terms of returning phone calls, e-mails, and finding meeting times. While my participants were responsive and willing, I constantly felt that I was taking up their valuable time, which should have been reserved for their patients and students. Maybe it was the residual clinician in me that brought on that guilt. They were very gracious and seemed honored that I asked their opinion. It was my privilege to listen.

In addition to the ability to coordinate schedules and time, I faced another issue for which I had not accounted. I had initially intended to interview three OTAs and four OTs, thinking that would give me a balanced participant pool. After one OTA dropped out, I was concerned that I had too many OTs to give me good insight into the community college context, which was a core part of my research. However, it ended up working out nicely as

two of the OTs had previously been OTAs. Therefore, I had two participants for each level of education, and I believe it gave me a nice balance.

I believe I have captured the lived experiences of my participants and given them a voice. That was my goal. I have felt for a long time the significant gap between practice and education. Having served at the highest levels of our professional organization, I have witnessed what I believed to be the academy making decisions for practice that did not reflect practice, and more importantly, did not reflect the people our profession serves. My participants are not just occupational therapy practitioners. They live occupational therapy. It permeates their lives. The trademarked brand for our profession is “Occupational Therapy: Living Life to Its Fullest.” This participant group not only participates fully in life, they also work very hard to help others, whether patients or students, do the same.

I believe there is so much more work to be done on the issue of fieldwork and clinical education. What some have referred to as “the fieldwork crisis” is not going anywhere. My hope is that with all stakeholders participating in the discussion, we can find some resolution.

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APPENDIX A
INTERVIEW QUESTIONS

Interview Questions

The experiences of occupational therapy clinicians as educators: the community college context

Interview 1a (face to face):

Context and Background of Role Development

Where are you from? Describe your upbringing?

Describe your high school experiences.

Describe your college experiences.

OT School Experiences

Describe your experiences in OT/OTA school?

Describe your fieldwork experiences?

Tell about your fieldwork supervisor.

Describe any volunteer or committee work you do either for OT or outside of the profession?

Interview 1b (face to face)

Facility Information

Describe the clinical education program at your facility.

Clinical Fieldwork Supervisor Experiences

How did you decide to become a CFWE for CC students?

How were you trained to do CFWE?

Describe your experiences with your first OTA student.

What have been your challenges as a CFWE?

Describe characteristics that contribute to success as a CFWE.

Describe a negative CFWE experience.

Tell me how you know when you have been effective.

What type of relationship do you have with the community colleges?

How much responsibility do you believe you have in the success of the student or of the program for which you take students?

Describe how you feel when a student is not successful.

How much employee support do you receive?

Interview Questions**The experiences of occupational therapy clinicians as educators: the community college context****Interview 2: Follow-up telephone interview**

What meaning do you make of the role of CFWE to CC OTA students?

Did your concept of your role change after the initial interview and self assessment?

Why do you continue to do it?

What is your philosophy of teaching?

APPENDIX B

SELF-ASSESSMENT TOOL FOR FIELDWORK
EDUCATOR COMPETENCY

SELF-ASSESSMENT TOOL FOR FIELDWORK EDUCATOR COMPETENCY

A. PROFESSIONAL PRACTICE COMPETENCIES	KEY DEFINITION STATEMENT: <i>The fieldwork educator demonstrates competencies in professional knowledge, skills, and judgment in occupational therapy practice that supports the client's engagement in meaningful occupation</i>					
The fieldwork educator:	CIRCLE ONE					COMMENTS
	Low Proficient			High Proficient		
1. Uses a systematic approach to evaluation and intervention that is science-driven and focused on clients' occupational performance needs.	1	2	3	4	5	
2. Skillfully collects and analyzes clients' occupational profile and performance in order to develop and implement OT services.	1	2	3	4	5	
3. Considers context, activity demands, and client factors when determining feasibility and appropriateness of interventions.	1	2	3	4	5	
4. Understands clients' concerns, occupational performance issues, and safety factors for participation in intervention.	1	2	3	4	5	
5. Articulates the rationale and theoretical model, frame of reference and/or therapeutic approach for OT services.	1	2	3	4	5	
6. Incorporates evidence based research into occupational therapy practice.	1	2	3	4	5	
7. Collaborates with the OT/OTA to provide evaluation, interpretation of data, intervention planning, intervention, discharge planning, and documentation.	1	2	3	4	5	
8. Collaborates with individuals, colleagues, family/support system, and other staff or professionals with respect, sensitivity, and professional judgment.	1	2	3	4	5	
9. Works to establish a collaborative relationship that values the client perspective including diversity, values, beliefs, health, and well-being as defined by the client.	1	2	3	4	5	
10. Addresses psychosocial factors across the OT practice setting as a reflection of a client-centered approach.	1	2	3	4	5	
11. Effectively manages and prioritizes client-centered services (e.g., intervention, documentation, team meetings, etc.) that support occupation-based outcomes.	1	2	3	4	5	
12. Incorporates legal, ethical, and professional issues that influence practice (e.g., reimbursement, confidentiality, role delineation, etc.).	1	2	3	4	5	
13. Articulates and implements OTA/OT role delineations as relevant to the practice setting.	1	2	3	4	5	
14. Adheres to professional standards of practice and code of ethics as identified by AOTA and state regulatory boards.	1	2	3	4	5	
15. Assumes responsibility for and pursues professional development to expand knowledge and skills (e.g., understands own strengths and limitations, etc.).	1	2	3	4	5	
16. Is knowledgeable regarding entry-level practice skills for the OT and OTA .	1	2	3	4	5	

B. EDUCATION COMPETENCIES	KEY DEFINITION STATEMENT: <i>The fieldwork educator facilitates the student's development of professional clinical reasoning and its application to entry-level practice. The fieldwork educator assumes responsibility for ensuring her or his own competence as a fieldwork educator.</i>					
The fieldwork educator:	CIRCLE ONE					COMMENTS
	Low Proficient			High Proficient		
1. Provides ongoing assessment of a student's individual learning needs based on review of academic curriculum design, OTA and OT roles, prior experiences, and current performance level.	1	2	3	4	5	
2. Collaboratively develops student and fieldwork learning contracts to support occupation-based fieldwork experience (develop outcome-based measurable learning objectives).	1	2	3	4	5	
3. Sequences learning experiences to grade progression toward entry-level practice.	1	2	3	4	5	
4. Facilitates student-directed learning within the parameters of the fieldwork environment.	1	2	3	4	5	
5. Maximizes opportunities for learning by using planned and unplanned experiences within the fieldwork environment.	1	2	3	4	5	
6. Uses a variety of instructional strategies to facilitate the learning process (e.g., role modeling, co-intervention, videotaping, etc.).	1	2	3	4	5	
7. Adapts approach to work effectively with all students, including those who have physical and/or psychosocial impairment(s).	1	2	3	4	5	
8. Demonstrates sensitivity to student learning style to adapt teaching approach for diverse student populations.	1	2	3	4	5	
9. Guides student integration of therapeutic concepts and skills (e.g., facilitates discussions to elicit clinical/professional reasoning, convert practice situations into learning experiences, and/or to process personal feelings/values that interface with practice).	1	2	3	4	5	
10. Reflects upon educator role as complimentary to OT practitioner role.	1	2	3	4	5	
11. Self-identifies and implements a Fieldwork Educator Professional Development Plan. (See page 8 for suggested plan.)	1	2	3	4	5	
12. Identifies resources to promote student and fieldwork educator professional development (e.g., academic program, student and supervisor mentors, AOTA, Commission on Education, Education Special Interest Section, workshops, in-services, etc.).	1	2	3	4	5	
13. Provides reference materials to promote student and fieldwork educator professional development and use of EBP (e.g., publications, texts, videos, internet, etc.).	1	2	3	4	5	
14. Uses evidence-based research to guide student performance and learning for effective teaching strategies.	1	2	3	4	5	

C. SUPERVISION COMPETENCIES	KEY DEFINITION STATEMENT: <i>The fieldwork educator facilitates student achievement of entry-level practice through a student-centered approach.</i>					
The fieldwork educator:	CIRCLE ONE					COMMENTS
	Low Proficient			High Proficient		
1. Uses current supervision models and theories to facilitate student performance and professional behavior	1	2	3	4	5	
2. Presents clear expectations of performance throughout the fieldwork experience, appropriate to entry level OT practice (e.g., student OTA/OT role delineation, Level I/II fieldwork, practice environment, etc.).	1	2	3	4	5	
3. Anticipates and prepares student for challenging situations.	1	2	3	4	5	
4. Provides activities to challenge student's optimal performance.	1	2	3	4	5	
5. Provides the student with prompt, direct, specific, and constructive feedback throughout the fieldwork experience.	1	2	3	4	5	
6. Uses a progression of supervisory approaches throughout the student learning cycle (adapts the amount and type of supervision, changes approach to support student learning, challenges student at current level of performance) to facilitate student performance.	1	2	3	4	5	
7. Uses a variety of strategies to provide communication and feedback to promote student professional development (verbal, non-verbal, group, direct, indirect).	1	2	3	4	5	
8. Is aware of his or her own personal style of supervision and is able to adapt the approach in response to student performance.	1	2	3	4	5	
9. Initiates interaction to resolve conflict and to raise issues of concern.	1	2	3	4	5	
10. Elicits and responds to student's feedback and concerns.	1	2	3	4	5	
11. Collaborates with the student and academic fieldwork coordinator to identify and modify learning environments when student experiences difficulty.	1	2	3	4	5	
12. Models appropriate professional behaviors when interacting with students, clients, and peers.	1	2	3	4	5	
13. Consults with other FW educators and sites to develop creative learning experiences for the student.	1	2	3	4	5	
14. Uses innovation within own fieldwork setting to enhance the student learning experience during fieldwork.	1	2	3	4	5	

D. EVALUATION COMPETENCIES	KEY DEFINITION STATEMENT: <i>The fieldwork educator evaluates student performance to achieve entry-level practice in the fieldwork setting.</i>					
The fieldwork educator:	CIRCLE ONE					COMMENTS
	Low Proficient			High Proficient		
1. Reviews the evaluation tool and expected entry-level expectations (e.g., behavioral objectives, weekly objectives, etc.) with student prior to mid-term and final.	1	2	3	4	5	
2. Assesses student according to performance standards based on objective information (e.g., direct observation, discussion with student, review of student's documentation, observation by others, etc.).	1	2	3	4	5	
3. Assesses student's performance based on appropriate OTA/OT entry-level roles of the fieldwork practice setting.	1	2	3	4	5	
4. Facilitates student self-reflection and self-assessment throughout the fieldwork and evaluation process.	1	2	3	4	5	
5. Uses an evaluation process to advise and guide the student regarding strengths and opportunities for growth based on site-specific objectives.	1	2	3	4	5	
6. Uses fieldwork evaluation tools to accurately measure student performance and provide feedback.	1	2	3	4	5	
7. Completes and distributes in a timely manner all evaluations regarding student performance, including but not limited to the midterm and final evaluation (e.g., AOTA Fieldwork Performance Evaluation, Fieldwork Experience Assessment Tool [FEAT], etc.).	1	2	3	4	5	
8. Guides the student in the use of the Fieldwork Performance Evaluation as a method of promoting continued professional growth and development.	1	2	3	4	5	
9. Documents student's fieldwork performance recognizing ethical and legal rights (e.g., due process, confidentiality, ADA, integrity).	1	2	3	4	5	

APPENDIX C

STUDENT EVALUATION OF FIELDWORK EXPERIENCE

STUDENT EVALUATION OF THE FIELDWORK EXPERIENCE (SEFWE)

Purpose:

This evaluation serves as a tool for fieldwork sites, academic programs, and students. The main objectives of this evaluation are to:

- Enable the Level II fieldwork student who is completing a placement at the site to evaluate and provide feedback to the supervisor and fieldwork setting;
- Enable academic programs, fieldwork sites, and fieldwork educators to benefit from student feedback in order to develop and refine their Level II fieldwork programs;
- Ensure that all aspects of the fieldwork program reflect the sequence, depth, focus, and scope of content of the curriculum design;
- Provide objective information to students who are selecting sites for future Level II fieldwork; and
- Provide a means of evaluation to ensure that fieldwork is performed in settings that provide educational experiences applicable to the academic program.

This form is designed to offer each program the opportunity to gather meaningful and useful information. Sections outlined with thick black double borders are designed to be customized by your program as needed. Pages involving evaluation of individual fieldwork educators have been positioned at the end of the form to allow academic programs to easily remove these pages before making them available for student review, if they choose to do so.

STUDENT EVALUATION OF THE FIELDWORK EXPERIENCE (SEFWE)

Instructions to the Student:

Complete this STUDENT EVALUATION OF THE FIELDWORK EXPERIENCE (SEFWE) form before your final meeting with your fieldwork supervisor(s). It is imperative that you review the form with your supervisor and that both parties sign on page 1. Copy the form so that a copy remains at the site and a copy is forwarded to your Academic Fieldwork Coordinator at your educational program. This information may be reviewed by future students as well. The evaluation of the student (FWPE) should be reviewed first, followed by the student's evaluation of the fieldwork experience (SEFWE), allowing the student to be honest and constructive.

Fieldwork Site _____ Site Code _____

Address _____

Placement Dates: from _____ to _____

Order of Placement: [] First [] Second [] Third [] Fourth

Living Accommodations: *(include type, cost, location, condition)*

Public transportation in the area:

Please write your e-mail address here if you don't mind future students contacting you to ask you about your experience at this site: _____

We have mutually shared and clarified this Student Evaluation of the Fieldwork Experience report.

Student's Signature

FW Educator's Signature

Student's Name *(Please Print)*

FW Educator's Name and credentials *(Please Print)*

FW Educator's years of experience _____

ORIENTATION

Indicate your view of the orientation by *checking* "Satisfactory" (S) or "Needs Improvement" (I) regarding the three factors of adequacy, organization, and timeliness.

TOPIC	Adequate		Organized		Timely		NA
	S	I	S	I	S	I	
1. Site-specific fieldwork objectives							
2. Student supervision process							
3. Requirements/assignments for students							
4. Student schedule (daily/weekly/monthly)							
5. Staff introductions							
6. Overview of physical facilities							
7. Agency/Department mission							
8. Overview of organizational structure							
9. Services provided by the agency							
10. Agency/Department policies and procedures							
11. Role of other team members							
12. Documentation procedures							
13. Safety and emergency procedures							
14. Confidentiality/HIPAA							
15. OSHA—Standard precautions							
16. Community resources for service recipients							
17. Department model of practice							
18. Role of occupational therapy services							
19. Methods for evaluating OT services							
20. Other							

Comments or suggestions regarding your orientation to this fieldwork placement:

CASELOAD

List approximate number of each age category in your caseload.

Age	Number
0–3 years old	
3–5 years old	
6–12 years old	
13–21 years old	
22–65 years old	
> 65 years old	

List approximate number of each primary condition/problem/diagnosis in your caseload

Condition/Problem	Number

OCCUPATIONAL THERAPY PROCESS

Indicate the approximate number of screenings/evaluations you did; also indicate their value to your learning experience by *circling* the appropriate number with #1 being least valuable and #5 being the most valuable.

	REQUIRED		HOW MANY	EDUCATIONAL VALUE				
	Yes	No		1	2	3	4	5
1. Client/patient screening								
2. Client/patient evaluations (Use specific names of evaluations)								
				1	2	3	4	5
				1	2	3	4	5
				1	2	3	4	5
				1	2	3	4	5
				1	2	3	4	5
				1	2	3	4	5
				1	2	3	4	5
				1	2	3	4	5
3. Written treatment/care plans				1	2	3	4	5
4. Discharge summary				1	2	3	4	5

List major therapeutic interventions frequently used and indicate whether it was provided in group, individually, Co-Treatment, or consultation. List other professionals involved.

Therapeutic Interventions	Individual	Group	Co-Tx	Consultation
Occupation-based activity, i.e., play, shopping, ADL, IADL, work, school activities, etc. (within client's own context with his or her goals)				
1.				
2.				
3.				
4.				
Purposeful activity (therapeutic context leading to occupation)				
1.				
2.				
3.				
4.				

Preparatory methods, i.e., sensory, PAMs, splinting, exercise, etc. (preparation for occupation-based activity)				
1.				
2.				
3.				
4.				

THEORY—FRAMES OF REFERENCE—MODELS OF PRACTICE

Indicate frequency of theory/frames of reference used

	Never	Rarely	Occasionally	Frequently
Model of Human Occupation				
Occupational Adaptation				
Ecology of Human Performance				
Person–Environment–Occupation Model				
Biomechanical Frame of Reference				
Rehabilitation Frame of Reference				
Neurodevelopmental Theory				
Sensory Integration				
Behaviorism				
Cognitive Theory				
Cognitive Disability Frame of Reference				
Motor Learning Frame of Reference				
Other (list)				

FIELDWORK ASSIGNMENTS

List the types of assignments required of you at this placement (check all that apply), and indicate their educational value (1 = not valuable ----- 5 = very valuable)

Case study applying the Practice Framework	1	2	3	4	5	N/A
Evidence-based practice presentation: Topic:	1	2	3	4	5	N/A
Revision of site-specific fieldwork objectives	1	2	3	4	5	N/A
Program development Topic:	1	2	3	4	5	N/A
In-service/presentation Topic:	1	2	3	4	5	N/A
Research Topic:	1	2	3	4	5	N/A
Other (list)	1	2	3	4	5	

ASPECTS OF THE ENVIRONMENT

	1 = Rarely 2 = Occasionally 3 = Frequently 4 = Consistently			
	1	2	3	4
Staff and administration demonstrated cultural sensitivity				
The Practice Framework was integrated into practice				
Student work area/supplies/equipment were adequate				
Opportunities to collaborate with and/or supervise OTs, OTAs, and/or aides				
Opportunities to network with other professionals				
Opportunities to interact with other OT students				
Opportunities to interact with students from other disciplines				
Staff used a team approach to care				
Opportunities to observe role modeling of therapeutic relationships				
Opportunities to expand knowledge of community resources				
Opportunities to participate in research				
Additional educational opportunities (<i>specify</i>):				
How would you describe the pace of this setting? (circle one)	Slow	Med	Fast	
Types of documentation used in this setting:				
Ending student caseload expectation: _____ # of clients per week or day				
Ending student productivity expectation: _____ % per day (direct care)				

SUPERVISION

What was the primary model of supervision used? (check one) <input type="checkbox"/> one supervisor : one student <input type="checkbox"/> one supervisor : group of students <input type="checkbox"/> two supervisors : one student <input type="checkbox"/> one supervisor : two students <input type="checkbox"/> distant supervision (primarily off-site) <input type="checkbox"/> three or more supervisors : one student (count person as supervisor if supervision occurred at least weekly)

List fieldwork educators who participated in your learning experience.

	Name	Credentials	Frequency	Individual	Group
1.					
2.					
3.					
4.					
5.					

ACADEMIC PREPARATION

Rate the relevance and adequacy of your academic coursework relative to the needs of **THIS** fieldwork placement, *circling* the appropriate number. (Note: may attach own course number)

	Adequacy for Placement					Relevance for Placement				
	Low				High	Low				High
Anatomy and Kinesiology	1	2	3	4	5	1	2	3	4	5
Neurodevelopment	1	2	3	4	5	1	2	3	4	5
Human development	1	2	3	4	5	1	2	3	4	5
Evaluation	1	2	3	4	5	1	2	3	4	5
Intervention planning	1	2	3	4	5	1	2	3	4	5
Interventions (individual, group, activities, methods)	1	2	3	4	5	1	2	3	4	5
Theory	1	2	3	4	5	1	2	3	4	5
Documentation skills	1	2	3	4	5	1	2	3	4	5
Leadership	1	2	3	4	5	1	2	3	4	5
Professional behavior and communication	1	2	3	4	5	1	2	3	4	5
Therapeutic use of self	1	2	3	4	5	1	2	3	4	5
Level I fieldwork	1	2	3	4	5	1	2	3	4	5
Program development	1	2	3	4	5	1	2	3	4	5

What were the strongest aspects of your academic program relevant to preparing you for THIS Level II fieldwork experience? Indicate your top 5.

<input type="checkbox"/> Informatics	<input type="checkbox"/> Occ. as Life Org	<input type="checkbox"/> A & K	<input type="checkbox"/> Foundations	<input type="checkbox"/> Level I FW
<input type="checkbox"/> Pathology	<input type="checkbox"/> Neuro	<input type="checkbox"/> Administration	<input type="checkbox"/> Theory	<input type="checkbox"/> Peds electives
<input type="checkbox"/> Env. Competence	<input type="checkbox"/> Research courses	<input type="checkbox"/> Prog design/eval	<input type="checkbox"/> Consult/collab	<input type="checkbox"/> Older adult elect.
<input type="checkbox"/> Interventions	<input type="checkbox"/> Evaluations	<input type="checkbox"/> Adapting Env	<input type="checkbox"/> Human comp.	<input type="checkbox"/> Community elect.
<input type="checkbox"/> Social Roles	<input type="checkbox"/> History	<input type="checkbox"/> Occupational Sci	<input type="checkbox"/> Other:	

What changes would you recommend in your academic program relative to the needs of **THIS** Level II fieldwork experience?

SUMMARY

	1 = Strongly disagree 2 = Disagree 3 = No Opinion 4 = Agree 5 = Strongly agree				
	1	2	3	4	5
Expectations of fieldwork experience were clearly defined					
Expectations were challenging but not overwhelming					
Experiences supported student's professional development					
Experiences matched student's expectations					

What particular qualities or personal performance skills do you feel that a student should have to function successfully on this fieldwork placement?

What advice do you have for future students who wish to prepare for this placement?

- Study the following evaluations:

- Study the following intervention methods:

- Read up on the following in advance:

Overall, what changes would you recommend in this Level II fieldwork experience?

Please feel free to add any further comments, descriptions, or information concerning your fieldwork at this center.

Indicate the number that seems descriptive of each fieldwork educator.
Please make a copy of this page for each individual.

1 = Strongly Disagree
2 = Disagree
3 = No opinion
4 = Agree
5 = Strongly agree

FIELDWORK EDUCATOR NAME: _____
FIELDWORK EDUCATOR YEARS OF EXPERIENCE: _____

	1	2	3	4	5
Provided ongoing positive feedback in a timely manner					
Provided ongoing constructive feedback in a timely manner					
Reviewed written work in a timely manner					
Made specific suggestions to student to improve performance					
Provided clear performance expectations					
Sequenced learning experiences to grade progression					
Used a variety of instructional strategies					
Taught knowledge and skills to facilitate learning and challenge student					
Identified resources to promote student development					
Presented clear explanations					
Facilitated student's clinical reasoning					
Used a variety of supervisory approaches to facilitate student performance					
Elicited and responded to student feedback and concerns					
Adjusted responsibilities to facilitate student's growth					
Supervision changed as fieldwork progressed					
Provided a positive role model of professional behavior in practice					
Modeled and encouraged occupation-based practice					
Modeled and encouraged client-centered practice					
Modeled and encouraged evidence-based practice					

Frequency of meetings/types of meetings with supervisor (value/frequency):

General comments on supervision: _____

AOTA SEFWE Task Force, June 2006

APPENDIX D
IRB DOCUMENT

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office for Responsible Research
Vice President for Research
1138 Pearson Hall
Ames, Iowa 50011-2207
515 294-4566
FAX 515 294-4267

Date: 10/17/2011

To: Nichelle L Cline
1712 Taft Dr SW
Cedar Rapids, IA 52404

CC: Dr. Frankie Santos Laanan
N225A Lagomarcino

From: Office for Responsible Research

Title: The Experiences of Occupational Therapy Clinicians as Educators: The Community College Context

IRB ID: 11-465

Study Review Date: 10/17/2011

The project referenced above has been declared exempt from the requirements of the human subject protections regulations as described in 45 CFR 46.101(b).

The determination of exemption means that:

- **You do not need to submit an application for annual continuing review.**
- **You must carry out the research as described in the IRB application.** Review by IRB staff is required prior to implementing modifications that may change the exempt status of the research. In general, review is required for any modifications to the research procedures (e.g., method of data collection, nature or scope of information to be collected, changes in confidentiality measures, etc.), modifications that result in the inclusion of participants from vulnerable populations, and/or any change that may increase the risk or discomfort to participants. Changes to key personnel must also be approved. The purpose of review is to determine if the project still meets the federal criteria for exemption.

Non-exempt research is subject to many regulatory requirements that must be addressed prior to implementation of the study. Conducting non-exempt research without IRB review and approval may constitute non-compliance with federal regulations and/or academic misconduct according to ISU policy.

Detailed information about requirements for submission of modifications can be found on the Exempt Study Modification Form. A Personnel Change Form may be submitted when the only modification involves changes in study staff. If it is determined that exemption is no longer warranted, then an Application for Approval of Research Involving Humans Form will need to be submitted and approved before proceeding with data collection.

Please note that you must submit all research involving human participants for review. **Only the IRB or designees may make the determination of exemption**, even if you conduct a study in the future that is exactly like this study.

Please don't hesitate to contact us if you have questions or concerns at 515-294-4566 or IRB@iastate.edu.

APPENDIX E
INDIVIDUAL SELF-ASSESSMENT SCORES

Table E1

Participant Scores on the American Occupational Therapy Association Self-Assessment Tool for Fieldwork Educator Competency

	Years in practice/Years in clinical education	Professional Practice (80)	Education (70)	Supervision (70)	Evaluation (45)	Administration (80)
Karen	11/10	72	62	65	45	77
Laura	35/20+	70	63	64	44	75
Linda	25/20+	74	63	65	44	74
Cathy	6/4	59	26	47	31	54
Sharon	20/19	76	62	62	42	80
John	20/19	No data	No data	No data	No data	No data

Note. Number in parenthesis is highest possible score for that competency.

APPENDIX F
MEMBER CHECK

Participant	First	Second
Cathy	2/20/12	3/1/12
Karen	2/20/12	3/1/12
Linda	2/20/12	3/1/12
Laura	2/23/12	3/1/12
Sharon	2/23/12	3/1/12
John	2/23/12	no data

APPENDIX G
PEER REVIEW

Name	Date Sent	Comments Returned
Bill Backlin	8/2/12	8/13/12
Seth Gilbert	8/2/12	8/5/12