

**DEFINING AND CLARIFYING THE ROLE OF CLINICAL
SUPERVISION ACCORDING TO PHYSIOTHERAPISTS AT A
HIGHER EDUCATION INSTITUTION**

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the degree Master of Science in the Department of Physiotherapy,
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ABSTRACT

Background: The roles of doctors and nurses in clinical supervision and clinical education are well defined in literature. However, the role of the physiotherapist in clinical education has not been clearly defined. This could be because the understanding of a clinical supervisor varies from discipline to discipline.

Aim of the study: To define and clarify the views and experiences of physiotherapy clinical supervisors regarding clinical education and their role in contributing to student learning.

Research question: What are the views and experiences of physiotherapy clinical supervisors on clinical education?

Study Design: This study was a qualitative exploratory study

Population and sample: The population consisted of seventeen physiotherapy clinical supervisors, employed at UWC Physiotherapy Department for the 2014-2015 academic periods. Twelve of the seventeen participants agreed to participate in the study.

Data collection process: Data were collected by means of in-depth interviews, which were audio taped by the researcher at a time convenient for the participant.

Analysis of results: Each transcript was read individually by the researcher, and notes made in the margins to highlight interesting concepts that emerged. The different types of concepts were listed and categorised, while common categories were grouped into themes. To ensure that the information gained was accurate during the interview process, the researcher concluded and summarised the findings after each question in order to ensure that there was a common understanding of the information obtained.

Findings: The study highlights the importance of the clinical supervisors', as well as the clinicians' active involvement in clinical education. The clinicians' role is viewed as a valuable asset in clinical education and it was clearly identified that clinical supervisors cannot work in isolation.

Conclusion: The study highlights that clinical education is a collective responsibility where each stakeholder, namely supervisors, educators and clinicians contribute to clinical education in different ways.

Ethics: Ethical clearance and permission was obtained from the Ethics Committee at the University of the Western Cape and the Department of Physiotherapy. Participants were informed of the purpose of the research, prospective research benefits, expected duration and procedures, and that confidentiality would be ensured at all cost. All participants consented to be audio taped and the consent forms were signed.



KEYWORDS

Capacity building

Clinicians

Clinical education

Clinical leadership

Clinical practice

Clinical supervision

In-depth interviews

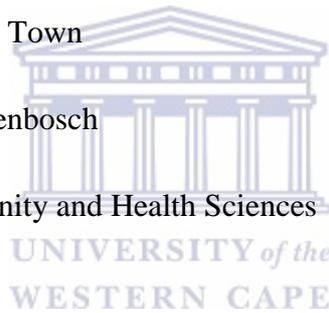
Qualitative study

Reflective journal



LIST OF ACRONYMS

p.	Page
e.g.	Example
CPD	Continuous professional development
HPE	Health professions education
PBL	Problem-based learning
MDT	Multi-disciplinary team
UWC	University of the Western Cape
UCT	University of Cape Town
US	University of Stellenbosch
FCHS	Faculty of Community and Health Sciences
ICU	Intensive care unit
SCI	Spinal cord injury
NMS	Neuromusculoskeletal
SWOTS	Strengths weaknesses opportunities threats
Ortho	Orthopaedics
Neuro	Neurology



DECLARATION

I declare that “Defining and Clarifying the Role of Clinical Supervision According to Physiotherapists at a Higher Education Institution.” is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted, have been indicated and acknowledged by complete references.

Name: Taryn-Lee Warner Voges

Date: 14 August 2017

Signed:



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I wish to acknowledge the University of the Western Cape for allowing me to commence my studies at such a diverse institution of higher education. I am proudly a UWC undergraduate, who is excited about returning home and continuing my postgraduate studies here at the University of the Western Cape. I believe that I have not chosen UWC, UWC has chosen me. I will continue to come back to the foundation of my education and career. Thank you for providing opportunities of education to those less fortunate and underprivileged.

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DEDICATION

I dedicate my dissertation work to the almighty, giver of life, the alpha and omega. Without God I am nothing: “I can do all things through Christ who strengthens me” (Philippians 4:13). God has surely carried me through this season in my life and I am truly humbled by his faithfulness.

To my loving husband, thank you for your unbelievable support through this journey. I thank my God for blessing me, with you! I am because of your love, support, caring and understanding. When you tell me, “I will do anything for you, anything!” I truly see and feel it through your love for me. Growing old with you and the twins is a daily prayer of mine, every day spent with you is a gift; I love you!

My mother, my rock, Gloria Warner, and my grandmother, Magda Warner, have always supported me in all my dreams and endeavours. Your prayers continue to keep me going. My mother is a single parent, who raised her children and made us believe that we can accomplish all things through Christ, if we believe. I will forever be grateful for what you have done for me and still continue to do, I love you!

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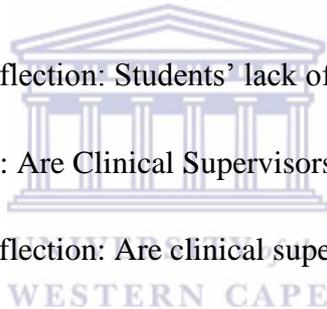


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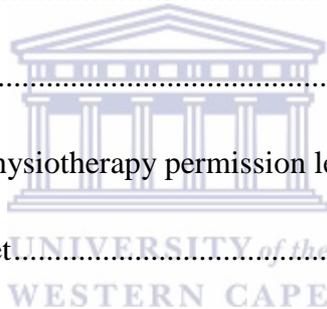


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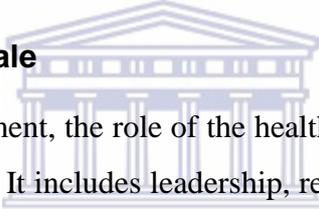
CHAPTER ONE

INTRODUCTION

1.1. Introduction to the study

In this chapter, the researcher introduces the background and foundation of this current thesis, which explores the views and experiences of physiotherapy clinical supervisors regarding clinical education. The concept of clinical education is explained in detail, while the rationale for, as well as the importance of, conducting this research study among clinical supervisors, who form part of the stakeholders, is presented and clarified. The aim, research question, objectives and significance of the study are described in this chapter, concluding with a summary of the chapters for the rest of the thesis.

1.2. Background and Rationale



In our current healthcare environment, the role of the health professional does not necessarily focus only on the care of patients. It includes leadership, research, administration and clinical supervision. Since the early 1990s, clinical supervision has been a familiar concept for some healthcare professionals (for example, counsellors, psychotherapists, midwives, occupational therapists', health visitors and mental health nurses) as a mechanism to support staff and facilitate professional development (Hall & Cox, 2009: p. 283). In addition, clinical supervision is widely used in the healthcare profession, and is “embedded in practice” (Hall & Cox, 2009: p. 283). Across the globe, the role of clinicians, as leaders and managers of healthcare, has been viewed as increasingly important, shifting the focus to establishing ways of developing and supporting clinical leaders more effectively, to address policy agendas, such as patient safety and quality improvement (McKimm & Swanwick, 2011). “Clinical supervision” is a term commonly used in the health and social care professions; however, its definition may vary, implying that the understanding of clinical supervision, internationally, may be different to its local context (Archer, 2011).

The Chartered Society of Physiotherapy (2000) highlighted that the concept of clinical supervision was considered to play a key role in the future development of local, robust systems of on-going professional development. Sellars (2004: p. 74) concurs, “...clinical

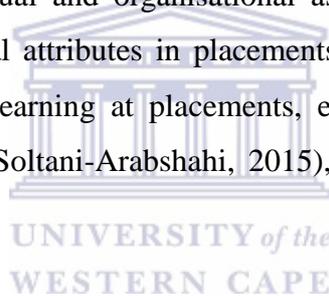
supervision provides the opportunity for a formal system of professional support and development, which is valued by individuals engaged in the process”. Professional development in clinical placements is the way forward, as confirmed by the Australian Department of Health (2005), stating that clinical supervision is defined as “the process of two or more professionals formally meeting to reflect and review clinical situations with the aim of supporting the clinician in their professional environment”. However, in the United Kingdom, Hall and Cox (2009) explains that clinical supervision is less understood as one aspect of continuing professional development (CPD) and reflective practice. These authors explain that clinical supervision is a familiar term for physiotherapists in the context of workplace learning for undergraduate students, as well as an activity that occurs with senior colleagues to develop clinical reasoning, and for support. This definition similarly defines the way clinical supervision is understood in the South African context. In the South African context, the role of the health professional in the clinical setting is linked to the provision of quality undergraduate education to health professional students, through clinical supervision (Archer, 2011).

Among physiotherapists in South Africa, the term “clinical supervision” refers to the clinical education of students (Archer, 2011). Therefore, according to Schoen, Tomaka, Chriss, Gutierrez and Hairston (2008: p. 263), “Clinical education enables physiotherapy students to acquire information, skills and competencies necessary for clinical practice, and to gain confidence in their clinical reasoning and application of theoretical knowledge”. Consequently, the belief underpinning clinical supervision is about learning from practice. Clinical supervisors are employed at the university to facilitate this learning and critical thinking, as well as teach and evaluate students’ clinical performance (Schoen *et al.*, 2008). Keiler and Hanekom (2013) asserts that critical thinking is the ability of a clinical supervisor to analyse complex data and situations, in order to implement appropriate strategies or actions, and is necessary for effective problem-solving and decision-making in the clinical arena.

Within health professions education (HPE), a variety of educational strategies, including problem-based learning (PBL), has been proposed to develop the clinical reasoning and critical thinking skills of undergraduate students (Keiler & Hanekom, 2013). In 2006, a study conducted by Savery (2006, as cited in Keiler, & Hanekom, 2013) defined PBL as “an instructional and curricular learner centred approach that empowers learners to conduct

research, integrate theory and practice, and apply knowledge and skills to develop a viable solution to a defined problem.” This strategy has reportedly provided benefits to professionals in the social and cognitive dimensions, after graduation (Keiler & Hanekom, 2013). Therefore, the researcher is of the opinion that, if this is to be employed as a possible strategy, the key role of clinical supervisors and clinicians, in driving this agenda, has to be understood, in addition to understanding whether clinical supervisors view this as their role.

The role of clinicians as educators and supervisors has been explored in literature (Manninen, Henriksson, Scheja & Silèn, 2015). These authors highlight that the pedagogical role of “supervisors” is to facilitate student learning. Therefore, the researcher is of the opinion that supervisors should assist in seeking opportunities for students to practice their clinical skills, as well as aim to facilitate experiential learning (learning by doing) among students. Jokelainen, Turunen, Tossavainen, Jamookeeah and Coco (2011) highlight that student mentoring integrates the individual and organisational aspects, as well as environmental, collegial pedagogical and clinical attributes in placements. Literature reveals that there is significant progress in clinical learning at placements, evident among doctors (Razmjou, Baradaran, Kouhpayehzadeh & Soltani-Arabshahi, 2015), as well as nurses (Bos, Silèn & Kaila, 2015) in this area.



However, although some health professionals, acting as supervisors, may be experts in their respective fields, they do not always possess the necessary teaching skills (Archer, 2011). Undergraduate programmes for several disciplines require clinical supervisors to teach their students in the clinical settings. Physiotherapy undergraduate programmes, offered across all universities in South Africa, employ clinical supervisors, who are required to educate their students in clinical settings. Archers (2011) explains that, despite the clinical supervisors being employees of the universities, the onus is on the universities to ensure that all the clinical supervisors receive the adequate support and opportunities to improve their skills in supervising. While it is assumed that university staff members are responsible for assessment and formal feedback to students, Archer (2011) advises that everyone can facilitate behaviours that inspire learning, which should be considered. Archer (2011) asserts that, although most clinical teachers are enthusiastic, and seriously assume their role as teachers of future generations of healthcare professionals, they often lack knowledge of educational principles and teaching strategies, and, therefore, may be inadequately prepared for this additional professional role.

Consequently, building the capacity of all health professionals, to empower them for their various roles, is essential (Kumar, Adhish & Deoki, 2014). In South Africa, the relationship between health institutions and universities is essential for the training of students, but the relationships needs to be beneficial to both parties, implying that the capacity building of clinicians, who serve as clinical supervisors, needs to be addressed. Capacity building has become a popular strategy to develop sustainable human resources for health in developing countries (Kumar, Adhish, & Deoki, 2014). However, the researcher considers that before intervention strategies can be designed, it is important to understand the views of the key stakeholders, which in this research study refers to the views of the physiotherapy clinical supervisors, employed at higher education institutions.

A systematic review, conducted by Farnan, Petty, Georgitis, Martin, Chiu, Prochaska and Arora (2012), focusing on the effects of clinical supervision on patient and residency education outcomes, highlights that, if clinical supervision is improved, both patient and education related outcomes will be improved. However, according to Bos *et al.* (2015), if both patient and education outcomes are to be achieved a more systematic collaboration is required between the clinical settings and the universities. As stated by McKimm and Swanwick (2011), clinical teachers, working both in higher education and in practice, have a key role to play in leadership development. In the South African context, therefore, it is understood that clinical supervisors will develop their students as leaders in the clinical arena. However, this needs to be supported by the clinicians in the clinical setting, as clinical learning aims to promote the integration of theory and practice. When providing supervision to students, the clinical supervisor and clinician should consider the welfare of the patient and the welfare of the student (McKimm & Swanwick, 2011).

The transition from the classroom to clinical practice is stressful for many students, and is even more difficult, given the reduced time that clinicians have for supervising undergraduate students, which is often due to the current situation in South Africa, with the shortages of health professional posts in hospitals (Faure, Unger & Burger, 2002). Therefore, the role of clinical supervisors at the higher education institutions becomes vital. This highlights the need to improve the interaction between the universities, clinical supervisors and the clinicians in the clinical setting, which, in turn, would improve the standard of clinical supervision. According to Faure *et al.* (2002), government cutbacks on posts for hospital clinicians of all disciplines have resulted in enormous and far-reaching effects on

undergraduate clinical education. Specifically in South Africa, these cutbacks have intensified the pressure on clinicians, who have to treat larger numbers of patients, while still being expected to continue taking some responsibility for student supervision (Faure *et al.*, 2002). This in turn leads to the lack of time, confidence and adequate support to combine the roles of clinician, educator and role model, effectively. With all these additional challenges, it is difficult to sustain implemented clinical education and supervision programmes, as Sellars (2004: p. 64) asserts, “Clinical supervision is not widespread and where it has been implemented it is difficult to sustain”. Students, therefore, are forced to take direct responsibility for the care of their patients, as well as their own learning, during clinical placements (Faure *et al.*, 2002). Due to the lack of support for students, the provision of an effective introduction to clinical practice will present an ever-increasing challenge (Faure *et al.*, 2002). Consequently, the importance of the clinical supervisor is accentuated, as they have an active role to play in facilitating the learning process of students in the clinical setting.

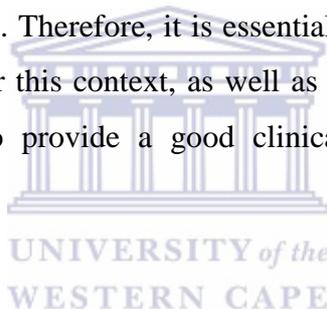
McKimm and Swanwick (2011) aver that, if the important role of clinical supervision in clinical education is to be successful, there needs to be a change in culture. In the researcher’s opinion, a culture needs to be installed that encourages all physiotherapists to contribute to this vital process of clinically educating undergraduate students in this field, in order to give rise to competent entry-level physiotherapists. According to Schoen *et al.* (2008), clinical education provides students with opportunities to integrate the knowledge, skills and behaviour required for practice, and leads to the development of entry-level physiotherapists, who act with professionalism, competence and leadership. These authors emphasise that, if clinical supervisors value the contribution they make in the process, the impact of clinical supervision will be far reaching. Schoen *et al.* (2008) continue that physiotherapists perform a vital role in clinical education, by sharing their professional, clinical expertise and knowledge with physiotherapy students.

Therefore, the role of the stakeholders in clinical supervision needs to be clarified, in order to help physiotherapy clinicians, clinical supervisors and higher education institutions to utilise the process of clinically educating students more effectively. According to Schoen *et al.* (2008), all physiotherapists can show their commitment to the future of the profession, by regularly sharing their expertise and time with physiotherapy students, in their role as mentors and clinical supervisors. The questions raised are, “Are all the stakeholders on the

same page?” and “What are the clinical supervisors’ perceptions about their role?” According to Ladyshefsky and Richard (2010), development of competence is an ongoing journey, and one that is punctuated in the early part of a health professional’s career. Therefore, it becomes important to understand the views of health professionals in the local context, in order to develop models, or a capacity programmes that are suitable for the local context. In addition, the Chartered Society of Physiotherapy (2005) observes, “while physiotherapists are undoubtedly using what equates to clinical supervision on an informal basis, research shows that the majority of physiotherapists are unaware of what formal clinical supervision is, and how it can support them in their practice”.

1.3. Problem statement

The understanding of clinical supervision is essential, as it is an important aspect of physiotherapy education. Differing views on clinical supervision can result in a poor clinical education experience for students. Therefore, it is essential for a clear understanding of how clinical supervision is defined for this context, as well as the role clarification pertaining to clinical supervision, in order to provide a good clinical experience effectively for the students.



1.4. Research question

How do physiotherapy clinical supervisors define clinical education and their role in contributing to student learning?

1.5. Aim of the study:

To define and clarify the views and perceptions of physiotherapy clinical supervisors, concerning clinical education and their role in contributing to student learning.

1.6. Objectives

- To explore and describe how clinical supervisors’ define clinical supervision and education;
- To explore and describe the views and perceptions of clinical supervisors concerning their role as clinical educators;

- To explore the experiences of clinical supervisors with clinical supervision and education.

1.7. Significance of the study

The concept of clinical supervision in clinical education among health professionals may vary, therefore, it is important to have a better understanding in the physiotherapy arena. If clinicians and clinical supervisors are unsure of their role in the clinical setting, what guarantee exists that the students are developing into qualified professionals? Clinical education is a critical component of physiotherapy education programmes and is essential to the future provision of quality physiotherapy healthcare (Schoen *et al.*, 2008). As previously mentioned, the role of the health professional in the clinical setting is linked to the provision of quality undergraduate education to health professional students, through clinical supervision. The clinicians and clinical supervisors working in the clinical setting need to be aware of what their role is in clinical education, in order to give students effective practical exposure with the aim of laying a solid foundation.

By defining the roles of the academic leaders, clinicians and clinical supervisors, patient outcomes will be optimised, as the lack of supervision may be harmful to both the patient and student. Therefore, this current study additionally explores how the clinical supervisors view the role of the clinician in clinical education. According to Sellars (2004: p. 65), “Within the clinical governance framework, both the organization and the individual have a responsibility to improve the quality of services and safeguard standards of care.” In addition, it is important that health professionals have explicit mechanisms of support and professional development, not only to enhance their own practice, but also to ensure a sustained development of their professions in future years.

This study also explores the views of clinical supervisors, in order to get an understanding on how they perceive themselves contributing to student learning. According to Blaikie (2000), an *explorative design* is conducted to gain understanding of a situation. The need for such a study arises out of the lack of knowledge, or insufficient literature, regarding the topic. As previously mentioned by the Chartered Society of Physiotherapy (2005) and highlighted by Ernstzen, Bitzer and Grimmer-Somers (2009), not much research has been done concerning teaching and learning in physiotherapy clinical environments, while the majority of

physiotherapists are unaware of what formal clinical supervision is, and how it can support them in their practice (Chartered Society of Physiotherapy, 2005).

1.8. Definition of terms

Clinical supervision

Clinical supervision refers to a collaborative process between two or more practitioners of the same or different professions. This process should encourage the development of professional skills and enhance the quality of patient care through the implementation of an evidence-based approach to maintaining standards in practice. These standards are maintained through discussions around specific patient incidents, or interventions, using elements of reflection to inform the discussion (Chartered Society of Physiotherapy, 2005).

Clinical education

Clinical education is a complex activity, fundamental to professional socialisation, communication and interpersonal competencies, professional ethos, roles and responsibilities, as well as generic and discipline-specific knowledge and skills, which are usually learned and assimilated in the practice context, through experimental learning (Ramklass, 2013).

Health practitioner

A health practitioner “is an individual who carries on, and is registered in terms of legislation to carry on, an occupation which involves the provision of care or treatment for the physical or mental health or for the well-being of individuals” (Croome & Olivier, 2011).

Health professional

A health professional “is any person who is registered to practice his/her profession in terms of the Health Professions Act, or any other Legislation applicable to such professions, e.g. Nursing Act, Pharmacy Act.” (Health Professions Council of South Africa, 2016)

Clinical supervisor

The clinical supervisor is a health practitioner with current general registration, who has agreed to assess and monitor a physiotherapist undertaking supervised practice, and report to the Board about the performance of the physiotherapist under supervision, and who, in the opinion of the Board, is suitably qualified and experienced (usually a minimum of three years’ experience). The registration of a supervisor should not be subject to conditions, or undertakings that would affect their ability to supervise the physiotherapist under supervision,

effectively. Only in exceptional circumstances would a health practitioner, who is not a physiotherapist, be considered as a supervisor (Australian Board of Physiotherapy, 2016).

1.9. Summary of the chapters

Chapter One encompasses the foundation upon which this study was based. The researcher explains the aim, objectives, as well as the significance of the study and outlines the problem that was identified. The manner in which the study proposes to minimise this obstacle is also presented, as well as the definitions of terms as they are used in the study.

Chapter Two comprises a literature review of all available literature that supports and validates the need for this study. The literature accessed provides evidence of the need for a study of this nature, as well as the importance of conducting this study. The literature review, therefore, adds value to this research project highlights its difference and contribution to new knowledge in the world of research.

Chapter Three comprises the methodology that was used to conduct this study. It explains the reasoning for using the research design implemented. The population sampling, data collection tools, data collection, data analysis, as well as the reliability and validity of this study is presented in this chapter.

Chapter Four contains the presentation and discussion of the findings/results. The chapter highlights the data, the analyses and explains the findings of the study. In this chapter, the themes, sub-themes and categories that were identified from the qualitative data are discussed. This discussion is based on the objectives of the study, and compared to and contrasted with the literature.

In **Chapter Five**, the research study is summarised. The researcher offers short-term and long-term recommendations, as well a conclusion.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

In this chapter, the focus is on literature linked to clinical education, clinical practice, clinical teaching, clinical leadership and clinical supervision. The literature accessed illustrates the importance of conducting this study and presents previous works, which authenticate the need for this study. Additionally, it highlights the difference, as well as the contribution that this study could provide in the world of research, which, in turn, could help researchers to further investigate related topics.

2.2. Clinical Education

Clinical education is an essential component of health science education. According to Ham (2003), it has been a topic of extensive discussion for decades. Clinical training, or clinical education, therefore, forms an integral part of physiotherapy education (Hobbs, Henley, Higgs & Williams, 2000). The clinical setting allows students to integrate theory with practice. As stated by Ladyshevsky and Richard (2010), the challenge in health science for students and new graduates, when entering a clinical practice, is to transfer their knowledge from the academic environment to the clinical environment. Therefore, it is essential that the clinical setting be seen as a safe learning environment for undergraduate students. Learning in “real” practice situations is invaluable for all health professional students, as they aim to develop their clinical skills. In these clinical settings, clinicians daily deliver a service to their patients, but whether they take on the added role of clinically educating the students effectively, is questionable. These learning experiences in the clinical context provide the students and staff with the opportunity to apply their theoretical knowledge in a clinical situation (Lindquist, Engardt & Richardson, 2004). The purpose of clinical education is to provide clinical opportunities for students to attain competence at the level of a beginning practitioner, by integrating their knowledge and skills at progressively higher levels of performance and responsibility, while under the guidance of qualified practitioners. Several authors have emphasised the importance of professional supervision for the development of professional performance, and clinical education is regarded as crucial for the students’

professional socialisation and their future professional career (O'hman, Hagg & Dahlgren, 2005). This reveals that clinical supervision is beneficial to the student, clinical supervisors and clinicians, as it improves the professional development, which in turn improves patient safety and quality improvement.

Although clinical education can improve patient safety and the quality of treatment, there are positive and negative outcomes linked to clinical education. The aim of clinical education is to provide medical students with opportunities to grow and develop through experience with patients, by enhancing a wide range of skills (Conn, Lake, McColl, Bilszta & Woodward-Kron, 2012). These authors explore the positive and negative outcomes and highlight the strengths of clinical education. Clinical education is decidedly relevant to future professional practice, integrates students into healthcare teams, and provides role modelling by clinical teachers (Conn *et al.*, 2012). However, the negative outcomes regarding clinical education include criticism of it being haphazard, lacking in evidence-based rigour and failing to provide students with adequate opportunities for observed practice. Therefore, the way in which clinical education is conducted needs to be investigated. If executed incorrectly the effects on both the student and the patients could be detrimental. Researchers need to determine how they can aid clinical education in the clinical setting. They could start by establishing how the stakeholders view their role in this complex process. In this current study, the views of the clinical supervisors, regarding the definition and clarification of their role/s in clinical education, are explored, as well as their fellow colleagues' role/s as clinicians in clinical education, while, simultaneously, exploring their understanding of clinical practice and teaching, as clinical education is often associated with these terms.

2.2.1. Learning in Clinical Education

In order to promote student learning, it is important to prepare the students effectively for the clinical setting, by creating appropriate learning environments (Severinsson & Sand, 2010). These appropriate learning environments could be created by providing opportunities for learning and creating positive environments to learn, by embracing positive attitudes and role modelling professionalism (Severinsson & Sand, 2010). According Tomlinson (2015), role modelling is an important influence of culture, as the medical student's concept of a "good doctor" is often challenged by the negative role models they witness in practice. This author emphasises how role models can support, or hinder, learning about professionalism, patient-centred care and empathy. Positive

role models are good teachers, who pay attention to the doctor-patient relationship and are concerned about the psychological and social aspects of disease (Tomlinson, 2015). A systematic review by Chan (2013) emphasises that clinical educators promote learning, and influence the students' critical thinking, by role modelling, facilitating and guiding.

Supervising students by stimulating their critical thinking, or taking care of patients, are deemed equally important, and should be considered as integral, not separate, tasks in learning (O'hman, 2005). As stated by Manninen *et al.* (2015: p. 7), "Balancing patients and students' needs is a matter of identifying needs, making plans and following them up: a learning plan for students and nursing plan for patients." The researcher, therefore, is of the opinion that this is possible when clinical supervisors and clinicians work together in the clinical setting. The aim is to assist the student in bridging the gap between theory and practice, as well as between the classroom and the clinical setting.

When focusing on integrating theory with practice, students should be guided into understanding what skills are needed during patient management, as well as the knowledge that informed the action to manage the patient. A recent study conducted with physiotherapy students highlighted that clinical supervisors were considered a resource that provided valuable feedback and assisted in integrating theoretical and clinical knowledge (Gard & Dagus, 2016). This highlights that the quality and type of clinical placement influences the clinical learning outcomes of the student (Al-Kandari, Vidal & Thomas, 2009). Therefore, as emphasised by Sealy, Raymond, Groeller, Rooney, Grabb and Watt (2015), there is a need for supervision to provide an authentic learning experience in clinical education.

2.3. Clinical Practice and Clinical Teaching

Clinical education enables physiotherapy students to acquire the information, skills and competencies necessary for clinical practice, as well as gain confidence in their clinical reasoning and application of theoretical knowledge (Schoen *et al.*, 2008). Clinical practice is challenging for new graduates; therefore, it is important that undergraduates are competent once they complete their degree and start to work in clinical environments. According to

Ladyshefsky & Richard (2010), this competence is cultivated by seeking constructive criticism and feedback from others about knowledge, skills and attitudes towards clinical knowledge. This is supported by a study conducted by Henderson, Twentyman, Heel and Lloyd (2006), which established that a stable clinical environment could support further learning and assist in importing more knowledge to students in the clinical setting. A productive learning environment depends on the contribution of the clinical supervisor and clinician. The idea is that knowledge will come from the clinical supervisors and clinicians at the clinical placements. The transfer of training is the ability to take formal knowledge, acquired through training, and apply it to regular practice (Ladyshefsky & Richard, 2010).

In clinical practice, clinical reasoning needs to be facilitated. A study conducted by Edwards, Jones, Carr, Braunack-Mayer and Jensen (2004) explains that clinical reasoning refers to the thinking and decision-making process applied in clinical practice. These authors defined clinical reasoning as a process, in which the therapist, interacting with the patient and others (such as family members or others providing care), helps patients structure meaning, goals and health management strategies, based on clinical data, patient choices, professional judgement and knowledge. Clinical reasoning can be stimulated by asking questions and subsequently facilitating the students thinking process.

According to Tomlinson (2015), narrative-based supervision could be performed in a formal or informal way; however, it should be made explicit when supervision is done. This author explains that “narrative-based supervision”, also referred to as “conversations inviting change”, shares the same dialogic questioning that characterises narrative-based medicine, from which it was developed. This concept of “narrative based supervision” was suitable for qualified physicians. However, whether the concept could be used in the relationship of clinical supervisors and students, or include undergraduate students, needed to be explored. What exactly the role of the clinicians would be, concerning clinically educating students, also needed investigation. Ideally, the student would be influenced by the clinical supervisor, while the clinical supervisor would oversee/manage the student, and clinically educate him/her, as if the student was a fellow physician. Tomlinson (2015) further explains that the story, told by the patient or supervisee, is recreated and re-interpreted by the questions of the listener doctor or supervisor. The underlying assumptions and interpretations, therefore, are challenged and the emphasis is placed on the importance of *how* clinical supervision is

executed, when provided. The aim is to create an environment, which the student and trainee perceive as positive, comfortable and conducive to learning (Tomlinson, 2015).

Strategies on how clinical supervisors and clinicians could be supportive in their approach to clinical teaching/ training and facilitating clinical reasoning, are available. Currently, the aim is to move towards a more student centred approach to learning. According to Erstzen *et al.* (2009: p. 103), “In recent years, a paradigm shift has taken place in higher education from a teacher-centred to a student-centred focus”. This author explains that a higher education institution exists to produce learning and not to provide instruction (Erstzen *et al.*, 2009: p. 103).

In a study conducted by O’hman *et al.* (2005) in Sweden with physiotherapists, the clinicians presumed that practice is developed with a considerable degree of tacit knowledge. Most clinical teachers are enthusiastic and consider their role as teachers of future generations of healthcare professionals as essential. However, they often lack knowledge of educational principles and teaching strategies and, therefore may be inadequately prepared for this additional professional role (Steinert, 2005). The researcher is of the opinion, therefore, that it is imperative for researchers to educate all stakeholders on existing strategies, to improve this shortcoming. According to Ramsden (2003), there are three methods, through which educators can understand their role. These methods are related to how clinical teaching can be supported and how students are expected to learn. The methods are namely, 1) transmission of information, 2) organising students’ activities, and 3) making understanding easier. Each of these teaching perspectives has consequences on the teachers’ focus in clinical teaching; either a focus on the teacher's knowledge and behaviour, or the student’s behaviour and understanding. The study suggests that an increased awareness of the strategies in use will increase the clinical teachers’ teaching skills and the consequences they will have on the students’ ability to learn (Nilsson, Pennbrant, Pilhammar & Wenestam, 2010). If these strategies are considered, the focus will be student-centred, through experiential learning.

The researcher suggests that, in order for clinical supervisors and clinicians to support students, using these strategies, all stakeholders must be enthusiastic to be involved in clinical education. Those who are not, should be educated on the importance of contributing to clinical practice, and be encouraged to participate. The mind-set of health practitioners need to change from one of abdication (not our responsibility) to one of joint responsibility with

each party contributing within the scope that their individual clinical setting allows. Physiotherapists in both academic and clinical practice settings need to adopt a culture that fosters the learning of undergraduate students, in order to produce generations, which are competent practitioners. Tomlinson (2015) explains that culture is a social construct that comprises shared values, assumptions and learning; it is both resilient and in constant flux. This author also highlights that culture, as expressed by doctors' attitudes, is strongly influenced by the nature of the relationships and rituals they experience at medical school, and in practice – the so-called hidden curriculum. This curriculum is often forgotten and not discussed. Schoen *et al.* (2008) reports that, as qualified physiotherapists, the aim should be to strive towards this culture that fosters learning, as it aims to encourage all physiotherapists to contribute to this vital process of clinically educating undergraduate physiotherapists, in order to produce competent entry-level physiotherapists. The views of the clinical supervisors and clinicians need to change from the present culture, into one where clinical teaching is seen as a role that involves both parties (Schoen *et al.*, 2008).

The energies of the clinical supervisor and clinician need to be harnessed in the quest for improved performance that benefits patients and fellow clinicians (O'hman *et al.*, 2005). To boost quality improvement and patient safety, all stakeholders need to demonstrate an interest in clinical teaching. Once all the stakeholders realise that their contribution to the experience of the student is of importance, they could progress to creating learning opportunities for the undergraduate students (O'hman *et al.*, 2005). The clinicians can contribute to the teaching of students through creating learning opportunities. Teaching in the clinical setting could be done in various forms, such as role modelling, engaging with the student to identify their learning needs, assessing the student's skills and providing feedback. In professions, such as nursing and medicine, the role of the clinician has been formally acknowledged as "teaching at the bedside" (Kelly & Ahern, 2009). Therefore, it is clear that, in the clinical learning environments, the activities of the clinician contribute to learning and the progressive development of the student (O'hman *et al.*, 2005).

The process of student's applying knowledge in clinical settings is largely influenced through leadership from qualified clinicians and clinical supervisors (Kelly & Ahern, 2009). This literature highlights that, in order to commence clinical teaching at a clinical placement, the clinical supervisors and clinicians need to take a leadership role in clinical practice (Godfrey, Dennick & Welsh, 2004). Leadership is instrumental in shaping the nature of the interactions

with staff and the clinical experiences that become available (Kelly & Ahern, 2009). Literature emphasises that clinical leaders do not become teachers by virtue of their medical expertise, but by a reflective approach to teaching and professional development, which fosters excellence in clinical teaching (Godfrey, Dennick & Welsh, 2004).

2.3.1. Reflective practice

In clinical practice, some form of reflection is required for the growth of the student and the stakeholders, who are involved in clinical education and clinical supervision. This concept of recognition and application of reflective practice is relatively new for therapists (Ernstzen *et al.*, 2009: p. 102), further stating, and “Reflection is a metacognitive strategy through which learning may occur.” In addition, these authors highlight the theory of experiential learning, which describes learning as a four-step cyclical process, involving a concrete experience, reflective observation, abstract conceptualisation and active experimentation (Ernstzen *et al.*, 2009: p. 102). An American educational theorist, David Kolb (2014), states that learning is the process whereby knowledge is created through the transformation of experience. David Kolb presented this theory as a cyclical model of learning, consisting of four stages. The stages can begin at any time; however, the stages must follow each other in sequence. The first stage is known as concrete experience (CE), which is where the learner actively experiences an activity, such as a lab session, or fieldwork. Reflective observation (RO) is the second stage, where the learner consciously reflects on that experience. In the third stage, the learner attempts to conceptualize a theory, or model of what is observed, which is known as the abstract conceptualisation (AC). The last stage is active experimentation (AE), or “Plan”, where the learner is trying to plan a way to test a model, theory, or plan, for a future experience. This theory is built on earlier research, conducted by John Dewey and Kurt Lewin (Kolb, 2014).

Some authors suggest that clinical supervision provides a structure to support and promote reflective practice; therefore, clinical supervision and reflective practice go hand in hand (Hall & Cox, 2009). Reflective practice is often viewed as private, either as thoughts or as written record that is not often shared. According to Hall & Cox (2009), learning gained is limited when the reflections are not discussed verbally. Clinical leaders need to realise that reflecting is a skill that develops over time in the

clinical field; therefore, reflections need to commence from undergraduate level, in order to develop the skill to use reflections effectively (Hall & Cox, 2009).

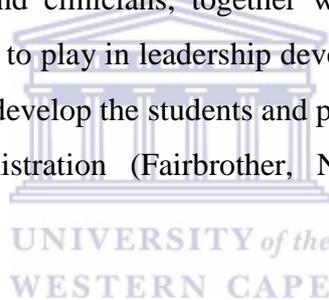
2.4. Clinical Leadership

Clinical leadership is a readily used term to describe doctors as leaders in the health service; however, to date it has been less well defined for allied health professionals (Long, Lobley, Spurgeon, Clarke, Balderson & Lonetto, 2011). According to these authors, there has been much progress in medicine, as the profession has been actively meeting the challenge that systematically addresses policy, regulation, education, training and workforce development. This progress, however, is not evident in the other regulated clinical professions, such as allied health, pharmacy or healthcare science. The larger professional groups may have the capacity (resources and professional staff) to undertake the necessary developmental activity, whereas the smaller groups are less well advanced and resourced (Long *et al.*, 2011). Unfortunately, physiotherapy forms part of this smaller group. The literature on leadership is broad and means different things to different people; therefore, according to Swanwick and McKimm (2011), it is difficult to summarise a global understanding, as leadership is often described within the contexts in which it is exercised. These authors define “leadership” as setting direction, influencing others and managing change. Leadership is argued to be necessary “at all levels”; therefore, the “leadership development”, assessment and feedback has to be provided throughout the education and training of health professionals (Swanwick & McKimm, 2011).

There are many ways to act as a clinical leader, for example, in self-development, working with others (including students), or improving and managing services. Physiotherapists can show their commitment to the future of the profession by regularly sharing their expertise and time with physiotherapy students, as mentors and clinical supervisors (Schoen *et al.*, 2008). Therefore, clinical supervisors and clinicians in clinical environments could lead in many ways, both formal and informal, as part of their organisational positions and through their collegiate relationships. According to Ernstzen *et al.* (2009: p. 103), “Little has been reported on research into the processes and outcomes of teaching and learning in physiotherapy clinical environments”; particularly the lack of information on the effectiveness of various teaching methods used during physiotherapy clinical education.

Long *et al.* (2011), confirms a widespread acknowledgment that leadership is important, and that the development of clinical leadership is viewed as critical. Frontline clinicians in clinical placements would be at the heart of driving this change, and as support for the clinicians, the leadership capacity within the system would have to be developed further (Long *et al.*, 2011). This can only be achieved if the views of the clinicians, regarding their role, are understood, and the importance of clinical leadership, acknowledged. Clinical leadership is a skill that should be developed in students, which would prepare them for the workplace (Gonzalez, Abukasm & Naimie, 2013)

According to Tomlinson (2015), all physiotherapy health professionals have a certain degree of responsibility, which entails ensuring safe and effective patient care through training, establishing and maintaining an environment for learning, teaching and facilitating learning, enhancing and learning through assessment, and continuing professional development as an educator. Clinical supervisors and clinicians, together with clinical teachers, working in higher education, have a key role to play in leadership development. It is essential, therefore, that these three work together to develop the students and prepare them for the clinical setting in both leadership and administration (Fairbrother, Nicole, Blackford, Nagarajan & McAllister, 2016).



The sooner health-professionals realise that clinical leadership is a vital component in the creation of learning environments, the sooner clinical education could commence. At various levels in the hospital, or clinical setting, there are recognised “gate-keepers”, who could assist in establishing an environment that welcomes learners, and assists staff to develop behaviours that facilitate learning in the clinical arena (Andrews, Brodie, Andrews, Hillan, Thomas, Wong & Rixon, 2006). These local leaders are therefore instrumental in shaping the motivation of teams to support learning. According to Henderson (2011: p. 4), “...through exhibiting effective leadership behaviours, such as open communication and the sharing of knowledge and ideas, leaders and senior staff members could influence other staff to interact in a positive manner that fosters learning. Learning becomes embedded within everyday clinical practices through these layers of supportive leadership”. Therefore, health professionals do not automatically become clinical leaders, as there is a process involved to build capacity among the clinical leaders.

2.4.1. Capacity building as clinical leaders

To influence the ability of trainees to develop as future leaders, certain factors need to be considered. These factors represent a fundamental change in the way clinicians are trained and educated. The Capacity building and strengthening framework (Republic of South Africa. Department of Social Development [DSD], 2012) lists these factors as the quality of supervision, the on the job professional socialisation, the relevance, as well as breadth of knowledge and skills acquired, the congruence between formal curricula and practical exposure, and workload. In addition, the framework defines capacity building as an evidence-driven process of strengthening the abilities of individuals, organisations, and systems, to perform core functions sustainably, and to continue to improve and develop over time. Through capacity building, clinical opportunities will be created for practical skills and theoretical knowledge, developed in academic study, to be applied (RSA DSD, 2012). Delany and Bragge (2009) explain that capacity building transpires through interaction with clients and professional practitioners in the workplace.

2.5. Clinical Supervision

All members of the multi-disciplinary team (MDT), including doctors, senior nurses and allied health professionals, are involved in some form of clinical supervision. Regarding government workers in the clinical field, it is the duty of the health professional to ensure that patients receive safe and quality patient care at all times, including during clinical education.

Some of the initial questions asked during the interviewing phase of this study dealt with how the participants viewed their role as clinical supervisors, and how they contributed to clinical learning. Manninen *et al.* (2015: p. 2) state, “A supervisor can be defined as a professional role model supporting a student, individually and/or as a member in a group, to link together theoretical and practical knowledge and skills in clinical settings.”

Various definitions exist for clinical supervision; therefore, the nature of clinical supervision will vary. According to Sellars (2004: p. 65), “Despite many definitions of clinical supervision in the literature, there is no single, all-encompassing definition, with different authors placing different emphases on the term.” This lack of a clear definition has led to some confusion and ambiguity related to the concept of clinical supervision. The concept of

clinical supervision, as a means of professional learning and support, is well known in some social and health care professions, but there is a dearth of literature related to clinical supervision and physiotherapy (Sellars, 2004).

A study conducted by Razmjou *et al.* (2015: p. 248) explains that the various factors influencing clinical supervision are as follows: “The nature of the speciality (surgical or non-surgical), location (primary care or hospital) and the structure of the clinical team”. The authors highlight that providing the service for patients will be the primary determinants of the sort of supervision required, but in all cases the object of the supervision will always be the same: “to provide the patient with the best possible quality service under the prevailing circumstances.” The understanding of most health professionals is that clinical supervision is about learning from practice and, therefore, refers to the clinical education of students.

2.6. Summary of the chapter

In this chapter, the researcher presented literature that explained the importance of clinical education by important stakeholders, namely, clinical supervisors employed at universities, as well as clinicians employed by government institutions. In addition, the reasons why clinical education is important, as well as how it positively affects students, when executed correctly, are further highlighted in the literature. The negative effects of clinical education, as well as its effects on students in the future, even after graduation, are also explored. Subsequently, the researcher reviewed the literature on clinical practice and teaching, defining the terms, while briefly exploring the topic of reflective practice, as literature revealed that reflections are important for the growth of clinical supervision in a clinical setting. Clinical educators, therefore, need to initiate this skill of reflection early on in the undergraduate programme.

Clinical leadership was defined; highlighting that clinical education cannot exist if clinical supervisors do not take leadership in the clinical setting. Finally, the researcher focusses the literature review on capacity building of leaders and clinical supervision. Consequently, this literature review reveals the importance of clinical education in the clinical setting. The following chapter/s explores the views of the individuals, who are personally involved in clinical education, as well as whether they perceive themselves as contributing to student learning. The aim of the exercise is to clarify their roles and arrive at consensus on who, in

their opinion, is responsible for guiding, mentoring, teaching and moulding the future generation of physiotherapists.



CHAPTER THREE

METHODOLOGY

3.1. Introduction

In this chapter, the researcher discusses the methodology employed to conduct this current study. The aim of the study was to explore the views of the clinical supervisors employed at the UWC Physiotherapy Department on the topic of clinical education, specifically their roles as educators and the clinicians. A methodology is an approach that the researcher chooses to conduct a research study; therefore, this approach prescribes the way this research will be conducted, as well as the tools that will be utilized (Leedy & Ormrod, 2005, p. 12). It has also been referred to as "...the procedures by which researchers go about their work of describing, explaining and predicting phenomena..." by Rajasekar, Philominathan and Chinnathambi (2013: p. 5).



3.2. Research Setting

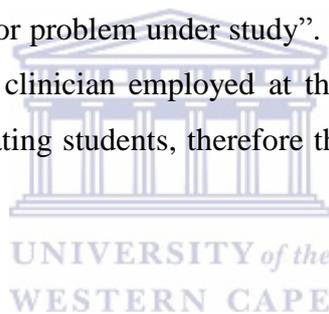
The University of the Western Cape (UWC) is a national university, alert to its African and international context, as it strives to be a place of quality and a place to grow. UWC was founded in 1959 for people classified as "coloured" in the apartheid era. Initially, it was known as the "University College of the Western Cape", as a constituent college of the University of South Africa. The university is committed to excellence in teaching, learning and research, as well as to nurturing the cultural diversity of South Africa (University of the Western Cape [UWC], 2013). This renowned, internationally acclaimed research institution forms the training ground of health professionals, including physiotherapy.

The physiotherapy department forms part of the Faculty of Community and Health Sciences (FCHS), and offers an internationally recognised undergraduate and postgraduate programme by a dedicated team of academics. The curriculum offered in the department is aligned with the healthcare system and burden of disease of the country and is directed by global policies and statements. The undergraduate curriculum consists of a practical and theoretical component. At third; and fourth-year levels, the students are exposed to clinical placements, where they assess, work out a clinical hypothesis and formulate a treatment plan, which they

initiate. The physiotherapy department employs clinical supervisors to provide clinical supervision and education to physiotherapy students on their clinical placements.

3.3. Research Design

The research design selected for this study is a qualitative exploratory design. A qualitative research design is a study of people in their natural environments (Punch, 2005: p. 20). The design is exploratory as it explores the views and experiences of the clinical supervisors on clinical education and clinical supervision, as well as their contribution to student learning. In addition, it explores the clinical supervisors' view of what the role of the clinician is, or should be, in the clinical setting. Qualitative research is used to answer questions about the complex nature of phenomena, with the purpose of describing the phenomena from the participants' point of view (De Vos, Strydom, Fouche & Delpont, 2011, p. 64). According to Creswell (2009: p. 5), "qualitative researchers tend to collect data in the field where participants experience the issue or problem under study". The clinical supervisors employed at the university, as well as the clinician employed at the government institution, play an important role in clinically educating students, therefore the views of these stakeholders are vital.



3.4. Population

The population for this study was clinical supervisors, who were employed by UWC for the 2014 and 2015 period, to provide clinical supervision to undergraduate physiotherapy students, enrolled at the Physiotherapy Department. The clinical supervisors were employed, currently, or previously, as either clinicians, or lecturers at a university, while others had experience of working in private practices. According to De Vos *et al.* (2011: p. 223) "a population in a research study is the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned". The population for this research project consisted of seventeen (17) physiotherapy clinical supervisors. These supervisors educate students, clinically, at third- and fourth-year levels, in areas that include, ICU, neurology, spinal cord injury (SCI), cardiothoracic NMS and orthopaedics. All seventeen (17) physiotherapists were contacted via email, as well as telephonically, and invited to be included in the study.

3.5. Sampling

Sampling involves the selection of a sample, which is a small representative portion of the total population (Barker, 2003, p. 380). De Vos, Strydom, Fouche & Delpont (2005: p. 131) asserts that utilizing samples is crucial, because more accurate information might be obtained from the sample, as opposed to studying the entire population. The sampling technique utilized in this phase was purposive sampling, as it allows the researcher to select interview participants, based on their suitability for the study, their knowledge of the phenomenon and the purpose of the study (Cozby, 2012: p. 18). The final sample size for this study was twelve (12) supervisors, out of a total of seventeen (17), as one supervisor refused and four did not respond to the emails, or telephone calls.

3.6. Data Collection Instrument

The data for this current study was collected by means of face-to-face, in-depth semi-structured interviews. The interviews allowed for in-depth exploration of clinical supervision exposure; views about the process, how equipped the participants were to be clinical supervisors, as well as to encourage student learning. The interviews allowed the researcher to explore the understanding of the leaders in the health system, regarding clinical supervision and the contribution of therapists (clinicians) to student learning. The researcher used an interview guide (Appendix E), with clear instructions and research questions for the interviews with the participants. According to Cozby (2012: p. 145), interview schedules allow the researcher to stay on topic and clarify any interesting and relevant issues that might be raised by the participants. Drawing up an interview guide before the actual interviews, allows the researcher to think about possible controversial and sensitive issues that might surface, as well as the correct and appropriate wording of the questions.

3.7. Data Collection Procedure

Hox and Boeije (2005) state that collecting information from primary sources means retrieving raw data from the participants themselves, using questionnaires, interviews or discussions. In this study, the primary sources the participants, who were the clinical supervisors, invited to participate in the research process. The participants were informed about the nature and purpose of the study by means of an information sheet (Appendix C), after which they were asked to sign a consent form (Appendix D) that represented their written informed consent. All the participants, who agreed to participate in the study, signed

the consent forms. The researcher engaged the participants directly, face-to-face, which created a safe environment for the participants to provide their responses without any restrictions. Maynard (1994) argues that the relationship between the researcher and the participants has to be reciprocal and non-hierarchical, to ensure the retrieval of rich data from the participants.

The researcher started the interviews with a pre-interview discussion and introductory comments, before introducing the first question, to encourage the participants to share their perspectives and experiences (Zikmund, Babin, Carr & Griffin, 2009). The questions in the interview guide were derived from the research question, aim and objectives of the study. The questions were only a guide and more questions were added, by using probes as interesting topics emerged during the interview process. The researcher aimed to 'break the ice' by asking about the participants' demographic information and years of experience. The last question was directed at bringing closure to the interview and summarising the views of the participants.

Various interviewing techniques were used to ensure that rich data would be obtained. During the interviews, the researcher asked for clarification when she was unsure about the implication of a response. As mentioned previously, probing was also employed to ensure that the topic was fully explored. Before concluding the interviews, the researcher used summaries and paraphrases to confirm that the participants' views were recorded accurately (Smith, 2003: p. 80; De Vos *et al.*, 2011: p. 345).

The data collection was done by the researcher, who is currently a production level therapist (clinician) at GSH. The researcher recorded reflections on personal experiences in a reflective diary. According to Holly (1989), when researchers document and reflect on their own experience, they create an awareness of themselves as people and professionals, and indicate an awareness of being able to make informed decisions. Therefore, as the researcher unpacks the understanding of clinical supervision among clinical supervisors, she engages and reflects on this topic, as a clinician.

All the interviews were organised at the convenience of the participants, who were informed of their right to withdraw at any time during the interview process, without prejudice. They were also assured of confidentiality, at all times. The interviews were conducted at a time that

did not affect the work-schedule of the clinical supervisors. After obtaining permission from the participants, a tape recorder was used to record the interviews, while the researcher made notes.

The interview was initiated with a broad question: “What do you think your role is as a clinical supervisor in clinical education?”, and the researcher used probes to facilitate deeper discussion. During the interviews, the participants were allowed to introduce related topics, which were not on the interview guide. Mathers, Fox and Hunn (2002) assert that, although the questions are pre-determined, they allow the interviewee flexibility. With in-depth interviews, the questions are structured in such a way as to elicit in-depth answers. However, the interviewer should allow the interviewee to introduce topics that are not on the list of questions and be prepared to follow the participants’ train of thought (California Department of Health Services and Northern California Grantmakers AIDS Task Force, 1998), which prevents the interviewee from being limited, or restrained.

3.8. Trustworthiness

Although many critics are reluctant to accept the trustworthiness of qualitative research, frameworks for ensuring rigour in this form of work, have been in existence for many years (Shenton, 2004: p. 63). The trustworthiness of qualitative research, generally, is often questioned by positivists, perhaps because their concepts of validity and reliability cannot be addressed in the same way in naturalistic work (Shenton, 2004). Guba is one of many naturalistic investigators, who prefer to use different terminology to maintain a distance from the positivist paradigm. Guba’s constructs correspond to the criteria employed by the positivist investigator; however, criticisms of this kind of work continue to be made by positivists (Shenton, 2004: p. 73).

According to Guba (1981: p. 76), “The term ‘naturalistic’ describes a paradigm for inquiry, not a method. There are many paradigms for arriving at ‘truth,’ including, for example, the legal paradigm that characterizes courtroom proceedings; the ‘expert judgment’ paradigm that characterizes accreditation site visits, peer review of proposals, and judgments of athletic performance.” The naturalistic paradigm rests on the assumption that there are multiple realities; that inquiry will diverge rather than converge as more and more is known; and that all “parts” of reality are interrelated, so that the study of any one part necessarily influences all other parts (Guba, 1981: p. 77).

According to Crowther and Lancaster (2008), positivism, as a philosophy, holds the view that only “factual” knowledge is trustworthy, as it is gained through observation (the senses), and includes measurement. The authors further explain that in positivism studies, the role of the researcher is limited to data collection and interpretation through an objective approach and the research findings are usually observable and quantifiable. The researcher, therefore, is independent from the study and there are no provisions for human interests within the study (Crowther & Lancaster, 2008).

Guba proposes four criteria, which he believes should be considered by qualitative researchers in pursuit of a trustworthy study (Guba, 1981). These constructs correspond with the criteria employed by the positivist investigator and have been accepted by many:

- a) credibility (in preference to internal validity);
- b) transferability (in preference to external validity/generalisability);
- c) dependability (in preference to reliability); and
- d) confirmability (in preference to objectivity).

To ensure that the data is credible, in this specific study, the sessions were tape-recorded and notes were taken. In addition, the researcher, personally, conducted the sessions to allow participants to be frank and answer honestly, which is one of the key criteria. Ensuring *credibility* is one of the most important factors in establishing trustworthiness (Shenton, 2004, p. 64). According to this author, when addressing *credibility*, investigators attempt to demonstrate that a true picture of the phenomenon under scrutiny is being presented. Credibility, deals with the question, “How congruent are the findings with reality?” Therefore, while the researcher conducted the interviews, during and at the end, the researcher summarised the conversation and confirmed with the participant that the recorded version of what the participants disclosed was accurate. The data was reported with direct quotes, as an indication of *confirmability*; therefore, it will serve as an indication that it was not the predispositions of the researcher. This is a very challenging process in qualitative research. According to Shenton (2004, p. 63), to achieve *confirmability*, researchers must take steps to demonstrate that the findings emerged from the data and not their own predispositions; therefore, in this current study Tesch’s eight (8) steps (see section 3.10 Data Analysis in this chapter) were used to analyse the data (Creswell, 2009: p.186).

In addition, when presenting the information, the researcher provided enough detail of the context of the data collection procedure, setting and the participants, in order for others to determine whether the environment is similar to another situation, and, therefore, justifying whether the findings can be applied to another setting. Finally, the study is reported with detailed information and methodological rigour to ensure that others can repeat the study, which ensures *transferability*. Finally, Shenton (2004: p. 63) explains that meeting the *dependability* criterion is difficult in qualitative work, although researchers should, at least, strive to enable a future investigator to repeat the study. Dependability was ensured by keeping accurate and detailed records of the research methods and strategies in data collection and analysis (Cozby, 2012: p. 115). These records were stored in a locked cabinet, to which only the researcher, the transcriber and the study supervisor had access.

3.9. Reflexivity

The researcher's personal involvement in the daily activities of the hospital and the process of clinical supervision could be a limitation, or an asset in this study. The limitation to the study could be the researcher's reflexivity about her own practices, and her perception of the phenomenon, through her practices. The challenge is the ability of the researcher to perceive the phenomenon as a whole, and to take a step back from it. In order to address this issue the researcher kept a reflective diary/journal. According to Wall, Glenn, Mitchinson and Poole (2004), the reflective diary should include the following phases, namely pre-reflective preparation, reflection, learning and action to learning. The reflective diary/journal of the researcher was used in the study as collected data and analysed along with the views of the participants, this helped to understand the bias of the researcher.

3.10. Data Analysis

The researcher made use of Tesch's eight (8) steps, as provided in Creswell (2009: p. 186), to analyse the qualitative data (See Table 3.1).

Table 3.1: Tesch's 8 steps to analyse qualitative data

Brief Concept	How to use the steps
<p>Step 1: Researcher reads each transcript individually:</p> <ul style="list-style-type: none"> ➤ Transcribes the data ➤ Reads through the Transcripts ➤ Obtains a sense of what was said 	<p>Notes made in margins</p> <ul style="list-style-type: none"> ➤ Highlight interesting concepts emerging

<p>Step 2 :</p> <ul style="list-style-type: none"> ➤ Selecting one transcript to start off: ➤ Going through each transcript individually. 	<ul style="list-style-type: none"> ➤ Different concepts were listed & categorised. ➤ Common categories were grouped into themes. ➤ During this process the researcher wrote down thoughts.
<p>Step 3:</p> <ul style="list-style-type: none"> ➤ Making a list of these thoughts 	<ul style="list-style-type: none"> ➤ Identify common themes and put them together. (Based on the list) ➤ Common themes were arranged into: <ul style="list-style-type: none"> - Major, unique and leftover topics
<p>Step 4:</p> <ul style="list-style-type: none"> ➤ Return to the data 	<ul style="list-style-type: none"> ➤ Relate each theme and topic into codes ➤ Used different highlighters to: <ul style="list-style-type: none"> - Identify the themes and topics ➤ New topics were also identified & included
<p>Step 5:</p> <ul style="list-style-type: none"> ➤ Under each theme form the most descriptive wording for the topics 	<ul style="list-style-type: none"> ➤ Turn them into sub-themes and categories
<p>Step 6:</p> <ul style="list-style-type: none"> ➤ Make a final decision on themes, sub-themes and categories. 	<ul style="list-style-type: none"> ➤ Place all the verbatim responses under: <ul style="list-style-type: none"> - Themes, sub-themes and categories.
<p>Step 7:</p> <ul style="list-style-type: none"> ➤ The verified process and consensus was reached 	<ul style="list-style-type: none"> ➤ On the final themes
<p>Step 8:</p> <ul style="list-style-type: none"> ➤ Recoded the existing data 	<ul style="list-style-type: none"> ➤ Used bracketing to highlight aspects from the reflective diary

The initial two interviews were transcribed by transcribers used by the university, who understand the ethics of participating in research. The different types of concepts were listed and categorised by selecting one transcript to start with and then going through the rest of the transcripts one at a time. This process was repeated for each transcript, and, subsequently, the common categories were grouped into themes. During this process, the researcher wrote down thoughts that emerged while reading (Creswell, 2009: p. 186).

The researcher then moved on to Step three by making a list of these thoughts. Based on this list, common themes were identified and grouped together. The common themes were arranged into major topics, unique topics and leftovers (Creswell, 2009: p. 186). Thereafter, the researcher returned to the data, related each theme and topic into codes, and used different

coloured markers to identify the themes and topics in the text. New topics that were identified were included. The researcher found the most descriptive wording for the topics under each theme and formulated sub-themes and categories. A final decision was made about what themes, sub-themes and categories to include. All the verbatim responses were placed under the relevant themes, sub-themes and categories. This verified the process and consensus was reached on the final themes. Finally, the existing data were recoded. In addition, different aspects from the researcher's reflective diary were highlighted with the use of bracketing (Wall *et al.*, 2004).

3.11. Ethics

When conducting a research study, an array of ethical requirements faces the researcher. Ethical procedures that should be followed by social science researchers govern education research, as participants should be respected as human beings (Cohen, Manion & Morrison, 2011). Ethical clearance and permission to conduct the study was obtained from the relevant Senate Research Committee and the Ethics Committee at the UWC before the study commenced (Appendix A), as well as the Western Cape Department of Health. Permission to conduct the study was then granted by the Head of Department of Physiotherapy of the University of the Western Cape (UWC) (Appendix B). The selected participants, who were the physiotherapy clinical supervisors, employed at UWC. They were invited to participate in the research study, which was explained to them, in detail, via email and telephone (Appendix C). Regarding the participants, the researcher has an obligation to protect the rights of the participants to informed consent, anonymity and confidentiality. According to Greaney *et al.* (2012), the researcher needs to ensure that the participants understand the voluntary nature of their participation, by informing them that they may withdraw from the study at any point, without prejudice.

3.11.1. Informed consent

Participants were informed of the purpose of the research, expected duration and procedures, as well as any prospective research benefits. All participants were assured that the information obtained would be confidential and anonymous, and that the data collected on the digital recorder would be kept in a locked cabinet on UWC premises, in the Community and Health Services Faculty, only accessible to the researcher, supervisor and transcribers.

3.11.2. Voluntary participation and Right to withdraw at any stage of the study

The participants were informed that they had the right to withdraw from the study at any time, if they so wished. Their right to withdraw was explained to them before the interview commenced (Holloway, 2005), including the fact that there would not be any negative consequences, should they decide to withdraw. This right was clearly outlined in the consent form (Appendix D).

3.11.3. Confidentiality

The participants were assured of confidentiality at all cost. Confidentiality and anonymity are often confused, confidentiality is promising to keep a participants' responses from going public (Babbie & Mouton, 2004). To ensure confidentiality, the only people who had access to the collected data (audio tapes) were the researcher, the study supervisor and the transcribers.

3.11.4. Anonymity

The participants have the right to anonymity, as they are not obliged to give identification details, in order to participate. According to Babbie and Mouton (2004), the clearest concern in the protection of the subjects' interest and wellbeing is the protection of their identity, and anonymity is one technique to ensure that. Anonymity of the participants was guaranteed because they were not required to provide identifying details and their real names were not utilised during the interviews. The interviewees' were referred to as participants 1-12, to ensure anonymity throughout the interview.

3.12. Limitations of the Study

- This research study has a limited population size, as it was conducted at one tertiary academic institution (UWC) situated in the Western Cape, and due to this, the study cannot be generalised to other settings, but provides a basis for understanding the concept of clinical education at clinical placements.
- The interviews were conducted in private offices, close to the wards, although no information was lost during the interviews, there were a few interviews that had background noise in the audio recordings, which was noted during the transcribing process.

- A few of the participants who were clinicians before, spoke of their previous experiences as clinicians, and, therefore, had different views on how clinicians could contribute to clinical education. However, the other participants who lecture at the university, displayed a form of bias, as it seemed as if their loyalty was towards the university on the matter.
- The volume of the data made it difficult to analyse and prevent repetition. This caused the interpretation of the data to become time consuming.
- The data was transcribed by different individuals, which implies that the study could be influenced by the researcher's, as well as the transcribers' personal biases.

3.13. Conclusion

In this chapter, the researcher explained the methodology followed in this qualitative exploratory study. The background of the research setting was explored and the research design, selected for this study, was discussed in detail. The population, sampling technique, sampling procedure, data collection instrument used, the data collection procedure as well as the data analysis followed. The interviews were conducted personally by the researcher, in order to collect rich data from the twelve (12) participants. The sample consisted of clinical supervisors employed by UWC Physiotherapy Department, in the 2014 and 2015 periods.

The trustworthiness and reflexivity of the study were highlighted and the data analysis procedure was presented in detail. The ethical requirements of the study were explained under the sub-headings, informed consent, voluntary participation, confidentiality, as well as the right to withdraw, without prejudice, at any stage of the interview process. Permission was obtained from the Ethics Committee at UWC. Finally, the limitations of the study were presented.

In the next chapter, the researcher presents the results, as well as the associated discussions. The identified themes that emerged from the qualitative data are discussed on the basis of the set objectives, in relation to the literature.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1. Introduction

In this chapter, the researcher introduces the demographic data of the participants and presents, as well as discusses the themes and sub-themes, which emerged from the data analysis. The themes and sub-themes were agreed upon, after consensus discussions, with the study supervisor. In addition, the findings are contrasted and compared with existing literature (Creswell, 2009).

Firstly, the findings are focused on how clinical supervisors view their role in clinical education, and their perceived contribution to student learning. Subsequently, the researcher, intentionally, explores the interpretations of their views on the role of the clinician in clinical education, as well as how they differ from their role as clinical supervisors.

4.2. Demographic data of the participants

In this current study, the views and experiences of twelve physiotherapy clinical supervisors are explored. The clinical supervisors were employed by the university to clinically guide and educate students in the clinical settings, on both third and fourth year levels. Experience among the participants varied, as both practicing physiotherapists, as well as clinical supervisors. Their experience ranged from one-and-a-half years to twenty-seven years as practicing physiotherapists, and from six months to twenty-two years as clinical supervisors (See Table 4.1.). Most of the participants had experience of working at a clinical placement as clinicians, prior to being clinical supervisors.

Table 4.1: Demographic Table

Participants	Clinical Supervisor	Qualified Physiotherapist	Clinician
Participant 1 (46)	4 years	13 years	10 years
Participant 2 (47)	5 months	3 years	2years
Participant 3 (48)	4 years	11 years	17 years
Participant 4 (50)	17 years	22 years	22 years

Participant 5 (51)	2 years	4 years	2 years
Participant 6 (53)	6 months	2 years	1 year
Participant 7 (54)	27 years	27 years	11 years
Participant 8 (55)	11 years	19 years	-
Participant 9 (56)	6 months	3.5years	1 year
Participant 10 (58)	10-11 years	16 years	16 years
Participant 11 (59)	18 years	4-5 years	4-5 years
Participant 12 (57)	1 year 6 months	9 years	-

4.3. Themes and Sub-themes

The key themes and subthemes that emerged from the analysed data are illustrated in Table 4.2.

Table 4.2: Emerging themes and sub-themes

Themes:	Sub-themes:	Categories:
Theme 1: The role of the clinical supervisors in clinical supervision	<ul style="list-style-type: none"> • Educator Role 	<ul style="list-style-type: none"> ➤ Integrating theory into practice ➤ Teaching strategies ➤ Clinical reasoning ➤ Reflections: Educator role
	<ul style="list-style-type: none"> • Mentor Role 	<ul style="list-style-type: none"> ➤ Becoming independent workers ➤ Building interpersonal relationships ➤ Providing support ➤ Providing guidance ➤ Reflections: Mentor role
	<ul style="list-style-type: none"> • Clinical supervisors as role models 	<ul style="list-style-type: none"> ➤ Reflections: Role models
	<ul style="list-style-type: none"> • Communicator 	<ul style="list-style-type: none"> ➤ Being a mediator ➤ Providing feedback ➤ Reflections: Communication
Theme 2: Challenges experienced as a clinical supervisor	<ul style="list-style-type: none"> • Role Clarification/Identification? 	<ul style="list-style-type: none"> ➤ Reflections: Role identification
	<ul style="list-style-type: none"> • Students' lack of theoretical knowledge 	<ul style="list-style-type: none"> ➤ Reflections: Students' lack of theoretical knowledge
	<ul style="list-style-type: none"> • Are clinical supervisors equipped to teach? 	<ul style="list-style-type: none"> ➤ Reflections: Are clinical supervisors equipped to teach

Theme 3: The clinician's role, according to clinical supervisors	<ul style="list-style-type: none"> Understanding the importance of the clinician's role 	<ul style="list-style-type: none"> Reflections: Understanding the importance of the clinician
	<ul style="list-style-type: none"> Clinicians taking responsibility 	<ul style="list-style-type: none"> Reflections: Clinicians taking responsibility
	<ul style="list-style-type: none"> Clinicians providing clinical guidance in the clinical setting 	<ul style="list-style-type: none"> Administration role Management role Patient management Reflections: Clinicians providing guidance
	<ul style="list-style-type: none"> Role modelling and professionalism 	<ul style="list-style-type: none"> Professionalism Role models Unprofessionalism Reflections: Role-modelling and professionalism
Theme 4: Ways the clinician can assist in clinical education	<ul style="list-style-type: none"> Clinicians role in creating learning opportunities 	<ul style="list-style-type: none"> Clinicians highlighting learning opportunities Learning opportunities for administration and management Learning opportunities for teaching by clinicians Reflections: Learning opportunities
	<ul style="list-style-type: none"> Providing appropriate patients 	<ul style="list-style-type: none"> Reflections: Providing appropriate patients
	<ul style="list-style-type: none"> Clinicians providing feedback in the clinical setting 	<ul style="list-style-type: none"> Reflections: Clinicians providing feedback in the clinical setting
	<ul style="list-style-type: none"> Relationship between and clinicians and clinical supervisor 	<ul style="list-style-type: none"> Find ways of communicating Build a relationship of trust Showing appreciation and thanking clinicians Reflections: Relationship between the clinician and clinical supervisor
Theme 5: Recommendations for clinicians	<ul style="list-style-type: none"> Guidelines for clinicians 	<ul style="list-style-type: none"> Reflections: Guidelines
	<ul style="list-style-type: none"> Willing to teach and clinically educate 	<ul style="list-style-type: none"> Encourage lifelong learning Reflections: Encourage life-long learning
	<ul style="list-style-type: none"> Improving the student clinical experience 	<ul style="list-style-type: none"> Formulating objectives with students Supporting learning environments Reflections: Improving clinical learning experience

Theme 6: Student challenges	<ul style="list-style-type: none"> • Students not taking responsibility for learning 	<ul style="list-style-type: none"> ➤ Reflections: Student challenges
	<ul style="list-style-type: none"> • The effects of a negative environment on students learning 	<ul style="list-style-type: none"> ➤ The negative attitude of clinicians and clinical supervisors ➤ Reflections: The effects of a negative environment on student learning
	<ul style="list-style-type: none"> • Students are there to learn and not as workforce 	<ul style="list-style-type: none"> ➤ Reflections: Students are there to learn and not as workforce

4.3.1. Theme 1: The role of the clinical supervisors in clinical education

Clinical supervision in physiotherapy is a practice that requires the clinical supervisor to supervise and facilitate student learning, through guidance and support in the clinical arena, providing links between theory and practice. The role that emerged from this first theme included four (4) sub-themes, namely, being an educator, mentor and coach, role model and communicator. In the sub-theme of the educator role, the following categories emerged namely, integrating theory into practice, teaching strategies, and clinical reasoning, followed by the researcher's reflections.

4.3.1.1. Sub-theme 1.1: The educator role

Category 1.1.1: Integrating theory into practice

The participants were of the opinion that, in their specific role of clinical educator, they facilitate learning, which is a form of clinical education. Their view was that the students already possessed the knowledge from lectures and theory. The participants added that the clinical supervisors could assist by re-teaching, or reminding the students, thereby filling in the knowledge gaps and linking the theory to the practical. This highlighted the fact that not everything can be taught in class; some things are best taught in the clinical placements, practically with patients. "Clinical placements' are a key part of healthcare profession education providing students with opportunities to participate in a range of experiential learning activities." (O'Keefe, Burgess, Mcallister & Stupans, 2012: p. 884)

"An educating role is fulfilled...I do play a role in educating them because sometimes in the facilitation process you will find they got gaps, so gaps in their knowledge perhaps things that

they have been taught... I can not necessarily re-teach them those things but remind them about things that they were taught.” (Participant 3)

“I’m educating them how to work clinically with their patients, so evaluating a patient properly and thoroughly identifying, missing components searching for clinical reasons for those components then treating them effectively. In essence, I educate them further I help them with their clinical skills...” (Participant 5)

The participants believed that facilitating students to recall the foundation knowledge they were taught in first and second year at university, takes place in the clinical placements. The participants added that the students would be taught how to apply this theory in their fourth year, by linking all the boxes. According to literature, this concept is the integration of knowledge: “This kind of integration of learning and practice, professional and personal development; bridges the gap between theory and practice in working life” (Jokelainen *et al.*, 2011; p. 2863).

“Linking up theory with the practical but... somehow it’s a bit difficult... because you can’t cover everything within your theoretical setting that students would encounter in a practical setting. You reach a plateau where you can only teach that much and not anything else.” (Participant 2)

A few participants expressed that, too often the clinical supervisors and clinicians refer students back to literature ‘to read up’, without an effort to stimulate the thinking processes of the student to reach the answer. According to Bos, Silen and Kaila (2015: p. 39), the current educational goals of students are different to those of previous years, as students often require qualified support to integrate theory into practice. This highlights that the way clinical teaching was done before, compared to current methods, varies a great deal; therefore, when students do not know their theory, they not solely be instructed to ‘read up’. An attempt should be

made to link the existing boxes and facilitate the learning by integrating the existing theory into clinical practice. Edgar and Connaughton (2014: p. 29) state, “Clinical educators offer an important link between the institution and healthcare environment by providing supervision of students undertaking work-integrated learning”. This raised the different strategies that different participants use, when clinically educating students in the clinical environment.

“...students often get this: ‘go read up.’ I will often take the time and say: ‘okay so this is the patients situation, this is the diagnoses, this is how it affects the lungs’...so I do take that time to explain if I see that they just not get it...I will give information if I feel that this was something that was overlooked, I would say go and read up if it was something basic.” (Participant 4)

“I do not believe in telling a student go find out for yourself, I think that is not facilitation at all, that is just laziness. You can quote me on that... they just tell students to go and look it up...So that is the thing with theory and practice it is very difficult to bring the theory to practice and that to me is a very exciting process. When I ask them questions and help them link things and there is nothing more beautiful than a student that says: ‘oh I know that’, yes I love it when they link stuff.” (Participant 11)

Category 1.1.2: Teaching strategies

The participants highlighted a few teaching strategies, their bedside teaching demonstrations and experiential teaching. They believed that their role was to assist in grounding and applying the fundamentals of physiotherapy and, therefore, highlighted the different teaching strategies and styles that worked for them. Edgar and Connaughton (2014: p. 32) aver, “Versatility with the ability to know how to teach in a variety of styles was acknowledged as an important skill in the clinical educator role”. Clinical supervisors believed that, when engaging in assessments and treatments

with the students, while getting to know their needs, is a teaching strategy. Others considered asking students questions and encouraging them to do research is an important strategy that facilitates learning. Being able to change teaching strategies and having a variety of teaching styles, facilitates self-directed learning and sharing of knowledge from experience. All these strategies attempted to improve the clinical reasoning of the student, thereby improving the quality of the assessments and treatments. A study conducted by O’Keefe *et al.* (2012) encouraged students to learn from other healthcare professionals. It should be explained to students that working alongside clinical staff and students from other disciplines could assist them to develop skills in a collaborative clinical practice. This is an important teaching strategy, as it provides the opportunity for students to learn from their peers and superiors.

“...maybe see the first two patients with the student so they know, this is what I am actually expected of and this is what I am supposed to do... Then they (students) have expectations and standards that are known to both and then they can execute...So back to again knowing all your student’s that is on that block, so the student will feel comfortable.”(Participant 6)

“...I give them instructions but they have to learn to treat and I also have to learn to facilitate learning and help them to think on their feet by asking them a lot of questions and the idea is not to catch them out but to guide them to get there...they find those answers by getting involved with people and working hard, and they will get there.” (Participant 7)

“That’s my first strategy, you have to know who the clinician is. The clinician has to know when to expect you, strategies of when supervision will be, they can also plan in advance on those days they might not give the students new patients or maybe I want a new patient for that session.” (Participant 5)

This participant added:

“By getting the students to think deeper and indulge deeper into their own knowledge and also helping them to identify some weaker areas that they have so that they can do more research on it, e g as a student... I was given a hell of a lot of research work to do and it benefitted me, like pieces here and there because they didn’t want to just give me the answers.”
(Participant 5)

Category 1.1.3: Clinical reasoning

While trying to understand the focus of integrating theory into practice, the words ‘clinical reasoning’ emerged several times. This concept of clinical reasoning has emerged as a subject for study over the last decade, due to the skills expected of physical therapist, and the development of the profession in a changing healthcare climate that requires increasing accountability in decision-making, as part of the process of providing desirable outcomes (Edwards *et al.*, 2004). When asked about clinical reasoning, the majority of the participants expressed their views on facilitation of clinical reasoning.

“...finding this problem and then automatically brainstorming and I think that is important for us to educate them (the students) on, clinical sense is taught that way. Clinical reasoning they kind of have to link the boxes and by linking the boxes they have to understand. It’s almost like they don’t have the key to start the car yes, so we have to be the key...then let them go and drive them in the right direction.” (Participant 6)

“I think my role as a clinical supervisor would be to basically facilitate in the practical setting, what the students has learnt at the institution, when they come into the clinical block. Teaching them, helping them apply the theory to the practical setting and facilitating that clinical reasoning process between theory and practice. Sometimes them learning the ICU theory in class does not make sense but once faced with a patient in the practical setting and you apply the actually theory to the patient it starts

making sense. So for me my role is to facilitate the bridge between practical and theory.” (Participant 3)

“My experience is that the students are here, working at the clinical environment, I feel that my role is to facilitate their theoretical knowledge and especially with being a general block. It is to bring all those different things together for them in a practical way. There is a lot of clinical reasoning that we facilitate, because we are in the clinical setting because we get to actually facilitate the taking of theoretical knowledge and changing that into practical technique or clinical thinking.” (Participant 12)

The participants emphasised that students should know their principles, to use as a foundation, to aid in integrating theory into practice. Lekkas *et al.* (2007) studied graduates’ prize learning from participation in clinical contexts and explained that there is wide acknowledgement that professional skills are crystallised through the integration of theory and practice in the workplace. The role of the educator is revealed as one that aids the students to integrate theory into practice. The goal is to improve the students’ decision-making skills, which is referred to as clinical reasoning. When doing so, the educator needs to take cognisance of which teaching strategy is best to use in the process. Teaching strategies may need to be altered, depending on the educator, as well as the individual being taught. Therefore, the role of the educator is to integrate theory into practice, to stimulate the clinical reasoning of the student, and to use appropriate teaching strategies. Clinical reasoning was said to be a process that needs to be facilitated through linking the boxes and, therefore, integrating theory into practice. According to Higgs, Jones and Loftus (2008), clinical reasoning can best be developed when students work with clinical educators in the clinical setting. These clinical educators, therefore, act as mentors in the clinical placements.

“...but not just practical but they are being taught these techniques at campus. I really think my role is to facilitate the

practical and their theoretical knowledge in clinical setting and facilitating that clinical reasoning by bringing practical and theoretical knowledge together and being able to manage the patient...” (Participant 12)

“I think if...you know your basics and your principles, I think then that will immediately help you to clinically reason because lots of the students I think they mainly just do stuff because this is how you suppose do it and they not thinking or applying there are certain basics for most of the stuff.” (Participant 10)

“My role as a supervisor is to guide students and facilitate their learning, and to help them with whatever they learn in class to apply that in a clinical setting. They must bring their theory and bring it in practical use. For some students it is difficult, because they have this theory in their minds so they cannot really select...It’s not like ‘I’m telling you’... but ‘let me facilitate your clinical reasoning’. Clinical vision for me is about teaching them attentiveness and it’s not about them.” (Participant 7)

Category 1.1.4: Reflections: Educator Role

One of the participants referred to ‘integrating theory into practice’ as helping the students to remember the background information, or foundation knowledge that they were taught in their first and second year at university, and learning to apply it in practice. The researcher is of the opinion that this would be true in an ideal situation, where the students know their theory. However, in the researcher’s experience, students often do not have this foundation; therefore, the questions that surface are, “What should be done? How should they be assisted? Should they be assisted with their inadequacy?” The participants were divided in their views. Personally, the researcher’s view was to teach, if it was required, regardless of being a clinician or clinical supervisor. When a teaching opportunity emerges, it is advantageous of all to use it.

The most outstanding teaching strategy for the researcher was teaching at the bedside, which, often, was exactly what the clinical supervisors and clinicians accomplished. The patients' real life scenarios are used as learning opportunities, in a positive manner, to expose the students to clinical pictures. The researcher was of the opinion that theory is taught in the class, as well as the practical, namely, how to do vibes, shaking and percussions on peers. However, in the clinical setting, students can differentiate between the normal, as well as the abnormal, and are able, therefore, to reason things out. Teaching clinical reasoning, according to the researcher, occurs when theory is optimally integrated in the clinical field, and clinical reasoning is stimulated by facilitating and guiding the thought processes through questioning and reasoning.

The role of the clinical supervisor is broad, as supervisors play a huge role in integrating theory into practice, and stimulating the thinking processes of clinical reasoning. When the basic knowledge or foundation is lacking, the educators, namely clinicians and clinical supervisors, should step in to “teach in the moment” and later report to the university the lack of theory, if needs be.

4.3.1.2: Sub-theme 1.2: The mentor role

The participants acknowledged that they share a collective role with the clinicians regarding the mentoring of the student. A study conducted by Jokelainen *et al.* (2011: p. 2855) highlights the lack of unified use and understanding of the term ‘mentoring’ in the context of students in clinical practice; therefore, there are variations of mentoring approaches. These authors explain that in many countries there are no nationally agreed upon standards for mentor preparation, as existing education varies by country, and is voluntary. In addition, the mentoring has mainly been focused on career development in long-term relationships among health professionals, and not necessarily students; however, this all changed in the early 1900s, when mentoring was presented as a long-term mentorship relationship between a student and an older, more experienced expert in the field. Jokelainen *et al.* (2011) assert that the work of a mentor is to supervise, teach and

assess students in placements, during their clinical practice period. In a student-mentor relationship, positive emotional aspects are considered as very significant. Relationship building, therefore, is important in mentoring. A study conducted by Lekkas *et al.* (2007) highlighted the lack of information on the effectiveness of various teaching methods in physiotherapy clinical education.

“I think firstly a role as my goal, secondly I see myself as a learning tool and then I also see myself as a mentor sometimes and a coach many times and obviously we have to be examiners. That’s not my favourite role, but examiner we have to assess them.” (Participant 11)

“Maybe that we also act as role models and mentors... well I think that, especially to the third year students, they look up to us. If I do a session with them then I must make sure that I am following my guidelines and I am doing it exactly as it should be because they will take that home and they will they would do as exactly as you taught them so we also need to be up to standard with our knowledge.” (Participant 9)

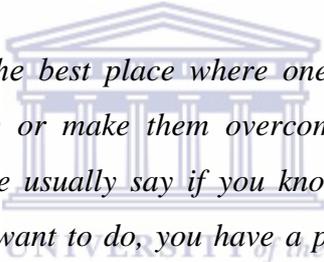
“...they (clinicians and clinical supervisors) both educate even the supervisor can have a role as a mentor or can be a role model for the students, so there is an overlap between the two areas. I don’t think it differs that much perhaps just the extent.” (Participant 3)

During the interviews, the participants felt very strongly that clinical supervisors have an additional role of mentoring and coaching. A number of studies have demonstrated, or argued that mentoring (by someone from a similar background) is an effective way of providing role models and support for students (Kilminster & Jolly, 2000). The participants suggested that, in order to be effective, clinical supervisors must follow the guidelines when they conduct educational sessions with the students, because the students are watching their every move. In the mentor role of the clinical supervisor, various categories emerged, including, mentoring in the area of becoming independent workers, building interpersonal

relationships, providing support and providing guidance, followed by the researcher's reflections .

Category 1.2.1: Becoming independent workers

The study conducted by Jokelainen *et al.* (2011) reveals that mentoring is focused on increasing students' responsibility to work independently in stages, and helping students to grow from observers to independent workers, which increased students' skills to cope with nursing actions, independently. Even though students would like to be independent, clinical educators still need to support and guide them. This support and guidance is improved through building relationships. Literature highlights that, in order to assist students, clinical educators need to have skills in areas, such as relationship building, exploring and probing, empowering and challenging (Shebib, 2003a).



“I think the best place where one can boost their (students) confidence or make them overcome their fear... it is a new setting. We usually say if you know your stuff and you know what you want to do, you have a purpose and a plan for your patient and you know your precautions, you half way there you can never harm a patient. Some of those things come in times and sometimes I think we are impatient...I want my students to be competent.” (Participant 7)

“I think as a supervisor we should try to guide them in the right direction in terms of to assist them to treat patients holistically, a lot of the students seem to struggle with treating the patient as a whole and seeing that its actually for the patients and not for patients and not for themselves...” (Participant 6)

The participant added:

“I think that's our biggest thing that we can contribute to the student, because if the student can do well in terms of assessing and getting a holistic approach, what more can we teach them? You know that's really the ultimate. If they can see the patient

and try to fix things and link the components all together...then it's perfect.” (Participant 6)

Category 1.2.2: Building interpersonal relationships

This discussion with the participants elicited emotions, such as trust, as well as reflecting on themselves, as more than just clinical supervisors. A study conducted by Naude and Mokoena (1998) highlighted that clinical educators should assist in developing strategies to build trust and create a caring environment for the student. As mentioned by the participants, building relationships are important in the clinical setting; referring to the way that students and clinical educators interact with patients, as well as colleagues. Trust is only built when there is a caring environment for the student. Caring behaviour builds a good teacher-student relationship, and should be characterised by mutual trust, open and authentic communication, and interest in the student's personal and academic needs (Redmond & Sorrel, 1996). The clinical supervisors and clinicians require this support from their mentors.

“...and act as mentors.’...bedside manner with a patient, but bedside manner with colleagues as well, the way they interact with their colleagues the way they interact with their superiors perhaps their boss.” (Participant 3)

“...between the clinician and myself we looked at ways to help the student and that was a personal problem that she was having and it was affecting her ability to perform but it meant trusting...Generally speaking, if you look at physio's...Our character is that of caring for others so therefore we will take that extra little time to say 'ok, so how can I help you', 'who else can you talk to'...in that sense.”(Participant 4)

Category 1.2.3: Providing support

One of the key observations, made during the interview process, is the role of supporting students. Literature highlights that clinical supervision has three key functions, namely, administrative, educative and supportive (Hall

& Cox, 2009). In addition, it has been emphasised that the impact of external socio-cultural factors on the student has to be acknowledged in the clinical learning environment.

The level of support needed by students, as indicated by the participants, was more than academic, or educational support. The support included social and emotional support and, therefore, as mentors, clinical supervisors fulfilled this role; despite literature proving that the external socio-cultural factors of the student has to be considered in the clinical learning environment (Hall & Cox, 2009). The participants elicited mixed emotions, as some considered purely providing academic support as their role, while others assumed that supervisors should have insight into the aspects of the social needs possibly affecting the student. A few participants presumed that they do not engage in the social problems of the student; they offer support by trying to accommodate the needs of the student, and, subsequently, refer the student to the university. In this situation, the supervisors are supporting students by referring them to the university. The participants are therefore providing support, but in different ways.

“My role entails being a support system for a student from the university side...Support holistically, whether they need it on an academic level or whether they need it on a personal level I will be there...I don't want to come across as being the meanie because I want to be the mediator between the hospital and the university. So if there a problem they must come to me first...like trust.” (Participant 1)

“...personally for myself, I would want to support that student socially or emotionally if there was an issue that needed to be supported I would not say: ‘hold on....I'm not here for that...I won't do that. I would look at how I can help you and again is it something that we should take to the university because the university has other resources there that could assist the student

and the university often says “If you don’t come forward with the problem I can’t help you.” (Participant 4)

“I am not sure how the university handles it, but I am sure there is support from them. In terms of the supervisor I do not engage in their personal issues or problems, however they are free to tell me if they have a personal issue and I will tell them okay it is fine maybe you can hand in your work a few days later or whatever but I do encourage them to deal with it...” (Participant 9)

“I don’t even think the clinical supervisor should know about it. I guess it depends on the issue, so as a supervisor I would not want to know that a student is having financial stress, for example because that shouldn’t determine the outcome...I think both clinicians and clinical supervisors should know but also not to the extent where we should ever sympathise we can empathise with the students ...” (Participant 3)

Category 1.2.4: Provide guidance

Several participants were of the opinion that they were helping and guiding students; however, it was clearly stated that this should not be confused with spoon-feeding. One of the participants assumed that they were helping to guide the students with topics that were both related and unrelated to physiotherapy. According to literature, effective supervision includes direct guidance on clinical work, joint problem solving and theory practice linking (Hirons & Velleman, 1993). Sometimes students do not know how to handle situations; therefore, guidance on ethics is important for undergraduates in the workplace. This demonstrates how complex supervision is, as well as the emergence of its various definitions. According to Razmjou et al. (2015: p. 1), “This complexity is due to supervision incorporating provision of monitoring, guidance and feedback on matters of personal, professional and educational development in the context of care of patients, the ability to anticipate strengths and

weaknesses in particular clinical situations in order to maximise patient safety.”

In addition, providing advice, good role modelling and feedback were identified as crucial components of effective supervision (McCrea & Milsom, 1996). In order to fulfil a mentoring role, the educator needs to understand the term mentoring, as well as explore different mentoring strategies. When mentoring a student, the mentor aids the student in integrating into the professional environment through teaching independency, being supportive and setting an example on how to build relationships in the workplace.

“...it’s more of guiding students than just to provide them with all the information or spoon-feeding them. I would rather just guide them more than just telling them what to do...its more as a supervision role. When they go on their placements I will supervise, see how they progressing through their clinical rotations and if there are aspects that they might be struggling with I will maybe assist them with regard to that. So it’s more of a guidance and trying to get them back onto the right path with regard to patient assessments, treatment and management of patients.” (Participant 2)

“I am there to guide the students, I am there to help them prepare for their exams and their evaluations, I am there to help them with their hands on techniques. I am there to facilitate their learning further, help them understand concepts, help them to clinical reason out difficult situations.” (Participant 5)

“Something kind of related to physio but also unrelated to physio; just to guide them in terms of ethics. I think sometimes that could be a problem where the students are too scared about the exams and they forget what the patient wants. They would do a treatment it sounds great but maybe it is not what

the patient wants to get fixed. So in terms of guiding their thinking as well to contribute to their learning...I think that is also what we should also try to focus on.” (Participant 6)

The participants in this current study are correct in identifying that the role they play is multi-dimensional, and could be different concepts. Educator was one of those roles, as well as being a mentor, mediator and role model. Heshmati-Nabavi and Vanaki (2010) concur that clinical educators must have the ability to provide feedback (communicator), be clinically competent (clinical role model) and know how to teach (educator).

Category 1.2.5: Reflections: Mentor Role

To become independent practitioners, the mentor should strive to move the student to a level of being able to work independently. These skills are required of the clinical teachers. The clinical placements, therefore, should guide students and mould them, as successfully developing independent students will aid them in the future.

The researcher considered the mentor role to be one of the most important roles that emerged. The clinical supervisors', the researcher agrees, act as mentors, who build long-term relationships with students. The researcher suspects that the bond between the mentor and student could lead to the student seeking guidance, even after the student qualifies, whether it is for assistance with patients, or postgraduate studies. Mentoring, ultimately, the researcher believes, assigns students the confidence to be independent practitioners. Once students are in a trusting safe environment, they tend to have the liberty to ask more questions and reflect more on their feelings and experiences without prejudice. The researcher's perception of a mentor is an individual, who generally provides support and guidance on whichever level it is required, whether emotionally or academically. When students receive this type of guidance and support they will, hopefully, adopt this behaviour and become mentors themselves, once they become independent practitioners.

4.3.1.3. Sub-theme 1.3: Clinical supervisors as role models

In this current study, the participants expressed that role modelling was perceived as a very important role that both clinical supervisors and clinicians fulfil. Some of the participants believed that both parties did not fully understand, or notice how students mimic and observe their superiors' behaviour. The participants articulated that clinical educators could not expect students to become good practitioners, without good role models. Jokelainen *et al.* (2011: p. 2864) state, "It is significant that mentors motivate students to learn in placements and act as role models." These authors explained that acting as a role model for students, fell under the category of promoting growth and commitment. It was expressed as motivating students to study with psychological support and encouragement.

There is a need for both clinical supervisors and clinicians to realise that students revere their educators; observing their behaviour and attitudes. According to Kilminster and Jolly (2000: p. 834) "A teachers' interpersonal behaviours, planning and preparation and the ability to run a session are key factors in good teaching." Educators should be keen to be good role models and accept the importance thereof. All clinical supervisors and clinicians are modelling behaviour, either good or bad. Ultimately, the student will choose to either mimic the behaviour of the educator, or refuse it. Therefore, educators have to be a role models that student would be proud to imitate.

"I also want to be a role model for them like when they are watching. They must see if you treat the people with respect it does not matter whether it's a gangster or a beggar." (Participant 8)

"You need to be a role model...I need to respect them if I want them to respect me and I feel that I must be approachable. Role model is important and we are in a caring profession and we need to think of students as people who are developing they do not come ready made." (Participant 7)

"I think the role modelling is important we can't expect our students to be good students if they don't have good role models and that's not only clinicians but supervisors as well..." (Participant 4)

Category 1.3.1: Reflections: Role Model

Clinical supervisors, as role models; this concept was conspicuous as many health professionals do not pay much attention to it. Students observe how physiotherapists treat and work with fellow physiotherapists, MDT members, clinicians and other students. As health professionals, physiotherapists need to be more alert on how they behave and treat people. When students do not have good role models in clinical settings, physiotherapy graduates are negatively affected. The researcher believes that the teaching role surpasses practical techniques and clinical reasoning. It is the area where students are taught, indirectly, how to be professional in the workplace.

4.3.1.4. Sub-theme 1.4: Communicator

The role of being a communicator was highlighted under the theme of role modelling. The clinical supervisor has to facilitate communication between the university and the hospital staff, as well as between the university and the student. According to a study conducted by O'Keefe *et al.* (2012), communication and feedback to clinical staff is just as important as ensuring that communication and feedback is provided to students. Clinicians and clinical supervisors need to communicate more; it should be a two-way communication. This open relationship between the stakeholders will help the struggling student, as the clinical supervisor could notify the clinician to be vigilant and report to the clinical supervisor any issues with which the student was struggling. Edgar and Connaughton (2014: p. 35) state, "Further development of communication skills including listening, debriefing and mediation may assist clinical educators with managing conflict and challenging situations in the workplace." Literature, therefore, reveals that communication solves many challenges in the clinical setting. Clinical supervisors should take on this role of communicating, and role model good communication skills, by being mediators in the clinical arena. It is important to communicate with the clinicians about the supervision of the student and provide them with a platform to express their concerns, or views, on student learning.

“I think there could also be a bit more communication between the university and the clinicians...on what they expect of the clinicians or what they expect from the supervisor. That they clear on what their job is, and what will the supervisor manage... I think there’s often a bit of hostility towards the students ...I think if the university communicates with the clinicians there also might be a bit of a more positive feeling towards the student.” (Participant 12)

“Communication between the supervisor and the student is very important instead of one sided. I think they should work together its more efficient this way. I find...my age it is similar to the student. It just seems to work better and they still have that respect...The students must communicate like I always emphasise to the student, I don’t know what you thinking I cannot read your mind. If you don’t tell me what you thinking I can’t tell you whether it’s right or wrong but then by the time you did it, its late.” (Participant 6)

“It depends how you as an individual are able to communicate with people in general... I just find that it’s easier to work with a clinician. Each clinician I communicate with them, I tell them when I plan on doing mocks and which times I plan on doing exams and they give me feedback. If you just have that communication and if there’s any issues make time to sort it out and then that should be fine.”(Participant 5)

Category 1.4.1: Being a Mediator

The participants highlighted that they wanted to be observed as mediators between the university and the clinicians. The participants believed that improving the communication skills between clinical supervisors, clinicians and students, could enhance the relationship between clinical supervisors and clinicians. The supervisors were happy to assume this role. Jokelainen *et al.* (2011: p. 2863) assert that mentoring allowed students and supervisors to work in a close interactive relationship, including, acting as equal pairs in co-operation; having mutual, trusted communication and interaction; and working together as collegial friends. The participants mentioned that, often, acting as a mediator between the clinician and the

student simply involved communicating to ensure that both parties understood each other. According to Kilminster and Jolly (2000) there are factors that facilitate change in teachers' behaviours and thinking, when they are developing a collegial relationship, or establishing a relationship and reflection.

“I see the clinical supervisor as the link between the clinician and the university, because the university loses touch with the clinical area, and the clinical area loses touch with the clinician and the student is in the middle. The supervisor can actually facilitate the process of the two working together quite nicely.”(Participant 6)

“I also want to feel like that person where a student can come and talk too...I want to be a person in the middle like a mediator or a mom and come to me if they have any problems...”(Participant 8)

“I know on a previous block I had a clinician who had issues with the student regards to certain professional behaviour...I had to facilitate that so I had to make the clinician sort of see the student's point of view and I had to teach the student a little bit about what it is to be professional and what would be expected of them in a year or two once they are actually qualified. So the clinician would think of things from their point of view and the student would think of things from their world and I just sort of point out the differences between the two...”
(Participant 3)

Category 1.4.2: Providing feedback

In this theme, the value of feedback emerged strongly. The participants highlighted that feedback should be used effectively to assist the clinical reasoning skills of the students. In addition, the way in which information is communicated, and feedback provided, is essential. According to O'Keefe *et al.* (2012), “Feedback is a central component of quality assurance and

improvement activities.” These authors explain that the clinical environment offers a range of feedback opportunities for students, universities and health services. The participants, therefore, considered it important to realize that feedback was not about belittling students, it has to be a platform to encourage students.

“I think the way we give feedback is important we cannot belittle them or make them feel stupid...and I think that is a very important part in how we as physios’ or as educators’ give feedback. I think is important in terms of how the students receive that feedback and what the student then does with it because it doesn’t really help for us to shout at them...If you are telling them no not like this, do it like that, they also don’t understand, so you are not helping them with their critical reasoning or their clinical reasoning skill, you also need to explain.” (Participant 4)

“...at the end (block/placement) the clinicians sit down with the students and they discuss their patients. They give feedback about the patient and then the clinician also gives them feedback on what they have been doing about the patient. I think that should be implemented at all institutions because it is only a few that do that” (Participant 9)

“How you give feedback also depends on the way we as supervisor are able to connect with our students. I am younger, I was in their position five years ago and I have a lot to do with students, I’m able to connect with them very quickly. The way it (feedback) gets given is just as important as literally in front of whom you giving it” (Participant 5)

The participant added:

“Positive feedback and negative feedback it really does depend on the situation, but talking to the student alone for me that’s the number one thing ...I won’t do it in front of the patient and I

won't do it in front of other students because at that time they might just feel offended or they need to stand up for themselves but if I take them one side and I tell them and I actually give them good feedback not just tell them you did this and that wrong...Positive feedback is always good, you can do that in front of anybody just boost the motivation and the confidence a little bit.” (Participant 5)

The topic on feedback made the participants reflect on the past and their own negative experiences as students. One specific participant expressed being conscious of the negative experience of feedback continually, to the present day. This participant articulated that there was no support and guidance in the feedback, as it was provided in a negative manner, which de-motivated the participant. However, reflecting on this incident, the participant could apply what was learned the experience to improve current supervisor-student relationships. The findings of a study conducted by Ernstzen *et al.* (2009) highlight that feedback to students is an important variable in the effectiveness of physiotherapy clinical education. Feedback creates a mental state of confidence, as well as competence, and improves relationships. These authors explain that feedback to students should be clear and unambiguous, in order for them to become aware of their mistakes and weaknesses.

“...as a student I would prepare a patient then they (clinicians) would give me critic afterwards not necessarily the good type of critic. For me personally I feel that clinical supervision is the only way that a students can have someone with them for an hour they can question you can question them and it has this backflow of communication and practicing techniques that they struggle with. They should have somewhere they can ask someone listen here I'm struggling with this help me. Clinical supervision, I feel, is there for them to address a problem in clinical practice. I didn't have that as a student unfortunately not on all my blocks...” (Participant 5)

One of the participants expressed that giving feedback involving all stakeholders is very important and especially important for continuity. All supervisors need to be like-minded regarding the clinical education of future physiotherapists. The participant highlighted that on one of the placements, the clinical supervisor and clinicians together gave feedback to the student about patient management. This allowed everyone to be collectively involved with organising the best treatment plan for the patient. According to Kilminster and Jolly (2000, p. 833), "The collaborative model helped students increase the number of positive specific interactions they had with their pupils..."

The participants highlighted the need for students to engage in feedback regarding their learning experience with the clinical supervisor. In a study conducted by Bos *et al.* (2015), supervisors (participants) stated that students gave them constructive feedback on their supervision and nursing care, which they perceived as positive and a benefit for further development of supervision. In addition, these participants described supervision as constant give-and-take between students and themselves, which could potentially lead to personal fulfilment. This revealed that the participants recognised that the entire clinical experience was a two way street, where both parties could learn and grow from the experience.

"I think the problem sometimes is that the clinician and the supervisor is never together with the student. I think mainly the clinician is there then when the supervisor comes then the supervisor is there on his own. They discussing their own thing then they go away then next week you just see the supervisor again. I think more if they involve the clinician also in that session with the supervisor. I think in a way then, you as a clinician know what is expected. You can also give your input from the clinical side because you spending most of time with the student. You can also maybe give positive feedback or strategies that can maybe also help, but if you as a clinician is

the one way and the supervisor is the other way then it's just not working.” (Participant 10)

Category 1.4.3: Reflections: Communicator

The role of a supervisor was revealed to be a communicator; someone who acts as a mediator between the student and other parties. It is important for the student that someone communicates with the university, clinician and, at times, even the patients. The researcher believes that the students need clinical supervisors to mediate for them. The university and the clinical placements could be overwhelming for the students; therefore, they need to know that they have a mediator, who will communicate their concerns. Being a clinician, the researcher is aware that there are various challenges that both the supervisor and the clinician encounter, when working with students, it is not as simple, as it seems. It not just about teaching students, examining them, and moving on; students are individuals, who have their own challenges, whether personal or academic.

In addition, communicating, in terms of providing feedback to students regarding their outcomes and progress, needs to be constructive and not negative. Clinical supervisors should be trained to communicate as clinical teachers, to uplift and grow the students and not belittle them. The researcher is of the opinion that clinical teachers often do not realise how important feedback is in learning; it is one of those aspects of clinical education, which should not be neglected.

4.3.2. Theme 2: Challenges experienced as a clinical supervisor

Although clinical supervisors were able to identify the roles that they played, this did not mean that they were comfortable with the identified roles. The main category that emerged as an area considered challenging to clinical supervisors was the teaching role. The participants questioned their skills as educators, in terms of knowledge and passion, as well as whether it was part of their role.

4.3.2.1. Sub-theme 2.1: Role clarification

Although being an educator was identified as being part of their role, a few of the participants reported they did not consider teaching as part of their duty. They were of the opinion that students should come prepared with the baseline theory. Razmjou *et al.* (2015: p. 248) assert, “Medical residents found poor supervisory roles in clarification of their responsibilities and learning goals”. A few participants declared that, whether it was their responsibility or not, they would rather treat patients to ensure that the student received clinical education, while other participants deliberated how each stakeholder could contribute to educating the student. According to Ernstzen *et al.* (2009: p. 103), “In recent years, a paradigm shift has taken place in higher education from a teacher-centred to a student-centred focus. Characteristics of the student-centred education include: learning by discovery, active construction of knowledge, specific learning results and assessment throughout learning. In the student-centred paradigm the students experience is seen as most important, but in clinical education the patients care is most important and the student takes the role of a service provider”.

“I think I have a limited role in educating them (the students) on theory on anything that we do. I feel like that’s the role of the lecturers at varsity, so my role in teaching is limited to practical...”

(Participant 12)

“I don’t know whether it is my responsibility or not... and yes there is a debate about it, but I would be happy to rather tell the student because then I feel like this is my duty...even if you say to me the university didn’t teach it to me. I might think what I want about the university but the point is this currently you are my student you are on my block...I’m just here to facilitate that knowledge that is supposed to be there. But if the student doesn’t have it who is to blame? Is the university to blame or the student is the student to blame? ...at the same time as a supervisor there is nothing wrong with you saying; taking a few minutes and saying let me explain this to you....”(Participant 4)

There were a few participants, who protested fervently that their “job” was not to teach. Their opinion was that, in order for supervisors to carry out their role of integrating theory into practice, the theory needs to be existent. If the theory is not existent, it not only impedes the supervisors with their facilitation, but also disadvantages the student and, consequently, less time is spent on practicing techniques. Cross (1995) avers, “Training should be the subject of contractual arrangements between purchasers and providers. In effect, this places ownership of clinical education in the hands of both employers with schools of physiotherapy as ‘purchasers’ and host units as ‘providers’ of placements”. Therefore, the mind-set of ‘our job, your job’ is unfavourable; the stakeholders should be working together, as one unit, towards a common goal.

“Theory for them (students); they can do at home. That’s not our job that’s their work that they must do. I feel that as a supervisor we need to tell them this stuff you need to focus on, you need to know how to do that, once you know that this will be much easier.” (Participant 6)

“I’m not there to teach according to the university. I am not there to teach, personally for me I also don’t really go about teaching them if I see there’s a situation that they never had like ever before, just to save on a bit of time we will have a discussion on it or a quick tutorial on it. It will be a two-way flow, not just me teaching them because the university doesn’t expect me to do that.” (Participant 5)

“I basically like to facilitate, I am not much but when it comes to it I demonstrate and I coach them. I personally do not like and I don’t see myself as a teacher of theory, I always say to the students you come here you must have your own knowledge, and it’s about what and where does your theory fit in and how can it be applied in a practical way.” (Participant 7)

According to one of the participants, in previous combined meetings, a university statement declared that clinicians were not expected to teach, or assist the student. This participant disagreed with this statement and explained in detail how this type of response, or attitude, negatively affects student learning. This contradicts

the findings of a study conducted by Ernstzen *et al.* (2009: p. 102), stating, “Clinical education and the supervisory process it involves is an important and distinct part of health care education. The clinical learning environment is the ideal area in which to facilitate professional skills”. Clinical placements, therefore, should be perceived as areas, or opportunities, to learn, so that when the needs arise in clinical placements, both supervisors and clinicians need to take the responsibility.

Role clarification is important to move forward in physiotherapy clinical education, and clinical supervisors need to ensure that they are like-minded regarding this matter. One party cannot believe that his/her role is not to teach, while the other believes it is. There should be consistency in placements. Ultimately, the students are the ones who fail to benefit by not getting the necessary clinical education to become competent independent practitioners. According to Cross (1995: p. 503), “Potentially conflicting aims and viewpoints may contribute to difficulties in implementing effective clinical education programmes and in attaching meaning to quality measurements.”

“At the meeting that we had there was one university that was saying they don’t expect the clinician to teach anything to the students, they were saying we don’t expect that at all. I’m thinking what does that mean if you don’t expect clinicians to teach? But I do expect you to show them something the practical side show them how to suction, how to position a patient, how to test muscle tone whatever. The point is this, we have taught it in class they not seen it on a patient it is so difficult for a student to.” (Participant 4)

Category 2.1.1: Reflections: Role clarification

During the interviews, the researcher found that not all clinical supervisors were comfortable with the roles identified. The researcher was convinced that all clinical supervisors and clinicians should be like-minded. Each stakeholder needs to know his/her role in the clinical education of undergraduate physiotherapy students, including the university. The researcher was aware that most supervisors perceived themselves to be separate from the university, whereas the researcher, a clinician, always

considered the university and the supervisors to be the same “stakeholder” and viewed the training of students as a collective effort, rather than individual. The researcher regarded the participants, who are supervisors, to have the same role as the university (lecturers). Therefore, the university needs to play its part by educating on a theoretical level, as well as teaching technical skills. The researcher imagined that clinical educators possess the skill of teaching, as they draw on experiences from their professional journey. According to the researcher, health professionals had one foot through the door, as long as they had the passion to teach.

4.3.2.2. Sub-theme 2.2: Students’ lack of theoretical knowledge

It is perfectly reasonable that the practice of medicine has evolved in a way that has left many trainees working with minimal supervision (Kilminster, Cottrell, Grant & Jolly, 2007). According to these authors, this does place a great responsibility on the supervisor to ensure that the trainee is competent and performing at an appropriate level; however, accomplishing this without compromising patient safety may be very difficult. There are associated dangers and risks when students are not prepared in the clinical field. A participant noted the dangers of students, who lack theoretical knowledge, and expressed that this unpreparedness could be detrimental. Ultimately, the patients would suffer and both the university, as well as the clinical placement would receive bad reputations, when unsafe activities occurred. Cross (1995: p. 506) states, “Inconsistency and inequity of students’ learning experiences, lack of validity and reliability in assessment of students’ clinical performance, varying standards of clinical teaching and levels of motivation among clinical educators, and lack of time and staff devoted to clinical education by clinical managers, have all been causes for concern.” In addition, this author notes that the impact of such factors on learning outcomes and the overall quality of the clinical education experience, are central to this concern.

A few participants reported that it was a challenge when the students do not know their theory. Therefore, time that is supposed to be used to integrate the theory into practice is spent on teaching theory and, consequently, the students’ practical skills and clinical reasoning receive minimal attention. The participant explained

that to work on the one aspect without the other was unacceptable; the foundation theory has to be embedded. Chipchase, Buttrum, Dunwoodie, Hill, Mandrusiak and Moran (2012: p. 112) state, "...attention to preparation allows students to take full advantage of the clinical opportunity by making sense of their experiences: to achieve this, health professional curricula are generally sequenced to ensure that students are prepared for clinical learning prior to a specific clinical experience." Literature confirms that the foundation of theory has to be embedded when starting in the clinical environment, in order to reap the benefits of practical learning.

"It is very difficult because I only see the student one hour per week and it is very difficult because if they don't have backup (theory) I cannot effectively use that hour. Then you really have to spend that hour on theory, then it is not good...There is really no time to spend on basic theory to teach a student, how to apply and to reason clinical if there is no theoretical back ground...I would refer them back to the faculty...because the university has classes that they can attend to make sure they are in place and work on their basic skills."
(Participant 8)

"I will assist the student basically in terms of the theory...there's a limit to that, a time constraint to how much you can do. I often found that in the past that when a student does come in with very poor theoretical knowledge. You cannot work on clinical reasoning, you can't get there because you busy on basics. So you literally sit and discuss the theory...then you don't get to clinical reasoning...I find that very difficult because as a supervisor teaching...I'm explaining things and I'm not getting to the practical implication, what I'm supposed to be doing ideally." (Participant 4)

"There is a difference for me, when they cannot link theory and practical and I am happy to help them with that. But if I ask them which nerve supplies a certain muscle and they do not know or which muscles will be supplied at this level, if it's a paraplegic...usually they can find out right there 'so Google it, Google it boy you have five

seconds and tell me' or I will send them back if I can... I will say if you get that information you share it with us and then I write it, I have a little black book that I write everything in, and then with the next session I follow up...because if you do not understand the condition you cannot even begin to assess.” (Participant 11)

As mentioned before, if a student is not prepared theoretically, when placed in the clinical setting, it undoubtedly has a negative effect on the students. However, this negatively affects the relationship between the student and the clinical supervisor, as well. The lack of theoretical knowledge could discourage the educator, as it limits the learning of the student's clinical reasoning in the practical field, due to time constraints and shortage of resources. This is confirmed in literature, according to Chipchase *et al.* (2012), who notes that in the clinical setting, supervision of a poorly prepared student with an inadequate knowledge base, adds to the demanding nature of the supervisory relationship.

“...I use to have a test to see where they passed a test or not and that will also give me an idea of what, where and how because we need to establish what we have in our camp. If the student does not have basic knowledge they are a danger to the patient. I don't know how other clinicians feel but I would watch my student...I feel sorry for my students because I know I don't do them any favour if I pass them, because they are a danger out there and that comes back to the name of the university...if you (student) don't put up your game you are going to fail because lives are in danger.” (Participant 7)

Category 2.2.1: Reflection: Students' lack of theoretical knowledge

Under this topic, a few participants felt that it was not their duty to teach and that students should know their background theory. The researcher's view on the topic is, if students are not prepared theoretically, it makes it quite difficult to move forward into the practical and clinical reasoning of assessments and treatments. However, if the student is not prepared, the researcher believes that the clinical supervisor and clinician should tutor that student on the topic; thereafter, if warranted, the clinical supervisor or

clinician should report the student to the university, so that extra classes, or supervision sessions can be arranged.

The researcher's opinion is that role of the clinical supervisor is broad; integrating theory into practice and stimulating the thinking process of clinical reasoning. According to the researcher, it is evident from the data, that the role of the clinical supervisor is multi-faceted; however, the lines should not be blurred. When asking this question, the researcher, as a clinician at a tertiary hospital, believed that the supervisors were being truthful and honest about how they perceived their roles. The researcher personally agreed with the participants, who noted the role of the supervisor in clinical education, as facilitating and guiding students in the clinical field, and so doing, integrating the theory into practice. Their role as supervisors is to integrate the learning of theoretical knowledge, which should already be present, into the practical setting. The researcher believes that each stakeholder is involved in the clinical education of students; however, only different aspects of clinical education. As stated earlier, clinical education consists of different aspects; therefore, when lecturers, clinical supervisors and clinicians come together, they can work collectively

4.3.2.3. Sub-theme 2.3: Are Clinical Supervisors Equipped To Teach?

The participants stated their views on the topic, which indicated that clinical supervisors educate by drawing from their own experiences. In a study conducted by Edgar and Connaughton (2014), the position of the educator was reviewed, with their findings highlighting the broad skill-set requirements necessary to fulfil this role. Most of the participants considered that the supervisors are equipped to teach, or clinically educate, even those, who are fresh out of university and commencing community service. However, there were participants who considered that on-going learning should continue, to better equip clinical supervisors. According to Archer (2011), short courses are vitally important in the institution, if the quality of clinical supervision is to improve in clinical areas, which opinion is in line with other studies conducted by healthcare providers.

“We do, I am sure we do, it’s easier to teach someone from an understanding. I’m sure all of us have enough experience to teach as a newly qualified. At first I also doubted if I had the equipment or this ability to actually help the students but from their standard and from what they shown you can definitely help them even with the little amount that you can offer it’s still something to contribute. I mean the experience I can share with them is just one year, it’s enough for them.” (Participant 6)

“...especially if you have the experience you don’t really need to have a teaching course or to share the experience that you have with the student...I must say even though I have been teaching at UWC, UCT, and US, it is still difficult for me to stand in front of the class and do a lecture. You have to go and read theoretical things but I am sure we can do it especially if you have a patient with you that you manage and teach them through demonstration. Something that student really lack is an experience. I am sure it could be easier if you can do maybe a year diploma, but I don’t think it is necessary.” (Participant 7)

“Maybe a lot of them don’t know hey it truly depends. If you do not know how to work with students it’s going to be difficult. I mean truly in the beginning students was walking all over me because in my community service when I was a clinician I didn’t know what I was supposed to do so I didn’t know how to work with students. We had education on how to give feedback how to go about your supervision sessions.” (Participant 5)

A few participants doubted whether clinicians and clinical supervisors should teach everything and that maybe they should concentrate on the areas in which they have experience. It has been highlighted that supervisors draw on their experiences in their field of work; be it experiences as a student, clinician, lecturer or clinical supervision. They agreed that the more years as a qualified clinician, the greater the contribution, due to the amount of experience to draw from. However, Archer (2011) asserts that for teachers to succeed at their teaching tasks, faculty development is essential. The challenge, therefore, lies in

the process of convincing all clinical supervisors of undergraduate students to attend courses.

“...I think we have those [teaching] skills but I think certain aspects you much better in than others,...I don’t think all the aspects you are entitled to e.g. if I must go and teach ICU now (laughing) when last did I do ICU. I think certain aspects you will be able to teach but not all”. (Participant 10)

“...with regards to the teaching skills, I think it does depend on how qualified clinician is. Also still on the learning process it is maybe a good way to learn because you have students and you can learn with the students you don’t even have to have to admit to the students. I think experience does help a lot.” (Participant 4)

A few participants mentioned that they have their physiotherapy knowledge and experiences to draw from, which, therefore, equips them to teach. However, a few participants emphasised that supervisors need to attend regular workshops on how to teach and deal with students. Edgar and Connaughton (2014) explore the role and skill-set of the clinical educators in work-integrated learning and reveal the necessity for soft skills training, to complete their role. The authors explained that the clinical educators emphasised the necessity of strong non-clinical skills, or soft skills, in discussions regarding their role, skill requirements and challenges. These skills include communication skills, critical thinking and problem solving, teamwork, leadership, professional ethics and morals, lifelong learning and entrepreneurship.

Ultimately, the participants’ holistic reserve of experience, workshops and a passion for teaching was deemed important for clinically educating students. “Although most clinical teachers are enthusiastic and take their role of teachers of future generations of healthcare professionals seriously, they often lack knowledge of educational principles and teaching strategies and thus may be inadequately prepared for this additional professional role” (Archer 2011: p. 6). Therefore, clinical experience has very little to do with the ability to teach in the

clinical setting, and clinical supervisors need to receive some form of education to positively impact student learning.

“We obviously have our physio knowledge to teach, but I think that there should be some sort of education regarding how to supervise students. We need maybe a tutorial session because our knowledge is there but also we do not know how to. It is the same as a person studying to become a teacher they have certain guidelines...there is something, missing between us as graduates being able to supervise students.” (Participant 9)

“I think we need to be equipped and I think we need to attend workshops, teach us in terms of the skills. To help us help the student in a clinic setting, like how to approach that.” (Participant 7)

“I think that is very important the student is responsible for their own learning, I’m there to facilitate that learning no one taught me how to be a teacher I didn’t do a degree in education or in teaching. I was a physiotherapist, you a physiotherapist no one taught us how to teach but, why is it that we have students that we facilitate learning? No one sat down with us and said these are methods, this is how people learn, you know these are good things to learn...but we know practical knowledge and practical skills, we need to impart that on students. We need to do our own research on what was used in the past or do a course a teaching course to learn this is how students respond.” (Participant 4)

“...I have been teaching for a year and a half and I still don’t know...do the students feel comfortable with that, do they feel that they learnt something from that? The students at the end of the block will tell me thank you so much we’ve learnt so much from you it’s been a wonderful opportunity but I mean you say that to someone who is going to mark you and give you marks for whatever you doing.” (Participant 12)

Some participants held that there was more to teaching than years of experience. One participant highlighted that a love for teaching is vital, as not every physiotherapist has a passion to teach students. It was also noted that the therapists should love their field of teaching. In addition, Bos *et al.* (2015: p. 39), established that “district nurses were willing to share their enthusiasm with the students so that they could better understand the complexity of and variety within the district nurses’ work and profession.” This enthusiasm affects clinical teaching experience positively. According to Archer (2011), the clinical educators’ motivation to attend courses was mainly intrinsic, as educators with a passion for their work were keen to attend courses and further their knowledge.

“I don’t think that you are taught to be a teacher; does not mean you are going to make a good teacher. I think part of it you need to have a passion for that and you need to enjoy the students. One person can finish varsity and the theoretical knowledge how it should be done and still not make a good teacher because it’s not his passion and the other thing I think you should have some form of experience because sometimes is from the experience that I know.” (Participant 12)

Category 2.3.1: Reflection: Are clinical supervisors equipped to teach

All stakeholders need to realise that the world is constantly changing and so is evidence based practice. Therefore, teaching tutorials on how to equip clinical supervisors are important. There were a few participants, who considered that their role was not to teach, and that the lack of theory was not acceptable. However, the researcher considered that, when this happens the educators should find ways to deal with the problem and prevent its re-occurrence. Educators should ensure that when students arrive on the block, they are well prepared, in order to integrate the theory into practice.

One participant mentioned that some universities do not expect clinicians to teach, as it is the supervisor’s duty. According to the researcher, this was untrue as students from all universities, work closely with clinicians and constantly receive guidance and feedback at the institution, at which the researcher is employed. Other participants expressed that it is not the

clinicians' responsibility to do one-on-one sessions and tutorials, because of time constraints. The researcher's response is that, under the circumstances, whatever can be done should be done; every situation should be treated as a tutorial, by guiding the students through processes and practical skills with the available resources. However, regular courses and tutorials on how to teach students the best, in order to equip and prepare them for the professional world, are vital. In addition, the love for teaching needs to be extant.

4.3.3. Theme 3: The clinician's role, according to clinical supervisors

In theme two, the data and discussion dealt with the challenges that confronted clinical supervisors in the clinical setting. The identified roles were not necessarily the roles agreed on by the participants. In theme three, the role of the clinician in clinical education is discussed, as viewed by the clinical supervisors. The participants highlighted three sub-themes under theme three; understanding the importance of the role of the clinician, providing guidance in the clinical setting, role modelling and professionalism.

4.3.3.1. Sub-theme 3.1: Understanding the importance of the clinician's role

In identifying the role of the clinician, the supervisors noted that there were overlaps in the roles of supervisors and clinicians. Many participants agreed that the clinician should play a supportive role regarding students. In a study conducted by Edgar and Connaughton (2014), it was established that clinical educators may be supervisors employed by the educational institutions, or clinicians employed in the sector. However, despite the varied role of the clinical educator, the authors explained that it was not appropriate to add the role of educator to that of clinician. Even though the roles overlap, it cannot be assumed that the clinician has the capacity to take on this role, due to the various barriers, which do not allow clinicians to educate clinically in the clinical placements.

The participants strongly endorsed that the role of the clinician is important in the clinical exposure of the student; however, do they have the time? The clinician has more access to the student; however, do they have the resources to educate the student clinically? Manninen *et al.* (2015: p. 55) assert, "As previous studies

have shown, it is more common that supervision of students is secondary to patient care and the allocation of resources and structures is not always optimal". These are only a few of the barriers that exist in clinical education.

The participants expressed that clinicians have the ability to provide the student with learning opportunities, as they are in the same environment as the student. Therefore, the decisions of the clinicians, regarding students learning, are important. However, the factors that impede this process should not be ignored. One participant shared an experience of working at another university, where the academic staff and clinical supervisors explored the effect that clinicians have on students in the clinical education. The participant noted that the students excelled in exams at clinical placements, when clinicians were more involved in clinical education. According to Cross (1995: p. 503), "Clinicians are the members of the profession who are spending the majority of their time treating patients, achieving the mastery level of their clinical skills and becoming familiar with modern equipment. It is these members of our profession who have so much to offer students and who should be at the forefront of the clinical education process."

"I think clinicians has a big role, okay the university itself is obviously the biggest in terms of theory and getting the foundation right, but clinicians definitely play an important role because what happens in the hospital is between the clinician and the student. The decisions that the clinician makes actually impacts on the student whether the students going to like neuro or paedics etcetera."
(Participant 6)

"My view on the role of the clinician, is the clinician is the first hand, first line person, the person they see the first day, I come somewhere in the week. I think the role of the clinician is very important because it has a very very big impact on the student with regards to the rest of the block." (Participant 1)

"Big contribution, big contribution, I was a clinician as well, so for me when I step in my supervision hour I'm not like a normal supervisor. I treat it a little bit like a clinician as well because we do

have overlapping roles but the contribution clinicians can have, I mean just exposing the students to different type of diagnoses. If you a good clinician you will give your students that chance, just by getting them exposed to different conditions and helping them understand the treatment etc. it gives the developing professional graduates a better base to work from.” (Participant 5)

“Number one, I think the clinician has a crucial role in student education; we have actually looked at marks at Stellenbosch and compared marks in different blocks and the blocks where the clinicians are more involved. The students do at least ten per cent better in their block exams. This is not research it is just an observation that the staff has made they actually looked at it. I come in once a week, I see the student one hour or maybe if it is a third year student two hours in a week. That is not enough I see them with one patient it is not enough.” (Participant 11)

Category 3.1.1: Reflections: Understanding the importance of the clinician

The researcher was fascinated by the views that a clinical supervisor had of clinicians. The impression created was that the participants are looking from the outside in and yet the same is true about clinicians. Everyone seems to have an idea about what might work better, even though not in individual’s shoes, at the time. The researcher always wondered what clinical supervisors required of clinicians in clinical placements; what their opinions were on how clinicians could contribute to the clinical education of the students and was it realistic. Drawing from the researcher’s own working environment, when approached, the clinical supervisors suggested different ideas of what could, and should be done. Therefore, it is important to understand that the different stakeholders’ roles overlap, and do not exist in isolation.

4.3.3.2. Sub-theme 3.2: Clinicians Taking Responsibility

The need for good educational supervision, appraisal and assessment in postgraduate education has been highlighted in literature. However, it is not

always clear what supervision entails; or who should or could supervise; what the effects of supervision are; or what the benefits are to patients and the service (Kilminster *et al.*, 2007). Conflicting views emerged during the interviews, with one participant disagreeing that the clinician should spend one-on-one time with the student, because time did not allow this to take place. However, the participant agreed that treatment was still the clinician's responsibility. On the contrary, the opinions of other participants were that clinicians should spend time, and be more concerned with facilitation in the clinical setting; even though the participants were unsure about the actual time that should be spent with students.

A few participants felt educating students was not only the role of the supervisor, but the clinician's role, as well. The participants maintained that, if the hospitals allow students into the environment, the clinical settings should take some responsibility for educating students. Manninen *et al.* (2015: p. 55) assert, "A challenge and a need for future clinical practice is to create learning environments where supervision of students and patient care are acknowledge as equally important". According to the participants, the same applies to clinicians; if their patients are being treated by students, it is their responsibility to supervise the student, to ensure that harm is done and the patient is receiving adequate treatment. Bos *et al.* (2015), avers that clinicians, who supervised students during their clinical placements, were cautious about leaving the students alone with their patients, as they were unsure whether the students possessed sufficient knowledge and skills to take care of their patients; solely because they had the ultimate responsibility for the patient's care. The following refers:

"First of all I think the clinician does not have to spend one to one sessions with the students because they do not have time for that but their role should be involved in the treatment of the patient they must still be responsible for the treatment of that patient they must make sure that the student knows what is the plan...I feel the clinician should be the ones that are responsible for the client...The clinician must do whatever is necessary to take care of that patient and the clinician must go to the student and talk to that student...Are you in

the right track with my patient because this my patient.” (Participant 8)

“Clinicians often have a big role in facilitation of learning and I think its missed because they more concerned about their workload is getting done because they don’t spend as much time with the student; I don’t know what amount of time they should be spending with the student.” (Participant 2)

“You can’t put a student in ICU and say: ‘do this, do that’ walk away and tomorrow when something goes wrong and then you want to blame the student. Never forget that the environment the student is being put in is still the clinician’s environment and I think it’s only right that the clinician takes responsibility for that environment or for the patient that they giving for the student.” (Participant 1)

The participants emphasised that the student was the clinician’s responsibility. The justification for the statement was that, if the clinician allocates patients, whom they responsible for, then the student automatically becomes the clinician’s responsibility. Manninen *et al.* (2015: p. 55) contend, “we are responsible for the patients...we meet them together with the students and without them.” The participant added that clinicians should ensure the patient’s adequate treatment by the student. According to Edgar and Connaughton (2014), clinical educators, namely, clinicians and clinical supervisors, typically have the responsibility for graded, or competency-based, assessments of the students’ knowledge and skills, as well as the development of professional workplace skills.

“In terms of assisting the students they should also play a role in checking up and assisting because clinicians give their patients to the student, so it’s also the clinician responsibility to make sure that the patient is suitably treated or appropriately treated, so they should follow up on these patients whether the student is doing the right thing and therefore kind of like a safety net for a student.” (Participant 6)

“It is their responsibility because they are working at an education facility so when they applied and accepted that job they should have known that their responsibility will include the students. I think that the hospital forgets that it is an educational facility, I think physio students are neglected in that sense whereas in your nursing you doctor there is a lot of attention given to them but the physio students are neglected, the same can be said about OT students.”(Participant 9)

“My advice to the clinician is to remember that it’s still their patients; at the end of the day it’s still their patient they are responsible for the patient not the students. It’s not the student’s responsibility to treat the patient well, it’s the clinician’s responsibility to make sure that the patient is treated well. So if it means that they must stand and watch a student and facilitate the students so that their patient is treated well at the end of the day, they are responsible for the patients.” (Participant 3)

The participants were of the opinion that, when the student forgets theoretical knowledge, it is the responsibility of all the stakeholders involved to remind the student. Consequently, the patient and everyone else are protected and working in a safe environment. According to Manninen *et al.* (2015: p. 55), learning environments, such as clinical education wards, allow supervisors to focus on the students’ learning processes, as well as patient care. These authors explain that, in the ward, the supervisors regard the supervising of students and taking care of patients, as equally important and not separate tasks. In addition, “balancing patients’ and students’ needs is a matter of identifying needs, making plans and following them up: a learning plan for students and nursing plan for patients.” (Manninen *et al.*, 2015: p. 55). In order to achieve this, the supervisors should highlight the need to spend time with both students and patients.

“It’s also our (clinical supervisors and clinicians) responsibility to tell the students if they don’t know but obviously it’s also the lectures or the university’s role to play. If the student forgets therefore we

have to put in reminders just to protect everyone the patient, clinician, supervisors and students themselves just to make sure everything the environment is safe to work in.” (Participant 6)

“I think it should be both and don’t think it should be either or I think it should be both because...they giving their education from a more clinical setting we giving it maybe more from a theoretical and practical setting to a smaller extent. But they (clinicians) in the clinical setting so they can give more clinical input regarding that. Where if we give lectures we only giving what we stated in textbooks or in course notes with regards to how patients presents but they giving a more clinical background and adding something different that we unable to add to our classes.” (Participant 2)

The participants highlighted the differences between the roles of the supervisor and clinicians, which was deemed equally important. It is important when understanding the role of the clinician that consideration is given to the lack of resources that limit the clinicians’ interactions with students in the clinical setting. In a government setting, service delivery always comes first, which in turns leads to students taking a backseat. Now that the importance of the clinicians’ role is acknowledged, strategies have to be implemented to broaden resources for the clinicians to be more involved in clinical education, without negatively affecting service delivery. According to a study conducted by Cross (1995), the dilemma facing clinical educators is the commitment they have towards patient care, at a time of increasing workloads and decreasing resources.

“I actually feel that the clinicians have a very very big role because they spend more time with the student than the supervisor does. The clinical supervisor’s role is very much too sort of apply a lot of the things that the university is teaching the students within certain parameters that is set by the university. The clinicians are with them every day. For example sometimes in the practical setting certain pre-cautions contra-indications doesn’t necessary apply even though it’s been taught to the student...The clinical supervisor’s role is very much too sort of apply a lot of the things that the university is

teaching the students within certain parameters that is set by the university.” (Participant 3)

“...the clinicians are with the students most of the time, they also have patient to see obviously. Maybe having sessions with them (students), showing them how to do certain techniques and identifying the student’s weakness...they (clinicians) can give more input regarding teaching students of how to approach patients in the clinical setting; how to manage them; how to look at a patient in a more holistic point of view and that is the type of thing that’s difficult to tell them in the classes. As well that you should try to look at a patient in a more holistic way...they (clinicians) have more input or real life experience working in that setting than certain clinical supervisors who are academics that have at limited experience, that just do most of their research.” (Participant 2)

Category 3.2.1: Reflections: Clinicians taking responsibility

Clinicians must take responsibility for the area they work in, and the patients they manage. The students caring for the clinician’s patients, become the clinician’s responsibility. The future of physiotherapy clinical education depends on all stakeholders moving towards viewing patient care and the supervision of students, as equally important. During the interview process, the participants envisaged that their role and the supervisor’s role overlap and are equally important. It was acknowledged that the clinicians’ role was vital and important. The researcher wondered whether the clinicians were aware the fact that clinical supervisors value their contribution and the role they play, or could play, in clinical education. The researcher, therefore, was convinced that clinical education is teamwork, involving various individuals: the university (lecturers), clinical supervisors, the students and clinicians. The researcher’s views were confirmed that clinical education was not only taught by those employed by the universities, was a harsh, but a true statement. Personally, the researcher considered that pushing the responsibility onto a different party seemed to ever present, with clinical supervisors denying responsibility to teach, as it

was the lecturers responsibility, and clinicians claiming that it was not their responsibility to supervise, as it was the clinical supervisors responsibility. In the interviews, the role of the clinician was deemed important. The researcher believed that, as clinicians, more time is spent with the students than the supervisor, because of easier access to the students; however, whether the time spent is quality time, is debatable.

4.3.3.3. Sub-theme 3.3: Clinicians providing guidance in the clinical setting

In a study conducted by Kilminster *et al.* (2007), the finding suggest that helpful supervisory behaviours include, giving direct guidance on clinical work, linking theory and practice, engaging in joint problem-solving, offering feedback and reassurance and providing role-models. The participants highlighted that clinicians could provide guidance in the clinical setting, in terms of administration, time management and patient management, including discharge planning.

Category 3.3.1: Administration role

In a study conducted by Manninen *et al.* (2015), the clinicians, supervising students, were informed about the students' competencies and, based on this information, they made decisions about what type of support the students required. The support, therefore, was adjusted according to the individual student's needs and based on the learning outcomes. According to the study, supervision covers several pedagogical activities, referring to the guidance and support of students in their learning process, as well as the assessment of their performance. Administration was deemed one of these activities that required guidance.

The participants of this current study highlighted that each clinical block had its own rules and regulations, regarding administration. These were aspects that the students could not learn in class, and were only exposed to them in the clinical setting. Clinicians, therefore, should be the ones to guide and orientate the student, as well as educate them on the management, in terms of administration. The participants were convinced that students only learn these management skills in a clinical setting, when

they are exposed to different patient scenarios. According to Sellars (2004: p. 69), “Management support is vital if a system of clinical supervision is to be implemented successfully, not only in terms of agreeing resources but also in respect of how supervision is introduced to staff”. The following extracts refer:

“I think that if they (clinicians) have a morning meeting and they decide who’s seeing which patients. Just quickly sit down with the student, you have your list and quickly facilitate your planning. How do you planning to go about seeing these patients, especially at the beginning of the block, just to help them to see which patients first.” (Participant 12)

“...the role of the clinician should be also supportive and more of a guiding one, like because they are going to be the ones whose going to show them admin from day one, show them the ward and show them the routine and things like that. The role of the clinician should also be a bit of a positive one because I think the reflection that comes off the clinician can affect the student very vastly on a block.” (Participant 1)

“Then they (clinicians) have to help us choose patients and mark exams. You know how hard it is and in between they have to manage the whole process; and they have to orientate about the area, about the logistics, about the stats, where the referral forms are, everything. Every area will have its own little set of staff rules and regulations...the clinician is patient centred, practice centre...they teach...and working with the rest of the staff, discharging....” (Participant 11)

Category 3.3.2: Management role

The participants noted that the clinicians acted as managers in the clinical setting, as they managed students, as well as patients. As mentioned previously, clinicians spent more time with the students because they worked together on placements. According to Sellars (2004), “At an

organisational level, the support and commitment of managers is vital to encourage staff, who also need to be committed to the process.” This author explains that management’s commitment to provide resources, in terms of time for training and delivering supervision, is essential. Clinicians, therefore, should take on the role of being managers and encourage the students to do the same.

“...they can be coaches but I think also they are a managers. They play an important role as an manager of the students especially in places where you have one clinician and you have got twenty or thirty patients...where the clinicians are overwhelmed with all the work. They are always advising, managing the students. Do not take on patients for yourself, let the students do all the patients and you supervise. So that you are hands on, you know what is happening all the time, but you are not busy and cannot be because they are all your responsibility. You cannot work and help the student and the thing is the supervisor is not there, she is only there once a week. I think yes, their role as a manager if that could be developed that would help them because it is a skill it is not easy.” (Participant 11)

“Firstly the clinicians are there all the time, so I think that the main difference is that there is always a clinician around. I think the clinician is supposed to be an ongoing support, more of helping them with management skills in terms of time management, running of the department, that is a skill that a clinician should assist the students with because they struggle with time management...Clinicians should help the students to organize their patients like those in the same ward, and simple stuff that you take for granted.” (Participant 12)

Category 3.3.3: Patient management

A few participants had experience as lecturers, clinicians and clinical supervisors. They mentioned that clinicians could assist in the learning

environment by assisting and guiding students more often in patient treatments. The participants drew from their previous experience and valued their opinions. As mentioned previously in literature, supervision has three functions: educative, supportive and managerial or administrative. In addition, guiding patients management is also included (Kilminster *et al.*, 2007).

“My personal experience being a student as well, and being now a lecturer and clinical supervisor that I think to a large extent the clinician should also try to provide some input with regard to clinical supervision. We not saying that they must spend hours with the students but if there are certain aspects that they might be struggling with that would be nice that certain clinicians would assist...They can give more input regarding teaching students of how to approach patients in the clinical setting;” (Participant 2)

“Assisting them again, guiding them to the right direction and basically tell the student this is what you doing wrong now improve on...so, you should actually tell them look think about of something you can do then talk to me before you do it so I can tell you I think you going the right way so let’s continue or we should think of another way or I thought of another way.” (Participant 6)

A study conducted by Bos *et al.* (2015: p. 39) highlighted that when clinicians wanted to devote time to students, their workload often did not allow them to do so. This created conflict between equipping students with skills and actual patient care. In addition, for the clinicians, it was challenging to plan the supervision of students, as they were torn between caring for their patients and properly supervising students. These authors highlighted this tension when they explained that the clinicians are responsible for patient safety; however, they also have to allow the students to act as independently as possible, both individually and in a group. Both these responsibilities are equally important to the clinical educator. These

authors continued to explain that allowing students their independence challenges the balance between the patients' needs and those of the students.

The role that clinicians play in the clinical setting can differ to the role of the clinical supervisors; however, they are equally important. The clinician's main role was identified as being involved in administration, time management and patient management. The clinical supervisors indicated that it would be appreciated if resources could allow clinicians to be more involved in aiding clinical supervisors to provide students with tutorials on how to assess, treat and do discharge planning of patients. According to O'Keefe *et al.* (2012), "Juggling workload requirements and teaching responsibilities is a constant challenge for staff. Although, many clinical staff are committed to ensure students are supported appropriately through their placements, during busy or stressful periods it is very difficult to provide the same level of support and learning opportunities as would be the case in less demanding work contexts." The authors encourage the creation of pre-planned "back-up" activities for students, such as self-directed learning tasks, or being paired up with students, who are more senior. The following quotations refer:

"...In South Africa resources is a problem and also staff is always overburden, but at least spend a few hours but enough time with the student to actual identify problems and I'm sure every student has their own problems whether it is confident issue or a theoretical issue or you know they will always have something that they struggle with whether we identify it or not and that's what I think clinician should try to identify and find out because everything is so practical." (Participant 6)

"I know the clinicians are busy and I know they have their own work load but I also feel that it is an academic hospital and its only right to make sure that your student is safe and safe to be

in your ICU and the only way you going to find that out is if you spend time with your student.” (Participant 1)

Category 3.3.4: Reflection: Clinicians providing guidance

Clinicians spend quality time with students by providing guidance in the clinical setting, whether it be planning the day, administration or physical techniques; whatever the need may be to be supportive. It was highlighted that every setting has different rules and regulations to which the students have to adhere. The students are only exposed to this opportunity at the placements and, therefore, need guiding and coaching to perform effectively.

The researcher believes that, when students lack theory knowledge, they should be educated and the university and supervisor subsequently informed. In this way, the support can be provided to the student by the clinical supervisor or clinician. However, the ultimate determinant will depend on whether resources allow, as the researcher doubts whether it is possible for clinicians to teach a student for an hour.

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4.3.3.4. Sub-theme 3.4: Role modelling and professionalism

Category 3.4.1: Professionalism

The participants doubted whether clinicians and supervisors realised how much students respect their seniors. The participants considered that role modelling professional behaviour was one of the ways that clinicians could contribute to developing professional graduates. During the interviews, professionalism was highlighted as a huge role that clinicians play, which is not necessarily a subject that could be taught. Ladyshevsky (2010: p. 77) asserts, “We build our competence by seeking feedback from ‘others’ about our knowledge, skills and attitudes towards professional practice”. This occurs especially in role modelling.

Students observe the way clinicians communicate with patients and other health professionals. If the clinicians and clinical supervisors act unprofessionally, the student will assume that professionalism is not

important. In a study conducted by Jokelainen *et al.* (2011, p. 2862) that focused on the empowering and development of professional attributes and identity among students, it was emphasised that, when students are treated as professionals by working with them in a professional relationship, the students' growth in the profession is stimulated.

“The only way to teach someone to be professional is to be professional yourself...to be professional you must be on time, you dress professionally...but if the clinician is not going to do that, the student won't do that. I just think at the moment there are no clinicians that do that, but they tell the students to do that. Some of them do not really care, just look at the things like how they address the patient...and the student would think if the clinician can get around the whole day like that then why should I bother? The clinicians that are always with the patients and treating the patient those are the clinicians that students need...I also feel like because they see the students every day I think they should implement the professional conduct...how they perform in the gym from a professional point of view and the staff.” (Participant 8)

“When I say professionally, is that they do their job well and that they behave ethically towards everybody around them especially the patient and the student. I have heard how people have been broken for physio because of poor clinical experiences where a clinician is just rude or lazy or and you know what it is hard for students to take.” (Participant 11)

“The clinician plays a big role in whether they will be professional or not because if we close our eye and let them do whatever...what are we nurturing them to be? Patients are all people and we all human so we should kind of try treat everyone equally even though it is difficult...” (Participant 6)

“They don’t realize the implications of these things...if I get the general idea that the students, their professionalism and their communications skills are lacking but their clinical skills are on par. If I had to employ or advise a friend of mine to employ a student. I would employ someone with the better professionalism and communication skills because that’s the image of your practice or your business. The physical skills is something you can work on but I don’t think that the students or the university often realize how much of your institution or your hospital gets carried by professionalism or communication skills.” (Participant 12)

Category 3.4.2: Role models

The participants articulated that clinicians and clinical supervisors are health professionals and, therefore need to behave in a manner that is appropriate to the profession. The student will hopefully learn from this and mimic that behaviour. Therefore, it is very important to expose students to difficult scenarios, so that they can observe how the clinicians deal with various situations. Lekkas *et al.* (2007, p. 19) assert, “The term clinical education refers to the supervised acquisition of professional skills and it is especially appropriate to courses which utilise clinical settings as teaching forums”. The following quotations refer:

“...clinicians are role models...at the end of the day you (the students) want to be that clinician that is able to suction that is able to treat a patient. They would normally model or once again from a personal experience I would model another physiotherapists because that’s the way... I don’t have anything, you know something, I want to do that, I would do it in the manner in which you doing it. I think to a large extent clinicians are a model to students” (Participant 2)

“...you model what you say that is more powerful. When you role model your attitude, your behaviour and the way you are speaking to the patient.. The knowledge that you portray, you

will get asked: 'how do you approach difficult patient?' ...as a young person who is developing, you must have patience and that is a skill. In this generation they (students) want to do things now and they need to learn people skills and also be related to the patients' pain." (Participant 7)

"Energy gets transferred...if I'm treating a patient and I'm going there with a depressing voice the patient is already sick they already depressed. What benefits are we doing here? and I understand everyone has their moods and everything but you know therefore professionalism comes in. If the student sees that you kind of demotivated then why are you trying tell me to treat the patients holistically...the student definitely looks up to us and because they going through student life. They know how difficult it is...we are graduates so they will look at us and they will see us as role models maybe not as much but the things that we do in a way will definitely affect them whether its long term or short term it will definitely affect them." (Participant 6)

"...by actually having that position they (clinician) are able to either motivate the students because I want to be like you one day or literally some of the students turn away from the hospital and say I don't know why I did physio in the first place I don't want to be like that. So how the clinician handles themselves professionally and also the supervisor definitely has a big influence on how the students see the profession especially...they (students) imitate...unfortunately that is true. How the clinician portrays themselves or goes about their task with patients definitely has a huge role how the student will participate and treat their patients." (Participant 5)

In a study conducted by Jokelainen *et al.* (2011: p. 2863) on interacting as professional partners in a co-operative relationship, it is important to note that students observe how the stakeholders interact with each other and the multi-disciplinary team in the clinical setting. Supervision, therefore, was

perceived as a time to develop personally, as well as professionally. In addition, a study conducted by Sellars (2004: p. 72) for those participants working in community environments, having protected time to meet colleagues made them feel less isolated, professionally.

“Be the actual example to the students of what a professional or how a professional must be in the work setting...and not just bedside manner with a patient but bedside manner with colleagues as well...then again by just being the role model of what a professional physiotherapist would be. The way you conduct yourself with your MDT with your boss, the way you are dressed, the manner in which you approach your patients. Which is something that students won't necessarily have the skills yet at that stage.” (Participant 3)

“The fact that they are role models...so that's something where the clinician, where they interact with staff they go on ward rounds together, the clinicians shows you how you speak to a doctor, how you speak to a nurse, how you speak to the cleaner and the family and what not. They really role models in the reality of being a clinician they don't see the importance but I see the students they are wide eyed looking at these clinicians that already are clinicians, and clinicians must be very careful and behave professionally.” (Participant 11)

“I think the first thing that the clinicians should look at is being a good role model a positive role model. That's very important how they are within the work area, how they are with other staff, how they are with their patients just normal mannerism because if a student is following you and you with a patient, to greet and you know to be kind...I think that goes a long way.” (Participant 1)

In the interviews of this current study, the participants added that the learning experience is excellent simply by offering support. The clinical

leader is a resource to others, supporting and educating colleagues through mentoring and modelling best practice, building good working relationships and assuming accountability for client outcomes (Fealy *et al.*, 2011: p. 2024). The positive attitude of the clinician is very essential in transforming the students' learning experience into one of anticipation. According to Jokelainen *et al.* (2011: p. 2862), "Aspects of positive attitudes towards the student as a human being, including respecting and honouring the student as person and honouring the student as person and a learner." In addition, these authors explain that students want to be treated as individuals and colleagues during placement learning; therefore, enthusiasm and positive attitudes in placements are important, as they influence student learning significantly. The following quotations refer:

"I think the attitude of clinicians is very important where students are concerned and what they take forward with them...the positive attitude is very important towards excellent learning. Be a good support system or structure for the students is also very good to have an excellent learning experience at the place (block). If there's financial problems... and it's a stressful issue then I think it's only important because we not trying to put the student down but it just makes sense you understand the student. Everyone is human, everyone has issues no one life is perfect. We all come with baggage be it that it's family or personal, martial, children whatever so today students...they have extra things...So I just think we... apart of looking at the student as a student there is a person that's got a life outside" (Participant 1)

"The clinician, firstly I would say the approach to the student is to be positive and be friendly to make sure they okay, you know that they comfortable, it's a new block even though everyone talks about getting use to a new block takes like a week or two weeks maybe even three weeks but if a clinician is happy and willing to facilitate for the first week or two the student will get

used to it by the fourth day definitely and by the second week they can already be independent if the student is capable not strong or weak just average plus they will be fine so for the clinical experience to be an excellent learning experience.”
(Participant 6)

“I think it’s just being approachable. I think that’s a big thing cause if you not approachable people don’t want to talk to you. Students won’t want to speak to a clinician that’s not approachable; so immediately that’s not very enjoyable. Then you intend to speak to those clinicians that are always willing to give you advice who are always willing to take time out of their work even though they busy to come and speak to you with regards to that. ” (Participant 2)

A participant added that the learning experience of the student can be improved by the clinician’s attitude, as the student will sense that it is safe to ask the clinicians for help. However, if the student does not feel supported, and fears the clinician, learning will not be optimised. If the clinician does not have an amenable attitude, the students will not be interested in learning. Kilminster and Jolly (2000: p. 830) states, “The environment in which learning takes place profoundly affects what is learnt and the learners’ responses; clinical settings which are considered to have a positive orientation to teaching are also usually seen ‘to provide high quality supervision, good social support, appropriate levels of autonomy, variety and workload.”

“First of all it must be positive and they must feel comfortable in that environment to ask questions and discuss questions with clinicians and not being scared to actually go to the clinician and ask questions about the patient. They must also have the necessary respect that they deserve and they must be in a friendly environment for learning...They not going to learn and they won’t feel free to go to the clinician and ask questions and I think they going to do as little as possible just to get through

the day, and they actually won't want to come to work because student they want the area that the clinician are not nice.”
(Participant 8)

“Attitude again is a big thing if the clinician doesn't have a good attitude then the students are not interested, also because they don't want to be shouted at and be belittled or felt that they are not worthy of being here or being a physio because they know so little, no theoretical knowledge. That's often the things that the clinician will say to them which make them feel that it's not worth it for them to be there what I am doing here. I think we encourage people to give constructive feedback and to look at how we give feedback as well, that we not at any point negative in our feedback. The tone of your voice is very important and I think we all guilty of this.” (Participant 4)

“I would say that is a big factor; from personal experiences as well if clinicians are not approachable if they don't provide necessary input or assist students I think that would deter students sometimes from asking them question that would be detrimental to the way they go through the block or there block outcomes that they might want to achieve. So I think that is definitely a problem or something that we need to look at...you will obviously notice most of the time when students finished a block and then they will say oh, but they couldn't do this or they didn't do this because they said no the clinicians weren't approachable. That's always the case and then you ask them why didn't they speak to them but then they say how they are supposed to approach them.” (Participant 2)

A few participants mentioned some ways or means of offering support to students, which could contribute to turning their experience on a block into an excellent learning experience. One participant believed the university should take charge and investigate the areas where students are being placed to ensure this outcome. Literature highlights that, what and how

students learn is influenced by factors such as culture of learning, the environment and climate of learning in the learning organisation, the student and the students' approaches to learning (Ernstzen *et al.*, 2009: p. 103). Therefore, the universities along with the clinical supervisors, should not continue sending students to placements that are not conducive to learning. The following quotation refers:

“I have my students reflect on the clinical area as a learning environment, whether it is conducive or not, and also the clinicians themselves and also the clinicians that do not pull in their weight. I send them (clinicians) the reflections and feedback to the clinicians about what the student say. I thank those that deserve so and tell the others students are not happy because I feel ultimately responsible for students having a good learning experience, we cannot keep sending the students to institutions that give them bad learning experiences.”
(Participant 11)

The participant added:

“I have been in situations where the clinicians have been plain difficult...everybody had the same experience and the whole institution was just negative...I could do nothing about it even if you had a meeting, it was your fault it was not their fault. At Stellenbosch, Stellenbosch is very good with that, if their learning environment is not good for their students they pull their students and I think that is the responsibility of the university to do that then, you have to protect your students.”
(Participant 11)

Category 3.4.3: Unprofessionalism

One participant mentioned clinicians who behaved unprofessionally by talking about her supervision times to other students behind her back. Bos *et al.* (2015: p. 39) states, “poor support from our own profession generates a bad atmosphere for students. Even students could notice conflict and a

supervisor's heavy workload." This unprofessionalism was noted by clinical supervisors; therefore, it is important for all clinical educators to behave professionally.

According to the participants, the clinician plays an immense part in whether or not the students will be professional. The participant opined that health professionals have the power to nurture students. It was evident that participants considered the clinicians more as role models, as they worked in the same clinical setting as the student. This was seen as one way for clinicians to teach the students professionalism; by simply acting professionally. In addition, it was noted that clinicians are the ones who interact with members of the multi-disciplinary team (MDT), teaching students how to build interactive relationships with their future colleagues. This is important to create an environment that is conducive to learning. According to Cross (1995: p. 506) "The provision of clinical learning experiences for physiotherapy students depends on effective collaboration between schools of physiotherapy and providers of clinical placements". Clinical education, therefore, is based on a tripartite relationship between clinicians, students and academic staff, who should work together and behave professionally towards each other.

"The clinician's...talking to students about supervision instead of just coming to me and discussing it with me. I think it's truly unprofessional, if I speak to the students about the clinician or if the clinician speaks about the supervisor with the students that's unprofessional. We adults so discuss it amongst each other...There's a little bit in your upbringing as well not all people are good with communication, not all people have that filter where if something is bothering them. They don't think maybe I shouldn't speak to the student maybe I should just go to the source. Not all people work that way people are different."
(Participant 5)

“...that mutual respect, I can’t tell the students: ‘Well I know she not a good clinician but that’s what you stuck with now’. There is that mutual respect of not saying anything negative about a clinician to a student. I think the responsibility lies more with the supervisor than the clinician in that regards, to ensure good relationships so that communication is open and comfortable.” (Participant 12)

Category 3.4.4: Reflections: Role modelling and professionalism

Another way that clinicians can teach or help students is by role modelling professionalism. The researcher concurs, as clinicians are the ones whom students have a high opinion of; therefore, they could want to either emulate a clinician/supervisor or have contempt for them. That is the power health professionals possess; therefore, they should be aware of the impression they create when at work, because they are role modelling. Students observe the way in which they communicate with colleagues and patients. The researcher emphasises that the goal should be to behave in a professional manner, with the intention having students emulate and adopt similar behaviour as students, as well as independent health professionals, once they qualify.

Stakeholders in the area of clinical education should not keep students in environments that are not optimal for learning. The placements should be assessed to reveal where the students going. Being able to choose where the students should go for placements is not possible, as placements are limited in the South Africa; therefore, universities cannot be selective about where students can be allocated.

4.3.4. Theme 4: Ways the clinicians can assist in clinical education

As mentioned previously, clinicians can help significantly in the clinical education of students by creating learning opportunities, providing appropriate patient care, providing feedback in the clinical setting and building a relationship between the clinicians and clinical supervisors.

4.3.4.1. Sub-theme 4.1: Clinicians role in creating learning opportunities

Category 4.1.1: Clinicians creating learning opportunities

The participants felt that clinicians could contribute to the development of professional graduates by exposing students to opportunities of learning. They were convinced that a good clinician would give their students that chance. Lekkas *et al.* (2007) explain that the purpose of clinical education is to provide clinical opportunities for students to attain competence at the level of a beginning practitioner, by integrating their knowledge and skills at progressively higher levels of performance and responsibility, while under the guidance of qualified practitioners. This coincides with the participants' responses, as they were of the opinion that clinicians and clinical supervisors should understand the reason why students do not know; because they were never exposed to that learning opportunity. Therefore, the students should be assisted, by exposing them to different learning opportunities.

Chipchase *et al.* (2012: p. 2) asserts, "Clinical education involves learning clinical and professional skills in the workplace. This provides students with the opportunity to actively build and incorporate theoretical and practice knowledge, to socialise into a professional practice community and to understand the complexities of health care service delivery". One participant expressed that students do not understand; when clinicians allocate patients to them, they not pushing their load off onto the students. The students should accept this as more exposure to learning and an opportunity to learn and grow. In the participants' opinion, clinicians and clinical supervisors should convince the student that the workload given to them was learning opportunities that would improve their clinical skills and professionalism. The following quotations refer:

"The clinician must provide or highlight the opportunity, must facilitate that opportunity for learning, they (clinicians') must provide the correct or appropriate patients...it's something they (students) need to practice, so they here to practice. I think

clinicians often forget that. They (students) not qualified yet, they still learning, so you need opportunities for learning, you need time for learning and you need input for learning.”
(Participant 4)

“To create learning opportunities...it is a different situation, the student real life situation and the theory comes to life and it becomes a new theory when it comes to life because they must now adapt, compare the two and see where they fit to guide and help the patient...and also learn all those principles and apply them to the patient.” (Participant 7)

“The one thing that maybe the students should actually change, is if they think the clinician giving them a patient is because they must see that patient...but more like an opportunity to treat that patient. A lot of the misunderstanding come from that and at times the clinician also gives that impression where: ‘How many patients do you have? Let me give you another two’. The clinician should not kind of give their job away and even if they do, they should actually go and assist that student. It should not be more of how many patients do you have? but more of what haven’t your seen? or here’s a patient you haven’t seen.”
(Participant 6)

Category 4.1.2: Learning opportunities for administration and management

Administration and management forms an important part of any institution. Clinicians in the clinical setting are aware of the rules, regulations and protocols of the institutions they work in. Each institution differs in the way they discharge certain procedures and protocols; therefore, students should be orientated and groomed on how the various systems function in the professional world. Kenyon, Dole and Kelly (2013) assert, “The clinical component of entry level curriculum allows students to apply the knowledge, attitudes, behaviours and skills learned in the didactic component of the curriculum within the real life context of the clinical

environment”. The participants emphasised that administration and management cannot be taught by the university or the clinical supervisor; therefore, the clinicians are best suited to take on that responsibility, as they work in the respective clinical settings. Supervision should include record keeping and the content should include management and administration. (Kilminster & Jolly, 2000). The following quotations refer:

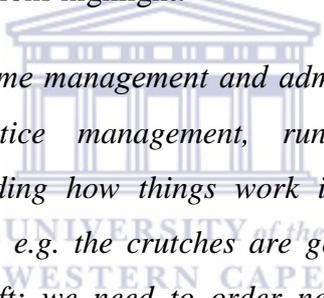
“I think they (clinician) should teach them that (statistics) because I don’t think at university you taught that. Different people want different stats so for you sometimes you get the hospital criteria but it’s the clinicians responsibility to teach them...” (Participant 10)

“I think it is also just the time management, we all have a lot of patients, we want to get done and go home but I think for the importance of the students you just have to set up. Even if it is half an hour or 20min just to discuss patients with the students, just to sum up, to check if students are on the right track. Some students feel like they can approach some of the clinicians, they can also ask for advice...” (Participant 9)

“The clinician can also educate them on time management in terms of getting their assessment and getting treatment done in a certain amount of period. That is also very important because once we go into the world it’s one of the things they need to manage.” (Participant 6)

Jokelainen *et al.* (2011, p. 2860) refer to learning opportunities as “organising training in an interpersonal learning environment”, which describes actions that supported the students’ learning issues in placements. These authors explain that it comprises familiarising the student with the placement as a working environment, including adjusting to the hospital’s different units (as well as the students’ own wards), the culture of care and the climate in those wards. The participants deemed the above-mentioned topics as vital in the real working world. Nurturing skills in this aspect of

physiotherapy prepares the student, when in community service and beyond, to cope with the management of both human and physical resources, by being able to do stocktaking and ordering, as well as other duties. The participants believed that treating patients was only a part of the clinical learning experience; other factors, such as time and administrative management, which are equally important to running a clinical department, become apparent. Ernstzen *et al.* (2009: p. 103) explain that clinical environments differ vastly from classroom environments. In the classroom, the learning activities are planned and structured; however, in the clinical learning environment patients are present and expect treatment. This makes the clinical environment less flexible to deal with student enquiries; therefore when unplanned events occur with patients, or the health professionals, this could restrict the opportunities of learning, as the following quotations highlight:



“I think time management and administrative management. So like practice management, running a department and understanding how things work involving the students with things like e.g. the crutches are getting less we only have ex amount left; we need to order new ones like basic skills of managing and running a department I think the students can have valuable lessons there and time management. I think is a skill. Like I said I don’t think it matters whether you see seven or fifteen patients its being able to plan how you going to do it.”
(Participant 12)

Category 4.1.3: Learning opportunities for teaching by clinicians

Clinical supervisors usually visit the student in the first week of the block, which could be early in the week, or at a later stage. Although the clinical supervisor orientates the student and shows the student how to manage a patient, whether it is an assessment or treatment, the participants expressed that it would be appreciated if the clinician could orientate, or show the student around, to make the student more aware of the environment. The participants added that clinicians could possibly show the students how to

assess and treat, as well, prior to the supervision, or even after. According to the study conducted by Ladyshevsky and Richard (2010), it is “important to seek multiple opportunities for practice with patients.” This will help significantly, as the one will prepare the student before and break the ice or fear, and the other way will refresh the students learning. When students are involved in complex and holistic care, opportunities for, and challenges to, student learning are created on how to take responsibilities and become an independent professional (Manninen *et al.*, 2015). One participant recalled a student, who revealed that a certain clinician turned every situation into a tutorial, so that students could learn from it, which in turn constantly stimulated their practical thinking. The following quotations refer:

“to provide the students with suitable patients, they need to be able to assess the patient first and see okay is this is either a third year level or a fourth year level and they should also know the students ability whether again this is a strong student or a weaker student so from there they again judge whether I’m going to give the student this patient or not.” (Participant 6)

“In terms of clinicians contribution, their eagerness to learn arranging maybe talks or tutorials even if it’s like twice in a block you arrange half an hour sessions doesn’t have to be an hour...I think the clinician, should be to provide appropriate patients for our students...to select appropriate patients to maybe see them to make appointments with them and say to them I’m available twice a week make an appointment in the diary to see one of the clinicians patients.” (Participant 4)

“The clinicians role with the students definitely...if there’s new conditions like in the moment; I’m (clinical supervisors) only here one day in a week maybe two hours with the student. She is here every day so she can do small tuts with the student help them to understand things that they never seen before because they will see new conditions everyday maybe there’s some

uncertainty with regards to precautions they can quickly go to the clinician...For some of them it's there first orthopaedic block so the unsurities are way beyond what we can measure.”
(Participant 5)

The participant added:

“One of the students told me that one of the clinicians takes each and every opportunity she can to turn every situation into a tut (tutorial) and I thought it was an amazing idea so that can make it an excellent experience... the clinician can take that opportunity to maybe create, depending on what the questions is create a scenario and work with it step by step through with the students... It's guiding there critical thinking if it makes sense.” (Participant 5)

One participant expressed that, in order for a learning experience to be excellent, clinicians need time to educate. According to Ham (2003), on the topic of engaging clinicians in clinical education, the findings revealed that several interventions were required. However, in many of these interventions, clinicians needed the time and space. During the interviews, the participants reported that the clinicians could not be expected to have a full load of patients and teach students, as well. A process or plan needs to be implemented to allow clinicians to educate the student, as well as attend to patients. It was suggested that one of the clinicians take on the role of teaching and guiding the students, while the other treats patients. The participant disclosed a personal strategy that was used as a clinician. All the patients were allocated to the students. Consequently, the participant would go around to each student to educate, guide, and treat all the patients, along with the students, and in this way the participant remained updated on each patient's status. Kumar *et al.* (2014) assert that, in order to lead and manage a team and organisation, the clinical leader needs to possess the skills to develop individuals to work together effectively, for the achievement of the team and organisational goals; thereby, placing the right member in the

right job. One of the participants referred to a placement she specifically works at, as follows:

“Having a process in place ...clinicians they have a clinical person assigned to the students and he really helps but they also use the community services (physiotherapist). They (Physiotherapists) go with students to the patients, they allow the students to actually watch them treat. You do not know how valuable that is to the student, it is so valuable to the students to just watch someone with the know-how that treats a patient. It opens their eyes to a lot of things they did not even consider or think of in a very specific way. Taking responsibility if they can for the learning and just having a good attitude and I have seen clinicians having a process in place for students and it just works so much better...” (Participant 11)

A few participants considered that, even though resources are minimal and barriers exist, which limit the clinician, as well as student time, more effort should be made to block off time, by scheduling appointments to make the learning opportunities possible. The participants supposed that the clinician has more access to the student, even though they might not have the time, they should book off time to help guide, facilitate or even teach the student. According to Razmjou *et al.* (2015, p. 248), “most of attending physicians are aware of its great significance but due to the collision of educational and therapeutic responsibilities, there has been less paid attention on clinical supervision in teaching hospitals.” The dilemma lies in the fact that, if clinicians must be given time to teach in an environment where service delivery comes first, there will be less time to treat patients. More posts have to be filled, which is not possible with the poor economic status of the country.

In a government setting, the learning opportunities are endless; however, the barriers that restrict clinicians in clinical education cannot be ignored. The participants opined that an extra effort should be made about learning opportunities in the clinical setting. The clinician should prioritise learning

opportunities for student, by allocating appropriate patients and administration tasks to students. According to Sellars (2004), the lack of time, mainly due to staff shortages and increasing load pressures, is perceived as the main reason for the difficulties with the uptake of supervision. The following quotations refer:

“The clinicians, they have a huge role with the type of patients they expose the developing graduates to...On the other hand, if you just give the student a hell of a lot of different patients and they don't follow up on that role, they don't give guidance, they don't help the student to thoroughly work through the patient treatment protocols. Then that student is probably just going to be overwhelmed and they won't have a good foundation anyway. It goes both ways depending on the clinician. A good clinician will expose their students to a lot of different types and also guide there thinking or facilitate there thinking and planning around those patients.” (Participant 5)

“We not saying that they must take over the role of the supervisors within the clinical setting but I think providing extra assistance. Where the supervisor only maybe come once a week for two hour sessions with each student. Getting maybe extra supervision or assistance during the week will help a lot and they could identify things sooner and put in relevant things in place to help... maybe assist them with clinical reasoning with regard to certain situations.” (Participant 2)

Category 4.1.4: Reflection: Learning opportunities

It is important to progress to a point of realising that students need to be educated by both clinical supervisors and clinicians. Each stakeholder can contribute significantly to the clinical education of students; therefore, mind-sets need to change. In the interviews, the participants highlighted ways that clinicians could assist in clinical education. When clinical supervisors responded with the concept of clinicians creating opportunities, the researcher was convinced that the participants were on the right track.

As mentioned previously, administration and management are some of the ways a clinician could assist with learning opportunities. Usually a student will only learn these skills in the clinical setting, once they are faced with the challenges that emerge from this daily activity. In the researcher's considered opinion, there is no better place than to learn than on the job.

Lastly, the clinical supervisors articulated that, even though all of the above are ways to assist clinicians, more effort should be made to provide tutorials and teaching. The researcher believes that it is easier said than done, as often many factors are out of the clinician's control. The researcher agrees that more effort should be applied and more planning conceived, in order for this initiative to progress. Physiotherapists need to want to teach and learn.

4.3.4.2. Sub-theme 4.2: Allocating appropriate patients

Jokelainen et al. (2011: p. 2863) state, "The mutual relationship between an individual nurse and the student is an important aspect, but it is increasingly essential for the managerial level to provide opportunities for student mentoring with enough resources and education". The participants claimed that the clinicians could easily identify learning opportunities and inform the student, as well as the clinical supervisors. The clinicians screen the patients and allocate the workload to the students; therefore, if they know a student is struggling in a specific area of physiotherapy, they could voice their concerns to the supervisor and provide appropriate patients. The participants contended that learning opportunities are created, when the students are allocated patients with different challenges, as it helps the student to understand treatments and offers them a better foundation for learning. A study conducted by Ladyshevsky and Richard (2010) established that competence is not achieved in one, two or three patient encounters; however, a series of encounters, each linked to a specific type of pathology is needed to build competence to an entry-level standard.

The participants noted that appropriate patients could be allocated to students by screening patients; therefore, the students will have the opportunity to work in areas of physiotherapy, which are a challenge to them, and increase their

knowledge base. In order for this happen, the clinicians need to assess and familiarise themselves with the students' weaknesses, in order to attend to their academic needs. According to Ladyshevsky and Richard (2010: p. 79), "This repeated exposure to patients with a common diagnosis, but with different manifestations of acuity, helps the novice transform their biomedical knowledge into clinical knowledge". However, due to resources being limited, clinicians might not have the time to assess students individually; therefore, it is important that clinical supervisors communicate the needs of the students to the clinicians. The following quotations refer:

"A better base to work from or foundation to work from is when they get exposed... Your base that you work from your foundation that you work from will not be that good. The clinicians they have a huge role with the type of patients they exposed the developing graduates to...A good clinician will expose their students to a lot of different types and also guide their thinking or facilitate there thinking and planning around those patients." (Participant 5)

"In terms of exposure, I think clinicians should give the students different types of patients so then they can get used to working with different types of patients...I do understand that not all patients are suitable for the students to see but at least give them that opportunity to maybe even do an subjective or even just do an observation even if the patient is not applicable for treatment. They can actually just do an objective assessments and not really treat the patient...just to give the student more exposure and more experience." (Participant 6)

"I think the clinician, well to me also again should be to provide appropriate patients for our students to look at what is third year level what is fourth year level for our patients to give them to select...I think the clinician role is basically to set the platform for availability of patients for them, giving them different conditions." (Participant 10)

Category 4.2.1: Reflection: Providing appropriate patients

As a clinician, the researcher is convinced that this collaboration could work in the clinical setting, as clinicians are not always able to have tutorials with students, due to their high workload at government settings with minimal resources. However, clinicians could create opportunities, which are student specific, to aid students individually, in the required aspect in physiotherapy. In order to do this, clinicians need to know what their students are struggling with, which entails being willing to get to know the students, so that their needs can be met. The researcher contends that it is important to adopt an attitude of wanting to expose students to learning opportunities; therefore, the clinicians allocate appropriate patients to students with for learning.

Personally, the researcher considers that the clinicians are in the area and have the advantage of providing feedback to the students. They have access to the students; therefore, they are able to identify the academic needs of the student. Besides, clinical supervisors only have one-hour-a-week access to students. According to the researcher, this all sounds great; however, cognisance should be taken of staff shortages that often hinder this process.

4.3.4.3. Sub-theme 4.3: Clinicians providing feedback in the clinical setting

The participants perceived feedback as a critical aspect in the moulding of future physiotherapists. Similarly, the way clinicians and clinical supervisors provide feedback, or communicate in the clinical setting, are just as important. The clinician's role, as well as the clinical supervisor's, was perceived as providing feedback to the student, university and to each other regarding the student. Lekkas *et al.* (2007: p. 28) assert, "Methods of communication, both informal and formal, must be agreed within the team prior to commencement with the views of all staff incorporated into student feedback an assessment processes."

"The clinician should actually also give feedback to the supervisor and say: 'This is what the student is struggling and you know what this is what the students been doing this week' and from there they can do appropriate role exchange. Clinicians can identify problems

about the student because they there every day and they kind of have feedback every day. The clinicians role is to read up the notes of the patient to see what the students has done and therefore if the notes is not done properly you can question what treatment was done and therefore the supervisor must be notified. The clinician role is to definitely to connect with the supervisor.” (Participant 6)

“I think I am fortunate to be at a hospital, they (clinicians) are very integrated with their students they are, they take a lot of interest in the students, every time I come we normally have about a ten minute talk about the students about their weakness and how they progressing.” (Participant 9)

“...Clinicians need to identify, report to the immediate student early and report to the supervisor or directly go to the coordinator immediately...” (Participant 7)

One of the participants explained that no one dictates to the clinicians, or the clinical supervisor's, ways and means of providing feedback. The participants added that often as an older clinical supervisor, they tend to lose your patience with the students. The participants mentioned how negative and positive feedback affected the student and learning in the clinical setting. O'Keefe *et al.* (2012: p. 886) articulate, “Evaluation strategies should always aim to promote positive approach to feedback”. Clinicians and clinical supervisors need to provide feedback to each other in the clinical setting, and work as a team, in order to support the students in clinical education. The way the feedback is provided is also important; if it is done negatively, it could affect the relationship of the two professionals. Labelling the student does not help the situation and creates bias. This has a negative effect on the quality of supervision, and, therefore, hampers learning. As stated by Kilminster and Jolly (2000), the quality of the relationship between the clinical educator and the trainee is probably the single most important factor for effective supervision. The following quotations refer:

“The feedback is negative, it's shouting, it's screaming, it's frustration: 'you don't know your work' Then again I find that

happens with the older clinicians as well because they so use to students. They know the difference between a strong student and weak student immediately, they smell it when the student walks in. This is a strong one and a weak one, it could be that when it not a good student they don't have enough patience that they had in the past or in the beginning of the year. In the beginning then they were more supportive, so the way they give feedback...it's not always constructive, its belittling the student the student often says: 'You can't imagine how this person made me feel' and that also sort of hampers their learning...no one taught the clinician or anybody how to give feedback" (Participant 4)

One participant highlighted the need to reflect in the clinical setting during feedback sessions. Subsequently, the participant explained the importance of the clinicians' reflections with students, after assessments and treatments. The participant contended that the clinician could guide the student on how to reflect. According to Sellars (2004), "Seeing clinical supervision as an opportunity to reflect on their practice, gain support and advice, and to develop both personally and professionally". The following quotations refer:

"I also think you just need some time just to sit down and discuss...because we have to be reflective practitioners. That's how you develop so if you don't reflect on what you've done you not going to improve on your skills in anyway and that's why you would go back and you check: 'How would I maybe improve on the way I treated this patient the previously day the next time I see a similar patient that presents in that way?' I think a big thing is become that you have try to incorporate reflection and be a more a reflective practitioner where we try to put that in." (Participant 2)

"I ask them for their weekly reflection each week so I can pick up if there's things that they are struggling with and I'll ask them to give me feedback specific on things like that as well, do they feel like they seeing patients that are contributing to their learning experience. So if I pick up that they don't, I'll take it from there." (Participant 12)

Category 4.3.1: Reflection: Clinicians providing feedback in the clinical setting

Providing feedback in the clinical setting to the student is important. The clinical supervisors provide feedback in their designated time; however, the clinicians have more access to the student and should try to provide constant feedback, as learning opportunities arise. Students should be taught to reflect in order to learn. In order for a relationship to exist between the clinical supervisor and the clinician, communication needs to transpire, by providing constant feedback in the clinical setting. There is also need for ways of enhancing and encouraging the relationship of all stakeholders in the community.

4.3.4.4. Sub-theme 4.4: Relationship between clinicians and clinical supervisors

When participants disclosed their experiences of working with clinicians, they also identified strategies that would enhance the relationship between clinicians and clinical supervisors. According to O'hman *et al.* (2005), communication between clinical supervisors and academic educators is a continuous dilemma in physiotherapy education and has been addressed in several studies. During the interviews of this current study, the participants responded by communicating regularly with scheduled meetings as a means of improving the relationship between clinicians and clinical supervisors. Edgar & Connaughton (2014: p. 29) avers, "The supervisory relationship has been identified as one of the most important elements of a quality clinical learning environment". A few participants expressed that the relationship between the clinical supervisor and the clinician is missing. The participants drew from their previous experience as supervisors. The following quotations refer:

"When I was a supervisor I hardly had contact with the clinician it was more like: 'hi bye, please let them see this patient, he's doing his exam here and he needs this patient.' It's more like a demanding factor than anything else. As a clinician when the supervisors demanded me to give them this patient or whatever but meanwhile that relationship is missing, the discussions that we having and also

the discussion in front of the student is also lacking. I think the student needs to know firstly what they lacking about in terms of both sides. What's the clinician seeing and what the supervisor is seeing and also to see what they working on, it's like they working on the same goal.” (Participant 6)

“Personally I do not feel that relationship is available because I feel coming into different clinical settings I feel like I am coming in their territory and I need obey by their rules and there is not this consensus about this is what physio is about. To keep the peace I sometimes, if the technique is correct. I tell the student well if the clinician wanted you to do it like this then you should, but they need to oppose if the that treatment is not effective or if anything is wrong with the instructions given to them.” (Participant 9)

“Well the clinician and the supervisor should actually go hand in hand; and in my experience that doesn't happen too often there's a little bit of friction at times but I try to work with the clinician because they see the students every day.” (Participant 7)

Category 4.4.1: Find ways of communicating e.g. Scheduled Meetings

According to Sellars (2004: p. 65), “There are increasing demands for personal and professional accountability and for professionals to demonstrate high quality, effective and efficient interventions in a changing healthcare environment that encourages collaboration and teamwork”. The participants expressed that conducting regular meetings would encourage a relationship between supervisors and clinicians. A few participants mentioned that the meetings did not necessarily have to be formal; it could be informal, as long as a form of communication exists. The participants viewed the input from clinicians as important in the clinical setting; therefore, these meetings need to take place regularly. In cases where the clinical supervisors had not met the clinicians on blocks, one participant was of the opinion that the problem could lie with the clinical supervisors themselves. The sooner communication occurs, the better for the student; therefore, a designated time needs to be allocated for communication. A

study done by Edgar and Connaughton (2014) established that the impact of the students' interactions with their clinical educator was just as great as the impact of dealing with patients. The following quotations refer:

“I think it’s important that supervisors and clinicians meet during a block like I’ve come through many years of blocks, where I had some areas a lot of input from the clinicians. Actually we have clinicians come to me and say can I help the student in anyway would you like me to work on an area and then there’s some blocks where you don’t see the clinician at all. I’m not blaming the clinician at all it’s probably my fault as well. I think there needs to be like a ground where we make it that there must be some kind of input, if not at least twice on the block because sometimes I would maybe liase with somebody towards the end of the block but sometimes it’s too late because then we talking about block evaluations and for me block evaluations is too late in the block.” (Participant 1)

The participant added:

I’m lucky because I come early and many a times the clinicians are still in the area so I can talk to them and greet them and (ask them) how’s the student and stuff like that so actually being on this specific block it’s been to my benefit because I have been liaising easily with the clinicians but on other experiences where it’s not so easy to actually get hold of the clinicians then there needs to be some ground level where you must say: in the second week can we meet for 15-20 minutes? Just to touch base with regards to the student and if there is problem areas how can I as a supervisor deal with it if you have a problem as a clinician, and if I feel you as a clinician can also just help a little bit. So it might be something that must come from both sides.” (Participant 1)

“I also need to set time with the clinicians and sometimes we tend to rush because now you have one setting with that person and one meet with another person, you need to set one meet with one person every morning. Because I mean with one student is two hour and with another student is two hours then the morning is gone. You rather go there early.” (Participant 7)

“The strategies would centre on communication having ten, twenty minute session every week between the supervisor and the clinician where they just communicate about the student what’s been happening with them and any problems, weaknesses, their strengths.” (Participant 9)

One participant felt that the teaching of theory is everyone’s responsibility; even though the clinician helps to identify problems, supervisors must still communicate. Cross and Hicks (1997: p. 249) assert, “In order to differentiate between those students who are performing well in the clinical environment and those who are not, specific assessment instruments are created by individual academic departments, in collaboration with clinical colleagues”. The participant reported the relationship between the clinicians, clinical supervisors and the student is perceived as “more work” rather than helping a colleague. The participant, therefore, thought that there should be more meetings with the student, so that each party knows what the student is being taught, what is lacking and where they can help. The following quotations refer:

“Communication, workshop, socialising, and meetings. I like this one on one thing because of different personalities. I don’t understand why someone would have a spoon face and quite looking strict and once you talk to that person you realise this is a nice person and you don’t judge a book by its cover. We meet each other at a professional level I don’t want your life and that is why we must open up to other people...Some clinicians expect the students to put the whole assessment, say look if this is what they want. We need to talk about it and we need to sort out

where we can get the midway here in term of the student because some of them are in the doctors notes and the doctor notes are in a file so we need to talk.” (Participant 7)

“...the students themselves have to work on their theory that’s fine that’s them, then the clinician will identify problems and the supervisor should also communicate...the relationship at the moment I think is more just work than I want to help this friend or this physio that’s going to be our colleague,. So maybe they should have meetings then the student can kind of express his thoughts and what he thinks you know it’s always good to hear everyone’s story so the three of them meeting all together and have a little meeting will be great.” (Participant 6)

Lekkas *et al.* (2007: p. 28) “There needs to be collaborative preparatory discussion of the organisation and structure of the clinical education experience by all members of the team to delineate role, tasks, and the manner in which normal workload will be distributed at commencement”. The participants considered that, if the clinicians spent more contact time with the students, the relationship between the clinical supervisors and the clinicians could benefit from it. The clinical supervisors will realize that the clinicians are creating opportunities for the student, and not hiding behind the excuse “we are busy.” One of the participants alluded to a way of improving contact time between clinicians and clinical supervisors to enhance their relationship. The participant suggested that the two parties, together with the student, work on the case management of a specific patient, to discuss management of the patient from both views. The following quotations refer:

“Even though clinicians are sharing the knowledge and interacting with the students they can still do more...I know that they have taught students certain treatment techniques but I think a bit more time can be spent...What would be nice if there would be some more contact time between the clinician and students. Once again it doesn’t need to be longer than maybe

two or three hours but maybe just a hour where the clinicians can just sit down with the students discuss patient outcomes discuss management. Which is the case in some healthcare facilities but then a comment that always get made is that we busy and we don't have time to sit with you guys...I think it's very important because we all were students', we all needed the necessary input. We always forget where we started and where we are now so I think if we understand what they going through we will also put that necessary input in so they can develop.” (Participant 2)

“I think maybe clinical supervisors and clinicians working together on case management of a specific patient, whereas certain hospitals have certain ways of doing things, let's say maybe for one or two of the patient which the student see the supervisor should be informed this is the patient also discuss the management of that patient.” (Participant 9)

A few participants remarked that contact time should be set aside to communicate and participate in student learning. The participants were of the opinion that, although the clinician makes time to communicate with the student, giving the student the opportunity to provide feedback regarding the patient, no contact time is set aside for the clinician and clinical supervisor to communicate, regardless of how busy both parties are. In the participants' opinions, more contact time between the stakeholders will strengthen their relationship. O'Keefe et al. (2012: p. 885) assert, “Health service staff need easy and effective mechanisms to rapidly communicate concerns and should, at all times, have a clearly identified university contact person for every student on their clinical unit”.

“I know the clinician meets up with the student because like in the morning or after lunch then they give feedback, but then the supervisor don't really get a chance to talk to the clinician because it's kind of like out of their work time because they get an hour and the student wants that hour but now the supervisor

is only there for an hour you know. It's understandable because people have places to be but if we maybe incorporate that or we extend that to an hour and a half or 1 hour 20 minutes whatever the case maybe then at least they can have that time dedicated to talk to the clinicians.”(Participant 6)

Category 4.4.2: Build a relationship of trust

One participant highlighted that an open relationship between the two parties must exist where a decision is made by both to meet with the student. Bos *et al.* (2015: p. 39) states, “a relationship between a supervisor and a student is based on trust and support for students to reflect on nursing skills and be professional.” These authors explain the mutual relationship between a student and an individual supervisor plays a key role in the clinical learning environment. Additionally, according to the outcomes of their study, “clinicians felt abandoned when they supervised students they did not have information about contact persons who were responsible for the students’ clinical learning; they expressed frustration concerning insufficient information and dialogue” (Bos *et al.*, 2015, p. 39).

The best means of contacting each other, whether by e-mail, telephone or messaging, should be decided upon by the three parties concerned. The participants mentioned that some clinicians and clinical supervisors were unapproachable; however, openness is a prerequisite when deciding what best suits both parties, in order to help the student. According Kilminster and Jolly (2000), clearly some defensive behaviours are likely to have a negative effect on the supervision process. The participant further explained that sometimes the clinical supervisor does not meet with the clinician at all, because the clinical setting is extensive and requires some effort to communicate.

“There’s two things again with that; it’s that open relationship between a supervisor and a clinician where again the supervisor needs to decide do I meet with my clinician or to meet with my students clinicians on a weekly basis or every

second week how do we keep contact? Do we exchange phone numbers do we exchange e-mails? Where if they have something to speak about that's the first thing...I think because when that doesn't happen then the clinician becomes frustrated because they don't see the sup they don't know what the students' progress is, they can't give feedback.” (Participant 4)

One participant mentioned that the students often trusted the clinician more than the supervisor, or vice versa. From personal experience, a student was afraid to communicate with the clinician regarding the types of conditions she was observing. As the supervisor, the participant communicated with the clinician to ensure that the student's goals were being met. The participant emphasised that, because she had a good, open relationship, it was easier for her to address the clinician. Kumar *et al.* (2014) assert that a leader develops and uses a strong network of formal and informal contacts, beyond the organisation/team that s/he leads, to receive regular feedback on how their organisation is perceived.

“I think well communication is very important because I've picked up that the students will tell me things that they won't necessarily convey to the clinicians that they work with every day because they feel like if they complain about something that will put them in a negative light...If there is a good relationship between me the supervisor and the clinician I can facilitate that by then contacting the clinicians to say I feel that this student is lacking a little bit with acute or more neuro rehab could you maybe facilitate the process so that the student gets exposed to more of those patients but I think there responsibility also lies with the supervisor to ensure because you the incomer so I think there the responsibility lies mainly with the supervisor to ensure that she has a good relationship with the clinicians.” (Participant 12)

The participants expressed that it was important for clinicians to know they could communicate and approach the clinical supervisor. According to O’Keefe *et al.* (2012), clinical staff members have difficulty in knowing who at the university to speak to regarding the needs of a particular student. Personally, the participants remarked that open communication was important, as everyone could contribute and assist the student to become good physiotherapist. The participants noted that everyone’s abilities should be respected, as all the stakeholders have something to contribute. Another participant responded that the clinical supervisors could initiate the communication prior to the block, which is how relationships are built. The following quotations refer:

“Communication is very important because they know they can come to me anytime there is problem, they can phone me and the can send me an e-mail. They can also talk to me for five minutes and I do the same to them and we have that open communication. Also because I am older the respect between the two is important and also you as a clinician speak to the as a clinician because they have done a lot of classes. They can add something and I can also add something and together we can actually open the student to become good physiotherapist then each role is important. They must not feel I am more important because I am an academic and I am from the university and I feel that they are not just clinicians. Therefore we must respect people abilities and they can always bring something to the table and help students to become good physiotherapists.” (Participant 8)

The participant added:

“I think my communication with the clinician is important but also the one with the university is important like the department, so that they know what is going on. Like some universities they will let me know before the season start...so that I know from day one I must actually focus on this

area...That depends on the supervisor how he/she handles the information, sometimes they will phone me and tell me that the supervisor is not professional. So you must set rules with that person and if she does not follow then you have a meeting with them. But if there is a problem that I can generally express then I would like to know that from day one and have five or six weeks to actually do something about it.” (Participant 8)

“I think the strategy is developing a good communication relationship between clinician and supervisor. I think that’s important because that’s the only way you decide together the student is struggling with this and what can we do to help the student... because often when that doesn’t happen somebody gets frustrated. Supervisors always in trouble because they (the clinician) don’t see the supervisor...” (Participant 4)

“I think by asking the supervisors to like send a report out before and after each block to say that: ‘The next students are and ... they will be arriving on Monday. I’m look forward to meeting them as well I will be there on wed at 9 am.’ So that when the student arrives they can already tell the students that is your supervisor she will come on Wednesday and at the end of the block to say thank you for your input with the student they both passed the exam and I think they learned a lot especially with regards to the ortho patients that you gave them. So they also just aware of what happened to the student did they pass, did they fail did they develop did they actually end off worse than they did at the beginning. I think if one can maybe ask the supervisors because then you also initiating some communication.” (Participant 12)

Category 4.4.3: Showing appreciation and thanking clinicians

Cross and Hicks (1997: p. 259) assert, “The way in which physiotherapy teachers perceive themselves and their students, influences the effectiveness of their teaching”. If clinicians perceive that they are appreciated, and that

the university is grateful for their contribution, they would consider themselves important stakeholders in clinical education. The participants highlighted this fact and suggested that one way of building on the relationship was by providing feedback to the clinicians, with the clinical supervisor thanking them on behalf of the students and the university. Bos *et al.* (2015: p. 39) state, “Receiving feedback on the function as a supervisor from units’ manager has been shown to be important. This finding agrees with other studies that have shown the importance of managers’ involvement in supervision, so that supervisors can feel appreciated and in turn create good student learning conditions”.

“...if a clinician could have the passion to offer the student education, if they could see their worth in student education. I personally think that we could have incentives for that. I mean if universities could make some money for that and I would say maybe you know: ‘clinician which of you would like the students?’ You would have an ICU block or whatever and know this one work with that student and this one does not. Since you have clinicians who enjoy working with the students...the clinician must put in the statistics...I spend so much time with students, and that it is valuable it has value for the clinician as well otherwise; they just feel I have wasted time now I cannot put it anywhere on that stats sheet.” (Participant 11)

“Maybe again they are being employed by the department of health but it’s the department of education or the university that are expecting things from them. I think maybe once a year if the universities could take the effort to actually take a cake and organize a tea at the end of the year for the clinicians at the departments where the students are placed and say thank you very much for the input with our students during the year we appreciate it. This is the stats all the students passed the block, you know something just a thank will go a long way because again...we expecting things in terms of education from

them...So they can also see you know I noticed that the student has improved with this so thank you for the input that you also had with this. Also the clinician if they already over loaded with work some positive feedback and thank might actually go a long way.” (Participant 12)

Category 4.4.4: Reflections: Relationship between the clinician and the clinical supervisor

The relationship between the clinician and clinical supervisor is a work-in-progress that needs to be cherished. Communication has always formed a vital part in any relationship. There needs to be procedures for communication on a regular basis, which might require one of the stakeholders to step forward and take the lead. Showing appreciation and acknowledging the contribution the other stakeholder helps to strengthen the relationship and, ultimately, benefits the students’ learning experience.

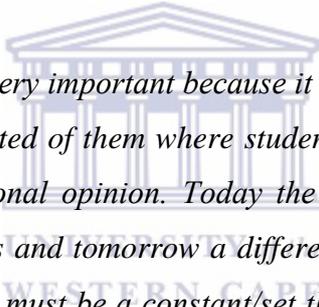
The ultimate aim is to build a relationship where students have the liberty to inform the clinicians and clinical supervisors of their challenges. It involves building a relationship with the student and the supervisor so that a medium can form, where it is easy to communicate, trust and support each other. As reported in the study, this can be done by scheduling regular meetings, formal or informal. The researcher emphasises the need to ensure that structures are set in place to view the concerns of everyone. In order to build trust, a relationship of positivity and a commitment to help and grow needs to be present. Two participants mentioned that the stakeholders should show each other appreciation, by thanking and motivating each other. These are all aspects of building a healthy relationship.

4.3.5. Theme 5: Recommendations for clinicians

4.3.5.1 Sub-theme 5.1: Guidelines for clinicians

A study conducted by Kilminster *et al.* (2007) identified the need for a definition of supervision, as well as explicit guidelines on supervision. During the interviews in this current study, a topic emerged regarding guidelines for clinicians. It was revealed that no standard exists, which guides clinicians on what

they should do, or how they could help to clinically educate a student in a clinical setting. The participants, across the board, emphasised that, when drawing up such a document, all the stakeholders should be involved, namely clinicians, clinical settings, universities, clinical supervisors and students. Manninien *et al.* (2015) mentioned that an important aspect to remember when facilitating students' learning is for supervisors to have procedures and guidelines, both regarding learning and patient care. In addition, the authors added that supervision, therefore, would not be based on individual supervisors' thoughts, but on common understanding and evidence-based knowledge. It cannot be assumed that clinicians and clinical supervisors guidelines would be the same, the guidelines are but the clinical supervisors view of how clinicians could contribute in clinical education. As mentioned before, in the South African context, there is scant literature on this topic in the field of physiotherapy. The following quotations refer:



"I think that is very important because it will give them a guideline as to what is expected of them where students is concerned and not like someone's personal opinion. Today the assistant director is saying you must do this and tomorrow a different assistant director is there so it changes. It must be a constant/set thing because it can't change all the time. Some departments are very big with a lot of physio's and all of them are different. I think there needs to be some ground level where it must be like at least give the student an orientation or at least see the student once a week one on one with a patient through the five week block at least make sure that you see a student assess one patient and treat a patient there should be guidelines like that. So it all depends like If I say I'm busy I'm busy but is that a valid enough reason to leave a student unsupervised unattended for days on end."
(Participant 1)

"...each clinician and each placement should have expectations and say this is what we expect, this is how we want things done, again it comes down to individuals...I think that is what we lack that is why you have one clinician who will spend a hour and a half doing a tutorial on another person is saying: 'This is not my job, I have

enough work to do, maybe if I have enough time I will do it with you but at this moment I don't have the time.' Then again students miss out on learning opportunities, so I think maybe we need guidelines as to what hours you know. If the university says an hour is enough for a fourth year student what is the clinicians saying? What is enough?...if we could have something in writing where we could say the clinician is responsible for 1 hour a week hands on with the student, where your supervisor has 1 hour with the student or two hours the supervisors whatever it is the supervisors hours are clear, is the clinicians contact hours with the student, do we have that? No!" (Participant 4)

One participant mentioned that there should be guidelines for clinical supervisors, as well. In a study on nursing, conducted by Bos *et al.* (2015: p. 39), clinicians displayed some uncertainty about how they could supervise students, as supervising was not clearly defined, nor was it aligned with the universities expectations. The participants in that study stated that the clinicians were not the only stakeholders, who required guidelines on clinical education. The participants were adamant that clinical supervisors also required guidelines on how they could improve clinical education. The following quotation refers:

"...even when you become a clinical supervisor nobody helps you, clinical supervision when I started eighteen years ago was just looking at students and watching them treat patients and helping them here and there. Today it is totally different we have so much research about what a clinical researcher should be. All the tools we use to enhance learning you know it is a whole new scope of practice. So a clinical person I think yes, yes I mean their role they have to make the choice. Can I trust this student with this patient? Can I give this patient to the patient? Is this patient suitable for a third year or a fourth year? So they have to make that decision." (Participant 7)

The participants in this current study raised their concerns regarding the matter they stated, even though they maintained that it was a good idea for all stakeholders to be involved. It might not be well received by clinicians and their

clinical settings. This can most likely be because, according to literature, it is not always clear what supervision entails, who should or could supervise, what the effects of supervision are, and what the benefits are to patients and the service in general (Kilminster et al, 2007). However, in the development of such a policy, all the stakeholders should be involved, especially the clinicians. The following quotations refer:

“I think it will more help the clinician as well; if the clinician is supposed to know what he should. If there’s a set rule it will help the clinician. e.g., look here you should help the student because they have this amount of experience in that or whatever but if the clinician don’t know exactly...I don’t know the other setup but in my set up students came basically and they didn’t exactly told me look here this is your role as a clinician. You just assume that you must be there for the student to help and then later on I found out in my way that the supervisor was more supposed to do certain stuff that I did. I think there should be, if they told you in the beginning this is what is expected of a clinician to set it beforehand...because some students just say that they weren’t taught. So I think there should be more like from all sides’ discussion not just from the university this is what is expected from students.” (Participant 10)

“...I think there should be some memorandum of understanding between what is expected from the clinician and supervisor as well but I think there would be a lot of politics involved with setting up such a document because each clinician or each health care facility will state but this is how they do things they not going to change it because the student says: ‘It’s actually not their responsibility the students are actually coming to the hospital to learn and the supervisors are actually there to assist them’. I think it would be beneficial if there is such a document that could hold them more accountable.” (Participant 2)

“...I think it will be difficult because all areas are different for you to do it and I think it will also depends on the description of the

university because I think you cannot really tell them what to do if it's not on their job description.” (Participant 8)

The participants suggested that it was the universities' responsibility to initiate the clinician's guideline or protocol, to help clinicians and supervisors know how they could assist. The participants expressed that the clinicians and placements should be involved fully in the development of such a document. According to Ernstzen *et al.* (2009), there is a need to develop guidelines for supervisors' clinical education practice and to advocate a need to re-evaluate methods by which doctors are taught clinical skills. One participant reported that some students were lucky to be working alongside clinicians, who communicate well and want to teach. The participant noted that this inconsistency is not fair on the other students. The participant suggested that the placements be audited to determine whether they are providing the supportive environments that students need. The following quotations refer:

“I think UWC should be more involved here in that case because if they say that basically this is what is expected of both of you, your roles and also this is the student's level at the moment, then I think if you have an understanding...” (Participant 10)

“I feel if the hospital is providing the university with the environment to teach these students, I feel like it is the role of the university to implement and to empower the 'clinician thing' with the skills... I think there should be a partnership between the university and the hospital, if the hospital agrees that the clinician should be involved with the treating of the education of the students, then it needs to be communicated to the clinicians firstly and then it should be the responsibility of the university to say what the clinicians would like them to do.” (Participant 12)

“I don't think the clinicians also realize that they are contributing to that and I think again because now it's unfair because the students gets exposed to them and they think that's what clinicians in the clinical setting, that's what it should be like...or someone else can be

lucky and they end up in an institution where the clinicians are all sharp and very professional and has got good communication skills but there's no standard and nobody goes around to audits the clinical settings. I don't know if they do they might do it in the beginning before they place students there but when they audit or make sure that the clinical environment is favourable for students do they actually check on do they just check the clinical setting or do they actual check on the professionalism and the communication skills etc. of the department.” (Participant 12)

Category 5.1.1: Reflection: Guidelines for clinicians

A recommendation was made that standard guidelines need to be set in each clinical setting, specific to the area, in order to get a form of consistency. Although there were concerns that emerged around this topic, the researcher's opinion is that all stakeholders have to be involved in the development of such a document. In addition, the document must be hospital-specific, as every hospital setting does not operate in the same way. The university should accept this responsibility and be careful when approaching the placements, as the placements need to be reassured that this initiative is a collective decision, where placements will have to be in full agreement.

Guidelines need to be reinforced, in order for a standard to be set that informs all clinicians on clinical education in the clinical setting. There is no room for placements, where the decision to assist students is based on personal preference. It should become part of the daily schedule of all physiotherapy departments, if resources allow. The university should take responsibility to initiate and liaise with clinical placements, to ascertain how these guidelines could be implemented, without hindering service delivery and patient care.

4.3.5.2. Sub-theme 5.2: Willing to teach and clinically educate

Category 5.2.1: Encourage Lifelong learning

During clinical placements, students' clinical learning is facilitated by clinical educators, also referred to as 'preceptors' or 'clinical supervisors'. Various models of supervision are used within the allied health professions. Clinical educators are generally responsible for facilitating the acquisition of profession-specific skills, while students are out in the field (Chipchase *et al.*, 2012). The participants expressed that, if clinicians assist students with practical education and facilitation of knowledge, it could aid the development of professional graduates. The student will realise that the clinicians are interested in growing him/her, and, therefore, once graduated, will adopt the behaviour of wanting to help other students grow. The importance of self-awareness, as a pre-requisite of staff development, has been widely emphasised. Therefore, becoming more aware can help individuals to be more sensitive in their dealings with others (Cross & Hicks, 1997: p. 258). The following quotations refer:

"The clinicians willingness to wanting to learn could sort of overflow or sort of impact onto the student and saying: 'Well let's do this together since I'm not sure'. We could look at clinicians being more enthusiastic about leaning and encourage students to be enthusiastic about learning...those are the things that I feel the clinician can identify in terms of promoting learning...When you looking at graduates a professional graduate it's again ongoing learning that we want. So how do we instil that in a clinician and therefore instil it in a student. It's the thirst for the ongoing knowledge, it can't be that you know everything. There has to be more to it." (Participant 4)

"I always tell the students that I'm supervising, 'I'm qualified but it doesn't mean I know everything. There is always going to be something you going to refer back to the text book to the notes. We learning from each other so you might know something that I might not know there's constantly literature

being published. You might have read something that I haven't covered and you might implement that. It doesn't mean that because I'm qualified, I'm your supervisor or I'm your clinician that I'm automatically right in what I'm trying to do."
(Participant 2)

The participants believed that, in order to teach and enjoy teaching, the clinicians and clinical supervisors needed to love the clinical area they work in. These players should want to teach, and not be coerced to do so. According to literature, "They must respect colleagues who don't want to supervise, some don't like to supervise. Some workplaces actually say "no" to students and right now, supervising student feels like a heavy burden" (Bos *et al.*, 2015, p. 39). Therefore, in order to create a learning environment the stakeholders need to be willing to learn and teach. The participants expressed that supervisors should also be open to learning. The participants noted that the clinician's enthusiasm about learning could influence the student's willingness to learn. The following quotations refer:

"I think you can make it an exciting learning experience for the student by being sort of in love with the area yourself. Personally I absolutely loved ICU which was a very daunting area for certain students to go into but I think because I enjoyed it and because I could show the students there's really nothing to be afraid of and I think my excitement to work with the student for example with the patients. You know the excitement when you are seeing a patient that's got a lung collapse and you treat the patient and the patients better. That carries through to the students and they will feed on your excitement and your positiveness...I think the clinicians can make it a learning experience by portraying their love for the field...again it's that mimicking of a role model if the students are seeing that they clinicians love what they are doing and their excitement and their passion for what they are doing."
(Participant 3)

“This whole thing about learning, if the clinicians is interested in learning and developing then the student will also be interested...the clinicians eagerness or willingness to learn because a clinician is still learning there’s always something that you going to learn on a daily basis...so there’s that ongoing learning with the qualified physio as well. You’re learning takes place I would say even only when you qualified because then you exposed all the time to patients, no theory or thesis hanging over your head. You done with all of that you just with a patient and that’s when you learn.” (Participant 4)

“...Firstly I would say the approach to the student is to be positive and be friendly to make sure they okay, you know that they comfortable... it’s a new block even though everyone talks about getting use to a new block... so for the clinical experience to be an excellent learning experience.” (Participant 6)

Category 5.2.2: Reflections: Encourage life-long learning

In order for clinical education in the clinical setting to be successful, clinicians need to be willing to teach the students through facilitation of knowledge. This, in turn, will help to improve the student’s clinical experience, as s/he would not imagine being a burden, when asking for assistance. As clinical teachers, supervisors should encourage students to be enthusiastic about learning, and portray an image of health professionals, who enjoy learning. However, this should not be forced on clinical teachers. Not every individual possesses the ability to teach, because his/her passion might not lie in teaching.

4.3.5.3. Sub-theme 5.3: Improving the student clinical experience

Chipchase *et al.* (2012: p. 2) assert, “Entry-level education of students within the allied health professions aims to equip graduates with the required knowledge, skills and professional behaviours to work safely and competently as contemporary health care professionals. At the core of entry-level education programmes that involves a symbiotic collaboration between clinical providers

and universities”. The learning experience can be improved through positivity. Providing support, working on collaborative objectives, supporting learning environments, being interested in learning, encouraging learning and having a positive approach to learning, are all ways that help to uplift the students. It is important for the student to view the clinical setting as a safe environment, where they are wanted, and where a love for teaching and learning exists.

Category 5.3.1: Formulating objectives with students

One participant reportedly requested that the student to bring along objectives, in order to gain insight into what the goals of the student were. Once the goals were identified, the clinical supervisors and clinicians could work on helping the student to reach those goals, by working together on the identified objectives. It was established that setting up the objectives should be executed by the students, clinical supervisors and clinicians. Bos *et al.* (2015: p. 39) avers, “Supervisors communicated with students when placement periods began; they listened to the students’ expectations and discussed their learning goals”. When the topic the concern emerged, the participants claimed that the students were not always willing to learn; they noted how students would not bring any objectives to their clinical supervisors and clinicians. The participants noted that the students, who were willing to take responsibility by formulating objectives, motivated clinicians to assist. Manninen *et al.* (2015: p. 55) state that the supervisors create a good learning climate, by communicating with the students and with each other; they collaborate and work as a team. The following quotations refer:

“...what I usually ask the students before they started is to bring me a block objective. At least if you come and then explain to me what you are there to come and learn but usually we get into to the fourth or fifth week, and you still begging for them: “Where’s your block objectives? Where’s your block objectives?” So it depends on the student as well, and I think the more effort the student puts in the more you as a clinician will assist that student.” (Participant 10)

“...the clinicians actually set out their objectives, e.g. this is what we need from the student this kind of a thing and then also that also guides the clinician in what the student needs or what we need, because they have had students who are not performing in these areas and are making life difficult for us (clinicians and clinical supervisors) in these areas. We need them to know before they come into the block, we need them to bring with them at the beginning of the block...” (Participant 11)

“...in the beginning of the block they do a SWOTS analysis and objectives and I go through that with them then ill communicate that through to the clinicians...and ask them to please provide the student with patients that would facilitate that objective that they got for this block... I do think that it needs to be communicated through to the clinicians or to whoever decides on which patients the students must see that’s important in facilitating there learning.” (Participant 12)

Fealy *et al.* (2011) states, “Interdisciplinary collaboration, such as the sharing of knowledge across professional boundaries, requires active facilitation to reconcile divergent interests in the world of everyday practice”. Another method of helping the student is to produce a file, to which students can refer, regarding orientation and the expectations of the block; the “do’s and don’ts.” In this way, there is collaboration between the stakeholders, where each one’s objectives or expectations are communicated. According to Bos *et al.* (2015: p. 39), there is a need for more communication and collaboration between placements and universities, regarding students learning and supervising.

“To maybe have a file whatever is expected so the expectations of the clinician must be in the file; again we get complaints the students don’t know how to write soap notes each clinician is different each placement is different. So yes they do know how to make soap notes but at some places they required to write more detail. If this is the

way you want your notes to be done have an example in a file and say this how I want it done. So that the student can have a clear understanding of, this is my clinicians expectation of this placement, that way they can also help our students.” (Participant 4)

Category 5.3.2: Supporting learning environments

The participants alleged that when students are not guided, or assisted in the clinical setting, the stakeholders are placing the environment in harm's way, by allowing a student, who is not yet competent to work independently. It is important to take cognisance of the fact that students require guidance in the clinical setting. Cross (1995) states, “If clinical educators perceive their primary role to be upholding the interests of the workplace, then compliance with these desired behaviours will happen only if this can be made congruent with that role.” The following quotations refer:

“...In both ways I can only see both benefitting from it because if the clinician doesn't do that then you actually exposing your environment to more harm because just think of it putting a student on a ventilated patient who has never ever seen a ventilator without actually going through the ventilator settings and things with the student could become dangerous. I don't see how a clinician could actually be comfortable doing that...so it all depends like If I say I'm busy I'm busy but is that a valid enough reason to leave a student unsupervised unattended for days on end.” (Participant 1)

“...it's easier and less time consuming to just give them the answer and say no man its fine walk with the patient. But that will happen again or maybe next time there's something contradicted but the student is overlooking because the clinician just said its fine mobilise anyway...so developing there thinking to know when it's safe and not safe. (Participant 5)

The participants claimed that clinicians could contribute to developing professional graduates, by making the learning environment conducive to

learning. This requires all role-players, namely, the clinical supervisors, clinicians and students themselves, to be involved, to ensure that students have a positive, supportive environment. According to Bos et al. (2015: p. 39), “Supervisors felt they did not get help and support from their colleagues and this had consequences for the atmosphere at the unit”. The following quotations refer:

“I know the clinicians are busy and I know they have their own workload, but I also feel that it is an academic hospital and its only right to make sure that your student is safe and safe to be in your ICU and the only way you going to find that out is if you spend time with your student.” (Participant 1)

“If you don’t help the student it’s not going to be pleasant, not going to be a good learning experience then what’s the point of the student being here? ...How do we make the environment? Its people we make the environment. So if we tend to have a negative environment that’s where things can go.” (Participant 6)

“First of all, it must be positive and they must feel comfortable in that environment to ask questions and discuss questions with clinicians and not being scared to actually go to the clinician and ask questions about the patient. They must also have the necessary respect that they deserve and they must be in a friendly environment for learning.” (Participant 8)

Category 5.3.3: Reflection: Improving the clinical experience

The learning experience can be improved through positivity. Providing support, working on collaborative objectives, supporting learning environments, being interested in learning, encouraging learning and having a positive approach to learning are all ways that help to uplift the students. It is important for the student to view the clinical setting as a safe environment where they are wanted and where a love for teaching and learning exists.

The researcher articulated that, as clinical teachers, the aim is to try and make the environment, in which students learn, more conducive to learning. In the researcher considered opinion, this is the collective responsibility of all the parties involved. When a participant highlighted that clinical teachers, including the university and the clinical supervisors, continue to send students to placements that are not conducive to clinical education, the researcher positively agreed, as the need exists to investigate the placements where students are sent. However, when all the factors are taken into consideration, it is obvious that this is not an easy task. Universities, unfortunately, cannot be selective about placements, as a shortage of clinical environment already exists. However, the researcher's opinion is that more can be done to keep placements conducive to learning, as one of the participants suggested, regarding auditing.

4.3.6. Theme 6: Student challenges

Students face various challenges and obstacles in the clinical settings; however, a few strategies were mentioned to assist students to overcome these challenges and obstacles. The participants highlighted that students are also at fault as some students are not motivated to learn and grow. Students need to take responsibility for their learning, as they are stakeholders in clinical education, as well. In a study conducted by Chipchase *et al.* (2012), educators tended to evaluate the characteristics of students in the themes of 'willingness', 'professionalism', and 'personal attributes', much more than in the theme of 'knowledge and understanding'.

4.3.6.1. Sub-theme 6.1: Students not taking responsibility for learning

The participants disclosed that the students do not play their part, and need to start taking responsibility for their learning, as well. Fealy *et al.* (2011: p. 2025) states, "Lack of competence or lack of engagement in clinical work is therefore a major barrier to clinical leadership development". At times, the students are not so eager to learn, even when the opportunity of learning is provided to them. The participants opined that the clinicians and clinical supervisors tend to change because of the students. The participant reported that, at times, the clinicians are enthusiastic about teaching students, but become discouraged by students' lack of interest in their own learning. According to Bos *et al.* (2015), supervisors

expressed frustration when supervising students, who were not interested in learning. The following quotations refer:

“Sometimes you can truly identify when a student isn’t doing their part...I just think clearly sometimes clinicians either might get fed up with lazy students. They might have four blocks in row of lazy students and they just have this idea of another university types of student it might have an effect or they just don’t know how to take a student under their wing.” (Participant 5)

“What I also find out is that sometimes we expect students to know certain things. You know by the end of the block I will also be fed up if you don’t know because we walk a road by now where we try to put the foundation. If it’s not there then I need to work it myself because the very end is important just like the beginning it is up to myself not to shout out of frustration. We need to be patient and we need to know we were also students and we also did not get it for the first time.” (Participant 7)

“The problem is I think....beside your educational aspects. There’s students that’s going to blocks unprepared or not fully committed to the block...as if they didn’t want to be there. There’s other aspects as well like basic professionalism, I think it depends on the student as well in my experience usually when the students start the block usually they like up to date with everything they know how to do and then...later during the block, I don’t know where is it going missing then there notes start to lack stuff. I don’t know if they lose interest in the block once they know alright I know what to do...” (Participant 10)

Students tend to hide their weaknesses and do not feel confident enough to highlight their problems areas and access assistance. According to the supervisors, the university offers support, in terms of extra hours, which the students do not utilise. Chipchase *et al.* (2012: p. 2) state, “the onus for creating effective and successful relationships during clinical learning also falls on

students who must present themselves as competent, professional and well prepared.”

“It is nice to know that you contributing to the student, but sometimes I just feel like they must come through. The students don’t play their part, what the student does is they will say they gave the weakest patient to me then it’s not the weakest, it’s the best patient. Then they have excuses about why they don’t bring patients with complicated conditions. The students then say “I can’t talk to the clinician or I don’t have any neuro patients”. Then the clinicians’ report but the students do have neurology patients on their list of patients, and at the end of the block the students pass the exam but you could see gaps.”(Participant 7)

A few participants articulated that students have the knowledge; however, the challenge is getting them to use the knowledge and apply it in the clinical setting. Students lack experience, therefore, they need the clinical setting to apply the knowledge. Students should be more open and willing to learn in the clinical environment. According to a study conducted by Cross and Hicks (1997: p. 257), ‘commitment’, ‘communication’ and ‘general disposition are the key attributes of a good clinical student. The following quotations refer:

“...it’s like you must know what you doing already and the students don’t often know that. A lot of the times they do have the knowledge you need to just pull it out of them. You need the practical situation for them to, otherwise how else they are going to learn? I think myself included often forget that they are only students they still in the learning process they not qualified yet...” (Participant 4)

“I think it could be firstly the clinicians are sometimes a bit difficult to handle, I did come across a few that’s seems to be a bit harsh on the student they tend to forget that the students are really not uneducated but in terms of physio they don’t have experience in terms of dealing with patients...actually all of them (students) have this knowledge, they have the ability... Where we have the ability to see

further than that and we have directional sense in a way in physiotherapy, where we should know this should be the patients main goal because they are struggling with this.” (Participant 6)

The participant added:

“...student forgets therefore we have to put in reminders just to protect everyone the patient, clinician, supervisors and students themselves just to make sure everything the environment is safe to work in...they need to know what they doing wrong and a lot of the time students do wrong things because they lack experience and we have experience...you know knowledge is power but we need to kind of know how to use that and use it for their own good for their education you know to improve on them...It could be that his unaware as well which is also a problem because for us to identify our own problems is quite difficult.” (Participant 6)

“On the other hand, I think back on my clinical experiences as a student I realise that I only started to reason clinically when I started working, because when you are a student you are just trying to get through. You have so much work and you just trying to pass this block. We try to develop clinical reasoning...but really we just trying for them to put things two and two together , we just trying to get them to get to link things. Only when they start working and they have a love and passion for their profession will they actually reason for themselves.” (Participant 11)

“I think that sometimes they struggle, they have got the knowledge but they struggle to like bring that different theoretical knowledge and the aspects of that together when managing a patient and tend to focus on one thing and forget that they know a lot of different things that they can use to actually manage this patient...The problem is that in class they practice on each other and they don't really know what they are feeling, in practice they deal with patients.” (Participant 12)

Category 6.1.1: Reflections: Students challenges

Students need to take responsibility for their learning. Clinicians and clinical supervisors become frustrated when opportunities for learning are provided to students, and they choose to abuse it. This discourages the educators, and could make the environment a negative place to be in, as the parties involved, become despondent.

4.3.6.2. Sub-theme 6.2: The effects of a negative environment on student learning

The participants opined that there was no place for negativity in the learning environment and that criticism should be given constructively. According to Fealy *et al.* (2011: p. 2025), “Because clinical leadership is associated with quality of care and patient safety, then its absence can threaten quality and patient safety”. The participants explained that the students were afraid of previous clinical supervisors and clinicians from previous blocks, which still affected them negatively on their new blocks, and had trust issues as a result. The participants shared how the negative feedback, or environment, affected them and their learning, during their student years. According to O’Keefe, 2012: p. 884), “Compounding these communication difficulties, in many clinical settings, shift work, staff turnover and high workloads mean that staff have little time to actively seek out information on individual students learning objectives”. The following quotations refer:

“If they’ve got a very scary clinician I find that the students are almost afraid throughout the block...I’ve found in the past it can make a student very negative towards a block and actually start not liking the area or type of work just because of the constant negativity and that is why I personally believe that everyone is entitled to positive and negative feedback because especially when you in a new environment and you already scared.” (Participant 1)

“In a hostile environment it’s not on, number one if your lecturer is not approachable then you don’t have the confidence to go and ask that person a question because you know that person will make you feel like stupid because you ask stupid question according to them.

Students don't know what they do not know and they allowed to ask but they need to find a point to learn on the question. Like I can ask you 'I am not clear on your question and what is it that you really want to know and you not sure about what then we talk about it....Shouting on the student and the patient is also not right. We address that at a certain level and come to understand that you frustrated and you have been explaining this to the student and they are not compliant so what we do, so we need to get that common ground.'" (Participant 7)

"Obviously if it is a negative environment it is going to stump their growth. I had a student recently where the clinicians were very criticising of the way he did things, the way he was treating his patients; that it was not effective because he had previously failed a block. He had taken this very personally and his attitude towards his patients and the work environment in general deteriorated. They should be resilient to criticism but also we should not forget that they are students going to a hospital, it is very scary for them. Positive reinforcement telling them you did this very well today however, you can improve. Not forgetting to encourage them and compliment them, constructive criticism than trying to break them down.'" (Participant 9)

"I know that students because they do not like a clinical area will not consider going in to that work area. Say they had a bad working experience they will not go back to Ortho...We have to remember if you have to work in an area with a difficult clinician or on the other hand a good clinician, you have to be the 8 hours of the day. If it's a negative experience it is hard and long negative experience for them, and you just want to get through the block...students write reflections you should know that, when they have a good clinical experience and that doesn't depend on me it depends on the clinician and the clinical area.'" (Participant 11)

Category 6.2.1: The negative attitude of clinicians and clinical supervisors

The participants reported how negative experiences affect students in the clinical environment. Everyone reacts differently; some students are able to carry on, while others hold onto the negative experiences. The participants disclosed their experiences as clinical supervisors, while others spoke about their experience as former students. The clinical supervisor constitutes an important resource in the development of students and the relationship between the student and the supervisor influences how students learn (Bos *et al.*, 2015: p. 39). This is true for both the clinician and the clinical supervisor.

The participants clarified how students communicate with each other regarding their experiences on a block - whether negative or positive. The students internalise this perceived idea about the block, and fear the area, which hinders their learning experience, even before they have experienced the negativity for themselves. Therefore, the self-management skills of leaders are important for the modelling of behaviour. According to Kumar *et al.* (2014), “These mix values and skills include such as vision, charisma, integrity, self-awareness, communication skills, anticipating, managing and adapting to change, time management, social and emotional competencies and keenness to acquire and learn new things including technical areas of expertise.”

“I have had students complaining about clinicians and crying about clinicians and not feeling that they are able to ask questions or ask for guidance when they struggling...quite a few of them feel that way already but I know some of the clinicians. I know how accurately they do their work, so sometimes in some student’s cases I know it’s just them (students).” (Participant 5)

“...the hospital I worked in there was students complaining about the clinicians being rude or disrespectful because they students but at the same time the student obviously had their

fault as well. It's from both sides definitely but as clinicians as qualified we shouldn't do this to our next generation because that's when they come and be our colleagues, we will be working together...they must do it appropriately and not kind of just tell you that to make you feel small and feel like you nothing or you know nothing but more like to help them in terms of what's that called is positive criticism.” (Participant 6)

“...if a student has a bad experience with a clinician it spreads like wild fire and the next students that comes on the block it's almost like they come with this perceived idea that this person is going to be horrible with 'me' and they have this fear. It is almost like they come on the block with this attitude and with this fear already and it's very very very difficult to work through it and no matter how much positive input you can give its something that is just there and it's got like a stigma attached to it and it all boils down to this one clinician in that specific area...” (Participant 1)

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The participants reported on their experiences as students; the negative experience made them feel insecure in that specific area of physiotherapy. The participants reported that they had internalised the experience for many years, as professionals. The participants highlighted that they continually tried to avoid that area of physiotherapy, due to the association of the area with their perceived incompetence and unintelligence. One participant explained about another university where students were removed from the placements, when they alleged that the environment is not suitable for learning. A study conducted by Manninen *et al.* (2015) revealed that, according to some studies, not all clinical settings are able to create favourable learning environments for student learning. The following quotations refer:

“I'm going to speak from personal experience as a undergrad I was at a block that had clinicians... they just had a very not nice of working with me as a student. They weren't rude but I was

made to feel stupid, I was made to feel like I knew nothing I was applying a lot of the things university was teaching and if I had mentioned it they would laugh about it... I carried that through into my professional career I have never ever treated a neuromuscular skeletal patient again. I just don't treat them because on that block I did not learn as much as I could have learned because I always feeling stupid and inadequate. It wasn't an environment where I felt that I could learn and they had a direct role in that. I was scared to go to them with questions, I was scared to go to them with ideas because I was scared I was going to be made to feel stupid again so I just opted to just get through the six weeks as quickly as I could..."
(Participant 3)

" If the student has a negative reflection of a clinician it's almost like that negative one stays in your head and then it's always like that is how the clinician was and it was okay, so you don't want the student to think that they bad...because they don't develop a passion in that area because of the negativity, It's almost like they don't want to go back, I was like that I mean I never had a good experience in ortho till today I don't like ortho. I mean that goes years back but I'm just saying like I think your fear you never ever overcome your fear, so after years of working I've never I've always fade away from ortho..." (Participant 1)

"... if their learning environment is not good for their students, they pull their students and I think that is the responsibility of the university to do that, then you have to protect your students...I think also the reality is that some clinicians really do not like students and you cannot force them to like students. And I would say, maybe ask... you know clinician which of you would like the students. I feel ultimately responsible for students having a good learning experience, we cannot keep sending the

students to institutions that give them bad learning experiences.” (Participant 12)

Category 6.2.2: Reflection: The effects of a negative environment on student learning

A negative environment affects the students, even beyond their days as a student. It might affect the student, well after they are qualified, and even affect the way they view a certain area of physiotherapy. When feedback is provided, it needs to be done constructively and carefully, so as not to break the student.

4.3.6.3. Sub-theme 6.3: Students are there to learn and not as a work force

One participant alleged that students should not be seen as a work force, or a means to decrease the workload; students are at placements to learn. The participants reported that the stakeholders’ mind-sets needed to change. One participant alleged that students were often taken for granted and overworked. The participant felt that students were not allocated patients, as a learning opportunity; instead, they were allocated patients to ease the workload for the area. Therefore, it should always be remembered that in a healthcare discipline, students are naturally focused on learning how to practice their own discipline (O’Keefe *et al.*, 2012).

“Sometimes there are cases where students are seen as just ‘cheap labour’ when going to certain healthcare facilities and I don’t think that is the case. We should also try to remember it is a learning experience you have to gain as much as possible at each clinical rotation therefore physio’s that are working in a specific setting such as ICU or orthopaedics or any NMS can give the students necessary knowledge pertaining to those settings, I think it is important.”
(Participant 2)

“They (clinicians) don’t have the time: ‘don’t come to me, we don’t have time for this’ The students are often seen as reducing the workload and therefore opportunities for learning are lost seen as an extra body to help with the load but not there to be taught
(Participant 4)

“I think it’s a mind-set, and often I think that they should realise that the students are there to learn. The students aren’t there to lessen their workload. I think then they will approach it differently; they will choose different patients for the students to see, they will manage the time or the amount of patients that they give differently, but they need to realise that the students aren’t there to add to their workforce. They need to realize that the students are there to learn not to work, they are providing a service in the process.”If the clinicians don’t make that decision based on a mind-set that it is there for the students to learn. They will always give the patients that’s going to decrease their workload.” (Participant 12)

Category 6.3.1: Reflection: Students are there to learn and not workforce

Due to the shortage of resources in the government setting, students are often perceived and treated as a workforce. They are allocated patients to treat in multiple numbers and overloaded. The point of the exercise is lost, as students do not get the opportunity to learn and grow, due to the high patient load that needs treatment. The researcher believes that this could lead to conflict between the clinician and the clinical supervisors, as the one party might feel that the student is being robbed of valuable learning experience.

4.4. Conclusion

This chapter introduced the demographic data of the participants, presented, explored and discussed the themes and sub-themes, as they emerged from data analysis. The themes and sub-themes were agreed upon, after consensus discussions with study supervisor.

The findings presented focuses firstly on how clinical supervisors view their role in clinical education, as well as how they think they contribute to student learning. The study further explores the interpretations of the participants’ views, on the role of the clinician in clinical education, as well as how it differs from the role of clinical supervisors. The study, subsequently explores and discusses three more themes, namely, ways that the clinicians can assist in clinical education, the recommendations for clinicians and lastly the challenges

students face in the clinical setting. The results and discussion are combined, based on the objectives of the study and the findings, which are related to the literature accessed.

The findings are summarised in the next chapter. The chapter consists of the summaries, recommendations and conclusion.



CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1. Summary

The aim of this study was to explore the role of the clinical supervisor (employed by the university), as well as the clinical supervisors' views on the role of clinicians (employed by the medical institution) in clinical education. In this study, the researcher highlights that clinical supervisors and clinicians play significant roles in integrating theoretical and clinical knowledge; therefore, it is considered a resource, which provides a valuable contribution, by clinical supervisors. In clinical supervisors' observations, clinicians contribute in different ways to clinical education, than do clinical supervisors. These different ways include teaching students how to be professional, by role modelling professionalism; teaching them how to complete administration tasks; teaching by engaging them in tutorials, assessments and treatments in authentic learning situations; and providing opportunities of learning to students, by attending to their needs. However, it has been highlighted that clinical supervisors would be keen on clinicians arranging more tutorials and treatment sessions with the students, to further improve their critical thinking skills, as well as practical techniques and the applications thereof.

When exploring the differences between the two roles, the participants noted that the supervisors engaged in more one-on-one input with the students, than the clinicians did, which was conducted through tutorials with patient assessments and treatments. The participants were of the opinion that all the stakeholders were in the clinical setting, whether a clinician or a clinical supervisor; therefore, their roles should not be different, as they have a common goal regarding students. The clinical supervisors believed that the student could be taught by the clinician as well, by spending one-on-one time with the students.

However, a few participants highlighted that clinical supervisors are employed by the university, and clinicians, by the medical institution; therefore, clinicians are administrated by different rules and legislations. Each stakeholder has a primary role that binds him/her to the job title, which, in turn, will regulate how actively the parties are involved in clinical teaching, as their job descriptions differ in the bigger context. In the government setting, the

health workers main duty is service delivery, whereas at the university it is the clinical education of students. However, if students are to render a service successfully and competently, clinicians will have to play a role in the clinical education of students.

The consensus was that, collectively, there are overlapping roles to support the students, as both parties could teach and guide, facilitate and demonstrate. The participants considered the clinicians to be clinical supervisors, as well; however, with a different influence on student learning. The aim of clinical education is to assist the student to bridge the gap between theory and practice, and between the classroom and the clinical setting. When focusing on integrating theory into practice, students should be guided to understand what knowledge and skills are required during patient management, which could be facilitated by both the clinician and the supervisor.

5.2. Recommendations

5.2.1. Short term recommendations

5.2.1.1. Creating learning opportunities

Firstly, opportunities need to be created in the clinical setting for students to interact in multi-disciplinary teams (MDT) as part of the outcomes of their clinical block; therefore, shifting the responsibility onto the students and the placement. The participants were concerned that the students were not particular about the way they conducted themselves around their colleagues, and were not aware of their misconduct. Interacting with the MDT to develop professionally is one of most important factors in clinical education. Helping students to develop into professional graduates is allowing them to communicate with other health professionals, or members of the MDT.

This can be achieved by involving students in ward rounds, where they are responsible for handing over and discussing their own patients, as well as commenting on the progress of the patient, under the support and guidance of the clinician. In addition, the students should refer to members of the allied health team in the hospital, for example social workers or occupational therapists, in order to demonstrate the importance of the holistic approach to treatment.

Students should also be afforded the opportunity to attend staff meetings regarding the administration of the wards and ICU's. This will involve them in the organisation of the daily programme, from a management point of view.

Opportunities should be created for clinicians to role model and interact with students, possibly as guest lecturers at the university, and at the clinical placements, as well. A partnership needs to exist between the universities and the clinical placements, as students need to observe the two institutions working together as one system, which will project a positive image and, consequently, have a positive effect on the students. Clinicians could be included at universities to deliver lectures at the department, in their specific field of practice at the clinical placements. In addition, the clinicians could move the lectures to the clinical setting and make it more practical, by doing tutorials on patients with real conditions. The students, therefore, would be aware that what was taught in class is followed through in the clinical setting, and that all the stakeholders are like-minded.

Clinical supervisors and clinicians need to demonstrate and guide the students by modelling what is appropriate or inappropriate in the working environment. The students' progress, or regress, is perceived as a reflection on, not only the university at which they study, but also the medical institution for which they work.

5.2.1.2. Communication

Communication is an essential element on different levels, as imparting the expectations of the university and the placements should be seen as vital, which was acknowledged by the participants. There are ways to ensure communication in the clinical setting, which cannot be taken for granted, as the stakeholders need to realise that communication is a topic that needs to be addressed, as follows:

1. Most of the participants agreed that a way forward is to have a guideline, or protocol on how all the stakeholders could be involved with clinical education in the clinical setting, which initiative should be driven by the university.

2. The university should have quarterly meetings with the clinical placements, as a regular interaction and feedback session. A communication forum should be created for clinicians to share ideas with universities on how to improve the clinical experience for students. The participants added that the clinicians would like to be more involved in students' education, by regularly attending network meetings for supervisors and teachers to voice their opinions. Improving communication between the clinical placement and the student could be facilitated through an online forum, welcoming students to the placement and regularly updating them on activities. In addition, the participants reported that regular meetings should include student representative councils, for them to speak and advocate on behalf of the students, as well.
3. Strategic planning meetings between the university and clinical placements, once a year, would assist in the collective planning of placements. Both parties need to be involved, in order to procure the viewpoints and concerns of both environments.

5.2.2 Long term recommendations

This study welcomes more research to be conducted on the following topics:

1. The views of the clinical supervisors employed at two other institutions in the Western Cape, South Africa, namely the University of Cape Town and the University of Stellenbosch.
2. The physiotherapy students' views on clinical education, in order to obtain a more holistic view of the topic under discussion.

5.3. Conclusion

As previously mentioned, in order for intervention strategies to be designed, it is important to understand the views of the key stakeholders. In this current study, the views of the physiotherapy clinical supervisors, employed by a higher education institution, were explored for a better understanding of the way in which they perceived clinical education, as well their contributions to it, and those of the clinicians. The role of clinicians, as educators in the

medical field, was covered extensively by literature, while allied health, in this instance physiotherapy, was not as clearly defined.

As the findings of this current study have highlighted the importance of the clinicians' involvement in clinical education, clinical supervisors, therefore, should not work in isolation without this valuable asset in clinical education. According to the study analysis, clinical education is a collective responsibility, where each party contributes in different ways. In addition, this study specifically adds to new knowledge, by revealing how clinicians realistically contribute to clinical education, in the South African context.

However, the findings of this current study also highlighted and considered the barriers that exist, which restrain the clinicians in educating students. The researcher explored ways in which the clinician could contribute to clinical education, from the clinical supervisors' perspectives. In addition, findings highlighted that a standard had to be implemented to guide, not only clinicians, but also clinical supervisors and lecturers at the university, on how clinicians could contribute. The researcher is of the opinion that further studies should be conducted, aimed at exploring the views of the clinicians on how they perceive their contribution to clinical education, in a realistic way.

The major findings are that clinical supervisors are aware that the clinicians should be involved in clinical education, and have highlighted how they could be involved. The majority of the clinical supervisors were clinicians at some stage in their careers and understood the challenges faced by clinicians. Consequently, this enabled them to determine ways and means that clinicians could contribute, as clinical education did not only involve assessing and treating of patients. The findings of this current study would also contribute to the origination of training programmes, to address some of the participants' perspectives. Additionally, with further investigations and studies, these findings could be used to develop models, or capacity programmes, that are suitable for the local context. Ultimately, the goal is to create clinical placements that are ideal for physiotherapy students, with clinicians and clinical supervisors, who are like-minded, adhering to the same guidelines regarding clinical education.

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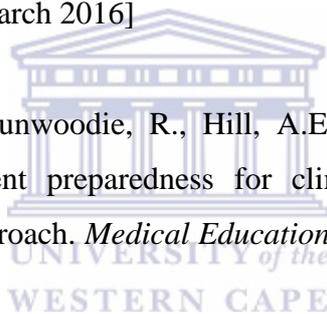
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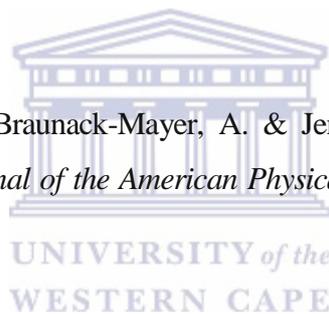
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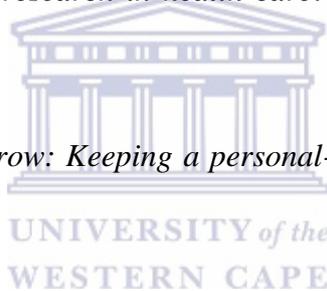
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APPENDICES

APPENDIX A: Ethics Letter



UNIVERSITY of the
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5 November 2014

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by: Ms T Warner Fabing (Physiotherapy)

Research Project: Defining and clarifying their role in clinical supervision according to physiotherapists at a tertiary hospital in the Western Cape.

Registration no: 14/8/10

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

*Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape*

A place of quality,
a place to grow, from hope
to action through knowledge

APPENDIX B: Department of Physiotherapy permission letter



UNIVERSITY of the
WESTERN CAPE

DEPARTMENT OF PHYSIOTHERAPY

13 April 2015

Dear Taryn

I am pleased to inform you that permission to conduct your research is granted. We are currently organizing our list of clinical supervisors so that you can be able to contact them.

Regards

A handwritten signature in black ink, appearing to read 'Mlenzana'.

Dr Mlenzana

Private Bag X17, Bellville 7535, South Africa
Tel.: +27 (0) 21 959 2542/3647.
Fax: +27 (0) 21 959 1217
Email: mcoetzee@uwc.ac.za
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A place of quality,
a place to grow, from hope
to action through knowledge

APPENDIX C: Information Sheet



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

E-mail: tarynfabing@gmail.com

INFORMATION SHEET

Project Title:

Defining and clarifying the role of clinical supervision according to physiotherapists at a higher education institution.

What is this study about?

This is a research project being conducted by Taryn-Lee Warner Fabing at the University of the Western Cape. We are inviting you to participate in this research project as you are a physiotherapy clinical supervisor at a higher education. The purpose of this research project is to explore and describe physiotherapist's experience with clinical supervision and their view regarding their role in contributing to student learning.

What will I be asked to do if I agree to participate?

You will be asked to take part in an interview. The procedure will be conducted at University of the Western Cape or at a clinical block which suits the participants best; the duration of the procedure will be 1 hour long for each interview. Listed below is a summary of the questions.

1. What do you think your role is as a clinical supervisor in clinical education?
2. What role do you play in the education of physiotherapy students and how do you think you contribute to their learning?
3. What is your view on the role of the clinician in clinical supervision? How does it differ from the role of the clinical supervisors?
4. What contribution do you think clinicians can make in developing professional graduates?
5. Can you identify strategies that would enhance the relationship between clinical supervisors and clinicians?
6. How do you think clinicians can make the clinical experience an excellent learning experience and how can you facilitate and support this strategy?

Would my participation in this study be kept confidential?

We will keep your personal information confidential. If we write a report or article about this research project, your identity will be protected to the maximum extent possible and no names will be used. All transcripts will be locked in a filing cabinet and coded to ensure confidentiality.

This research project involves making use of audio-tapes during the interviews and the researcher will then make notes. This is to ensure that the information gained is accurate and the researcher will conclude and summarise the findings after each question. The researcher and the supervisor will have access to the audio tapes; the tapes will be stored at the physiotherapy department at UWC and destroyed once all the data has been accessed.

___ I agree to be audiotaped during my participation in this study.

___ I do not agree to be audiotaped during my participation in this study.

What are the risks of this research?

There are no known risks associated with participating in this research project.

What are the benefits of this research?

The benefits to you will be that the roles of physiotherapy clinician and supervisor as educators will start to be clearly defined. Literature proves that significant progress is evident amongst doctors and nurses in this area; unfortunately it has not been clearly defined for allied health profession specifically physiotherapists and you will thus contribute in starting the conversation in the field of physiotherapy.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Taryn-Lee Warner Fabing and the Physiotherapy department at the University of the Western Cape. If you have any questions about the research study itself, please contact Taryn-Lee Warner Fabing at 66 Longboat Close Odin Drive Thornton 7460, 083 396 1358 and tarynfabing@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced, study related, please contact:

Head of Physiotherapy Department: Dr Nondwe Mlenzana

University of the Western Cape, Private Bag X17, Bellville 7535

Contact Details: Tel: +27 21 959 2542 Fax: +27 21 959 1217

Email: nmlenzana@uwc.ac.za

Dean of the Faculty of Community and Health Sciences: Prof Jose Frantz

University of the Western Cape, Private Bag X17, Bellville 7535

Contact Details: Tel: +27 21 959 2542 Fax: +27 21 959 1217

Email: jfrantz@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

APPENDIX D: Consent Form



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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E-mail: tarynfabing@gmail.com

CONSENT FORM

Title of Research Project: Defining and clarifying the role of clinical supervision according to physiotherapists at a higher education institution.

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study.

Participant's name.....

Participant's signature.....

Witness.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Taryn-Lee Warner Fabing

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021) 959-2542

Cell: 083 396 1358

Fax: (021) 959 1217

Email: tarynfabing@gmail.com

APPENDIX E: Interview Guide



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INTERVIEW GUIDE

Title of Research Project: Defining and clarifying the role of clinical supervision according to physiotherapists at a higher education institution.

1. What do you think your role is as a clinical supervisor in clinical education?
2. What role do you play in the education of physiotherapy students and how do you think you contribute to their learning?
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Study Coordinator's Name: Taryn-Lee Warner Fabing

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APPENDIX F: Editorial certificate

07 August 2017

To whom it may concern

Dear Sir/Madam

RE: Editorial Certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling, as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

Thesis title

Defining and clarifying the role of clinical supervision
according to physiotherapists at a
higher education institution

Author

Taryn-Lee Warner Voges

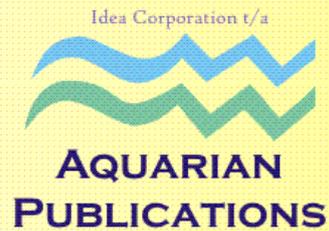
The research content, or the author's intentions, were not altered in any way during the editing process, however, the author has the authority to accept or reject my suggestions and changes.

Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone and fax numbers or e-mail addresses.

Yours truly,



E H Londt
Publisher/Proprietor



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