Assessment of professional behaviour in occupational therapy education: investigating assessors' understanding of constructs and expectations of levels of competence.

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Declaration

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualifications.

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Abstract

The development of professional behaviour is one of the core components of occupational therapy education. The assessment of professional behaviour poses a problem as the constructs and expectations are not clearly defined; this results in compromised inter-rater reliability. The purpose of the study was to investigate assessors' understanding of the constructs and the expectations deployed during the assessment of professional behaviour of third and fourth year occupational therapy students during clinical practice. A case study design was used in the qualitative study. Clinical supervisors were involved in: (1) a focus group interview to scrutinise the usefulness of the current assessment instrument and (2) a participatory discussion to determine their understanding of the constructs of professional behaviour and the level of expectations to be set for third and fourth year students respectively. This study confirms that the development of effective assessment of professional behaviour entails a number of pivotal steps that include developing a shared definition of the constructs thereof and the expectations at different levels of undergraduate training, the refinement of the assessment instrument and training of assessors in the use of this assessment instrument.

Abstrak

Die ontwikkeling van professionele gedrag is een van die kern komponente in arbeidsterapie opleiding. Die assessering daarvan bied egter uitdagings aangesien die konstrukte en verwagtings nie duidelik gedefinieer is nie; dit het gekompromiteerde geldigheid en betroubaarheid tot gevolg aangesien verskillende assessore die professionele gedrag van studente verskillend assesseer. Hierdie studie het die ondersoek van kliniese toesighouers se begrip van die konstrukte en hul verwagtings tydens die assessering van professionele gedrag van derde- en vierdejaar arbeidsterapiestudente tydens kliniese prakties ten doel gehad. 'n Gevallestudie ontwerp het die basis van 'n kwalitatiewe ondersoek gevorm. Kliniese toesighouers is betrek in: (1) 'n fokusgroeponderhoud om die bruikbaarheid en gebruikersvriendelikheid van die huidige assesseringsinstrument te bepaal; en (2) 'n deelnemende groepbespreking om hul begrip van die konstrukte van professionele gedrag en die verwagte vlakke van funksionering vir onderskeidelik derde- en vierdejaar studente te ondersoek. Hierdie studie bevestig dat die ontwikkeling van effektiewe assessering van professionele gedrag 'n aantal essensiële stappe behels. Hierdie stappe sluit die ontwikkeling van 'n gedeelde definisie van die konstrukte en verwagtinge van professionele gedrag in, asook die verskil in verwagtinge op die onderskeie vlakke van voorgraadse opleiding, die verfyning van die bestaande assesseringsinstrument en die opleiding van assessore in die gebruik daarvan.

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CHAPTER 1 - INTRODUCTION

1.1 Title

Assessment of professional behaviour in occupational therapy education: investigating assessors' understanding of constructs and expectations of levels of competence.

1.2 Introduction, motivation and literature review

Experience with Occupational Therapy (OT) education at Stellenbosch University (SU) indicates that fieldwork placements provide extensive opportunities for developing professionalism, but that the assessment of professional behaviour poses a problem as the guidelines that are set are subjectively interpreted. Anecdotal evidence suggests that students are assessed differently by different clinical supervisors. The reason for this trend needs to be investigated and analysed to identify possible inconsistencies that could inform recommendations aimed at ensuring more valid and reliable assessment of students' competence with regards to professional behaviour.

Van de Camp, Vernooij-Dassen, Grol & Bottema (2006) citing Arnold stated that valid assessment of professional behaviour requires that three critical issues are addressed: (1) what should be assessed, (2) how should it be assessed and (3) why should it be assessed? The conceptualization of outcomes relating to professional behaviour and their expression in written form is important, but challenging. Steinert, Cruess, Cruess & Snell (2005) and Schwartz, Kotwicki & McDonald (2009) argue that professional behaviour should be defined in explicit operational terms and broken down into objectively measurable behaviours that can be evaluated as this will enhance the strategies and methods that are employed in the assessment thereof.

Having clarified what should be assessed, it is also important that clinicians and clinical supervisors (assessors) responsible for the assessment of professional behaviour share a common understanding of the definition of professional behaviour and the characteristics that distinguish it (Schwartz, Kotwicki & McDonald, 2009; Wilkinson, Wade & Knock, 2009). Without this shared understanding inter-rater reliability will be compromised.

An investigation into the clinical supervisor's understanding of the constructs and the expectations that currently inform their assessment of the professional behaviour of third and fourth year occupational therapy students' studying at SU will serve to inform the Division of Occupational Therapy at SU of the strengths and weaknesses of the current system of

assessing professional behaviour and could lead to development of more valid and reliable assessment instruments.

1.3 Research question

The study was guided by the following questions*:*

To what extent do clinical supervisors (assessors) have a common understanding of the constructs of professional behaviour and respective levels of competence required at third and fourth year programme levels in the assessment of professional behaviour of occupational therapy students at one university?

How do clinical supervisors perceive the current assessment instrument used for the assessment of professional behaviour at this university?

1.4 Aims and objectives

The purpose of the study was to investigate the understanding that current clinical supervisors have of the constructs and expectations used in, and their expectations deployed during, the assessment of professional behaviour of third and fourth year occupational therapy students during fieldwork by: (1) involving clinical supervisors in scrutinising the usefulness of the current assessment instrument used to assess the professional behaviour of third and fourth year OT students at SU; (2) involving clinical supervisors in a participatory discussion process to determine their understanding of the constructs of professional behaviour and (3) involving all clinical supervisors in a participatory discussion process about the level of expectations to be set for third and fourth year students respectively. The ultimate objective of the study is to improve the assessment of professional behaviour.

1.5 Summary of the methodology

The study followed an interpretevist paradigm using a case study design. According to Nieuwenhuis (in Maree, 2007), the emphasis of a case study design falls on gathering information to inform a specific practice or context. In this study the process of the assessment of professional behaviour constitutes the case while the clinical supervisors (assessors) of third and fourth year OT students constituted the unit of analysis.

Qualitative data was collected by means of focus group interviews guided by open-ended questions and a participatory group process using the Participlan method during which visual mapping was used to stimulate and support group participation and the free flow of ideas in a focused, non-threatening environment (Participlan: Visual mapping for quick results, 2004; Facilitation, 2008). Purposive sampling was used for the identification of six participants for

the focus group interviews. All clinical supervisors (n=19) were invited to participate in the Participlan sessions.

Verbatim transcriptions of focus group interviews were coded and the coded detail then categorized into themes. The Participlan process (explained in greater detail in Chapter 3) entailed generation, collection, categorization and prioritization of data. This information was recorded in a document describing the specific behaviours and summarizing the levels of competence expected of third and fourth year occupational therapy students respectively. Once all the data had been coded and themes identified and tabulated, inferences were made in order to address the research question.

1.6 Anticipated risks

Some of the participants in the participatory group sessions and focus groups were involved in the design of the current assessment form used to assess the professional behaviour of third and fourth year OT students at SU. Had these participants felt threatened or judged by the investigation, they might have withdrawn or become defensive. The study was framed to communicate that the ultimate intention thereof was not judgment, but the improvement of practice. The involvement of an objective facilitator in a non-threatening participatory group session also counteracted this possibility.

The researcher and many of the participants have been employed as clinical supervisors at the University of Stellenbosch for some years; this may have led to bias caused by preconceived ideas and habits formed over the years of being involved in supervision of students. This was counteracted by rigorous, auditable methods as well as the reflective journaling during which the researcher was able to record and analyse her feelings and actions during the research process.

1.7 Anticipated benefits

Cook, Bordage & Schmidt (2008) state that clarification studies asking the “What?” and “Why?” questions are needed to deepen understanding and advance the art and science of education. The proposed study endeavoured to clarify the constructs and expectations pertaining to professional behaviour set for third and fourth year OT students studying at SU (what?).

By analysing and understanding current practices the researcher was able to identify best practices as well as deficiencies within the current program. This enabled her to make recommendations to: (a) enhance the alignment of the assessment instruments used for assessing the professional behaviour of third and fourth year OT students during fieldwork

practice with the expectations set in the assessment instrument and (b) ensure consistent implementation of the assessment instruments by the clinical supervisors involved so as to promote validity and reliability of assessments.

1.8 Ethical considerations

Confidentiality: While the participative session was face to face, inputs were written by participants on small sheets of paper that were passed to the facilitator. The source of any given piece of information was thus anonymous unless the writer opted to reveal their identity. During the participative group sessions the researcher gave each subgroup of clinical supervisors (i.e. those supervising only third year students, those supervising only fourth year students and those supervising both third and fourth year students) a different colour pen to record their comments/opinions. Although continued assurance of anonymity was deemed important, the researcher wanted to establish which sub-group generated the information as this could suggest differences in terms of the perceived expectations for third and fourth year students respectively.

During the transcription of focus group interviews the names of participants were replaced with codes without identifying data. To ensure non-traceability the identification codes were used in the transcribed information and the records attributing a specific code to a specific participant kept separately. Information was secured by keeping electronic copies on a password protected computer and back-up electronic copies on a password protected file saved on a memory stick. Paper copies were kept in a locked filing cabinet.

Informed consent: In his discussion of informed consent Mouton (2001) states that the researcher is obligated to explicitly communicate and discuss the aims and anticipated consequences of the research to individuals and groups that are likely to be affected by the study. In addition to being given the above information, participants were informed about measures to ensure confidentiality, the possibility of withdrawing without sanction, researcher and study supervisor's names, and offered the possibility of receiving a summary of the results. Having communicated the above information, the researcher requested written consent from all participants and all participants consented.

Approval to conduct the study: The researcher obtained approval to conduct the study from the Research Ethics Committee of the Health Sciences Faculty of the Stellenbosch University. (Reference number N11/03/090) The study commenced only after ethical approval was given.

1.9 Conclusion

In this chapter the study has been contextualized, preliminary readings reviewed, the topic identified, aims and objectives and the research question stated and the methodology introduced. In chapter two current literature substantiating the research focus is reviewed.

Definition of terms

Professionalism: Professionalism is a diverse and multi-faceted concept which, in occupational therapy education, is seen as having three main facets, i.e.: professional parameters (what we know), professional behaviours (how we behave) and professional responsibilities (ways in which we are accountable) (Bossers, Kernaghan, Hodgins, Merla, O'Conner & van Kessel, 1999: 119).

Professional behaviour: Professional behaviour is seen as the expression or demonstration of professionalism and includes behaviours related to the demonstration of skills and practice, relationships with clients and colleagues and personal presentation (Zijlstra-Shaw, Robinson & Roberts, 2011; Bossers et al., 1999).

Participlan: The Participlan method can be defined as a facilitation process that uses visual mapping to stimulate and support group participation and free flow of ideas in a focused, non-threatening environment (Participlan: Visual mapping for quick results, 2004; Facilitation, 2008).

Assessment and evaluation: The terms **assessment** and **evaluation** are sometimes used interchangeably. It is therefore necessary to make a clear distinction between these terms.

Assessment: Assessment is an activity performed by students and their teachers to obtain information for judgement and decision making about students' learning and performance (Cannon & Newble, 2000; Ramsden, 2003). "The results of the assessment of student learning are an important part of evaluation (Cannon & Newble, 2000:209)."

Evaluation: Evaluation is the process of obtaining information and feedback on teaching activities to form judgements and make decisions about programmes, courses and teachers (Cannon & Newble, 2000). The intention of evaluation is to contribute to change, development and improvement of teaching in higher education (Cannon & Newble, 2000; Ramsden, 2003).

Although the terms assessment and evaluation are often used interchangeably, assessment in this thesis refers to student assessment. The Occupational Therapy Division of Stellenbosch University has entitled the forms (Addendums A and B) used for the assessment of students' clinical work: *Evaluation of Clinical Work* and the author has referred to these forms as such.

CHAPTER 2 - LITERATURE REVIEW

2.1 Introduction

This literature review addresses the concept of professional behaviour as a facet of professionalism in health sciences education, specifically occupational therapy education, and focuses on the assessment thereof.

2.2 Background

The education and training of South African occupational therapists is governed by the Education Committee of the Professional Board for Occupational Therapy, Medical Orthotics and Prosthetics and Arts Therapy. The undergraduate programmes of the eight universities offering occupational therapy training in South Africa are registered with this Professional Board at the Health Professionals Council of South Africa (HPCSA). Nationally, minimum training standards are prescribed in the *Minimum Standards for the training of Occupational Therapists* (HPCSA, 2009) document. Internationally, guidance is provided by the *Revised Minimum Standards for the Training of Occupational Therapists* of the World Federation of Occupational Therapists (WFOT) (Hocking & Ness, 2002). Therapeutic and professional relationships and professional reasoning and behaviours are identified within the realm of 'essential knowledge, skills and attitudes for competent practice' and 'core content' in the minimum standards documents of the WFOT and the HPCSA's Professional Board for Occupational Therapy, Medical Orthotics and Prosthetics and Arts Therapy respectively.

The WFOT and HPCSA accredited Bachelor Degree in Occupational Therapy offered at Stellenbosch University (SU) qualifies graduates on National Qualifications Forum (NQF) exit level 8. In the *Level Descriptors for the South African National Qualifications Framework* (SAQA, 2010:6) the level descriptors for level 8 include ethics and professional practice "in respect of which a learner is able to demonstrate an ability to identify and address ethical issues based on critical reflection on the suitability of different ethical value systems to specific contexts."

2.3 Professionalism and professional behaviour

What is professionalism? Van Mook, de Grave, Wass, O'Sullivan, Zwaveling, Schuwirth & van der Vleuten (2009a) identified expertise, ethics and service as the three pillars of professionalism. "Professionalism requires specific knowledge, attitudes and values – all manifested in professional behaviours" (Kasar & Muscari, 2000:42). For the purpose of this study professionalism will be defined as a diverse and multi-faceted concept which, in occupational therapy education, is seen as having three main facets, i.e. professional

parameters (what we know), professional behaviours (how we behave) and professional responsibilities (ways in which we are accountable) (Bossers, Kernaghan, Hodgins, Merla, O'Conner & van Kessel, 1999).

Professional behaviour is viewed as an integral part of clinical practice in allied health and medical fields (Tsoumas & Pelletier, 2007:313). Such behaviour is not innate; rather its development requires practice, experience, role mentorship and evaluative feedback (Kasar & Musconi, 2000). Professional behaviour is also regarded as a fundamental component in the development of competent practitioners able to practice in diverse service delivery contexts. Speth-Lemmer (2007), quoting Speet and Francke (2003), echoes this and adds that the development of professional behaviour ultimately results in a practitioner who is able to practice his or her profession in a reflective, convinced, accountable and collegial manner.

Bossers et al. (1999) proposed professionalism as comprising of three themes: (1) professional parameters, (2) professional behaviours and (3) professional responsibility as illustrated in Fig. 1. This study is viewed by some as setting the benchmark with regards to the constructs of professionalism in occupational therapy practice and this framework forms the basis of the curriculum for teaching professionalism and professional behaviour to Occupational Therapy students at the Occupational Therapy Division of Stellenbosch University (SU).

Figure 1: Schema of Professionalism (Bossers et al. 1999)

The next section will discuss the assessment of professional behaviour as the focus of this study.

2.4 Assessment of professional behaviour

The goal of assessment in health sciences education is the development of reliable measurements of student performance as this has predictive value for subsequent clinical competence as well as having a formative, educational role (Wass, van der Vleuten, Shatzer & Jones, 2001). Meaningful, reliable and valid assessment is considered crucial in the promotion of professional behaviour of medical practitioners (Tromp, Vernooij-Dassen,

Kramer, Grol & Bottema, 2010). This statement is true for all health care practitioners including occupational therapists.

The need for both formative and summative assessment of professional behaviour is generally agreed upon; how it is assessed, however, remains a question of interest. Van Mook, Gorter, O'Sullivan, Wass, Schuwirth & van der Vleuten (2009: e153) pose a number of questions regarding the assessment of professional behaviour, i.e. should professionalism be assessed as an all-inclusive and integrated entity or should it be broken down into explicit elements which are measured individually? Who should be involved in the assessment of professional behaviour; faculty, peers, patients and/or the students themselves? Should assessments be performed only in clinical contexts or under simulated conditions? How often should assessment of professional behaviour be done - regularly, after short observations or less often after intensive observation? For the most part these questions remain unanswered as there is no 'magic bullet' assessment tool for professional behaviour.

A number of methods have been described and are currently being used for the assessment of professional behaviour in health sciences education, these include: written and oral examination questions, observation by faculty during fieldwork, self-assessment, peer assessment, multi-source feedback, objective structured clinical examinations (OSCE's), standardized patients, actual patient's perceptions, surveys, critical incident reports and learner maintained portfolios (Gordon, 2003; Wilkinson, Wade & Knock, 2009; van Mook, Gorter, O'Sullivan, Wass, Schuwirth & van der Vleuten, 2009b). Rating scales – standardised and not – will often be used as part of these methods. Literature suggests that a single measure is not sufficient, but that a combination of available methods should be used so as to allow the triangulation of results (Van Mook et al., 2009b)

Assessment of professional behaviour of SU OT students during fieldwork relies on assessment by observation thereof in clinical situations. This method of assessment presents many challenges of which inter-rater reliability is the most significant.

2.5 Assessment by observation

Assessment by observation has many advantages; it measures the 'shows how' and 'does' end of Miller's pyramid and provides a valid context for the assessment of professional behaviour (Miller, 1990; Fromme, Karani & Downing, 2009; Zijlstra-Shaw, Robinson & Roberts, 2011). Some disadvantages of assessment by observation include it being time consuming, prone to sampling bias and the "Hawthorne effect" i.e. students being on their

best behaviour when they know they are being observed (Scwartz et al., 2009; Fromme et al., 2009).

Despite the disadvantages, “direct observation of the student performing a technical or interpersonal skill in the real, simulated or examination setting would appear to be the most valid way of assessing such skills. Unfortunately, the reliability of these observations is likely to be seriously low (Cannon & Newble, 2000: 190)”. This is an important point to consider as the issues of reliability and validity need careful attention when assessing competence. Reliability refers to the reproducibility or consistency of the assessment in respect of the situation, the assessors and the assessment tool, “ensuring aggregation of multiple assessments by multiple assessors”, while validity focuses on whether the assessment succeeds in testing the competencies it is designed to assess within the situation, “using authentic interactions”, by the assessors using the prescribed rating scale (Wilkinson et al., 2009: 554)

It is important to identify the factors that influence observation, judgement and rating of students’ professional behaviour as these factors highlight the inconsistencies in the process of assessment by observation. Kogan, Conforti, Bernabeo, Iobst & Holmboe (2011) conceived of a model that illustrates the process of direct observation and the factors affecting it. In terms of this model assessors observe students in terms of a frame of reference after which they assign meaning to, interpret and synthesise their observations into a rating. Other authors have also highlighted the importance of a collective and agreed upon understanding and definition of the constructs, outcomes and expectations (Schwartz et al., 2009; Wilkinson et al., 2009). This is an important point to remember as the assessment of professional behaviour and attributes generally presents assessors with a problem as these skills are more abstract and more difficult to assess than cognitive ability and clinical skills (Bossers et al., 1999; Larkin, Binder, Houry & Adams, 2002). If the constructs of professional behaviour to be assessed are not explicitly unpacked or discussed, assessors will use their own frame of reference to inform their assessment and this will result in subjective and widely varying interpretation of the constructs.

The expectations or outcomes should thus be explicitly defined and described (Larkin et al., 2002) so that they can drive the assessment processes by identifying, defining and communicating the expectations (skills and qualities) of what must be acquired by students, the level of competence at which the expectations must be met and when these expectations should be met (Kogan et al., 2011).

Many suggestions have been made to minimize limitations and maximize inter-rater reliability during assessment by observation (van Mook, van Luijk, O'Sullivan, Wass, Schuwirth & van der Vleuten, 2009c: e92; Larkin et al., 2002; Steinert et al., 2005; Schwartz et al., 2009). These include that: (1) assessors should be trained (Larkin et al., 2002; Steinert et al., 2005) and (2) the overall assessment of the student should be constituted from independent observations by different assessors over time, and (3) a longitudinal assessment of students' progress should be done.

As regards training of assessors it is possible to minimise these limitations by investing in improving the performance of the assessor (observer) in the use and interpretation of the rating scale. This is important as competent, prepared assessors are essential to ensure valid assessment of professional behaviour. As part of the training and development of assessors, it is important that consistent assessment methods with clear expectations are established, accepted, agreed upon and applied during assessment (Larkin et al., 2002). This can be achieved by describing and communicating each construct that is to be observed, setting clear standards by criterion referencing and deciding on the minimum standard acceptable before the assessment.

In addition to improving the performance of the observer, Cannon and Newble (2000) add that the method of scoring should also be addressed. Rating scales is one of the commonest tools used to retrospectively rate categories of behaviour. Global rating scales, although easy to create and widely used, are used inconsistently by assessors and are of little use to identify specific areas that need to be improved (Schwartz et al., 2009: 447). Other problems related to rating scales include scarceness of comments as well as 'halo' and 'horn' effects and 'leniency error' (van Mook et al., 2009b). The 'halo' effect occurs when one strong point of a student taints the assessor's judgement while the 'horn' effect occurs when one weak point overshadows the assessor's judgements. 'Leniency errors' occur when students are rated generously regardless of their actual performance. Rating scales are often used in combination with checklists. The validity of checklists depends on the extent to which the behaviours reflect the components being observed; although checklists can be subjectively interpreted, they are viewed as being more reliable that global ratings (Schwartz et al., 2009).

Differing levels of rigour with which assessors rate the same performance is a common problem. Apart from training the assessors, judgement of the student by different assessors and observations made in realistic contexts can help ensure that these observations are representative of the students' performance (van Mook et al., 2009c; Hodges, Ginsburg,

Creuss, Creuss, Delport, Hafferty, Ho, Holmboe, Holtman, Ohbu, Rees, Ten Cate, Tsugawa, van Mook, Wass, Wilkinson & Wade, 2011). Longitudinal assessment can ensure that the student is progressing on the professional behaviour continuum. Longitudinal assessment of professional behaviour can be collected in a portfolio to serve as a clear, accessible and evidence-based record (Rogers & Ballantyne, 2010) of the students' development of professional behaviour over the course of the entire undergraduate course (Bossers et al., 1999; York, 2003; van Mook et al., 2009b; van Mook et al., 2009d). Bossers et al. (1999: 120) further suggests that a Professional Practice Portfolio involves three phases: (1) the collection phase when written feedback, evaluation reports, placement evaluations, case studies, personal statements and goals are collected, (2) the reflection phase during which the student reflects on the materials gathered in terms of personal growth, process, learning and progression towards professional goals and (3) the selection phase when the student selects the items that demonstrate continuous learning and development to form the portfolio. The use of learner maintained portfolios to record the development of professional behaviour will thus also serve to engage students' in the learning process as they are required to reflect on their own performance and development (Yorke, 2003).

The literature discussed in this chapter is synthesised in Figure 2.

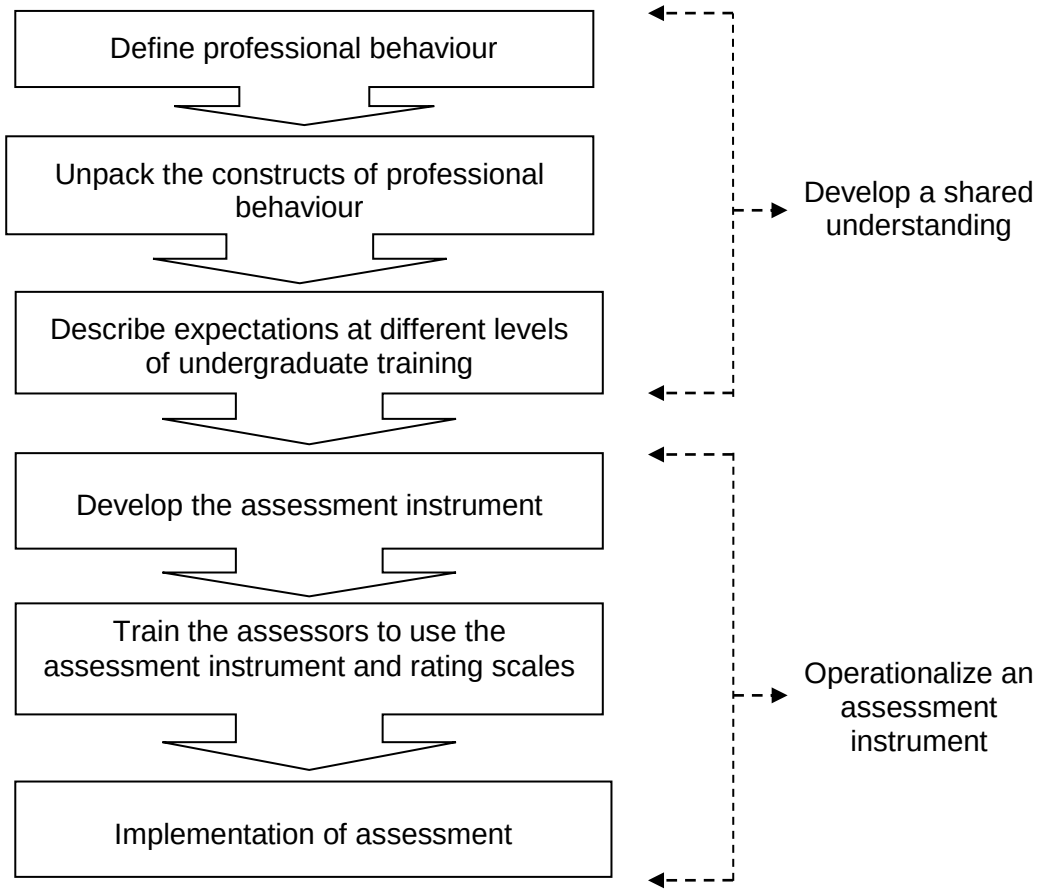

Figure 2: Process of optimising the assessment of professional behaviour

Given that the OT Division of SU uses assessment by observation, using rating scales and checklists for the assessment of professional behaviour, this study will focus on identifying the expectations SU clinical supervisors have for the assessment of students at third and fourth year levels of the course, thus the ***what*** question posed by van de Camp et.al (2006) will be addressed. This study will serve to describe the clinical supervisor's understanding of the constructs of professional behaviour, their perceptions of the current assessment instrument and expectations regarding the levels of competence required at third and fourth year programme levels in the assessment of professional behaviour of third and fourth year OT students.

2.6 Conclusion

This chapter provided an overview of current literature in the field of the assessment of professional behaviour and the practice of assessment of professional behaviour of third and fourth year OT students at SU. Chapter three documents the design and methodology followed during the study.

CHAPTER 3 - METHODOLOGY

3.1 Introduction

This chapter documents the research design and strategy giving insight into the qualitative and case study research methodology and methods used. Methods of data collection and analysis are described and discussed, assumptions and limitations are identified, rigor and reporting discussed and finally the issue of ethical considerations is dealt with.

3.2 Research design

The study was conducted within an interpretivist paradigm as it was aimed at ascertaining the meaning that individuals or communities assign to their experiences (Jansen in Maree, 2007). Researchers who do interpretive studies attempt to understand phenomena through the meaning attributed to them by people (ontology) and by analysing the situation under study to provide insight into the way a particular group of people perceive their situation or the phenomena they encounter (epistemology). Nieuwenhuis (in Maree, 2007:59) highlights the following common trend amongst interpretive researchers: “interpretive researchers start out with the assumption that access to reality (given or socially constructed) is only through social constructions such as language (including text and symbols), consciousness and shared meanings.” His view can be further explained by the statement that the interpretive paradigm is one focused on understanding the subjective world of the human experience and intentional, future-orientated behaviour or “behaviour-with-meaning” (Cohen, Manion & Morrison, 2003). Following the interpretivist paradigm, the researcher will be able to interact with the participants (clinical supervisors) to gain insight and form an understanding of their comprehension of the constructs and expectations used in the assessment of professional behaviour of third and fourth year OT students respectively.

Qualitative research stresses the importance of the subjective experience of individuals in the creation of their social world, it endeavours to understand the way in which the individual creates, modifies and interprets the world in which he finds himself (Nieuwenhuis in Maree, 2007). The following assumptions regarding the proposed study have been considered to justify the use of a qualitative paradigm to explore investigation of the constructs and expectations related to professional behaviour:

- the research design will be concerned with processes and not outcomes;
- the researcher was the primary instrument for data collection and analysis;
- the collection and subsequent analysis of data deals with meaning given to the constructs of professional behaviour by clinical supervisors;

- the process of analysis was inductive and involved interpretation and synthesis of the collected data.

3.3 Research strategy

The study was conducted by following a qualitative approach with a case study design. According to Nieuwenhuis (in Maree 2007) the emphasis of a case study design falls on gathering information to inform a specific practice or context. A further reason for the selection of the case study method was its facilitation of the gathering of in depth information about a particular situation. In the case of this study the research question related to clinical supervisor's understanding of constructs related to professional behaviour and expectations regarding the respective level of competence of third and fourth year OT students' professional behaviour during fieldwork based assessment. Thus, in this study the process of the assessment of professional behaviour constituted the case while the clinical supervisors (assessors) of third and fourth year OT students during fieldwork constituted the unit of analysis.

3.4 Practice at Stellenbosch University

At SU formal lectures of the theory of professional matters are staggered throughout the four year undergraduate course in preparation of students as health care professionals. In addition to lectures, students are given the opportunity to develop and demonstrate professionalism during fieldwork experiences in their third and fourth year. During these experiences students' are exposed to real-life learning environments that are instrumental in the development of professional competence. In order for students to develop into novice and ultimately competent, professional practitioners, it is crucial to offer sufficient opportunities for them to develop in terms of their professional behaviour, thus students are exposed to three fieldwork rotations in third year and four in fourth year; each fieldwork rotation is between five to seven weeks in duration, at a different fieldwork setting and students are supervised and assessed by different clinicians and clinical supervisors in each setting. Their level of competence is assessed according to specific assessment criteria.

The expectations are set and assessment guided by the subcategory of professional behaviour in the *Evaluation of Clinical Work Forms* (Addendum A & B) prescribed for each clinical affiliation in third and fourth year respectively. The constructs of professional behaviour that are to be assessed, are listed in the subcategory of professional behaviour in these forms (Table 1).

PROFESSIONAL BEHAVIOUR	
THIRD YEAR OT STUDENTS	**FOURTH YEAR OT STUDENTS**
1. Honours professional rules and ethical principles: • Benevolence • Autonomy • Truthfulness • Justice 2. Functions as a team member 3. Has knowledge of and uses correct communication channels 4. Use effective communication: • Gives and receives feedback • Response to feedback • Reflects on own task performance 5. Uses tutorials and opportunities 6. Adapts own behaviour according to patient response 7. Selects, organises and presents information correctly	1. Honours professional rules and ethical principles: • Benevolence • Autonomy • Truthfulness • Justice 2. Has knowledge of team members' involvement and involves them to benefit the patient 3. Interprets the OT contribution 4. Maintains/extends OT contribution 5. Maintains IPRs and communication: • Gives and receives feedback • Response to feedback • Reflects on own task performance 6. Regularly follows up on results 7. Clear formulation and presentation of own opinion

Table 1: Subcategory of professional behaviour for third and fourth year students

The student, clinician and clinical supervisor are involved in the assessment of professional behaviour. Clinicians are clinical occupational therapists employed at the institutions where students are placed for fieldwork who are involved in clinical supervision of students. Clinical supervisors are occupational therapists who are part time or full time employees of SU and who supervise students doing fieldwork at different institutions. In some instances the assessor is a part time clinical supervisor as well as the clinician and in others there are two individual assessors. An overview of the assessment form is given at induction of newly employed clinical supervisors, but no in depth on-going training is provided.

Observation by clinicians and clinical supervisors serves to inform assessment of professional behaviour. Informal observation of the students' professional behaviour by the clinician and clinical supervisor takes place throughout each fieldwork rotation. In addition, formal assessment thereof is performed twice during each fieldwork rotation; once during the mid-practical assessment and once during the final assessment. The current instrument allows for both summative and formative assessment of professional behaviour as it requires a percentage rating as well as feedback and recommendations regarding specific constructs

of professional behaviour. The rating during the mid-practical assessment serves to inform the student of his/her performance at that stage of the fieldwork placement and is justified and supported by the feedback based on observations and recommendations given by the clinician and clinical supervisor and is recorded as a preliminary mark. The rating given during the final evaluation, contributes to the formal mark for the fieldwork rotation.

SCALE	PERCENTAGE (%)
Outstanding (O)	80 - 100 %
Very Good (VG)	70 – 80%
Good (G)	60 – 70%
Satisfactory (S)	50 – 60%
Unsatisfactory (US)	40 – 50%
Poor (P)	30 – 40%
Very poor	0 – 30%

Table 2: Scale used when completing the *Evaluation form for Clinical Work*

The assessment commences with the student reflecting on his/her performance and performing self-assessment. During this process the student rates him/herself according to predetermined rating scales (Table 2) published in the *Guide for Clinical Work,* reflects and comments on his/her performance to motivate the rating. After the student has completed the assessment form, the clinician and clinical supervisor discusses the student's observed performance, rate it and record written feedback. Finally the student, clinician and clinical supervisor discuss the assessment, verbal feedback is given and recommendations for further development made.

3.5 Data collection

Qualitative data was collected in two waves by means of a focus group interview with clinical supervisors as well as during a separate participatory group process involving clinical supervisors during which the Participlan method was used.

3.5.1 Focus group interviews

Data collection started with a focus group interview. Focus group interviews originated in the late 1930's when a more non-directive approach to interviewing was developed. Focus group interviews are distinguished by a number of characteristics: they are contrived situations focused on the discussion of a topic of interest to the researcher, the interaction within the group leads to data and outcomes (Nieuwenhuys in Maree, 2007:90; Cohen et al., 2003). The contrived nature of focus groups can be viewed as both positive and negative – a

focus group is an unnatural setting, yet it is focused on a specific issue and will yield insights that might not have come to the fore in one-on-one interviews.

The focus group interview was conducted with six participants (see below for information on participant selection), during which an evaluation of the current instrument used in the assessment of professional behaviour of third and fourth occupational therapy students was done.

The researcher developed an interview guide consisting of four open-ended questions to set the agenda for the discussion within the focus group and to elicit maximum responses from participants. Design of the interview guide was informed by Lewis (2000), who holds that there are two important principles that the interview guide should adhere to: (1) questions should be ordered from general to more specific and (2) questions of greater significance should be placed early on the agenda, while less significant questions should be placed nearer to the end. The focus group interview was guided by the following questions:

- *What is your understanding of the term professional behaviour?*
- *How does the current assessment instrument help you to assess third and/or fourth year students' professional behaviour?*
- *Is the current instrument structured enough to guide you in your assessment of students' professional behaviour?*
- *In your opinion, what can be done to make the instrument more useful and user friendly?*

At the start of the interview, the researcher broke the ice and built rapport with the group by welcoming the participants to the group and ensuring that all group members were introduced to one another. She set the scene by giving an overview of the research questions as well as the aims and objectives of the study and by negotiating ground rules.

The focus group interviews were captured on a digital recorder (see below for a discussion of the ethical issues). The researcher tested and set up the microphone and recorder prior to the interview so that it was visible to all participants. Participants were encouraged to speak one at a time to ensure that all comments could be clearly recorded. The researcher made field notes after the session and the focus group interview was transcribed to facilitate data analysis.

Although the researcher made some notes during the focus group interview, she enlisted the help of an assistant to take notes during the interview so that she (the researcher) could focus on facilitating the discussion. The assistant was prepared for her task during a discussion that preceded the focus group interview. During this discussion the assistant was asked to keep question-by-question notes of her observations of proceedings, specifically noting verbal and non-verbal cues of participants. She was asked to identify group members in the notes by their initials so as to enable the researcher to identify the source of the data when transcribing the interview.

3.5.2 Participlan session

Participlan is a method that was developed by Business Presentation Group and is used in meetings, group discussions and workshops in the business world (Facilitate with Participlan, 2007). The Participlan method can be defined as a facilitation process that uses visual mapping to stimulate and support group participation and free flow of ideas in a focused, non-threatening environment (Participlan: Visual mapping for quick results, 2004; Facilitation, 2008). Although we find no references to describe this method being used for research data collection purposes, the process lends itself to the collection of rich data. During data collection group participation was facilitated by using this method to create a positive, non-threatening and engaging process. Sibbet (2010) suggests that the attention, engagement and participation of people can be 'pulled' by, amongst others, open questions/statements, silence and blank paper or blank spaces on display posters.

There are certain similarities between Participlan and the nominal group technique (Carney, McIntosh & Worth, 1996; Gordon & Hamer, 2004; Du Plessis, 2010). Both these methods:

- are highly structured,
- provide the opportunity to accomplish a considerable amount of work in a relatively short period of time,
- maintain focus on the objectives through carefully formulated questions,
- generate information that can be prioritised through group discussion and a voting process,
- validate all the contributions of all participants and
- keep dominant participants in check through the nature of the process.

In contrast to the nominal group technique where the participants contribute verbally, the Participlan method achieves anonymity through the use of cards by participants to communicate their ideas and opinions in written form (Facilitation, 2008). This distinctive characteristic of the Participlan method was instrumental in it being selected as the method of choice. The reason for this was that the group that were invited to participate in this

research project included persons who were involved in the development of the assessment instrument currently used in the OT Division at SU. Without the guarantee of anonymity this group might have been sensitive about potential criticism and could have become defensive about the information generated during the session. Had anonymity not been guaranteed, participants who were not involved in the development of the current instrument might have been inhibited in lieu of being seen as critical or judgemental. Another reason for the selection of the Particplan method was the fact that a concise visual record of input and the results of discussions would be generated on the posters with similar ideas clustered together, facilitating the process of prioritisation, and the results of voting would be recorded on the poster as a visual record of the session.

Given the lack of literature describing the Participlan process an extensive explanation will be given in this chapter.

The first participative group session took place one week after the focus group interview and the second two months after the first. The long time lapse between the two sessions was due to difficulty in co-ordinating the schedules of the researcher, facilitator and participants. During the sessions a trained, skilled Participlan facilitator created the opportunity for participants to anonymously write their ideas and opinions regarding pre-determined constructs onto paper cards to be displayed on posters.

Participants' attention was focussed on specific objectives by using incomplete statements which were carefully formulated to direct the discussion and prioritize information, thus enabling the group to focus their thinking and the researcher to gather information. The following four incomplete statements, addressing aspects of professional behaviour of OT students that are assessed during fieldwork, were used in this study:

- *A student who is able to function as a member of a team will…,*
- *A student who honours professional rules and ethical principles will...*,
- *A student who is able to build and sustain interpersonal relationships will...* and
- *A student who is able to communicate effectively will...,*

These incomplete statements were printed, displayed as a heading on a poster and used to facilitate, stimulate and focus the free flow of ideas as participants were given the opportunity to generate and write down a number of phrases that would complete the statements to reflect the behaviours that they expected students to exhibit in terms of each specific aspect of professional behaviour being addressed.

Participants received 30 blank cards (± 10cm x 15 cm) and a permanent marker on which to record their responses. They were requested to write legibly (visible to all participants from where they are seated) while responding to each of the incomplete statements by expressing themselves in brief sentences/phrases, generating as many ideas as possible in three minutes but writing only one idea on each card while avoiding “suitcase” words encompassing a number of concepts such as ‘communicate’. Participants were also requested to: give others space to think and contribute, discuss the principle (not the person) if and when conflict arose, speak one at a time and limit talking time to thirty seconds per idea. Sibbet (2010) suggests that the care taken during the orientation of participants will contribute to their productivity during the session and the quality of their contributions. The facilitator emphasised that all the ideas that were generated would be regarded as important and thus valued.

After the generation of ideas, the process proceeded to the clustering phase during which the participants were requested to each select the two most important ideas that they had generated and put these ideas forward to be clustered. The cards containing the two most important ideas of each participant were then handed to the facilitator. In order to ensure anonymity the cards were shuffled so that they would be put up in no particular order. The facilitator then commenced reading the first card out loud and stuck it, according to the recommendation of the group, onto a glued poster on the wall that provided a constant visual display of ideas. All subsequent cards were then viewed, considered by the group and placed as part of an existing cluster or as a new idea. Based on discussion in the group, cards were added on to clusters or shifted from one cluster to another and clusters were grouped or split. After the clustering of the first two ideas of each participant, the facilitator requested participants to review the cards they had not put forward in the first round to identify and put forward those cards containing ideas that were not yet represented on the cards stuck on the posters. This process ensured that all ideas participants wanted to share were displayed, discussed and clustered. This second collection of ideas was regarded as very important as it emphasised the notion that all the ideas that were generated, were important and valued.

The poster thus ultimately reflected all the ideas individuals in the group wanted to share and the results of the discussions and clustering. Anonymity was guaranteed by informing participants that they did not have to identify their cards/ideas during discussion. The meaning of cards could be clarified during group discussion and alternative opinions could be registered when participants disagreed with any opinion noted on a card.

After completion of the clustering of ideas, the facilitator summarized the main ideas represented in the clusters and proceeded to identify them alphabetically to facilitate the voting process. The summarizing of a discussion helps participants to consolidate their thinking and provides them with mental categories (Kaner, Doyle, Lindl & Toldi, 2007: 60). The facilitator then explained the dot-voting process and requested the participants to vote for each of the identified clusters according to its importance for third and fourth year students respectively. Participants were requested to consider the importance of each cluster in terms of its relative importance to third and fourth year OT students respectively. Each participant was then given orange and yellow dots to cast their votes according to the importance of each cluster for third and fourth year students respectively. The orange dots were marked with a three and the yellow with a four to prevent participants from getting confused about which colour represented which group of students. The number of clusters generated at each statement determined the number of dots that were provided for the voting process; eight dots of each colour was provided for voting when more than 16 clusters were generated and six of each colour when less than 16 clusters were generated.

During these sessions the incomplete statements related to teamwork, professional rules and ethical principles and interpersonal relationships generated more than 16 clusters and each participant was given eight orange and eight yellow dots for the voting process. The statement regarding communication generated less than 16 clusters, therefore each participant received six orange and six yellow dots for the voting process. The number of dots was limited to encourage the participants to prioritise their selections when voting while considering the relative importance of each cluster for third and fourth year students respectively. Participants were requested to vote for clusters that they thought were important for both groups of students with one sticker of each colour. After completion of the voting process the facilitator proceeded to the next statement and the whole process was repeated.

Involvement in the participative group process allowed participants to explore and express their own cognitive constructs of the specific aspects of professional behaviour as well as the behaviours students are expected to portray at third and fourth year level respectively.

It was deemed important to use a skilled facilitator to ensure a focused, productive discussion during which all participants could contribute to the ultimate product. Kaner et al. (2007) describes a facilitator as a person whose job it is to support participants to do their best thinking by encouraging full participation, promoting mutual understanding and

cultivating shared responsibility. The data generated during the session was analysed as part of the group process as the facilitator, informed by input from the group, clustered the responses to each incomplete statement on a poster; this led to the identification of themes that emerged from the information and ultimately, a voting process whereby participants could distinguish between expectations of importance for third and fourth year students respectively. The posters were photographed at the end of the session, thus together with the actual posters, producing a record of the discussion.

A video and audio recording (see below for a discussion of ethical issues) was made of the session to enable the researcher to review the session so that the rich data generated during the discussions could be analysed and interpreted. A video camera with microphone was set up on a tripod to make wide angled, static, audio-visual recording of the whole session. Participants were given the assurance of anonymity as the recording did not include any close-ups or face shots of the participants or the process of them generating specific written responses as its only intention was to produce a back-up recording of the session in addition to the researcher's field notes.

The researcher's role during the participative group sessions was that of an observer, she kept field notes, focusing on the actions and discussions as well as the situation so that these could be described in the context in which it occurred.

3.5.3 Target population, sampling and recruitment

Purposive sampling was done. Nieuwenhuis (in Maree, 2007: 79) states that "qualitative research is generally based on non-probability and purposive sampling…". They further propose that when purposive sampling is used the participants are selected because of defining characteristics, knowledge or experience identifying them as possible participants. Sampling decisions for qualitative studies are therefore made for the explicit purpose of identifying the richest possible source of information in search for the answers to the research question. The 19 clinical supervisors currently involved in the clinical supervision of third and/or fourth year OT students at US during fieldwork constituted the population from which a sample was drawn.

Focus group: According to Lewis (2000) the following considerations should govern the size of the focus group; the group should not be so large as to preclude adequate participation by most members, nor should it be so small that it fails to provide more data than could be collected in an individual interview. The total number of clinical supervisors currently involved in the clinical education of third and fourth year occupational therapy

students at US is nineteen (n = 19); of this group some are full time employees (n = 5) and others part time employees (n = 14) of Stellenbosch University. The nineteen clinical supervisors constitute a number of sub-groups, i.e.

- part time clinical supervisors supervising only third year students,
- full time lecturers supervising only third year students,
- part time clinical supervisors supervising only fourth year students,
- full time lecturers supervising only fourth year students and
- part time clinical supervisors supervising both third and fourth year students.

In order to obtain data that could be analysed and interpreted, the researcher selected participants' representative of all three sub-groups for the focus group interview.

Purposive sampling was done to select six participants for the focus group interview. After obtaining the clinical work schedules for third and fourth year students for 2011 from the Occupational Therapy Division of SU, six possible participants were identified. The constitution of the sample is illustrated in the table below (Table 3).

Clinical Supervisors (n = 19)	**Part time**		**Full time**	
	Total	**Sample**	**Total**	**Sample**
Supervising only 3rd year OT Students	n = 3	1	n = 1	1
Supervising only 4th year OT students	n = 5	1	n = 4	1
Supervising both 3rd and 4th year OT Students	n = 6	2	n = 0	0
Subtotal	14	4	5	2

Table 3: Sample for focus group interview

Six possible participants were selected and invited to participate via e-mail. Five of the six selected participants accepted the invitation and one declined due to prior appointments. An alternative participant out of the same sub-group (part time clinical supervisors supervising only fourth year students) was then selected and invited; she accepted. Five days before the focus group interview took place the researcher was informed that one of the selected participants could no longer participate due to illness. The alternative participant selected out of the same sub-group (full time clinical supervisors supervising only fourth year students) accepted the invitation extended to her. Care was taken to ensure that the constitution of the sample of participants for the focus group interview remained as planned.

Participative group session: In the case of the participative group session the sample potentially included all part time clinical supervisors and full time lecturers supervising SU OT students during fieldwork in 2011 (n = 19). All these clinical supervisors are routinely invited to quarterly clinical supervisors' meetings where training is offered and matters of interest are discussed. The use of one such meeting for a Participlan session during which data could be collected was negotiated with the Head of the OT Division at SU. The date for the Participlan session was scheduled in co-operation with the OT Division of SU; all clinical supervisors were invited to participate in the study via (1) a short presentation outlining the purpose of the study at the quarterly clinical supervisors meeting in May 2011 and (2) a follow-up e-mail that included information about the session and consent documents. Although all clinical supervisors were invited to the meeting, not all were able to attend. A detailed register was kept at the session to record the number and details of the participants (summarised in Table 4). The first participative group session was attended by 14 out of a possible 19 participants; according to the 2011 clinical work rosters for third and fourth year students one of these participants was a clinical supervisor involved with only third year students, eight supervised only fourth year students and five supervised both third and fourth year students during fieldwork affiliations throughout 2011. The second session was attended by 11 out of a possible 19 participants, of these one was a clinical supervisor involved with only third year students, three involved with only fourth year students and seven involved with both third and fourth year students.

Clinical Supervisors (n = 19)	Total	Present: Session 1	Present: Session 2
Supervising only 3rd year OT Students	n = 4	1	1
Supervising only 4th year OT students	n = 9	8	3
Supervising both 3rd and 4th year OT Students	n = 6	5	7
Subtotal	19	14	11

Table 4: Participants present at participative group sessions

3.6 Data analysis strategies

Henning (2004) describes the process of data analysis as the "heartbeat" of research as this is where the quality of the researcher's thinking becomes evident. The strength of an interpretive inquiry is not only in the use of multiple data collection methods, but also in the analysis of the data to build the interpretive text (Nieuwenhuis in Maree, 2007). In this study

both a focus group interview and a participative group session were used as methods to collect data.

Nieuwenhuis (in Maree, 2007:101) defines content analysis as a “systematic approach to qualitative data analysis that identifies and summarizes message content.” The term is used to refer to the analysis of written documents by looking at data from different angles with the aim of identifying key information in the text that will help us to understand and interpret the data. A verbatim transcription of the information collected during the focus group interview was done; this provided a complete record of the discussion and constituted the first step in the analysis of the data. Maree (2007) refers to the work of Lincoln and Guba when he suggests that the researcher will be able to study multiple constructed realities by listening to voices that differ from her own.

The researcher read and reread the transcription of the focus group interview before commencing with an inductive approach to the identification and categorization of units of meaning (codes). “Coding is the process of reading carefully through your transcribed data, line by line, and dividing it into meaningful analytical units” (Nieuwenhuis in Maree, 2007: 105). Content analysis was used to identify specific words, trends and patterns in the data of the focus group interviews. Nieuwenhuis (in Maree, 2007) describes this as an inductive and iterative process where the researcher looks for similarities and differences in text that will help her understand and interpret the data to reveal themes. To enhance the trustworthiness of the coding of data, the transcript of the focus group interview and the research objectives was sent to an independent coder with a post-graduate OT qualification to code and develop categories from the text, which was then compared to the researchers own codes and categories. The codes and categories of the researcher and an independent coder corresponded in terms of the themes and categories identified. Once all the data had been coded, themes identified and tabulated, inferences were made in order to address the research question.

As described in the previous section, during the participative group process analysis of data formed an integral part of the participatory process as clustering, categorization and prioritizing of data formed part of the process. The information gathered during the participatory group session was recorded in the field notes of the researcher, on photographs of the posters and in the video recording. The results of the voting process was recorded and summarized in a frequency table indicating the relative importance of specific behaviours expected of third and fourth year students respectively in terms of specific aspects of professional behaviour. The discussion documented in the video recordings and

the researcher's field notes were analysed and interpreted in relation to the abovementioned results of the process to constitute the totality of the data and add to the discussion of the process and its outcomes.

3.7 Rigor

Tuckman (1999:396-7) quotes the following methodological concerns associated with the qualitative approach that were raised by Guba and Lincoln; "the need to set boundaries and the importance of finding a focus to ensure a credible, appropriate, consistent, confirmable and neutral process". Truth value can also be termed credibility and relates to the researcher's job to represent multiple realities revealed by participants as accurately as possible. During the execution of the proposed research the researcher put the following measures in place to ensure trustworthiness of the research process:

- The researcher spent time ('prolonged engagement') with participants to immerse herself into the setting sufficiently to be able to identify and verify reappearing or recurrent patterns. To ensure that this was possible the time allocated for the focus group interview was one hour and two to three hours for each participative group session. The time spent with participants was deemed important, because as rapport increases, participants may volunteer different and often, more sensitive, information.

- The Participlan method is predicated on the principle that each participant's opinion is valid and can be heard. The rule of "what goes up, stays up", that refers to the cards that are posted onto the posters anonymously, ensures that all participants have equal opportunity to voice their opinion without the fear of being judged. This ensured that all voices were heard and not only those of the participant(s) with the strongest voices and/or opinions.

- To ensure that over involvement does not occur, the researcher kept a field journal in which she continuously analysed herself in the context of the research and reflected on her influence on data gathering and analysis. Writing these reflections aided the researcher in becoming aware of biases such as selection and respondent bias and preconceived assumptions so that methods or approaches could be altered to enhance credibility.

- Member checking is a technique whereby data is tested with the participants to ensure that the researcher had accurately transcribed and translated the informants' viewpoints into data. Henning (2004) refers to this process as "dialoguing the knowledge" or

"communication as validity." This technique was employed by the researcher when she sent the data, in the case of the focus group interview, the transcription of the interview to the participants for verification so as to decrease the chances of misinterpretations. In this case three out of the six participants responded to the transcription indicating they were satisfied that the transcript represented the discussion.

In the case of the participative group sessions, the posters were generated during the session with the responses and input of participants and were displayed for all participants to view. Each poster was photographed as a whole and the clusters displayed on each were photographed individually to ensure a detailed recording of the information generated during the session.

- Independent coding and examination involved the researcher inviting an independent coder to code the transcription of the focus group interview independently before comparing and discussing it with her own coding. She also discussed the research process and findings with an impartial colleague who has experience with qualitative research. The researcher identified such a person and these discussions contributed to deeper reflective analysis while increasing credibility.

- The researcher ensured that an external research audit to scrutinise and confirm the findings would be possible by keeping a rigorous record of the data gathering process, the data as well as data analysis. Data will be kept until the degree has been awarded and information has been published in the form of an assignment and/or article.

3.8 Assumptions and limitations

The study was restricted to one university; this implies limited transferability to occupational therapy education in general. Krefting (1991) and Graneheim & Lundman (2004) suggest that researchers are not required to provide an index for transferability; it however is their responsibility to provide a clear and distinct description of culture and context, selection of participants, methods of data collection and analysis as well as a rich description of the findings together with apt quotations that will allow transferability judgements to be made by others. Thus the findings of this study may well be viewed as interesting or relevant to occupational therapy educators at other institutions.

The study was limited in the sense that it dealt with espoused ideas rather than enacted assessment practice as it created the opportunity for clinical supervisors to discuss and

reflect upon the behaviours they expect to observe and assess in terms of professional behaviour of third and fourth year OT students. However, the possibility exists that their enacted behaviour could differ from these espoused ideas.

Some of the participants in the participatory group sessions and focus groups were involved in the design of the current assessment form used to assess the professional behaviour of third and fourth year OT students at US. If these participants felt threatened or judged by the investigation, they might have withdrawn or become defensive. The involvement of a skilled objective facilitator creating a non-threatening, voluntary participatory group session also counteracted this possibility. This was evident in the review of the videos as participants were interacting and sharing ideas freely. The study was also framed to communicate that the ultimate intention is not judgment, but to improve practice. It was evident in the willingness of participants to participate in the data collection sessions that they did not feel threatened or judged by the investigation.

Contrary to suggestions in literature that more than one focus group interview should be held to seek alternative perspectives (Nieuwenhuis, in Maree, 2007), the researcher decided to conduct only one focus group to discuss the current assessment instrument used for the assessment of professional behaviour. This decision was taken because the data collected in the participatory group sessions was the primary focus of the study, while the data collected in the focus group interview would serve to enrich the data by generating information regarding the strengths, weaknesses of the current assessment instrument. The decision was further informed by the limited time available for data collection and the fact that the possible participants were from a large geographical area. This made it difficult to get another group together in the same place at the same time for a second focus group interview. Although a second focus group interview could have provided additional information and confirmed the data collected in the first, the information gathered in the single focus group interview had substance that addressed the research question and provided the researcher with rich data.

It was deemed desirable for the process to be facilitated by a facilitator who was skilled and had the temperament to draw people out to voice their ideas and opinions, who would help people to feel heard, who would support people to keep thinking instead of shutting down. Kaner et al. (2007) describes the role of the facilitator to include four fundamental functions, namely to encourage full participation, promote mutual understanding, foster inclusive solutions and cultivate shared responsibilities. During the participative group session the first three functions were of utmost importance as the facilitator encouraged the participants to

participate, allowed discussion of responses to promote mutual understanding and included and involved the participants in the linking of ideas during the clustering phase.

The researcher and many of the participants have been employed as clinical supervisors at the University of Stellenbosch for some years; this could have led to bias caused by preconceived ideas and habits that had been formed over the years of being involved in supervision of students. The role of the researcher during the participative group sessions was that of observer. This was at times a difficult role to perform as she would have loved to interject to share her ideas with the group, but this was not allowed as it would have tainted the process. The accurate recording of the participants' contributions to the participatory group sessions on the posters and in the summary of the findings in chapter 3 of this study counteracted any possibility of the researcher imposing her ideas of beliefs on the information. No such bias in terms of participation was noted or recorded as all participants were willing to enter into open discussion of the instrument and the constructs involved in the assessment of professional behaviour of third and fourth year OT students.

Contrary to the initial planning, the first participative group session was insufficient to collect all the necessary data as all the incomplete statements could not be addressed. This necessitated a second session that took place two months after the first. The fact that a second session was needed could be seen as a limitation as the participants were 'alerted' to the issue of defining the constructs of professional behaviour during the first session, but the fact that the incomplete statements that would be addressed in the second session were not revealed during the first session counteracted this. The time lapse between the two sessions was due to difficulty in co-ordinating the schedules of the researcher, facilitator and participants. Eight of the fourteen participants who participated in the first session were available to participate in the second session, thus the composition of the participating groups in the two participative group sessions was different. Three of the participants in the second session had not been involved in the first; any problems that could have been posed by this was counteracted by ensuring that these participants satisfied the sampling criteria and orientating them to the Participlan-process and principles along with the remaining participants of the first session. Not only were there fewer participants in the second session, but the composition of the groups differed; in both groups there were only 1 participant who supervised only third year students, in the second session there were fewer participants who supervised only fourth year students (three as opposed to eight) and more participants who supervised both third and fourth year students (seven as opposed to five). Although this could have influenced the voting patterns in the dot-voting process, the increased number of participants supervising both third and fourth year students present at the second session,

could have partially compensated for the decrease in the numbers of participants supervising only fourth year students.

During the first participative group session participants were given five minutes to generate ideas and were asked to identify and put forward the five most important ideas they had generated. This resulted in the clustering of ideas taking up a lot of time as all ideas had to be clustered and many ideas were duplicated. It was thus decided that while the participative group process would remain the same for the second session, the participants would only be given three minutes to generate ideas and they would be asked to put forward the two most important ideas they had generated. Although this could possibly have attenuated the process, the data that was collected paints a different picture as after a first round of clustering participants were given a second and third opportunity to submit new ideas not yet displayed. The streamlining of the process resulted in the more economic use of time while generating a similar amount of information. In the first session one incomplete statement was addressed and it yielded 16 clusters of information, in the second session three incomplete statements were addressed and they yielded 19, 21 and 15 clusters respectively.

The posters of the participative sessions were summarised after the sessions. These summaries were not sent to participants for member checking. This might be viewed as a limitation, but due to time constraints and the participants being actively involved in the generation and clustering of information, the researcher decided not to engage participants in a member checking process.

3.9 Ethical considerations

3.9.1 Confidentiality

Participants were given the assurance that findings would be reported in such a way that no individual would be identifiable. According to Cohen et al (2003) participants who agree to face-to-face interviews should accept that the researcher cannot guarantee anonymity – at best she can promise confidentiality and non-traceability. Confidentiality implies that although the researcher knows who provided specific information, she will in no way make the connection known publicly. During the transcription of focus group interviews the names of participants was replaced with confidential identification codes. To ensure non-traceability the identification codes used in the transcribed information and the records attributing a specific code to a specific participant was kept separately. During the participative group sessions the researcher gave each subgroup of clinical supervisors (i.e. those supervising

only third year students, those supervising only fourth year students and those supervising both third and fourth year students) different colour cards to record their comments on. This was done to guarantee anonymity while enabling the researcher to establish which sub-group generated the information. Unfortunately there were only two clinical supervisors representing the group who supervised only third year students at the sessions, one at each session, thus their comments were easily identifiable. This did not seem to inhibit their participation in the group as they continued to contribute willingly. Information generated during the participatory group sessions were secured by: locking posters in a secure place, keeping electronic copies of photographs, video-recordings and summarised information on a password protected computer and back-up electronic copies on a password protected file saved on a memory stick. Paper copies are kept in a locked filing cabinet.

3.9.2 Informed consent

In his discussion of informed consent Mouton (2001) states that the researcher is obligated to explicitly communicate and discuss the aims and anticipated consequences of the research to individuals and groups that are likely to be affected by the study. In addition to the above information, participants were informed about measures to ensure confidentiality, the possibility of withdrawing without sanction, the researcher's and supervisor's names, and the possibility of receiving a summary of the results. Having communicated the above information, the researcher asked for and obtained written consent from all participants in both sessions. Permission regarding the audio recording of the focus group interview was asked verbally before the interview commenced, and all participants agreed to be recorded. Permission for the audio-visual recording of the participative group sessions was included in the participation information leaflet (Addendum C) that was given to participants before they consented to participate in the study, all participants signed the consent forms.

3.9.3 Objectivity and integrity in research

Researchers are obliged to disclose their theories, methods and research designs and report their findings fully without misrepresenting the results in any manner (Mouton, 2009). The researcher kept meticulous records to ensure that she is able to account for the methods used, data reported and interpretations made.

3.9.4 Approval to conduct the study

The researcher obtained approval to conduct the study form the Research Ethics Committee of the Health Sciences Faculty of the Stellenbosch University and commenced with the study only after ethical approval has been granted (Addendum D). (Ethics approval number: N11/03/090)

3.10 Conclusion

A detailed description of the research design and strategy of this study has been given. Data collection, analysis and reporting has been described, assumptions and limitations identified, rigor and ethical considerations have been accounted for. Chapter four presents the research findings.

CHAPTER 4 - FINDINGS

4.1 Introduction

The findings of the focus group interview and participatory group sessions will be presented in this chapter. The findings will be reported in three sections addressing: (1) clinical supervisors' understanding of the constructs, (2) perceptions of the current assessment instrument and (3) expectations regarding the levels of competence required at third and fourth year programme levels in the assessment of professional behaviour of third and fourth year OT students.

Findings based on data collected during the focus group interview will be discussed according to the themes and sub-themes identified and substantiated by quoting participants. To ensure anonymity of participants, quotes will be identified by the codes (A-F) that were allocated to each participant.

4.2 Understanding constructs related to professional behaviour

The definition and unpacking of constructs related to professional behaviour was addressed in both the focus group interview and in the participative group sessions.

4.2.1 Defining professional behaviour

The first of four questions addressed in the focus group interview was: *What is your understanding of the term professional behaviour?*

During the participants' discussion of their understanding of the term 'professional behaviour' it was evident that they defined it in general terms, including concepts of personal presentation, interpersonal relationships and professional parameters in their definition.

Themes	Sub-themes
Personal presentation	• Personal values • Work habits
Interpersonal relationships	• Patients • Colleagues
Professional parameters	• Ethical principles • Professional values

Table 5: Defining professional behaviour: themes and sub-themes

Personal presentation

Personal presentation, including personal values and work habits, captures the essence of how a professional person is expected to present themselves to patients and colleagues. Participants were of the opinion that personal values influence professional behaviour.

> *"I think it goes hand in hand with your values … how you live according to your personal and religious values … " (B)*

> *"In my view it is also very strongly about honesty … loyalty … not being too critical … integrity …" (F)*

Participants indicated that work habits such as appearance, punctuality, and timeous record keeping were important in terms of professional image.

> *"Your appearance, are you neat, is everything tucked in, are you clean … punctuality …" (A)*

> *"Punctuality in record keeping … handing things in on time …" (F)*

Interpersonal relationships

Participants were of the opinion that interpersonal relationships are an important concept when defining professional behaviour. The relationships professionals have with their patients and colleagues were addressed within this aspect of professional behaviour.

> *"it is about the manner in which you come across, are you friendly … not overly friendly … still have that distance … but in a way that people will feel comfortable to talk to you …" (A)*

> *"I think it is also about the manner in which you treat your patients and how you speak to them … communicate with them …" (C)*

> *"your behaviour towards your colleagues, you know … the physio, the speech therapist, the doctor or in ward rounds … how you come across." (C)*

Professional parameters

Participants viewed professional parameters such as ethical principles and professional values of importance when defining professional behaviour.

"… behaving in a way in which people see you as a professional person along with all the legal criteria that comes along with it …" (A)

"… the student spreading her time … to give equal attention and energy to patients … and also get other tasks done …" (F)

"I think it is also about adhering to the rules and regulations set by the institution… honouring and working according to the specific expectations set by the clinical area …" (B)

"Your ethics and things like confidentiality … handling of sensitive issues, disclosure …" (D)

4.2.2 Unpacking constructs related to professional behaviour

Two participatory group sessions were held during which four incomplete statements, addressing aspects of professional behaviour of OT students that are assessed during fieldwork, were presented to participants to complete. The incomplete statements were:

- *A student who is able to function as a member of a team will …,*
- *A student who honours professional rules and ethical principles will ...*,
- *A student who is able to build and sustain interpersonal relationships will ...* and
- *A student who is able to communicate effectively will ...,*

The participants were asked what they understood under each construct. The clusters of information regarding the constructs of teamwork, professional rules and ethics, interpersonal relationships and communication generated by the clinical supervisors have been grouped in themes where possible.

Teamwork

Participants indicated that a student who is able to function as a member of a team will: understand the working of a team as well as their own and other team members' roles, portray a professional image, have self-confidence, respect others and be adaptable, trustworthy and cooperative, use precise professional communication, share information and have good listening and conflict resolution skills, use time efficiently and behave in an ethical manner (Table 6).

Theme	Construct	Contents
Team roles and function	VII: Working of a team	• Knows and understands the working of the team • Able to contact team members effectively • Makes entries in patient files • Makes appropriate referrals to other team members when necessary • Conforms to the rules and norms of the team
	V: Role identity	• Understands the OT's role • Expresses how OT's role differs from that of other professionals
	VI: Team members' roles	• Knows and understand the roles and contributions of other team members
Personal presentation	VIII: Professional image	• Behaves professionally towards patients and staff • Courteous • Dresses neatly and according to the norms of the clinical area
	II: Self confidence	• Expresses their own opinion verbally • Confident in own knowledge • Confident in expressing their opinions in team meetings
Professional relationships	X: Respect	• Respectful relationships with team members • Respects others' opinions • Makes and prepares for appointments with team members
	IX: Adaptability	• Uses appropriate language in relation to team member • Adaptable in terms of time and treatment aims • Willing to move out of own comfort zone to accomplish general goals • Available – within limits
	XI: Trustworthy	• Takes responsibility • Performs and follows up on tasks • Fulfils the departmental duties expected of him/her
	III: Cooperation	• Actively involved in general tasks • Coordinates his/her therapy with other team members • Involves other team members in his/her treatment • Sets common goals for patient • Gets results in terms of patient treatment
Communication	XIV: Precise communication	• Able to communicate effectively and professionally • Able to convey own opinion clearly
	XII: Professional Communication	• Professional communication and use of language • Uses the correct (scientific) terminology to convey own opinion
	IV: Sharing	• Asks questions • Communicates with and gives feedback to OT and other team members regarding his/her clients • Gains knowledge regarding team members' treatment of patients • Initiates contact with team members when necessary • Actively participates in ward rounds
	XIII: Listen	• Able to listen
	XV: Conflict resolution	• Resolves conflict between self and team members
Work habits	IX: Efficient time use	• Timeous reporting in files for team's perusal • Punctual in the completion of tasks • Shows management abilities
Ethics	XVI: Ethical behaviour	• Maintains ethical behaviour towards patient and team members • Maintains open and honest behaviour • Contributes within the framework of OT and their training • Benevolent

Table 6: Themes and content of constructs related to teamwork

Professional rules and ethical principles

Participants indicated that a student who honours professional rules and ethical principles will: be honest and accountable, respect patients and colleagues and make them feel

comfortable, have a neat appearance, honour ethical principles such as confidentiality, informed consent and beneficence and discuss ethical dilemmas with mentors, ensure optimal and continuous treatment, communicate with patients and team members, discuss therapy, ask questions and do research to obtain more information, keep regular, concise and accurate records and understand and support professional behaviour (Table 7).

Themes	Construct	Contents
Professional relationships	X: Honest	• Honest in his/her communication
	VI: Respect	• Respectful of patients and colleagues • Respects patient in his/her context • Attends appointments with team members • Punctual
	IX: Attitude towards others	• Makes make colleagues and patients feel comfortable
Personal presentation	XVII: Appearance	• Dressed neatly and according to guidelines • Adheres to rules regarding uniform
Ethics	V: Confidentiality	• Confidential handling of patient information • Regards written reports as confidential
	XIX: Informed consent	• Acknowledge the autonomy of the patient • Will acquire informed consent
	III: Beneficence	• Puts the patients interests first • Has the best interest of the patient in mind • Attends to all his/her patients (equal attention)
	II: Ethical dilemmas	• Discusses ethical dilemmas with therapist/mentor
Clinical skills/practice	IV: Accountability	• Knows and applies professional and HPCSA codes of conduct • Does not discuss patients with non-HPCSA-members • Works according to the rules and regulations of the university • Remains within the scope of practice of OT • Understand they are liable for unaccountable practice and behaviour
	XIII: Optimal Treatment	• Prepares for treatment sessions • Strives for optimal treatment of patient
	XI: Continuous treatment	• Will ensure continuity of treatment
	XII: Question	• Questions current practice guidelines • Thinks critically
	XIV: Research	• Researches/finds out when they do not know
Communication	XV: Communication	• Correct communication with patients and team members
	VII: Accurate information	• Record accurate information in terms of her assessments
	XVI: Discuss therapy	• Discusses patient treatment with OT
Work habits	XVIII: Record keeping	• Writes clear daily reports • Concise record keeping
Professional parameters	XIII: Understand professional behaviour	• Attempts to understand the changing definitions of professional behaviour

Themes	Construct	Contents
	X: Support professional behaviour	• Supports acts of good professional behaviour • Speaks up against acts of unprofessional behaviour

Table 7: Themes and content of constructs related to professional rules and ethical principles

Interpersonal relationships (IPRs)

Participants indicated that a student who is able to build and sustain IPRs will: listen, observe role models, know him/herself, show compassion and be sensitive, honest, helpful, trustworthy, adaptable, receptive and accessible, respect professional boundaries, acknowledge team members' roles and be positive about OT, respond to evaluation and feedback, follow problem-solving and conflict resolution approaches, acknowledge diversity and respect confidentiality (Table 8).

Themes	Construct	Contents
Professional identity	XI: Positive about OT	• Feels accepted and positive about studying OT
	XVI: Observe role models	• Needs suitable role models • Needs acknowledgement of building and sustaining IPRs in training • Needs experience re building and sustaining IPRs in OT
	VII: Self-knowledge	• Aware of own limitations and strengths • Aware of own non-verbal communication
	XIX: Evaluation	• Needs to be evaluated re the building and sustaining of IPRs
Professional relationships	VIII: Compassion	• Shows empathy towards patient • Genuine interest in others
	IX: Sensitive	• Sensitive towards others' feelings • Communicates tactfully
	VI: Honesty	• Communicates honestly with team members
	XX: Helpful	• Being helpful
	XXI: Trustworthy	• Does what he/she has undertaken to do so that he/she can be trusted
	IV: Adaptable	• Ability to communicate on all levels • Knowledge of correct behaviour in various situations
	II: Receptive	• Open for the view of others'
	III: Accessible	• Being accessible
	XII: Respect	• Respect yourself and others
	XV: Professional boundaries	• Maintains a professional distance • Respects boundaries
	XVII: Team members	• Acknowledges the role of other team members

Themes	Construct	Contents
Communication	X: Listen	• Listens and does not only speak • Active listener, good listening skills • Ensures two-way communication
	I: Feedback	• Ability to handle feedback positively • Values both positive and negative feedback
	XIII: Problem solving approach	• Follows a problem solving approach
	XIV: Conflict resolution	• Able to resolve conflict • Resolves problems directly with the persons involved
Ethics	V: Acknowledge diversity	• Understands the patient in his/her context • Accepting of individuals and individuality
	XVIII: Confidentiality	• Respects the confidentiality of conversations

Table 8: Themes and content of constructs results related to IPRs

Communication

Participants indicated that a student who is able to communicate effectively will: respect others, be confident, know themselves and acknowledge their limitations, be able to explain the OT contribution, formulate and precisely communicate their own opinion, check spelling and grammar in written work, adapt their level of communication, practice two-way communication and be aware of non-verbal communication and be able to manage people, situations and relationships, resolve conflict, work towards outcomes and function as a team member (Table 9).

Themes	Constructs	Contents
Communication	I: Own opinion	• Formulates and expresses own opinion • Motivates own views • Conveys well-thought out opinions • Selective communication of ideas
	IV: Precise communication	• Precise and accurate when conveying own opinion • Concise • Correct use of terminology
	XIII: Spelling and grammar	• Checks spelling and grammar in written work
	IX: Level of communication	• Realistic • Adapts communication to the level of others • Takes the receivers' frame of reference into account
	X: Two-way communication	• Listens • Practices two-way communication
	V: Non-verbal communication	• Aware of own non-verbal output • Aware of the non-verbal communication of self and others
	XI: Conflict resolution	• Applies conflict resolution strategies

Themes	Constructs	Contents
Professional relationships	II: Respect	• Respects others
	XII: People, situations & relationships	• Able to manage people and situations • Builds and sustains good IPR's
	III: Team member	• Acknowledged as a member of the team • Gains the trust of the team
Professional identity	XIV: Self-confidence	• Conveys a positive, self-assured attitude
	VIII: Self-knowledge	• Uses reflection • Knows him/herself
	VII: Acknowledge limitations	• Acknowledge own limitations
	XV: OT contribution	• Knows what he/she is talking about • Clearly states OT contribution • Speaks with insight based on knowledge
Clinical skills/practice	VI: Works towards outcomes	• Works towards specific outcomes for the patient

Table 9: Themes and content of constructs related to communication

4.3 Perceptions of the current assessment instrument

The use and structure of the current assessment instrument was addressed in the focus group interview before asking participants to suggest possible ways to make the instrument more useful and user friendly. The discussion was facilitated by the following questions:

- *How does the current assessment instrument help you to assess third and fourth and/or fourth year students' professional behaviour?*
- *Is the current instrument structured enough to guide you in your assessment of students' professional behaviour?*
- *In your opinion, what can be done to make the instrument more useful and user friendly?*

4.3.1 How the current assessment instrument helps supervisors assess students

It is evident that the participants viewed the current assessment instrument as having positive features that assist them in the assessment of professional behaviour. The positive features, illustrated in Table 10, include the instrument being based on ethical principles, providing guidelines and allowing for more than one assessment opportunity.

Themes	Sub-themes
Ethical basis	• Minimum standards
Guidelines	• Breaks professional behaviour into smaller chunks • Uniformity • Informs student, clinician and clinical supervisor • Expectations vs. focus points
Learning opportunity	• Mid-practical and final assessments • Opportunity for feedback • Opportunity for recommendations for remediation • Multiple assessors involved

Table 10: Positive features of the current assessment instrument: categories and subcategories

Ethical basis

Participants viewed the ethical basis of the current form to be a positive attribute.

> *"… the background against which the form was compiled comes from the ethical principles and it can be taken back to the minimum standards set for a therapist … or a student to be able to qualify …" (F)*

> *"… it was not just thought up; it is based on a specific source and standards … not university-specific standards … international standards." (F)*

Guidelines

Participants acknowledge that the current assessment form provides guidelines that breaks professional behaviour into chunks, provides a basis for uniform assessments and informs all parties involved in the assessment of the content thereof.

> *"… it at least gives you guidelines …" (C)*

> *"… these guidelines then gives rise to uniformity in the sense that the student will know according to what he/she will be assessed and the clinical supervisor can say these are the aspects I will be looking at … then you can say this is the rationale for the mark given." (B)*

Learning opportunity

It is evident in the data that these participants were of the opinion that the current assessment instrument makes provision for more than one assessment opportunity, i.e. the mid-practical and final assessments.

"… this was a problem at the mid-practical assessment … has it improved?" (C)

"From mid to final in the third year you … even see the light comes on." (D)

Use of the assessment instrument also created the opportunity for feedback and recommendations for remediation.

"… often students will think they are professional, I dress smartly and I arrive on time … but the nice thing is - I'll kind of break it down and say you know but there were other smaller things … and they will start to see." (D)

"I always try and give them a small little goal … by the end of the week you are going to phone that parents. What are you going to ask? What is important?" (A)

"I try and lead them through that … planning their approach and not just: 'Come on now do it.' But: 'How are you going to do it?" (A)

The active involvement of the student, clinician and clinical supervisor was seen as a positive attribute as the assessment instrument serves as a guide for their discussion and the feedback given to the student.

"What helps me with this form is that … it is three people giving their opinions; the student, the clinician and the clinical supervisor. This helps me to put things into perspective." (B)

"I think these are good guidelines, but the interaction that takes place … that is what gives you the most corrective or most accurate information." (B)

4.3.2 The structure of the current assessment instrument

These participants were of the opinion that the current assessment instrument is not structured enough to ensure consistent and reliable interpretation and marks.

Themes	Sub-themes
Expectations	• Not clearly described • Inconsistent interpretation • Common expectations for third and fourth year • Differentiation between third and fourth year
Rating of performance	• Inconsistent interpretation • Inconsistent marking

Table 11: The structure of the current assessment instrument: categories and subcategories

Expectations

Participants identified a lack of specificity in terms of the description of expectations in the current assessment instrument as an issue, potentially allowing subjective interpretation rather than consistent interpretation by assessors.

> *"I think it is not described clearly enough, for me they are just headings … it has not been clearly qualified in terms of what we expect …" (F)*

Clinical supervisors were of the opinion that there some expectations that are common for third and fourth year students.

> *"I think there are certain things … whether you are first block 3rd year of last block 4th year that … should be there. Like some of the ethical kind of behaviour … confidentiality." (D)*

> *"… for me there are certain things like dressing neatly that is not negotiable, it is the same for third and fourth years …" (F)*

It is evident that clinical supervisors acknowledged that there should be a difference between what is expected of third and fourth year students respectively, but a clear differentiation does not exist.

> *"I know at the back of my head what I expect of a third and what I expect of a fourth year student. I don't think … I hope I don't … expect the same thing …" (C)*

> *"This makes me think of the difference between third and fourth year. I often sit with the third years and coach them through the process, but with a fourth year you expect that they will be able to do it independently." (E)*

Rating of performance

The data provides evidence that participants did not interpret the rating scales the same and therefore inconsistent marks are awarded to students.

> *"… it is sort of at our discretion and what is poor for you might be different for me." (D)*

> *"I can see a student behaving in a certain way and according to me that is good, but C can see a student behaving in a certain way and according to her it is satisfactory … and if you then add the issue of third and fourth year … it is very difficult to measure." (E)*

"… there is a lot of fluctuation in terms of marks given … and the correlation of the marks with the comments written. How was it measured?" (F)

4.3.3 Suggestions regarding the current assessment instrument

During the participants' discussion of possible ways in which the current assessment instrument could be made more useful and user friendly, participants were of the opinion that the current instrument and/or practices could be adapted to promote more valid and reliable assessment of professional behaviour. Suggestions included the unpacking and grading of the expectations, using portfolios and considering whether formative or summative assessment would be best.

Theme	Sub-themes
Unpacking the expectations	• Specifying, grading and weighting the expectations • Continuum of development • Context-specific opportunities and expectations
Proof of development	• Portfolios
Formative or summative assessment	• Giving a mark or not • Mediating and guiding students • Weighting • Entry to final exams

Table 12: Suggestions to make the assessment instrument more useful and user friendly: categories and subcategories

Unpacking of expectations

Participants believed that there is a need for the expectations to be unpacked to increase the specificity of expectations, to grade expectations on a continuum of development and to take content-specific factors into consideration.

Specifying, grading and weighting the expectations

Participants were of the opinion that the expectations regarding professional behaviour should be more specifically described so that everyone involved in the assessment will have a clearer view of what is expected at specific levels of undergraduate study and what will be assessed.

"… each of these things must be more specifically described and be graded … and that the tool of grading (… whether a student does something …) with help, with guidance and/or independent is taken into account. The student then knows what they have to be able to do and what help they can get with it …" (E)

"… then it would be telling them exactly what … it is like breaking the whole thing down … these are the skills that you need to develop" (A)

"The expectations must then be graded … so that we will specifically know … what do I expect of a 3rd year in the first affiliation, what do I expect at the end of 3rd year …" (C)

"If you sat with each of those and broke them down into sub skills of how those actually develop from the 3rd to the 4th year …" (A)

Continuum of development

The participants agreed that professional behaviour develops throughout the undergraduate years. They suggested that the expectations should reflect a continuum of development.

"I always say there is a fine line between being professional … it goes hand in hand with wisdom … we are working with the younger generation … the older you get, the wiser you become and then the professional behaviour comes in stronger." (B)

"… if we think about the development of skills … what we are talking about now is actually attitude … if you look at knowledge, attitude and skills … there is an element of knowledge … theory … they should know the four ethical principles, etc., but it is something within themselves … a value within themselves and you could look at it according to Bloom's taxonomy of how values develop …" (F)

"But now we assess them and we tell them you didn't do this, you didn't do that … I feel we should maybe say … this is a continuum, let's plot you … where are you, what evidence do you have to prove that you are here … and how are we going to get you from this point to the next …" (F)

Context-specific opportunities and expectations

Participants indicated that context-specific opportunities and expectations should be taken into account when assessing professional behaviour. They raised the issue that clinicians and clinical supervisors should inform students of context-specific expectations while orientating them to the fieldwork setting. In the case of the third year students it is suggested this be done in the first tutorial.

"I think when they (students) start an affiliation it is clearer to see what is expected of them in terms of patient treatment, because there is better criteria. We must maybe clarify the meaning of this (professional behaviour) so that the students will know what it

means in the environment they are in … How will you be able to act as a team member here … what are we going to expect of you. " (E)

"I am thinking of the subjects discussed in the tutorials … maybe this is also a subject … I think it could be the first one, when the orientation is done, where it should happen … be discussed." (E)

"The onus is also on the clinician and the clinical supervisor … they must ensure that there are opportunities where they can observe those aspects … you cannot observe a student doing something if you have not created the situation where the student can demonstrate it." (E)

Proof of development

Participants suggested that some record of development is kept to ensure that students have been exposed to and have mastered the important aspects of professional behaviour.

Portfolios

It is evident in the data that participants viewed a portfolio as a viable method of keeping track of students' development of professional behaviour.

"I think then we must think in terms of a portfolio … where they have to be able to deliver proof of … in the form of a report by the therapist to say that this student was able to present herself and her opinion well in the ward round …" (F)

"If you do something like a portfolio, you will have to develop a rubric or something according to which you can mark." (C)

"… because if you had almost like boxes that need to be ticked … by the end of fourth year this student must be able to do all these things … you've developed these skills … team member, communication channels, give and receive feedback." (A)

Formative or summative assessment

There were differing opinions amongst the participants about whether formative or summative assessment is more appropriate for the assessment of professional behaviour.

Giving a mark or not

Participants had questions regarding rating the performance of students according to a mark. Issues that were discussed included opinions that: the assessment process was more important than the mark given; marks are important to inform the student whether they

satisfy the expectations; and students who behave in a professional manner should be rewarded with marks.

> *"The process is why all of us do it, it is wonderful to be involved with students and to see how they develop … to speak to them about these things … what I try and do is make it explicit … what are their strong and weak points, what is easy or difficult for them … and then we have to give a mark. It might be wrong, but I often say, let's forget about the mark … where did you start … let us just aim at growing through the affiliation." (E)*

> *"… sometimes the students are so caught up with the mark, they miss the feedback because they are just waiting for the mark … and yet at other times that fail (mark) is important for the student to wake up … if it is just talked about, but it has been something major … they are not really so stressed about it because it doesn't determine whether they are going to fail or …" (D)*

> *"… at the end the student is a total packet, so I think it is important that if they have mastered these things and they act in the interest of the patient and the institution, then they must also be rewarded for that in their marks." (E)*

Entry to final exams

Participants were of the opinion that if professional behaviour is seen as a core subject or skill in OT education, it should have an equal weight in terms of students gaining entrance to their final exams.

> *"It relates to our sub-minimum mark … our clinical mark is what gives you entrance to the exam and not the mark combined with professional behaviour." (F)*

> *"… they must get a mark for clinical work and a mark for professional behaviour." (C)*

> *"… both marks are important … but they must not necessarily be combined into one mark." (F)*

> *"We can fail students because they do not have the clinical skills, but we cannot fail a student because they do not have professional … if we say it is a core (skill), then it must be weighted the same … because these are the standards. (F)*

4.4 Expectations of students

The results of prioritising expectations of students by way of voting regarding the constructs of teamwork, professional rules and ethics, interpersonal relationships and communication generated by clinical supervisors will be tabulated in this section. The constructs are

organised in the order of importance voted for in relation to the expectations for third year students. In tables 13, 14, 15 and 16 V3 represents the number of votes for third years and V4 the number of votes for fourth years. Only those clusters that received 30% or more of the votes were considered a priority for the respective year group.

4.4.1 Teamwork

In terms of teamwork, participants prioritised the following for a third year student i.e., to understand team members' roles and the working of a team; cooperate and share with team members; be trustworthy and respectful; use precise and professional communication; be self-confident and demonstrate a professional image and use time efficiently (Table 13).

For fourth year students, participants prioritised the following i.e., to: understand the working of a team and share and cooperate with the team; be trustworthy and adaptable; behave ethically and demonstrate a professional image; use precise communication; use time efficiently and understand and express (OT) role identity.

<table>
<tr><td colspan="2"><u>Common to both groups</u>

• cooperation (V3=8; V4=7)
• trustworthy (V3=8; V4=7)
• professional communication (V3=8; V4=7)
• professional image (V3=8; V4=6)
• precise communication (V3=7; V4=6)
• efficient use of time (V3=6; V4=6)
• sharing (V3=6; V4=7)
• working of a team (V3=6; V4=4)</td></tr>
<tr><td><u>Unique to third years</u>

• self-confidence (V3=7; V4=1)
• be respectful (V3=6; V4=3)
• understand team members' roles (V3=4; V4=1)</td><td><u>Unique to fourth years</u>

• be adaptable (V3=2; V4=7)
• behave ethically (V3=2; V4=7)
• resolve conflict (V3=0; V4=5)
• role identity (V3=3; V4=4)</td></tr>
</table>

Table 13: Prioritisation of constructs related to teamwork for third and fourth year students

It is evident that there is an overlap in the expectations in terms of teamwork for third and fourth year students respectively, but it is important to note that there are some unique expectations for both groups, i.e.: third year students are expected to be self-confident, respect team members and understand team members roles while fourth year students are expected to be adaptable, behave ethically, be able to resolve conflict and understand and express their (OT) role identity.

The construct not considered a priority for either group in terms of team work was the ability to listen.

4.4.2 Professional rules and ethical principles

Participants indicated that in terms of professional rules and ethics (Table 14), priorities for third year students were to: be accountable; be honest and respectful towards others and make them feel comfortable; provide optimal treatment; adhere to the ethical principles of beneficence, confidentiality and informed consent; discuss therapy and ethical dilemmas with therapist/mentor; record accurate information and keep regular, concise records and dress neatly and according to the rules.

Priorities for a fourth year student in terms of professional rules and ethics were to: be accountable; be honest and respectful towards others and make them feel comfortable; provide optimal and continuous treatment; adhere to the ethical principles of beneficence, confidentiality and informed consent; question current practices and use research to find information; keep clear and concise records; dress neatly and according to the rules and support professional behaviour.

<table>
<tr><td colspan="2"><u>Common to both groups</u>

• accountability (V3=10; V4=9)
• optimal treatment (V3=10; V4=7)
• respect (V3=9; V4=7)
• beneficence (V3=8; V4=7)
• confidentiality (V3=8; V4=6)
• honesty (V3=8; V4=6)
• attitude towards others (V3=5; V4=7)
• appearance (V3=4; V4=3)
• record keeping (V3=3; V4=5)
• informed consent (V3=3; V4=5)</td></tr>
<tr><td><u>Unique to third years</u>

• discuss therapy (V3=6; V4=2)
• discuss ethical dilemmas (V3=4; V4=1)
• record accurate information (V3=4; V4=2)</td><td><u>Unique to fourth years</u>

• question current practices (V3=1; V4=6)
• research to find information (V3=1; V4=6)
• ensure continuous treatment (V3=2; V4=5)
• support professional behaviour (V3=0; V4=3)</td></tr>
</table>

Table 14: Prioritisation of constructs related to professional rules and ethical principles for third and fourth year students

There is again a distinct overlap in the expectations in terms of honouring professional rules and ethical principles for third and fourth year students respectively. Unique for each group were: third year students are expected to discuss therapy and ethical dilemmas with the therapist/mentor and to record accurate information while fourth year students are expected to question current practices and use research to find information, ensure continuous treatment and support professional behaviour.

The construct not considered a priority for either group in terms of professional rules and ethical principles was the understanding of professional behaviour.

4.4.3 Interpersonal relationships (IPR's)

Priorities in terms of IPR's for third year students were to: be compassionate, sensitive, honest and adaptable while acknowledging diversity; listen and value feedback; observe role models; acknowledge team members' roles, be positive about OT and respect professional boundaries; follow problem solving and conflict resolution approaches; know themselves and respect confidentiality (Table 4.15).

Common to both groups	
• show compassion (V3=9; V4=6) • value feedback (V3=8; V4=8) • acknowledge diversity (V3=7; V4=8) • know professional boundaries (V3=5; V4=5) • observe role models (V3=7; V4=5) • be adaptable (V3=6; V4=9) • listen (V3=6; V4=10) • self-knowledge (V3=5; V4=3) • problem solving approach (V3=5; V4=4) • honesty (V3=4; V4=4) • conflict resolution approach (V3=4; V4=6) • be sensitive (V3=3; V4=3) • acknowledge team members' roles (V3=3; V4=4) •	
Unique to third years	**Unique to fourth years**
• be positive about OT (**V3=5**; V4=2) • respect confidentiality (**V3=3**; V4=1)	• be trustworthy (V3=2; **V4=3**) • be receptive (V3=1; **V4=4**)

Table 15: Prioritisation of constructs related to IPR's for third and fourth year students

For fourth year students, priorities were to: listen and value feedback; be adaptable and acknowledge diversity; follow problem solving and conflict resolution approaches;

acknowledge team members' roles and respect professional boundaries; observe role models; know themselves and be trustworthy and compassionate.

There is again an overlap in the expectations in terms of IPR's for third and fourth year students respectively. Unique expectations for both groups were for third year students to be positive about OT and respect confidentiality while fourth year students were expected to be trustworthy.

The constructs not considered a priority for either group in terms of IPR's were being helpful, respect, needing evaluation and being accessible.

4.4.4 Communication

In terms of communication, priorities for third year students were to: formulate and precisely communicate their own opinion; use two-way communication; communicate on the correct level; be aware of non-verbal communication; work towards outcomes; know themselves and have self-confidence; check spelling and grammar in written reports and communicate OT contribution (Table 16).

<table>
<tr><td colspan="2"><u>Common to both groups</u>

• own opinion (V3=10; V4=11)
• precise communication (V3=10; V4=9)
• two-way communication (V3=7; V4=5)
• self-knowledge (V3=4; V4=7)
• level of communication (V3=4; V4=6)
• self-confidence (V3=3; V4=3)
• OT contribution (V3=3; V4=6)</td></tr>
<tr><td><u>Unique to third years</u>

• be respectful (V3=8; V4=2)
• work towards outcomes (V3=5; V4=2)
• be aware of non-verbal communication (V3=4; V3=2)
• check spelling and grammar (V3=3; V=1)</td><td><u>Unique to fourth years</u>

• resolve conflict (V3=2; V4=5)
• manage people, situations and relationships (V3=2; V4=5)</td></tr>
</table>

Table 16: Prioritisation of constructs related to communication for third and fourth year students

Priorities for a fourth year student in terms of communication were to: formulate and precisely communicate own opinion; know themselves and have self-confidence;

communicate on the correct level; communicate OT contribution; use two-way communication; resolve conflict and manage people, situations and relationships,

It is evident that there is an overlap in the expectations in terms of communication for third and fourth year students respectively, but important to note that there are some unique expectations for both groups, i.e. third year students are expected to be respectful, work towards outcomes, be aware of non-verbal communication and check spelling and grammar while fourth year students are expected to resolve conflict and manage people, situations and relationships.

The constructs not considered a priority for either group in terms of communication were being acknowledged as a team member and acknowledging own limitations.

4.5 Conclusion

The data collected and resultant findings that were derived from the focus group interview and participatory group sessions were presented in this chapter. A number of themes and sub-themes regarding (1) the definition and constructs of professional behaviour and (2) the current assessment instrument used for the assessment of professional behaviour and (3) the differentiation between the expectations for third and fourth year OT students at SU that have been identified will be discussed in Chapter five.

CHAPTER 5 - DISCUSSION AND RECOMMENDATIONS

5.1 Introduction

The study was guided by the following questions*:*

To what extent do clinical supervisors (assessors) have a common understanding of the constructs of professional behaviour and respective levels of competence required at third and fourth year programme levels in the assessment of professional behaviour of occupational therapy students at one university?

How do clinical supervisors perceive the current assessment instrument used for the assessment of professional behaviour at this university?

5.2 Discussion of findings

Clinical supervisors at SU have a varied understanding of professional behaviour. When asked to define it, they generated a general definition that, broadly, includes the themes of personal presentation, interpersonal relationships and professional parameters. This broad definition of professional behaviour is problematic as it invariably leads to a lack of a clear breakdown of the constructs of professional behaviour into behaviours that are observable and measurable (Wilkinson et al., 2009; Schwartz et al., 2009) that forms the basis of assessment by observation.

Assessment by observation is the method of assessment employed at SU for the assessment of professional behaviour. If observational assessment of professional behaviour rests on a general - often idealised - definition, educators involved in the assessment of professional behaviour may think that they will recognise professional behaviour when they see it, but they may not be able to articulate the attributes and behaviours characteristic thereof (Steinert et al., 2005).

Although clinical supervisors at SU are able to identify and state behaviours they expect students to exhibit in relation to the specific constructs of professional behaviour that are assessed in the *Evaluation of Clinical Work Form*, they identified a wide range (between 15 and 21) of expected behaviours regarding each construct of professional behaviour, some of these expected behaviours were duplicated and featured as an expected behaviour related to all (for example respect) or more than one (for example conflict resolution, honesty, adaptability, listening skills) of the constructs.

The large number of expected behaviours identified in relation to each construct leads us to infer that individual clinical supervisors (assessors) at SU regard a number of behaviours when assessing professional behaviour. It is important to note that, if left to their own devices, assessors' may vary as regards the behaviours they attend to during assessment, how behaviours are appraised and the behaviours they consider important when providing global evaluations of professional behaviour (Rogers & Ballantyne, 2010). Under these circumstances, each assessor will consistently use their own frame of reference (personal and professional values, knowledge and experience) as the lens through which they will observe students, infer meaning and interpret observed behaviour (Kogan et al., 2011).

The current assessment instrument, the *Evaluation of Clinical Work Form*, provides evidence of the effort that has been made to structure and guide the assessment of professional behaviour of third and fourth year OT students during fieldwork. Although clinical supervisors at SU acknowledge that the form provides a guideline in terms of the assessment of professional behaviour during fieldwork, they are of the opinion that it lacks specificity in terms of the description of constructs and expectations to prevent subjective and ensure consistent interpretation by assessors. This echoes literature stating that subjective interpretation results in assessment that is based on assumptions in terms of what is expected (Kogan et al., 2011). This again emphasises the point made about the importance of a common understanding of the constructs of professional behaviour and the explicit breakdown of the constructs of professional behaviour into behaviours that are observable and measurable (Wilkinson et al., 2009; Schwartz et al., 2009).

There is awareness amongst clinical supervisors that these differences in interpretation raise questions about the content and face validity of the current assessment instrument. Content validity is described as the extent to which the assessment measures what it is supposed to and face validity as the acceptability of the assessment to users (assessors and students) in determining its usefulness to measure what it sets out to (Armin, Seng & Eng, 2006: 8-9). If individual interpretations of the constructs of professional behaviour are allowed, each assessor will assess students in terms of those behaviours that he/she deems important, leading to compromised content validity. Compromised content validity will ultimately impact on face validity as inconsistent interpretation of the constructs of professional behaviour by assessors will confuse students and result in what could be regarded as unfair and unreliable assessment.

Subsequently, clinical supervisors spontaneously voiced the need for a clear definition of the constructs of professional behaviour as they were of the opinion that this would result in the

assessors having a clear and uniform understanding of what is to be assessed. Developing and expressing clear, measurable expectations to ensure valid and reliable assessment of professionalism by different assessors for students at different levels of training and in different settings and explicitly communicating this information to assessors and assessees is supported in the literature (Larkin et al., 2002; Schwartz et al., 2009).

The duplication of expected behaviours further emphasises the issue of content validity as a student could be penalized for the same mistake or inability ("horn effect") or, conversely, benefit more than once during the same assessment opportunity ("halo effect"), thus impacting on fair and reliable assessment (van Mook et al., 2009b). In addition to validity, this raises the issue of reliability, specifically inter-rater reliability, in terms of the assessment of students' performance by different assessors. This is an important point to consider as individual interpretation and duplication of constructs may lead to subjective interpretation of behaviours resulting in unreliable assessment.

Thus it is not only important to (1) have a clear, agreed upon definition of professional behaviour (Larkin et al., 2002; Rogers & Ballantyne, 2010), but educators should also be able to (2) articulate the attributes and behaviours that characterise it (Steinert et al., 2005) and (3) share a common understanding of the constructs and behaviours that distinguishes it as this will make the implicit explicit and improve the assessment thereof (Schwartz et al., 2009; van Mook et al., 2009b).

The assessment of professional behaviour is further complicated by the need to differentiate between the expectations of third and fourth year students respectively. It is evident that clinical supervisors view the development of professional behaviour as a process, and even though there is an overlap between what can be expected of third and fourth year students, there are unique expectations to each year of undergraduate study. It is thus important to consider the voting patterns of clinical supervisors when confronted with prioritising the behaviours identified during the participative group sessions. The voting indicates that there are behaviours that are: (1) 'generic', i.e. important for third and fourth year students, (2) expected of third year students, (3) expected of fourth year students.

Clinical supervisors at SU acknowledge that there should be a difference between what is expected of third and fourth year students, but are of the opinion that a clear differentiation does not exist. They view the 'generic' expectations in the current assessment instrument as cause for concern as it does not provide enough scope to differentiate between the level of expectations for third and fourth year students. Larkin et al. (2002:1251) states that: "As

assessment progresses over the course of training, it must become increasingly more sophisticated to capture the many nuances of professional behaviour and development." This is an important factor to keep in mind as professional behaviours are not inherently present in students, but emerge by way of a developmental process that requires careful nurturing on the part of educators, clinicians and clinical supervisors (Kasar & Muscari, 2003:43). This progressive developmental process that should be evident in expectations at the different levels of undergraduate study and reflected in the assessment instrument is currently not reflected to the satisfaction of clinical supervisors in the SU assessment instrument.

When scrutinizing the unique expectations regarding the constructs of professional behaviour (Table 17) for third and fourth year students respectively, some progression in terms of expectations is evident in the data; i.e. in terms of teamwork third year students are expected to be self-confident, respect team members and understand team members roles while fourth year students are expected to be adaptable, behave ethically, be able to resolve conflict and understand and express their (OT) role identity. These expectations illustrate expected progression from third year ("knows" and "knows how") to fourth year ("shows how" and "does") (Miller, 1990), but are unfortunately not explicitly expressed in the current assessment instrument.

Construct	Unique expectations of third year students	Unique expectations of fourth year students
Teamwork	• Self-confidence • Respect team members and understand their roles.	• Adaptability • Ethical behaviour
Professional rules and ethical principles	• Discuss ethical dilemmas with therapist • Record accurate information	• Question current practices • Use research to find information • Ensure continuous treatment • Support professional behaviour
Interpersonal relationships	• Positive about OT • Respect confidentiality	• Trustworthiness
Communication	• Respect • Work towards outcomes • Aware of non-verbal communication • Check spelling and grammar	• Resolve conflict • Manage people, situations and relationships

Table 17: Unique expectations for third and fourth year students regarding the constructs of professional behaviour

Literature reveals that it is to be expected that the expectations of third and fourth year students cannot be the same as students should demonstrate some progression over the course of undergraduate training and experience during fieldwork. As the students are exposed to multiple fieldwork settings, they are offered real-life experiences involving professional socialisation during which aspects of professional behaviour are developed through practice, experience, role mentorship and evaluative feedback (Kasar & Muscari, 2000). There is a progression of skills involved, therefore the level of intellectual and professional development of students has to be borne in mind so that assessment progresses form the basis of knowing to the ability to apply knowledge and ultimately to professional behaviour in real life situations (Kasar & Muscari , 2000; Yorke, 2001; Larkin et al., 2002; Epstein & Hundert, 2002). This progression should be reflected in the assessment instrument.

Some expectations that were recorded during the participatory group session were not voted for as priorities for either third or fourth year students during the prioritisation phase of the process. This reiterated the notion of subjective interpretation of expectations. Some information that was seen as important enough to mention in the information generation phase of the session, was not deemed important enough by the group to be voted for. This underlines that if the expectations for the assessment of professional behaviour are not specified, participant(s) who generated the expectations that were not voted for will continue to use these during student assessment, thus compromising the reliability and validity of the assessment (Schwartz et al., 2009; van Mook et al., 2009b).

It is evident that there are different views amongst clinical supervisors regarding the formative and/or summative assessment of professional behaviour. Those clinical supervisors that feel strongly that professional behaviours are acquired through a developmental process, favour formative assessment. The learning and learner-centeredness of formative assessment fits in well with this perspective. On the other hand, some clinical supervisors viewed summative assessment as being important to inform students whether they satisfy the expectations. Furthermore, those students who consistently behave in a professional manner are ‘rewarded’ with marks. During the discussion it became evident that, clinical supervisors viewed the striking of a balance between formative and summative assessment of professional behaviours as important. The view prevailed that the development of professional behaviour should also be attended to while the importance of professional behaviour as a core subject or skill in OT education also be kept in mind. The need for both formative and summative assessment used as complementary approaches in the assessment of professional behaviour is generally agreed

upon in literature (Larkin et al., 2002; Schwartz et al., 2009; van Mook, van Luijk, Fey-Schoenmakers, Tans, Rethans, Schurwirth & van der Vleuten, 2010) as the assessment thereof may be used to help students improve their performance as well as confirming their competence.

During the discussion of possible ways in which the current assessment instrument could be made more useful and user friendly it was evident that clinical supervisors were of the opinion that the current instrument and/or practices could be adapted to promote more valid and reliable assessment of professional behaviour. Suggestions like the unpacking and grading of the expectations has been discussed earlier in this chapter. Other suggestions included the use of portfolios to provide a longitudinal record of the students' development of professional behaviour. It was suggested that a portfolio-based assessment system could be used to keep track of and record students' development so as to ensure that students have been exposed to and have mastered the important aspects of professional behaviour by the time they graduate. Literature both advocates for and describes the use of portfolios as a tool in the assessment of professional behaviour (van Mook et al., 2009b; Wilkinson et al., 2009) as they could potentially provide evidence of competence and progression. They may also stimulate reflection, an essential component of professional behaviour (Zijlstra-Shaw et al. 2010: 5).

5.3 Limitations of the study

Various limitations were highlighted in chapter three. Two will be highlighted here, in view of the results obtained.

Although the participative process followed during data collection created the opportunity for clinical supervisors to express their own opinions and discuss the expectations regarding the constructs of professional behaviour, the information at best provides a platform that can inform further discussion and refinement of the constructs.

The study population was limited to clinical supervisors at SU and thus depicts only this group's understanding of the constructs of professional behaviour, only their perception of the assessment instrument and only their opinion in terms of the respective expectations of students in the third and fourth year of undergraduate study. As clinicians observe students more regularly during fieldwork and they are actively involved in the assessment of professional behaviour, their opinions should also be heard. Although this impacts negatively on the generalizability of the study, the correlations to recent literature relating to the

assessment of professional behaviour indicates that the findings might well be transferable and have meaning in other contexts.

5.4. Recommendations

5.4.1 Recommendations for practice

A systematic and integrated development programme to promote the assessment of professional behaviour could have a positive influence on this practice at the SU OT Division.

Firstly, there is a need to ensure that clinical supervisors approach the assessment of professional behaviour with a shared mental model that includes explicit information clarifying expected behaviours and levels of competence at different levels of undergraduate training. Processes to ensure a common understanding of the definition of professional behaviour, the identification and description of the characteristics that distinguish it and the behaviours that are expected at different levels of undergraduate training need to be discussed and developed. This is extremely important given that assessment by observation is the assessment method of choice in this setting.

This should be done with the cooperation and involvement of clinical supervisors and clinicians as this is likely to improve their commitment to the process (Norcini & Burch, 2007). The Bossers et al. (1999) study that is used as the basis of the professionalism module at SU and the results of the participative group sessions recorded in chapter four of this study can be used as the basis of such a discussion. The results of this process should be included in the annual Guide for clinical work as a reference for clinical supervisors, clinicians and students during assessment.

Secondly, staff development and training, is a refrain that is repeated in literature as one of the most effective ways of ensuring valid and reliable assessment of professional behaviour (Larkin et al., 2002; Steinert et al., 2005; Kogan et al. 2011). Observational assessments also require staff to have been trained for greater reliability (Zijlstra-Shaw et al. 2011: 5). It is thus recommended that a staff development programme be developed for clinical supervisors and clinicians involved in the supervision of third and fourth year OT students during fieldwork. This should be approached as a systematic and inclusive process aimed at:

- communicating the definition and constructs of professional behaviour,
- identifying and clarifying the behaviours expected at different levels of undergraduate training,

- training clinical supervisors in the use of the assessment instrument,
- training clinical supervisors in the use of the rating scales,
- training clinical supervisors to translate their observations and judgements into numerical ratings and
- addressing the importance of feedback.

Initially, all clinical supervisors and clinicians currently involved with supervision of third and fourth year students during fieldwork will have to be trained. Subsequently, provision will have to be made for new staff to be trained as they join the ranks as well as for possible follow-up retraining as time passes.

Thirdly, the possibility of using a portfolio-based assessment system for recording the longitudinal development of professional behaviour should be investigated and discussed with assessors. A portfolio could contribute to the longitudinal evaluation of students' progress in terms of the development of professional behaviours. This record illustrating the longitudinal development of professional behaviour is extremely important when students only have transient interactions with a number of clinical supervisors over the course of third and fourth year undergraduate training. This longitudinal record would contain numerous 'snapshots' of students' development of professional behaviour that, when collated into a portfolio, could provide a clear picture (body of evidence) on which summative assessments can be based (Wilkinson et al., 2009:552).

5.4.2 Recommendations for further research

Before embarking on a staff training programme the opinions of clinicians supervising students during fieldwork should be investigated to ascertain if their opinions regarding the assessment of professional behaviour correlates with those of the clinical supervisors reported in this study.

Research regarding students' perspective of current assessment practices used to assess professional behaviour could add an interesting perspective.

It could also be interesting to research assessment practices at other South African universities to ascertain whether they experience the same problems and/or learn from their best practices.

It is proposed that an action research project could be undertaken to adapt and refine the current assessment form used for the assessment of professional behaviour of OT students at SU displayed by OT students during fieldwork placements.

5.5 Conclusion

In this chapter the findings of this study have been discussed, additional limitations identified and recommendations for practice and future research has been made. The conclusion to this study will be recorded in Chapter six.

CHAPTER 6 – CONCLUSIONS

Although professionalism is regarded as a core component of occupational therapy education, the findings of this study resonates with those found in literature that indicate that assessment of professional behaviour as an aspect of professionalism is generally regarded as difficult. This difficulty arises because of the complexity of professional behaviour as a construct and, if not addressed, will result in invalid and unreliable assessment thereof.

This study has illustrated that clinical supervisors at SU do not have a shared understanding of the constructs of professional behaviour. They acknowledge that, left to their own devices, they interpret and assess professional behaviour through the lens of their personal frames of reference. There is an expressed need amongst this group for the constructs of professional behaviour to be clearly defined and the expectations explicitly stated to limit subjective interpretation and enhance more valid and reliable assessment of the constructs of professional behaviour.

Clinical supervisors who participated in the study were objective in their discussion of the assessment instrument currently used for the assessment of professional behaviour. They demonstrated an awareness of some positive attributes of the current instrument, but they were also critical about the lack of specificity and the grading of expectations.

Clinical supervisors further view the development of professional behaviour as a process, and even though there is an overlap between what can be expected of third and fourth year students, there are unique expectations to each year of undergraduate study. The need for explicit differentiation between the expectations of third and fourth year students respectively has been identified and should be attended to.

Clinical supervisors also identified the need to keep track of and record students' development so as to ensure that students have been exposed to and have mastered the important aspects of professional behaviour by the time they graduate. The use of portfolios to establish a record of the longitudinal development of students' professional was suggested.

This study confirms that the development of effective assessment of professional behaviour entails a number of pivotal steps that include developing a shared definition of the constructs thereof and the expectations at different levels of undergraduate training, the development of an assessment instrument and training of assessors in the use of this assessment instrument. It has highlighted that competent and prepared assessors are essential to the

valid assessment of professionalism. Development programs should ensure valid and reliable assessment methods with clear expectations developed, accepted and applied. It is important that assessors are involved in the process of developing standards for behaviour and adhere to them. At SU, effort should be put into training and empowering assessors (clinical supervisors and clinicians) regarding the constructs of professional behaviour, the expectations at the level of third and fourth year undergraduate study and use of the assessment instrument.

The development of more valid and reliable assessment practices will require commitment from the SU Division of Occupational Therapy, clinical supervisors and clinicians. Resources, in the form of staff and time needed, should be allocated to further research and develop the assessment instrument and training course so as to enhance the assessment of professional behaviour at SU.

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ADDENDUM A: B OT III EVALUATION OF CLINICAL WORK

STELLENBOSCH UNIVERSITY
B.OCCUPATIONAL THERAPY III
CLINICAL WORK EVALUATION
AFFILIATION 1

Student:	Duration from: to
Institution:	Section:
Work hours:	No. of hours from student register:
No. of days absent:	Time caught up:

	Mark allocate to specific section of evaluation (%)	**Calculation of final mark**
1. Long-term case: Theory and Practical		35%
2. Clinical work over duration of affiliation with regards to patient care and the ability to render an Occupational therapy service through optimal use of knowledge and skills.		50%
3. Professional conduct, communication and work habits		15%
	FINAL MARK	

SIGNED:

Clinical Therapist: _____ Date: _____

Student: _____ Date: _____

Lecturer: _____ Date: _____

O	=	Outstanding	(80-100%)
VG	=	Very Good	(70-80%)
G	=	Good	(60-70%)
S	=	Satisfactory	(50-60%)
U	=	Unsatisfactory	(40-50%)
P	=	Poor	(30-40%)
VP	=	Very poor	(0-30%)

		FINAL		
STUDENT		**ST**	**OT**	**LECTURER/OCCUPATIONAL THERAPIST**
	1. **CONSULTATION IN DELIBERATION** 1.1 Understands precautionary measures/special requests and acts accordingly 1.2.1 Is able to discuss referral in terms of OT interventions 1.2.2 Has knowledge about the contributions of other team members. 1.3.1 Condition: knows and discusses: etiology; pathology; medication; course and prognosis 1.3.2 Understands and uses correct terminology regarding condition, circumstances and treatment.			
	MARK (out of 10)			

		FINAL		
STUDENT		**ST**	**OT**	**LECTURER/ OCCUPATIONAL THERAPIST**
	2. **ASSESSMENT** 2.1.1 Identifies and uses all appropriate data sources: - file - collateral - patient 2.1.2 Follows correct procedures to extract information 2.1.3 Medical information is accurately conveyed 2.1.4 Understands the 2.1.5 Presents personal information accurately and fully 2.2 Utilises all available opportunities for assessment 2.3 Able to identify correct assessment methods/ techniques 2.4 Observations are accurate and comprehensive 2.5 Conducts interview systematically 2.6.1 Knows and uses assessment principles correctly 2.6.2 Executes assessment methods/techniques correctly and comprehensively 2.7 Activity history is comprehensive, accurate and from the patient's perspective. 2.8 Practices skills in application of techniques/ methods 2.9.1 Able to integrate assessment information 2.9.2 Understands effect of illness on life style, roles and developmental tasks 2.9.3 Able to give a reasoned account of impact of illness/relevant aspects on ADL 2.9.4 Able to provide an integrated account of patient's assets and problems related to lifestyle and aims 2.10.1 Able to determine patient's assets 2.10.2 Able to determine patient's problems 2.10.3 Understands prioritisation of problems			
	MARK (out of 60)			

		FINAL		
STUDENT		**ST**	**OT**	**LECTURER/OCCUPATIONAL THERAPIST**
	3. **PLANNING** 3.1.1 Identifies correct OT programmes 3.1.2 Able to motivate OT programmes 3.2 Involves patient in assessment planning 3.3.1 Scheduling is comprehensive 3.3.2 Student adheres to plans 3.3.3 Scheduling is adjusted as needed 3.3.4 Weekly and daily plans are realistic and followed up 3.8 Plans correct assessment principles 3.9 Practical preparation is executed			
	MARK (out of 10)			
	4. **EXECUTION OF TREATMENT** * **Follows OT's guidance in treatment execution** 4.1 Explains treatment to patient 4.2 Pays attention to patient's response during treatment 4.3 Applies precautionary measures 4.4 Displays practical skill (apparatus and activities) 4.5 Applies principles, precautionary measures and grading (as provided by OT)			
	MARK (out of 5)			
	5. **EVALUATION OF TREATMENT** 5.1 Critically reviews subjective responses 5.2 Observes objective responses 5.4 Critically reviews own treatment and the treatment of others.			
	MARK (out of 5)			

		FINAL		
STUDENT		**ST**	**OT**	**LECTURER/OCCUPATIONAL THERAPIST**
	6. **RECOMMENDATIONS** 6.1 Gives feedback (SOIP) to OT on patient's assessment 6.2 Gives feedback (SO) to OT on patient's treatment 6.3 Gives feedback to patient on findings			
	MARK (out of 10)			
	FINAL MARK FOR CLINICAL WORK:			
	7. **PROFESSIONAL CONDUCT** 7.1 Honours professional rules and ethical principles: ▪ Beneficence ▪ Autonomy ▪ Veracity ▪ Justice 7.2 Acts as team member 7.3 Knows and uses correct communication channels 7.4 Uses effective communication: ▪ Giving and receiving feedback ▪ Response to feedback ▪ Reflects on own performance 7.5 Utilises tutorials and other learning opportunities 7.6 Adjusts own conduct to patient's response 7.7 Selects, organises and presents information correctly			
	MARK (out of 50)			
	8. **WORK HABITS** 8.1 Manages own work 8.2 Exercises control in area . 8.3 Accepts responsibility for stock, materials and tools 8.4 Completes practical work correctly Handel praktiese werk korrek af. 8.5 Evaluates own progress and accomplishments			
	MARK (out of 50)			
	FINAL MARK FOR PROFESSIONAL CONDUCT AND WORK HABITS			

EVALUATION BY STUDENT:

COMMENTS

Characteristic abilities:

_____

_____

_____

_____

_____

_____

Potential for work in the area:

_____

_____

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_____

_____

Problem areas:

_____

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_____

Planning for improvement in next affiliation:

_____

_____

_____

_____

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_____-

PLEASE NOTE: Marks will not be allocated unless this form is completed in full by student.

EVALUATION BY LECTURER AND CLINICAL OCCUPATIONAL THERAPIST: COMMENTS

Characteristic abilities:

Potential for work in the area:

Problem areas:

Planning for improvement in next affiliation:

PLEASE NOTE: Marks will not be allocated unless PREVIOUS PAGE is completed in full by student.

ADDENDUM B: B OT IV EVALUATION OF CLINICAL WORK

STELLENBOSCH UNIVERSITY
B.OCCUPATIONAL THERAPY IV

EVALUATION OF CLINICAL WORK

AFFILIATION 1

Student:	Duration: From to
Institution:	Section:
Work hours:	No. of hours from student register:
Days absent:	Time caught up:

	Mark allocated to section of the evaluation (%)	**Calculation of final mark**
1. Peer evaluation		10%
2. Long-term case: Theory		25%
3.1 Direct Services Practical work during affiliation with regards to patient care/programmes/projects /groups and the ability to deliver an occupational therapy service through optimal use of knowledge and skills. 3.2 Indirect services	____% ____%	50%
4. Professional conduct, communication and work habits		15%
	FINAL MARK	

SIGNED:

Peer: _____ Date:_____

Clinical Therapist: _____ Date _____

Student: _____ Date: _____

Lecturer: _____ Date: _____

DIREKTE DIENSLEWERING

U	=	Uitstekend	(80-100%)
BG	=	Baie goed	(70-80%)
G	=	Goed	(60-70%)
B	=	Bevredigend	(50-60%)
O	=	Onbevredigend	(40-50%)
S	=	Swak	(30-40%)
BS	=	Baie swak	(0-30%)

	MIDPRAK			FINAAL		
STUDENT	**ST**	**AT**	**KONSULTASIE MET OORLEGPLEGING**	**ST**	**AT**	**DOSENT/ARBEIDSTERAPEUT**
			1. Raadpleeg bronne soos beskikbaar en maak kontak met ander spanlede/familie/ betrokkenes om inligting te bekom. 2. Ken potensiële pasiënte uit. 3. Evalueer toepaslikheid van verwysing en bespreek bevindinge met verwysende bron.			
			PUNT UIT / PUNT UIT			
			BEPALING			
			BEPALING VAN INDIVIDUE/GROEPE			
			1. Beplan verlangde inligting. 2. Oefen bepalingstegnieke. 3. Vat inligting saam. 4(a) Kan pasiënt se bates en probleme identifiseer. 4(b) Kan gemeenskaplike en pasiënt-spesifieke probleme identifiseer en prioritiseer tydens groepbehandeling.			
			BEPALING – SLEGS 1 OF 2 KONTAKSESSIES			
			1. Beplan bepaling ten opsigte van inligting verlang, bronne wat gaan benut en metodes/tegnieke wat gaan gebruik. 2. Selekteer toepaslike bronne, metodes en tegnieke. 3. Volg korrekte prosedures om inligting te onttrek. 4. Kan toepaslike inligting doeltreffend onttrek. 5. Is vaardig in toepassing van bepalings-metodes en tegnieke. 6. Kan inligting saamvat/opsom asook korrek en akkuraat weergee.			
			PUNT UIT / PUNT UIT			

Skryf asseblief in verskillende kleure vir die midprak en finaal.

	MIDPRAK			FINAAL		
STUDENT	**ST**	**AT**	**BEPLANNING**	**ST**	**AT**	**DOSENT/ARBEIDSTERAPEUT**
			BEPLANNING VAN BEHANDELING VAN INDIVIDUE/GROEPE			
			1. Stel aanvangspunt van behandeling vas met inagneming van AT programme. 2. Identifiseer en formuleer doelstellings. 3. Koördineer behandeling om doel-stellings te bereik. 4. Sinvolle beplanning vir pasiënt-behandeling oor verloop van tyd om hoofdoelstelling te bereik. 5. Beplan behandeling in samewerking met die span. 6.1 Korrekte aktiwiteitsontleding doen en aanpas vir spesifieke situasie. 6.2 Beplan vir toepaslike gebruik van TM en AM. 7. Gee aandag aan praktiese voor-bereiding, probleemoplossing en afsluiting.			
			BEPLANNING VAN BEHANDELING – SLEGS 1 OF 2 KONTAKSESSIES			
			1. Identifiseer korrekte AT programme en kan uitvoering motiveer. 2. Kan oorhoofse plan saamstel.			
			PUNT UIT / PUNT UIT			
			UITVOERING VAN BEHANDELING			
			1. Bevorder pasiënt deelname en skakel belemmerende faktore uit. 2. Neem pasiënt respons gedurig waar. 3. Maak aanpassings. 4. Pas beginsels, voorsorgmaatreëls en gradering toe.			
			PUNT UIT / PUNT UIT			

	MIDPRAK			FINAAL		
STUDENT	**ST**	**AT**	**EVALUASIE**	**ST**	**AT**	**DOSENT/ARBEIDSTERAPEUT**
			EVALUASIE VAN BEHANDELING VAN INDIVIDUE/GROEPE			
			1. Beoordeel resultate in terme van gestelde doelwitte. 2. Interpreteer behandeling. 3. Bepaal doeltreffendheid en kwaliteit van behandeling. 4. Besluit omtrent staking van behande-ling. 5. Beoordeel eie werk.			
			EVALUASIE VAN BEHANDELING – SLEGS 1 OF 2 KONTAKSESSIES			
			1. Beoordeel resultate van aanbevelings. 2. Beoordeel eie werk.			
			PUNT UIT / PUNT UIT			
			AANBEVELINGS			
			AANBEVELINGS AAN INDIVIDUE/GROEPE			
			1. Beveel verdere behandeling aan. 2. Verduidelik beplande behandeling en verandering aan pasiënt en/of betrokkenes. 3. Neem deel aan spanbesprekings. 4. Beveel AT dienste aan. 5. Beveel verdere verwysings aan.			
			AANBEVELINGS NA SLEGS 1 OF 2 KONTAKSESSIES			
			1. Kan aanbevelings vir oorhoofse plan opstel. 2. Kan aanbevelings motiveer. 3. Implimenteer aanbevelings. 4. Kontroleer uitvoering van aanbevelings na aanleiding van beskikbare bronne. 5. Dra aanbevelings oor aan betrokkenes. 6. Volg aanbevelings op. 7. Maak verdere aanbevelings.			
			PUNT UIT / PUNT UIT			
			FINALE PUNT VIR DIREKTE DIENSTE - TOTAAL UIT 100			

	MIDPRAK			FINAAL		
STUDENT	**ST**	**AT**	**PROFESSIONELE GEDRAG**	**ST**	**AT**	**DOSENT/ARBEIDSTERAPEUT**
			1. Eerbiedig professionele reëls en etiese beginsels: ▪ Bevoordeling ▪ Outonomie ▪ Waarheidsgebondenheid ▪ Geregtigheid 2. Dra kennis van spanlede se betrokkenheid en betrek tot voordeel van pasiënte. 3. Interpreteer AT bydrae. 4. Handhaaf/uitbou van AT bydrae. 5. Handhaaf IPV en kommunikasie: ▪ Gee en ontvang van terugvoer ▪ Respons op terugvoer ▪ Reflekteer oor eie taakuitvoering 6. Volg resultate gereeld op. 7. Duidelike formulering en aanbieding van eie mening.			
			PUNT UIT 50	PUNT UIT 50		
			WERKGEWOONTES			
			1. Kontroleer eie werkverrigting aan die hand van die doelstellings. 2. Pas bestuursbeginsels toe. 3. Weetgierig, maak gebruik van navorsingsbeginsels. 4. Bied inligting objektief, sistematies en duidelik aan met sintese van begrippe. 5. Gereelde en wetenskaplike rekord-houding.			
			PUNT UIT 50	PUNT UIT 50		
			FINALE PUNT VIR PROFESSIONELE GEDRAG EN WERKGEWOONTES			

INDIREKTE DIENSLEWERING

U	=	Uitstekend	(80-100%)
BG	=	Baie goed	(70-80%)
G	=	Goed	(60-70%)
B	=	Bevredigend	(50-60%)
O	=	Onbevredigend	(40-50%)
S	=	Swak	(30-40%)
BS	=	Baie swak	(0-30%)

KOMMENTAAR : STUDENT	BESTUUR	ST	AT	KOMMENTAAR : DOSENT/ARBEIDSTERAPEUT
	BEPLANNING 1. Insameling van inligting. 2. Maak van voorspellings rakende program. 3. Stel en formuleer doelstellings vir program. 4. Besluit op metode. 5. Programmering en Skedulering. 6. Begroting (menslike hulpbronne, tyd, materiale, plek en vervoer).			
	ORGANISERING 1. Skep van strukture. 2. Mannekrag toedeling en pligte.			
	KOÖRDINERING 1. Met oorgeskiktes. 2. Met ondergeskiktes. 3. Met mede-geskiktes. 4. Met doelwit.			
	LEIDING 1. Leierskapstyle. 2. Toestande van sekuriteit. 3. Toesighouding (tipe en frekwensie).			
	KONTROLERING 1. Stel standaarde (meetbaar, realisties, verstaanbaar en aanvaarbaar). 2. Metingsmetodes is in plek (bv. weeklikse afsprake). 3. Evaluering van resultate van meting. 4. Beplanning en uitvoering van regstellende aksies.			
	BESLUITNEMING 1. Lewer van koste-effektiewe dienste 2. Besluite word volgens die prosedure vir besluitneming			

	geneem			
	SKEPPENDE DENKE 1. Tree met inisiatief op 2. Beskik oor deeglike kennis, wat ingewin is ter bevordering van die individu/groep en hoe dit inpas in die konteks van die inidividu/groep			
	DELEGERING 1. Die stappe van die proses van delegering word nougeset gevolg			
	MOTIVERING 1. Motivering is gegrond en beredeneer vanuit kennis van motiveringsteorieë			
	KOMMUNIKASIE 1. Maak gebruik van doeltreffende tweerigting kommunikasie 2. Lewer bewyse van doeltreffende verbale en nie-verbale kommunikasie			
	PUNT VIR BESTUUR UIT			

KOMMENTAAR : STUDENT	OPVOEDING	ST	AT	KOMMENTAAR : DOSENT/ARBEIDSTERAPEUT
	1. Toepaslike seleksie en gebruik van hulpmiddels en inligting. 2. Korrekte toepassing van onderrigmetodes en tegnieke.			
	PUNT VIR OPVOEDING UIT			
	KONSULTASIE			
	1. Toepaslike konsultasie met familie en versorgers (binne). 2. Toepaslike konsultasie met span, inrigting, gemeenskap (buite).			
	PUNT VIR KONSULTASIE UIT			
	SAMEWERKING MET ANDER SPANLEDE			
	1. Identifisering van geskikte spanlede en belanghebbendes. 2. Toepaslike skakeling met spanlede en belanghebbendes.			
	PUNT VIR SAMEWERKING UIT			
	REKORDHOUDING EN VERSLAE			
	1. Toepaslike tipe rekordhouding en verslae. 2. Kwaliteit van verslae. 3. Toepaslike frekwensie. 4. Stel toepaslike verslae beskikbaar.			
	PUNT VIR REKORDHOUDING EN VERSLAE UIT			
	FINALE PUNT VIR INDIREKTE DIENSTE UIT 100			

EVALUATION BY STUDENT:

COMMENTS

Characteristic abilities:

Potential for work in this area:

Problem areas:

Planning for improvement in next affiliation:

Note: Marks will not be allocated unless this form is completed in full by the student.

EVALUATION BY LECTURER/CLINICAL OCCUPATIONAL THERAPIST: COMMENTS

Characteristic abilities:

Potential for work in this area:

Problem areas:

Planning for improvement in next affiliation:

Note: Marks will not be allocated unless the previous page is completed in full by the student

ADDENDUM C: PARTICIPANT INFORMATION AND CONSENT DOCUMENT

PARTICIPANT INFORMATION LEAFLET

TITLE OF THE RESEARCH PROJECT:
Assessment of professional behaviour in occupational therapy education: investigating assessors' understanding of constructs and expectations of levels of competence

REFERENCE NUMBER: N11/03/090

PRINCIPAL INVESTIGATOR: Mrs M A Snyman

ADDRESS: Stellenbosch University
Department of Occupational Therapy
P O Box 19063
Tygerberg
7505

CONTACT NUMBER: **083 384 8515**

Dear Colleague

My name is Alma Snyman and I am a registered student working towards an M Phil in Health Sciences Education. I would like to invite you to participate in a research project that aims to investigate the assessment of professional behaviour in occupational therapy education.

Please take some time to read the information presented here, which will explain the details of this project and contact me if you require further explanation or clarification of any aspect of the study. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee (HREC) at Stellenbosch University** and will be conducted according to accepted and applicable National and International ethical guidelines and principles, including those of the international Declaration of Helsinki October 2008.

The study will be guided by the following question: To what extent do clinical lecturers (assessors) have a common understanding of the constructs and levels of competence required at different levels in terms of professional behaviour of third and fourth year occupational therapy students at one university?

The proposed study will follow a qualitative approach with a case study design. Data will be gathered during a participatory group session. Participants will be involved in a participatory discussion of (1) their understanding of professional behaviour and (2) the level of expectations for third and fourth year students respectively. In addition to the participatory group session the researcher plans to conduct focus group interviews with selected participants during which the usefulness of the current

assessment form used to assess professional behaviour of third and fourth year students will be evaluated.

The following measures will be taken to ensure confidentiality and anonymity: During the transcription of focus group interviews the names of participants will be replaced by identification codes and the records attributing the identification codes will be kept separately on a password protected computer. The nature of the participatory group process is such that contributions will be made anonymously. A wide shot video recording will be made of the group session for recording and analysis purposes. This video recording will not be used for identification of participants.

If you are willing to participate in this study please sign the attached Declaration of Consent and hand it to the investigator.

Yours sincerely

M A Snyman
Principal Investigator

Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled: Assessment of professional behaviour in occupational therapy education: investigating assessors' understanding of constructs and expectations of levels of competence

I declare that:

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

Signed at (*place*) .....……..…….. On (*date*) ……...…….. 2011.

.....

Signature of participant

ADDENDUM D: ETHICAL APPROVAL

MAILED

30 March 2011

Mrs M Snyman
Department of Occupational Therapy
2nd Floor
Teaching Block

Dear Ms Snyman

Assessment of professional behaviour in occupational therapy education: investigating assessors' understanding of constructs and expectations of levels of competence.

ETHICS REFERENCE NO: N11/03/090

RE: APPROVAL

30 March 2011

It is a pleasure to inform you that a review panel of the Health Research Ethics Committee has approved the abovementioned project on 30 March 2011, including the ethical aspects involved, for a period of one year from this date.

This project is therefore now registered and you can proceed with the work. Please quote the above-mentioned project number in ALL future correspondence. You may start with the project. Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary.

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Approval Date: 30 March 2011 Expiry Date: 30 March 2012

Yours faithfully

MS CARLI SAGER
RESEARCH DEVELOPMENT AND SUPPORT
Tel: +27 21 938 9140 / E-mail: carlis@sun.ac.za
Fax: +27 21 931 3352

ADDENDUM E: TURNITIN REPORT