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## **A study of respiratory therapy and medical radiation technology faculty who transitioned from clinical practice into academia: their transition experiences, and perceptions of students with disabilities.**

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Education degree in Education

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## **Abstract**

Challenges experienced by allied health clinicians transitioning to educator roles in post-secondary institutions are well reported in the literature. Indeed, the Western world-based research contends that such allied health faculty retain their health identity as their primary professional identity, alongside that of educator. More specifically, the influence of retention of the health identity by nursing faculty on their attitudes towards students with disabilities requiring accommodations is also well reported in the literature. Fears held by nursing faculty that students with disabilities may compromise patient safety can act as barriers to the full inclusion of those students in nursing education programs. By contrast, similarly themed research on the attitudes or perceptions of non-nursing allied health faculty towards students with disabilities requiring accommodations, is scant.

This Ontario-based research investigated the experiences of non-nursing allied health clinicians who transitioned into academia. The exploratory case study investigated their self-identification as health professionals rather than as educators, and the influence of their transition experiences and identification as health professionals, on their perceptions towards students with disabilities requiring accommodations. Applying Benner's theory of 'novice-to-expert', this exploratory case study employed purposive sampling with nine participants holding full-time faculty positions in two allied health programs—Medical Radiation Technology and Respiratory Therapy—in an Ontario community college, in one-to-one semi-structured interviews. A modified version of constant comparative data analysis was employed to uncover key themes.

Findings from the triangulated data showed that non-nursing allied health faculty: retain the primacy of their identity as health professionals; maintain adherence to their professional obligation of duty of care to the public; assign priority to maintaining currency in their health discipline; and, found their transition from an advanced or expert level of clinical practice to academia highly stressful, highlighting feelings of being novices in academia. Participants reported that mentoring from program faculty peers was the single most important organizational support mechanism experienced by them during their transition. As well, participants fully supported the inclusion of students with disabilities requiring accommodations in health programs but a notable number had concerns about whether some students with disabilities could succeed in clinical settings and deliver safe patient care once they graduated. Considerations for improving the induction of medical radiation technology and respiratory therapy faculty into academia are offered. Such considerations may increase the comfort of those allied health faculty with, and management of, students with disabilities who require accommodations.

**Keywords:** allied health faculty, clinician to educator, dual identity, duty of care, exploratory case study, novice-to-expert, role transition, students with disabilities in health programs, student accommodations.

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## **Chapter 1**

### **Introduction**

#### **The study's origin**

This dissertation topic arose from a problem of practice encountered in the work setting of the researcher. As a Chair of Health Sciences in an Ontario community college, the researcher perceived tension and stress among many of her faculty relating to some of the responsibilities inherent in their role as educators that seemed to them to conflict with their role and responsibilities as health professionals (specifically, as members of regulated health professions). Over a two-year period, the level of concern expressed by her faculty relating to what they described as growing stress and confusion about their roles and primary obligations (in the college setting) appeared to increase, both in terms of the number of faculty articulating this issue, and in the number of occasions where it was raised. The frequency with which the topic was discussed, either in one-to-one meetings (with the researcher) or in program team meetings, was increasing. It appeared to have two related but different aspects: the first corresponded to her (health sciences) faculty's perception that 'the college' did not understand that their approaches to, and concerns about, a variety of issues such as student admission criteria, grading/passing schemes, and personal continuing education priorities were rooted in their professional obligations as regulated health professionals. The second aspect related to the expressions of these health sciences faculty that it was appropriate that their management of student performance and progression (including of 'accommodated' students) reflected the duality of their (that is, the faculty's) identities as educators and as health professionals.

The issue was notably present during student academic appeals from within the researcher's school at the college, particularly for students 'with accommodations'. At those times, in conversations with staff from the college's counselling service and with the college ombudsperson, faculty regularly responded to questions about their judgement or assessment of students from the perspective of their legal and professional obligations as members of regulated health professions. References to their 'duty of care' to the public and to their professional licensure were common. When challenged to reflect on their obligations as educators, overwhelmingly they stated they believed they *were* respecting those obligations and supporting students, but that they had another set of obligations to which they were also accountable that could not be disregarded.

The researcher's perceptions about those exchanges were that many college staff held the opinion that health sciences faculty were frequently not student-centered, or appropriately committed to individual student success. Many of the allied health faculty in the researcher's school were concerned that others (perhaps even including the Ombudsperson and Office of the Registrar) perceived they erected unnecessary barriers (example, pre-admission health occupation aptitude testing) to applicants and current students, particularly students with disabilities and/or requiring accommodations. The researcher was troubled about the dissonance in the mutual understanding between these faculty teams and college colleagues, and its impact on her faculty. As a result, the researcher contemplated whether an attempt to better understand (and communicate to college colleagues) the motivations and perspectives of her faculty arising from their status as licensed, regulated health professionals might be beneficial.

Being an educational leader and the supervisor of these faculty, there was a desire to explore how the understanding of their competing obligations could be improved, and how the faculty could be supported to reduce the occasions when they felt that they were compromising one set of obligations at the expense of the other. As an academic chair, the researcher was aware of the growing expectations on all faculty with respect to human rights directives and accommodations policies in Ontario postsecondary education settings. Faculty were being asked to introduce universal design principles into their teaching and assessments, and to adjust their focus from whether students would be able to practice in their occupation after graduation, to a focus on supporting students to attain their academic credential. At the same time, the researcher was also aware of the substantial and growing expectations of the regulating provincial health bodies on their members.

A literature search was undertaken to discover if this topic had been widely researched and reported, which proved to be fruitful, as there existed a substantial body of work addressing particular elements of the issue. Specifically, the nursing literature was replete with reports of studies investigating the experiences of nursing professionals who had transitioned from clinical practice roles into educator roles, and the challenges they faced in their new, educator positions. There were also studies reporting on challenges encountered within nursing programs related to faculty attitudes towards students with disabilities and students with accommodations. Fewer studies were found related to non-nursing allied health faculty, but what were located focused on transitional experiences from clinical practice into academia. None focused on these (that is, non-nursing allied health) faculty's attitudes towards students with disabilities, and yet, in a

sense, those attitudes were possibly indicative of the tensions and dilemmas raised by faculty about what they saw as competing obligations. Proceeding from this preliminary review of the literature, the foundation of the researcher's proposed study was laid.

### **The context of the study**

Faculty in allied health programs teaching what are considered core courses in the discipline are required to hold a credential in that discipline as well as possessing a license to practice in that discipline. Typically, individuals are appointed to Faculty positions in these programs after having worked in the field, and after having demonstrated expertise as a practitioner. They are appointed into Faculty roles not primarily because of their credentials as an academic but because of their demonstrated competence and leadership as practicing clinicians. However, once having assumed a faculty position they are accountable for demonstrating additional competencies and for meeting obligations more synonymous with their role of educator than of practitioner.

Hurst (2010) noted from her study of physiotherapists who transitioned to university teaching positions that assuming the new professional role of lecturer was quite complex, and involved learning new attitudes and values as much as it did learning new skills. Boyd (2009), Smith and Boyd (2012) and McArthur-Rouse (2008) found that the uncertainty and stress felt by many clinicians transitioning to educator roles was not simply the result of being new to a job, but was particularly problematic because of feelings of role confusion and uncertainty of identity. Likewise, Logan, Gallimore and Jordan (2015) stated that "the challenge for the clinical practice disciplines ...has always been the identity transition from practitioner to academic or intellectual" (p.7). For a variety of reasons (credibility with students and colleagues, personal level of confidence

and comfort, belief in the prime importance of their health background in their teaching role) those faculty tended to hold on to their identity as health professionals, rather than adopt the identity of educators.

One consequence of continuing to identify primarily as a health professional, however, is that this can become the lens through which these faculty view educational processes, including those related to managing students with disabilities requiring accommodations. Research by Watson (1995), Carrol (2004), and Ashcroft, Chernomas and Davis (2008) on nursing faculty revealed that they had grave concerns about the ability of students with disabilities to be safe nurses, and were deeply worried about how they, as educators and nurses, could balance a student's right to education with their professional obligations regarding the protection of patient safety. When faced with accommodation requirements (particularly in clinical practicum settings), they assessed the issue through their lens of health practitioner. The issue pivoted around competence and the capacities of those students to perform safely and effectively. Given the expectations on faculty teaching in health programs to fulfill all of their obligations as educators, and most particularly, to support the principles and legal requirements for inclusion and accommodations, to view the issue only through a single lens was, and is, untenable.

### **The problem statement**

Ontario enacted legislation regulating health professions in 1991 (*Regulated Health Professions Act, 1991*), and lists the disciplines covered by the Act. Self-governing, regulatory colleges for each named profession were created and assigned authority for regulating the professions, which currently includes activities such as



determining qualifications for certification, maintenance of membership, disciplinary procedures, and standards of practice. Adherence to the rules and obligations of these colleges by members of the individual health disciplines is mandatory for licensure and the ability to practice, and members teaching in their discipline are not exempt from these obligations. Working as college-based educators, health professionals practice their profession within a framework that differs from their prior clinical one, and their 'clients' are not patients but students. As educators, they have a new duty of care, to new and different clients, but their health identity (as reinforced by their regulatory and professional bodies) ensures that their original duty to the public is first and foremost in their minds (College of Respiratory Therapists of Ontario ([www.crto.on.ca](http://www.crto.on.ca)), Canadian Society of Respiratory Therapists ([www.csrt.com](http://www.csrt.com)), College of Medical Radiation Technologists of Ontario ([www.cmrto.ca](http://www.cmrto.ca)), Canadian Association of Medical Radiation Technologists ([www.camrt.ca](http://www.camrt.ca))).

Expectations on post-secondary educational institutions in Ontario respecting the management of students with disabilities and/or accommodations continue to grow and evolve (example, Ontario Human Rights Commission letter to Ontario college presidents, 15 March 2016), and apply to all programs and all students. A faculty member who is a member of a regulated health profession therefore approaches accommodation requirements from the perspective of both identities (health professional and educator), and considers in her/his response both what is best for the student and what is safe for the public. As the literature briefly canvassed earlier showed, at times, faculty may perceive that what is in the best interests of a student and of the public, conflicts.

**Aim, scope, and design of the study.** The two research questions in this study were:

1. How did Respiratory Therapy and Medical Radiation Technology faculty who transitioned from clinical practice into academia at one Ontario college experience the transition?
2. What were the attitudes of Respiratory Therapy and Medical Radiation Technology Faculty towards students with disabilities requiring accommodations?

As indicated earlier, this was an exploratory, qualitative case study, with an Interpretivist stance that investigated the experiences of specific non-nursing allied health clinicians who transitioned into educator roles. This study used a single case design with a single unit of analysis, consisting of two subunits (two groups of faculty participants, drawn from two program teams, distinguished by their health discipline). The decision to utilize an exploratory, qualitative case study was based on the merits of this type of research in answering ‘how’ and/or ‘what’ questions (Yin, 2009), most especially in relation to investigating real world phenomena in-depth and in detail, through individual narratives. Given that Interpretivism acknowledges that people create meaning through their interpretation of events, and focuses on achieving an understanding of social reality, as a framework, it suited this investigation, which focused on personal perspectives and experiences.

This study’s conceptual framework was Benner’s (1984) ‘novice-to-expert’ theory. Benner developed a model to describe the stages through which novice nurses progress upon entry into clinical practice. This model describes five stages of skills acquisition (novice, advanced beginner, competent, proficient, and finally, expert), during which novice nurses gain experience and understanding. In Benner’s model, each stage builds on the previous one, and theoretical knowledge is enhanced through clinical (that

is, practical) experiences. Benner's research showed that not all nurses progress through the stages to become expert practitioners. Some, for example, achieve proficiency and remain at that level for the balance of their nursing careers. A particularly noteworthy element of this model is the proposition that knowledge and skills ('knowing how') can be acquired without having learned the relevant theory (which Benner called 'knowing that'). Nonetheless, Benner acknowledges the value of theory in addition to relevant research and practice being a part of sound nursing preparation. As will be discussed in the succeeding chapters, although Benner's 'novice to expert' theory arose from her investigations into the experiences of new clinical nurses, her model has implications for the induction on non-nursing individuals entering a new practice setting.

This study also explored if the participants' continued identification as health professionals (as their singular identity, or overriding their identity as educators) impacted their attitudes towards students in their programs with disabilities and/or requiring accommodations. The researcher hoped to contribute to the apparent gap in research done on non-nursing allied health faculty in terms of transitional experiences, and most particularly, in relation to their perceptions towards college students with disabilities, resulting from identity conflicts.

Participants were drawn from faculty teaching in two different disciplinary program teams in an Ontario community college, specifically, medical radiation technology (MRT) faculty, and, registered respiratory therapy (RRT) faculty. All were both full-time professors and were members of their respective regulatory colleges. This study employed a purposive sample, with the participants selected based on those characteristics (that is, one group was MRT faculty teaching on a full-time basis in the

MRT program, and the second group was RRT faculty teaching on a full-time basis in the RRT program). As previously noted, in total, there were nine participants (from a potential maximum of ten participants at the site): four medical radiation technology faculty (out of five potential MRT faculty) and five respiratory therapy faculty (out of five potential RRT faculty). Individual, semi-structured interviews were conducted, which were audiotaped and subsequently transcribed. As well, member-checking meetings were conducted.

All research ethics board protocols of the University of Western Ontario and of the college employing the participants were followed, including those related to the collection and storage of data. The coding and analysis of the data (the interview narratives) was followed by the triangulation of those data with other primary data sources, that is, publications and communications of relevant health regulatory bodies, professional health associations, Ontario Human Rights Commission, and education agencies (Ministry and college). One aim of the study was also to offer suggestions to educational leaders on how to better support the induction of non-nursing allied health faculty into educator roles, so as to expedite their adoption of a sense of identity as educators. Given the strength of a health identity, assistance given to allied health faculty to identify as educators sooner (and more fully) in their transition into academia holds the potential of enhancing their ability to support students with disabilities and/or requiring accommodations.

### **The significance of the study**

This study is important on the one hand because of the primacy of health care in people's lives, and on the other hand because the full inclusion of all persons in education

is equally important. The provision of expert, high quality, and compassionate health care services cannot be divorced from the learning and education of those who deliver such services. As well, the education of future health care professionals cannot be discussed or managed in isolation from an awareness of those who teach them. Ontario community colleges are mandated to be closely linked with ‘industry’ and their communities, and to produce quality graduates possessing the requisite vocational skills to enter the workforce. Quality faculty are necessary to prepare quality graduates, and allied health programs require faculty who possess high levels of expertise in their relevant health disciplines. It is to be expected that allied health programs will continue to recruit expert health clinicians into their faculty ranks, and that many, if not most, of those new faculty will be novices to academia.

Likewise, the selection and preparation of future health care practitioners should be guided by principles of social inclusion, respect, and belief in the potential of every learner. The health care system and individuals with disabilities, who have the capacity to be outstanding caregivers, are done a disservice if unnecessary barriers to entry to the health professions exist. Some barriers, in effect, may exist with no ill-intent when allied health faculty perceive competing sets of obligations are arising from their own dual identities. It can only be of help to identify those barriers, and take action at the college level to remove them in ways that do not jeopardize patient safety, and which help to reconcile these two sets of aspirations, interests and needs.

### **Definition of Terms**

In this exploratory case study, the terms below were operationalized for research purposes.

***Accommodation.*** In an Ontario educational setting, “is a means of preventing and removing barriers that impede students with disabilities from participating fully in the educational environment in a way that is responsive to their own unique circumstances, (and) involves dignity, individualization and inclusion” (Ontario Human Rights Commission (2004). Guidelines on Accessible Education, p.8).

***Allied health professionals, clinicians and practitioners.*** Individuals (other than a physician) qualified in the clinical (patient care) practice of health care as distinguished from one specializing in laboratory or research techniques, or in theory. Allied health professionals are involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders. Allied health professionals engaged in the direct provision of care and services to patients are clinicians and/or clinical practitioners. (Association of Schools of Allied Health Professions, [www.asahp.org](http://www.asahp.org))

***Canadian Association of Medical Radiation Technologists (CAMRT).*** This organization sets the code of ethics and professional standards for medical radiation technologists practicing in Canada. ([www.camrt.ca](http://www.camrt.ca))

***Canadian Society of Respiratory Therapists (CSRT).*** This organization sets the code of ethics and professional standards of practice for respiratory therapists practicing in Canada. ([www.csrt.com](http://www.csrt.com))

***Clinical practicum.*** For the purposes of this study, a clinical practicum is the period within a course or program of study when students are based in a client care (clinical) setting to provide care under the supervision of qualified health care professionals, who monitor and assess the students’ ability to apply in practice what they

learned in terms of theory and research. Key points are that clinical practicums are a structured element within a curriculum; that students provide direct patient care; and, that the students are supervised. Clinical practicums exist in all allied health programs.

***College of Medical Radiation Technologists of Ontario (CMRTO).*** This is the regulatory body for medical radiation technologists in Ontario, as provided under the Regulated Health Professions Act of Ontario and the Medical Radiation Technology Act of Ontario. Its mission is to regulate the profession so as to serve and protect the public interest. ([www.cmrto.org](http://www.cmrto.org))

***College of Respiratory Therapists of Ontario (CRTO).*** This is the regulatory body for respiratory therapists in Ontario, as provided under the Regulated Health Professions Act of Ontario and the Respiratory Therapy Act of Ontario. Its mission is to ensure that respiratory care services provided to the public by its members are delivered in a safe and ethical manner. ([www.crto.on.ca](http://www.crto.on.ca))

***Exploratory qualitative case study.*** An empirical inquiry about a real world, contemporary phenomenon (the case) set within its social context, using narrative data, and ‘how’ and/or ‘what’ questions, to develop explanations and/or hypotheses. (Yin, 2009).

***Medical radiation technologist.*** An allied health care professional who uses radiation or electromagnetism to produce diagnostic images of a patient’s body, or who administers radiation to treat patients for certain medical conditions, on the order of a physician or authorized health professional; in Canada is a graduate of diploma programs at colleges, or of collaborative college/university degree programs. (College of Medical Radiation Technologists of Ontario, [www.cmrto.org](http://www.cmrto.org))

**Reliability (in qualitative case study).** Refers to the degree to which qualitative research data is consistent across different researchers and different studies. (Creswell, 2014, p.201).

**Respiratory therapist.** An allied health care professional who monitors, assesses and treats individuals who have difficulty breathing; in Canada, is a graduate of diploma programs at colleges, or of collaborative college/university degree programs. (College of Respiratory Therapists of Ontario, [www.crto.on.ca](http://www.crto.on.ca))

**Semi-structured interviews.** Interviews that are less structured, and which use open-ended questions. (Merriam, 1998, p.74).

**Students with disabilities.** Disability as defined for an individual registered in a course or program of study “includes past, present and perceived conditions, (and) may be a physical limitation, ailment, a perceived limitation or a combination of all these factors. (Ontario Human Rights Commission (2004). Guidelines on Accessible Education, p.7).

**Triangulation (of data).** The use of multiple methods, data collection strategies, and data sources to assemble a complete picture of what is being studied, and to cross-check information. The process serves to build a coherent justification for themes. (Creswell, 2014, p.201; Gay, Mills and Airasian, 2012, p.632).

**Unit of analysis.** The ‘what’ or ‘who’ that is being studied; in qualitative investigations this typically means individuals or groups. (Creswell, 2014; Yin, 2009).

**Validity (in case study).** The degree to which qualitative data accurately gauge what the researcher is trying to measure. (Gay et al, 2012, p.633).



## **Overview of the study**

The study was completed with the assistance of a research assistant (a requirement of one of the educational institutions participating in the study), who both managed the collection of consents from the participants, and undertook the individual interviews with the participants, including the audiotaping of the interviews. All nine participants responded fulsomely to each interview question, and each agreed to be audiotaped so as to elicit transcriptions for data gathering purposes. The faculty from both program teams had a range of tenure time periods in their full-time teaching roles, from being relatively recent appointees to being seasoned faculty with many years of service. The MRT participants consisted of two women and two men. The RRT participants consisted of three women and two men. The resulting narratives were both rich in content and in personal reflections. The analysis of the transcribed interviews resulted in the identification of four dominant and two minor themes:

### **Dominant themes**

1. Faculty who participated in this study retained their primary identity as a medical radiation technologist (MRT) or registered respiratory therapist (RRT) irrespective of their tenure in their full-time teaching roles, although this primary identity co-existed with, and while, their second (dual) identity as an educator evolved.
2. It is critically important to the allied health faculty that they remain current in their original professional discipline of MRT or RRT, which they described as being met by attending conferences, engaging in professional development activities, serving on professional association committees/task forces (example, preparation of registration

- examination questions), and keeping abreast with technological changes in equipment commonly used in their disciplines.
3. The transition from clinical practice to academia was stressful and challenging for both the MRT and RRT faculty, and the single most important organizational support mechanism during that time was mentoring from their program faculty peers.
  4. The MRT and RRT faculty retained an acute obligation respecting their duty of care to the public and the provision of safe care by their students, while simultaneously fully embracing their obligations and responsibilities towards all of their students, including students with disabilities and/or requiring accommodations.

#### **Minor themes**

1. A notable number of RRT faculty are concerned about the clinical performance of students with disabilities and/or requiring accommodations, and their ability to deliver safe patient care while students and once they become graduate practitioners.
2. A notable number of MRT and RRT faculty are motivated to work in a clinical setting on a regular basis throughout the academic year.

Major differences in the responses between the MRT and RRT faculty were not evident in the dominant themes, however, noteworthy differences between the two groups were evident in both minor themes. With respect to the first minor theme (faculty concerns about the clinical performance, and ability to provide safe patient care, by students with disabilities and/or accommodations), although this theme was raised by only six of nine participants, all five RRT participants identified it as being of concern while only one MRT participant did. With respect to the second minor theme (faculty motivation to work in a clinical setting on a regular basis throughout the academic year),

four of five RRT participants raised it as a subject of interest while two of four MRT participants similarly raised it.

## **Conclusions**

The findings from this study supported those revealed in many similar studies, with respect to the experiences of allied health faculty when they transitioned from clinical practice into academia. Of specific note were the similarities between this study's participants and the participants of the relevant studies assessed during the literature review, respecting feeling like novices on assuming educator roles, retaining their health identity, and relying on peer faculty mentors. Also markedly similar to the findings in previous related investigations were this study's participants' retention of their duty of care to the public as an over-arching priority in their management of their students, including students with disabilities and/or requiring accommodations.

The use of Benner's (1984) 'novice to expert' model as the conceptual framework for this study was highly appropriate, as it aptly framed the journey of allied health professionals transitioning into academia. When allied health professionals assume educator roles (particularly full-time positions), they are, in effect, novices in their new milieu of academia. However, what differs from Benner's nursing novices is that these 'educator novices' had been experts in their previous (clinical) positions. Their professional journey is from 'expert, to novice, to expert'. Within the Ontario college system (and more specifically, within the employing college and school of this study's participants), successful applicants to full-time faculty positions must provide evidence of high proficiency as practitioners in their clinical discipline. (As the direct supervisor of the nine participants in this study, this investigator was aware of the qualifications each

participant possessed when hired.) An additional element of their transition, which continues throughout the process of acquiring new knowledge and skills based in academia, is the realignment of their professional identity from health professional to educator. As with Benner's novice nurses, these novice educators could benefit from additional supports to help them move forward in their new roles.

The findings from this study revealed that all nine participants fully supported the inclusion of students with disabilities and/or requiring accommodations in their programs. However, as noted above, all five RRT participants expressed concerns about the ability of students with disabilities and/or accommodations to practice safely, either while students and/or after graduation. The concerns expressed by the RRT participants were similar to concerns expressed by nursing participants in similar studies investigating faculty attitudes towards students with disabilities. All nine participants indicated that they frequently feel their obligations arising from being regulated health professionals conflicts with their obligations to students in their role as faculty. When a perceived conflict occurs, the participants in this study stated they refer to the obligations aligned with their health identity for guidance. These findings are also in line with those found in similar studies.

This study offers new insights into the experiences of (non-nursing) allied health faculty who transitioned from clinical practice into academia, notably in an Ontario, community college setting. It augments what is currently known about the existence of dual identities (health professional and educator) in allied health faculty, and, what is known about their attitude towards students with disabilities and/or requiring accommodations.

## **Implications and recommendations**

To meet governmental, accrediting agency, and health regulatory body expectations, Ontario community college allied health programs must continue to recruit faculty from the health care sector. These faculty will in all likelihood continue to be drawn from the ranks of expert practitioners, active in their disciplines, who wish to participate in the education of succeeding generations of health professionals. Typically, these individuals are highly motivated to make this career transition, and bring vast skills and knowledge to their new educator roles. However, although employing programs are hiring experts, they are, in effect, onboarding novices, whose preparation to be educators can be quite minimal.

Given what is known from the literature (and from the insights gleaned from this study) about the transitional challenges faced by this cohort of educators, and how their dual identities affect them (and by extension, sometimes also, students with disabilities and/or accommodations), perhaps there are strategies that could improve their induction into academia. Educational leaders responsible for allied health programs might consider revising onboarding activities to proactively address what seems to be commonly occurring challenges for new allied health faculty. Focused supports such as strengthened mentor programs, opportunities to dialogue about the management of dual identities, and specific assistance on supporting students with disabilities, merit consideration.

## Chapter 2

### Literature review

#### Introduction

The literature review informed the conceptual framework and methodological approach for this study. This researcher had hoped that she would learn through the review not only if her research interest had been shared by others, but also what methods had been used in similar investigations. The review was instrumental in informing whether, where, how and by whom, related research on the proposed topic of inquiry had been undertaken, and identified connections and dissimilarities among the research. From this analysis of existing relevant research, and of various possible research designs and potentially applicable theories, a pathway for how the researcher could meaningfully contribute to the literature became evident. The conceptual framework was finalized, and the overall study structure and course of action was subsequently designed.

This review suggested that current understanding of the transitional experiences of allied health faculty (particularly of *non-nursing* allied health faculty) who leave clinical practice to assume full-time teaching roles, could be augmented through this study. This literature review revealed that considerable research had been undertaken on nurses transitioning from clinical practice to academia, but there was scant evidence of similar research having been done on non-nursing allied health professionals making a similar transition. The review also suggested that an opportunity existed to add to what was known about how ‘incomplete transitions’ by health practitioners into academic roles (meaning the continued identification by these faculty as health professionals instead of educators) is linked to their attitudes towards students with disabilities and/or

accommodations. Here, too, it became apparent that a focus specifically on *non-nursing* allied health faculty could perhaps best augment current understanding on the topic.

Again, although research on nursing faculty attitudes was reported in the current literature, nothing could be found relating to the attitudes of non-nursing allied health faculty towards students with disabilities and/or requiring accommodations. As well, it appeared that current understanding on *both* topics (transitional experiences, and, attitudes towards students with disabilities and/or accommodations) could be augmented by situating the study in a Canadian community college setting.

Equally important, the literature review revealed that the method most frequently used by previous researchers to investigate this topic, exploring questions similar to this researcher's, was the exploratory qualitative case study method, within an Interpretivist stance, using individual, or one-to-one semi-structured interviews. Benner's (1984) 'novice to expert' theory was chosen as this study's conceptual framework because of its applicability in understanding the dynamics present in the induction, and subsequent progression, of individuals entering a new and unfamiliar work setting.

This researcher discovered through her literature review that she was not alone in her area of research interest, and more importantly, neither was she alone among educational leaders in experiencing the research topic as a current problem of practice. The literature review was instrumental in identifying for this researcher what would be her methodological approach, clarified and focused her specific research questions, and validated the study's purpose and merit.

### **The orientation and direction of the review**

The literature review began with a search in academic databases (education, nursing, allied health) using several keywords and phrases (allied health faculty, health faculty transition, professional identity, dual identity, students with disabilities and/or accommodations in health programs, and duty of care). Fifteen research studies were identified that bore a direct relation to the topic. Of this initial fifteen, two had investigated transitional experiences (meaning faculty had left employment in clinical practice to become fulltime teachers) *and* the ongoing retention of dual identities of nursing, midwifery *and* (non-nursing) allied health faculty, but with no focus on the issue of faculty attitudes towards students with disabilities and/or accommodations.

One study explored the transition experiences of faculty in a single allied health academic unit, with no focus on faculty attitudes towards students with disabilities and/or accommodations. The remaining twelve investigated solely the transitional experiences of nurse clinicians into nursing educator roles, and of these twelve, seven focused on nursing educator attitudes towards students with disabilities and/or requiring accommodations. Fourteen were qualitative case studies and one was a qualitative meta-synthesis. The research on solely nursing faculty was conducted in Canada, the United States, the United Kingdom, Ireland and Australia, and included university and college settings. One of the two studies of nursing and allied health faculty (Smith & Boyd, 2012) was conducted in the UK, and the second (the meta-synthesis), by Murray, Stanley and Wright (2014), reviewed research from the UK, Ireland, and the United States, and included both university and college settings. The study that investigated solely an allied health faculty group (Hurst, 2010) was conducted in a UK university.



Following this initial scan, the researcher's ensuing review of the literature was organized along two main themes, which were separate but interconnected: firstly, the experiences of non-nursing allied health faculty who had transitioned from clinical roles into full-time educator roles, and their sense of dual identities in their new roles; and secondly, the attitudes of non-nursing allied health faculty towards students with disabilities and/or requiring accommodations, linked to their retention of a primary identity as health professionals as opposed to an identity as educators. This researcher's study explored the intersection of these two themes, that is, where non-nursing allied health faculty become responsible for supporting students with disabilities and/or requiring accommodations in their programs, within the context of their transition experiences and sense of professional identity. This dynamic of transition, dual identity (health professional and educator) and attitudes towards students with disabilities and/or requiring accommodations was itself set within the context of diverse legislative, regulatory, organizational and professional obligations. The literature selected for use was restricted to post-secondary settings but included colleges and universities, and was not restricted as to country of origin. Nevertheless, as it happened, the research that was unveiled all emanated in Western countries.

Providing important environmental context to this exploration was information acquired from sources such as Ontario and Canadian regulatory health care agencies and professional associations, Ontario Human Rights Commission directives, Ontario legislation relating to service to Ontarians with disabilities (education is considered a service under the Act), Ontario Ministry of Advanced Education and Skills Development policies on accessible education, and policies of the Ontario community college which

was the site of the author's study, respecting support for disabled students and students with accommodation needs.

### **Results from the first area of focus: transition experiences and two identities**

The literature reviewed suggests that assuming a new professional role and identity – particularly in health care – is much more than “simply learning the skills and knowledge necessary to perform a particular job. It involves learning about the attitudes, values, norms, language and perspectives necessary to interpret experience, interact with others, prioritise activities and determine appropriate behavior” (Hurst, 2010, p.241). Benner (1984) and Berliner (1986) refer to the process whereby practitioners transition to new roles (particularly within clinical settings) as that of evolving from novice to expert. The ‘once expert’ can become a novice in the new setting, and moves through stages of development until once again she or he is proficient as (or close to being) an expert.

Arreola, Aleamoni and Theall (2001) describe an individual new to college teaching as bringing to the position what they refer to as “base profession’s skills and knowledge including content expertise, practice and/or clinical skills, research techniques appropriate to their field, and strategies for keeping current in their field” (p.1). As well, Arreola et al (2003) refer to college teaching for such educators as a “meta-profession (that is) a profession that is built upon the foundation of another (base) profession” (p.1). They have conceptualized the roles and work of higher education faculty as belonging to this larger, more comprehensive meta-profession because “a college professor must perform at a professional level in a variety of roles that require expertise and skills in areas that often extend beyond the faculty member’s specific area of expertise” (p.1). Educational employers require these individuals to be expert in the areas in which they

teach, however, “the act of practicing one’s *base profession* ...is substantially different than that of interacting with learners in such a way that they, too, gain the skills, knowledge, and practice skills of that profession” (Arreola et al, 2003, p.2).

Following their research on nursing educators in UK and Australian university settings, Logan, Gallimore and Jordan (2015) asserted that “The transition into universities of the education of the ‘minor professions’, including teaching, social work and professions allied to medicine, has not always been seamless, due, in part, to the inherent tension between intellectual knowledge and the experiential learning in practice needed to meet the demands of professional practice, as in nursing” (p.2). Weidman, Twale and Stein (2001) refer to the historical practice of educators in professional programs serving a “gatekeeping function, upholding the mystique that pervades entry into professions” (p.98) as being an aspect of the culture in the health professions that impedes their integration into the broader post-secondary educational milieu.

Research into the experiences of allied health care practitioners who transitioned into academic roles as professors in health care educational programs have been reported by Anderson (2009), Boyd (2009), Crist (1998), Duffy (2013), Duphily (2011), Hurst (2010), Logan, Gallimore and Jordan (2015), Murray, Stanley and Wright (2014) and Smith and Boyd (2012). Hurst’s (2010) study on physiotherapists who undertook this career change revealed that every one of the participants felt their transition was significant and challenging, with periods of marked anxiety and stress. Some of their uncertainty was related to being novices as full-time teachers, despite all of them having been seasoned clinical educators, responsible for supervising students in community

based clinical settings. Lack of confidence as educators appeared to result in their need to reaffirm their credibility and identity as professional practitioners.

The participants in Hurst's (2010) study were split in half in terms of those who believed they had been able to successfully undergo the shift from clinician to educator, versus those whose identity (even five years into full-time teaching) remained firmly associated with that of a physiotherapist. Hurst labelled the tensions existing in some of her study participants as 'dual professionalism'. "Whilst still practicing clinically had the potential to influence the participants' professional identity perceptions, the need to remain up-to-date in the field of physiotherapy and professionally credible was articulated by all participants, not just those still experiencing patient contact" (p.245). Hurst's (2010) study concluded that the transition experiences of her participants were multifaceted and heavily influenced by prior clinical and life experiences, and by the support offered by the educational organization early on in the onboarding. Hurst (2010) concluded that to improve the transition experiences for allied health faculty into academia, and to enhance the adoption by these faculty of an educator identity, improved induction strategies would be beneficial. Further, she added that formal training "to specifically address those aspects of transition particular to clinicians making the shift from clinical practice into academia is suggested" (p.240).

Boyd's (2009) study of newly-appointed lecturers in nursing and education departments in a higher education setting in the UK found that their experiences were challenging and confusing, noting that "they tend to hold on to existing identities as practitioners rather than embracing new identities as academics" (p.155). Participants expressed a "perceived loss of status" (p.158) and discussed "the importance of having

credibility with students because of their very recent practitioner experiences as a nurse or as a school teacher” (p.159). All of those participants assigned considerable importance to remaining current with changing practices and policies in their original discipline but this was especially important to the new nurse educators, who were “much more concerned about maintaining currency in terms of recent practical work as a clinical practitioner” (p.161). Boyd’s (2009) study concluded that becoming a professional educator was a struggle in identity reconstruction for these practitioners turned educators.

Smith and Boyd’s (2012) investigation into the transition of newly-appointed lecturers in nursing (including midwifery), physiotherapy, radiography and occupational therapy revealed similar experiences of challenge, overwhelm, and uncertainty. Each participant, to varying degrees, continued to self-identify as a health practitioner for a considerable period of time into their academic appointments. “Tensions in the role...and the confusion this causes for identity building, featured strongly (among the study’s participants)” (Smith & Boyd, 2012, p.69). Despite their strong motivation to succeed in the academic setting, the process of reconstructing their identity took time and conscious effort, along with organizational support. Positive transition experiences and the earlier adoption of an ‘educator’ identity, were associated with comprehensive, formal organizational strategies. As noted by Hurst (2010), appointment to a lecturer position in the UK is attained only after having established oneself as an expert clinician with demonstrated practice competencies and a solid identity as a professional leader. As such, the adjustment, if not diminution, of this identity to be replaced by a new one as an educator, is not easily done.

McArthur-Rouse (2008) studied the transitional experiences of new nursing educators in the UK, and here, too, established that the transition from being expert clinical practitioners to novice lecturers was problematic for them, with accompanying feelings of role confusion and uncertainty of professional identity. Crist's (1999) four case studies situated in the United States, on occupational therapists who assumed teaching positions in an occupational therapy program, reported that all four participants learned that "doing therapy and teaching therapy are not synonymous activities" (p.15). In Crist's study, the participants struggled with mastering the responsibilities in their faculty role while maintaining clinical competence to remain current in their health discipline. Crist concluded that "maintaining dual credentials, clinical and academic, is a continual challenge for occupational therapy educators" (p.17).

Duffy's (2013) research into the formation of an academic identity by nurse educators in the UK's National Health Service also demonstrated that "the transition into higher education has not been easy" (p.623). Many participants expressed a sense of loss for their previous roles and perceived a lack of recognition in the educational organizations for their professional values. "Participants who retained their first order identity as a nurse experienced a sense of cognitive dissonance between their substantive self and their situational self-located in HEIs (higher educational institutions)" (p.622). One long tenured faculty member stated "there wasn't anybody who said well you are in higher education now and this is the ethos, and this is how you should be working..." (p.621). Duffy posited the participants adopted three core identities: (i) a nursing identity based on principles of care and nurturing; (ii) an academic identity focusing on students' cognitive development, designed to prepare students to "operate at a societal level"

(p.623); and (iii) a hybrid identity “designed to preserve a strongly framed sense of self-worth in accordance with their nursing, academic and practice roles” (p.623).

Anderson’s (2009) investigation of the work-role transition of clinical nursing experts who became novice nurse educators in mid-western American degree nursing programs echoed the findings of others that the transitions were disruptive, stressful, and contributed to tremendous feelings of uncertainty. Struggles with professional identity were commonly expressed by the participants: “I still see myself as an advanced practice nurse, the clinician... I still see myself in that role and haven’t been able to make the change...” (p.7). Duphily (2011), referring to the American milieu, discussed the prevalence of cultural dissonance (defined as “an uncomfortable sense of conflict or uncertainty experienced by those undergoing change in their cultural surroundings”, p.14), in nursing education settings, arising when nurse clinicians inadequately and incompletely transition into educator roles. As well, Duphily (2011) asserted that novice faculty are challenged to choose among what many of them perceive as differing value systems in the education setting, and that the longer this persists and is not addressed, the longer and more incomplete their transition remains.

Cangelosi, Crocker and Sorrell (2009) examined issues surrounding the transition of nurses from clinical practice to educator in the United States through the lens of an ‘expert to novice’ journey. Participants in that study voiced that although they undertook their transitions with the confidence they were expert clinical nurses, they became aware that as educators they were very much novices. One stated “nurses are vigilant in ensuring patient safety, and the biggest difference you can make in a patient’s life is to provide...safe practice: (p.2). The investigators noted that the participants quickly and

early on in the study identified themselves to the interviewers as expert clinical nurses who were feeling pronounced anxiety, fear and tension as they grappled with their new roles in education.

A meta-synthesis was conducted by Murray, Stanley and Wright (2014) of seven qualitative studies about the transition from clinician to educator from nursing, physiotherapy, health (occupational therapy, speech pathology, dietetics and podiatry), and social care. The field sites of the seven studies were in the UK, Ireland, and the United States. “All studies had a similar question and purpose and used ...individual, semi-structured interviews to gather data,...(and) all had nurses as their participants except for two” (p.390), one of which was unclear and one which was of physiotherapists (Hurst 2010). The central theme that emerged from this review was that of an identity shift being required of the clinicians when they became educators. Murray et al noted that the adoption of the new identity took time (ranging from 1 to 3 years), and that among the participants in all seven studies there was a pervasive sense of “discomfort, stress, under-confidence, disempowerment, loss of security and fear which led to self-doubt” (p.392). Participants sought credibility with their students by drawing on their clinical experiences when interacting with them, and believed that through this they were more respected. As well, participants were “surprised at how ill-prepared they felt” and perceived the academic culture as having “a vocabulary I didn’t have...a language that goes with academia that is almost like learning the secret handshake” (p.393). Many participants in the studies reviewed stated they were uncertain about when to stop using the title of clinical practitioner and start referring to themselves as educators, with this



uncertainty about role identity contributing “to difficulties of letting go of the old ways of operating and establishing a new definition of self” (p.394).

**Summary and conclusions.** This section of the literature review suggests that dual identity exists among allied health faculty (nursing and non-nursing) who transition from clinical positions into educator roles. It affirms that allied health faculty are conscious of ‘wearing two hats’, meaning that they self-identify as belonging simultaneously to two professions and occupations, which are their original health discipline, and, education. The transition into the academic setting precipitates feelings of role confusion, fear of loss of credibility, uncertainty, stress and anxiety. Further, allied health faculty undergo a process of identity reconstruction (which can take a considerable period of time) before becoming comfortable in their role of educator. Noteworthy is the research evidence suggesting that even when they feel confident as educators, many of these faculty continue to retain their health professional identity as their primary identity. Given that continued employment as an educator in post-secondary educational health programs is contingent on maintaining a license to practice in their health discipline, the existence of a dual identity by allied health faculty is a career-long reality with which they must come to terms.

### **Results from the second area of focus: attitudes of allied health faculty towards students with disabilities and/or accommodations**

The search for research conducted in the area of the attitudes of allied health faculty towards students with disabilities and/or accommodations resulted in the identification of investigations done only with nursing faculty. The researcher could find scant investigations on this topic having been done with non-nursing allied health faculty.

The research reported on nursing faculty was conducted in Canada, the United Kingdom, and the United States.

From her survey of 247 baccalaureate nursing programs in the United States, Watson (1995) identified that “nursing educators are facing critical issues regarding the obligations of nursing programs to accept and accommodate qualified applicants with disabilities” (p.148). Her results revealed that although the survey respondents reported having in place a plethora of support strategies to admit and enable disabled students into nursing programs, faculty struggle with articulating what are the core competencies and performance standards for graduates entering the profession, specifically in relation to finding the appropriate balance between critical thinking and knowledge acumen versus technical motor skills. Faculty expressed discomfort with being forced to (as licensed nurses and as educators) rethink what one needs to be able *to do* to be a nurse (p.152).

Carroll (2004), Swenson, Havens and Champagne (1991) and Sowers and Smith (2004) identified in their respective studies strong support for the principle of inclusion of persons with disabilities into nursing programs, and revealed comprehensive and sophisticated supports for students with disabilities and/or requiring accommodations, in the organizations participating in those studies. However, concerns about the ability of students with disabilities to succeed in clinical placement settings, and to actually be able to practice as nurses upon graduation, were commonly expressed by the participants in their studies. In all three studies, nursing faculty were deeply concerned about nursing students with disabilities providing unsafe patient care (while students and also after graduation). Completed over 25 years ago, the US-based study by Swenson et al (1991) involved a random sampling of 383 degree and 715 college nursing programs, which

showed that nursing programs were less likely to admit applicants requiring modified terms (meaning accommodations) for study. Consideration for modifications in clinical practice settings was offered in less than 25% of responding programs. A theme pervasive throughout the studies noted above was that nursing educators (many of the respondents referring to themselves as gatekeepers to their profession) cannot divorce themselves from how a graduate nurse performs in the field after completing her/his program of study, and that faculty members' personal licensure expectations and role identity affect their response to accommodation requirements.

Tee and Cowan (2012), reporting on a UK-based action research study undertaken to develop strategies to assist nursing educators and clinical nursing mentors to support nursing students with disabilities, identified that a shared understanding between practitioners and educators was essential for success in improving the inclusion of students with disabilities into nursing programs. It was important for educators to not just understand the concerns of clinical mentors (which they typically did), but to also reflect on their responsibilities as educators. As educators, the faculty participants in the study became more aware of their responsibility to adapt and assist students with disabilities, and practicing clinicians alike, to introduce modifications to training that would allow students with disabilities to perform. The faculty surveyed in the study reported strong emotional resonance with students who had disabilities, but needed support and assistance from peers and their organizations to navigate how they could themselves better assist them, without compromising competency assessments and nursing training standards.

Magilvy and Mitchell's (1995) literature review and survey of 200 degree and associate degree nursing programs in the United States revealed support, in principle, for accommodating the needs of students with disabilities and/or requiring accommodations. This study also revealed considerable evidence of practical assistance being provided in terms of (for example) adjusted assignments, due dates, and technological aides in classrooms and simulation settings. Magilvy and Mitchell noted barriers did exist external to the school settings with respect to clinical placements and graduation requirements that were tied to licensure examinations. In a Canadian study, Ashcroft, Chernomas and Davis (2008) identified that nursing educators, when faced with accommodation requirements from applicants and current students in a nursing program, expressed concerns not about how the students could be supported in the classroom and simulation learning environment, but whether those individuals could provide safe patient care, asking "how disabled is too disabled to be a nurse" (p.2), and how they could balance a student's right to education with their professional obligations regarding the protection of patient safety. Both the Magilvy and Mitchell (1995), and Ashcroft et al (2008), studies concluded that nursing programs which actively promoted and supported dialogue among faculty about their concerns relating to students with disabilities in their programs, resulted in the development of strategies that enhanced communications (among faculty, students and clinical partners), improved student accommodations, and reduced faculty concerns about the ability of students with disabilities to be good nurses.

**Summary and conclusions.** This section of the literature review suggests that dual identity and role confusion prevailing in nursing faculty influences their attitudes and behaviours towards students with disabilities and/or requiring accommodations.

Participants in the studies expressed a common set of concerns: the ability of students with disabilities and/or requiring accommodations to provide safe patient care; how to determine whether someone is too disabled to be a health professional; how to balance patient safety with student/human rights; how to maintain professional nursing standards; and, how to manage resistance to accepting nursing students with disabilities and/or requiring accommodations from clinical placement supervisors and health care providers.

This research conducted on nursing faculty argues that nursing educators, whether in college or degree programs, and across geographic locations, share common concerns about the capacity of students with disabilities and/or requiring accommodations to become competent nursing professionals, capable of providing safe care to the public. Although the studies' results describe nursing faculty as being purposefully attentive to students with disabilities, and holding a genuine interest in supporting their success, their worries about these students' ability to meet the expectations of the nursing profession as well as those of clinical placement partners and health care employers, hinder their capacity to fully accommodate students with disabilities, and advocate on their behalf. Nursing faculty felt stressed when they perceived they were being pressured between two competing sets of equally ethically based imperatives: firstly, the requirement to ensure inclusion of all qualified applicants to their programs and to accommodate students where needed to allow their academic progression, and secondly, their legally mandated professional duty of care to the public and their profession.

### **Considerations on the intersection of the themes**

Allied health faculty who make a career change from clinical practice into teaching frequently appear to find the experience of transitioning to be complex, difficult,

lengthy, and suffused with unexpected challenges. Their original and strongly held identity as a health practitioner and member of a regulated profession carries with it belief systems, attitudes and behaviours that continue to influence how they practice as educators. One consequence of the continuation (if not primacy) of an overwhelmingly singular identity as a health professional as opposed to that of an educator, is a struggle to find the appropriate balance between respecting their legal and regulatory obligations to patients and the public (their duty of care), and their legal and professional obligations to their students.

This unresolved tension can present itself in the attitudes of faculty towards students with disabilities and/or requiring accommodations. The optimum and ideal management of such students by health faculty can be negatively affected when the singular or dominant lens through which these faculty assess accommodation issues is through that of their health profession. The longer new faculty perceive there exists differing values between their original professions (of health practitioner) from their new profession (of academic), the more incomplete will be their transition. The more incomplete their transition, the more there is dissonance between their two identities, and the more likely students with disabilities will be affected. Although the literature review produced research heavily focused on nursing, the similarity in findings and themes across those studies, in addition to the few specific to non-nursing allied health disciplines, suggests with some confidence that the issue may be widespread in the allied health sciences, including among non-nursing allied health faculty.

## **The environmental context influencing allied health faculty in Ontario**

**Regulation and licensure.** In Ontario, legislation regulating health professions is provided in the Regulated Health Professions Act, 1991 (Government of Ontario, 1991). Schedule 1 in the Act lists the health professions covered by this Act, and notes them as Self Governing Health Professions. This legislation established health regulatory colleges for each of the named professions, and devolved to each college the authority to regulate the professions. Section 3 of the Act states “It is the duty of the Minister (of Health) to ensure that the health professions are regulated and co-ordinated in the public interest, (and) that appropriate standards of practice are developed and maintained...”. Each college has the authority to develop and regulate the criteria for qualification for certification and maintenance of registration, for developing and monitoring standards of professional practice, and for developing the ethical framework to be followed by its members.

All members of a regulated health discipline in Ontario, and therefore all allied health faculty teaching in a program in their capacity as a member of that discipline, must maintain their registration with their relevant college. The specific requirements to demonstrate fitness and suitability to be registered can vary from college to college, however, all require that members provide evidence on an annual basis that they are adhering to the rules and regulations of their college.

As an example of one Ontario regulated health college, the College of Respiratory Therapists of Ontario, through the powers delegated to it under the *Regulated Health Professions Act, 1991*, states as its mandate that it “is dedicated to ensuring that respiratory care services provided to the public by its Members are delivered in a safe and

ethical manner” and that its ethical principles are to “act fairly, do good and do no harm” (College of Respiratory Therapists of Ontario, 2010). The competency framework for its members is periodically updated, with a new national competency framework (NCF) having been drafted in 2016 in consultation with respiratory therapy regulatory bodies across Canada. The new NCF document (National Alliance of Respiratory Therapy Regulatory Bodies, 2016) strengthens the language regarding members’ requirements to be patient centered and defines members’ duty to patients as “Respiratory therapists owe a duty of care to patients and their families. They shall perform their duties in a safe and competent manner, being guided at all times by their concern for the health and well-being of the patient” (p.30).

The Canadian Society of Respiratory Therapists (a national professional association for respiratory therapists) has a complementary code of ethics for its members that reflects that of the regulated colleges, and directs that “respiratory therapists are accountable for meeting the ethical and legal requirements of the profession of respiratory therapy...and are committed to life-long learning to upgrade their knowledge and skills in order to keep their practice current.” (Canadian Society of Respiratory Therapists, website, 2015).

A second example of an Ontario regulated health college is the College of Medical Radiation Technologists of Ontario, also existing pursuant to the *Regulated Health Professions Act, 1991*, which states its mission is “to regulate the profession of medical radiation technology to serve and protect the public interest” (College of Medical Radiation Technologists of Ontario, 1991). Its members’ national professional association – the Canadian Association of Medical Radiation Technologists – emphasizes



in its code of ethics that members are to respect the key principles of patient centered care and safety, and are expected to demonstrate commitment to the profession throughout their career (Canadian Association of Medical Radiation Technologists, 2015).

**Obligations to students with disabilities and/or accommodations in Ontario.**

The Ontario Human Rights Commission's Guidelines on Accessible Education (2004) was its interpretation of the Ontario Human Rights Code as it applied to disabled students. Education has the status of a service under the Code, and "education providers have a duty to accommodate the needs of students with disabilities in order to allow them to access educational services equally, unless to do so would cause undue hardship" (p.7). Although stating that "there is no set formula for accommodation (p.9) the Guidelines require individual assessments and accommodation plans for each student, including applying differential treatments if that is what is required to ensure equal opportunities for them.

In March 2016, the Ontario Human Rights Commission wrote all public Ontario colleges and universities (Ontario Human Rights Commission. Letter to Ontario college presidents, 15 March 2016, re: Medical Documentation Guidelines and Accommodation) with new directives for the management of interim accommodations for students with mental health disabilities, retroactive accommodations, and disclosure of students' medical information. The directives enhanced supports for students either with disabilities and/or for students requiring accommodations, and included new medical documentation guidelines. All recipient institutions were required to demonstrate they had already or would commit to implementing the directive's measures by 06 September 2016. The college considered as the site for this researcher's study amended its policy

related to the accommodation of applicants and students with disabilities (Ontario College, 2015, Board of Governors Policy A101: Accommodation of Applicants and Students with Disabilities) in response to the directives. In addition to including all the required language and revised processes directed by the Commission, the policy adds as an accommodations principle that “The possibility that the student might not be successful in the program or the possibility that the student might not find related employment, are not acceptable reasons for failure to accommodate” (section 5.2).

In 2012, the College of Medical Radiation Technologists of Ontario advised all Ontario educational programs in medical radiation technology of amendments to the registration regulation that would affect graduates applying for registration with the college (College of Medical Radiation Technologists of Ontario, letter to Program Coordinators, 08 May 2012). One of the new requirements for registration provides that an applicant’s “past and present conduct must afford reasonable grounds for the belief that the applicant...does not have any quality or characteristic including any physical or mental condition or disorder, that could affect the applicant’s ability to practice...in a safe manner” (CMRTO letter, 2012). The impact on this amendment for educational programs relates to the common practice in programs of informing applicants and incoming students of the registration requirements of the college, in the belief that full and early disclosure assists individuals in understanding their ability to be registered and eligible to practice upon graduation. However, applicants are not required to disclose any such information to be accepted as a student in the medical radiation technology program (or other educational programs), and as educators, faculty are neither expected nor permitted to make such inquiries of students. Directives such as this issued by the

regulatory college can, however, have the effect on faculty that as members of that college, they should support and reinforce its appropriateness.

The documents referenced suggest that there exists an array of directives and expectations on allied health faculty that can be perceived as conflicting and incompatible. These faculty are challenged to integrate in their practices as educators a collection of obligations that are equally important and essential but which relate to different aspects of their dual identities. Although these allied health faculty have adopted education as their meta profession, it is not necessarily clear to them that when navigating the tension between the various laws and directives, there is a hierarchy. The education sector has a 'higher bar' to meet than does the employment sector, if considering not to accommodate. The burden of proof clearly lies with the post-secondary institution to determine that to accommodate a student would create a health and safety issue for the student or others. Simply stated, human rights legislation eclipses other obligations.

### **Conceptual framework: Benner's 'novice to expert' theory**

As introduced in chapter 1, Benner's (1984) 'novice to expert' theory (which she developed after studying novice nurses entering clinical practice) was selected as the conceptual framework for this study. In her research, the internationally renowned expert nurse researcher Patricia Benner referred to the Dreyfus Model of Skill Acquisition, "that posits that in the acquisition and development of a skill, a student passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert" (Benner, 1984, p.13). The Dreyfus model asserts that expertise cannot develop without experience, and that expertise is highly context-dependent. In other words, there is a difference between "the level of skilled performance that can be achieved through

principles and theory learned in a classroom and the context-dependent judgement and skills...acquired in real situations” (Benner, 1984, p.21).

Benner studied the applicability of this model to nursing practice. Her US-based research involved novice nurses, experienced (having at least five years of clinical experience) nurse clinicians, and senior nursing students, in six hospitals. Individual and group interviews, in addition to participant observations in the hospitals’ clinical settings, were conducted. Through the analysis of her research findings, and following the Dreyfus model, Benner concluded that it was “possible to describe the performance characteristics at each level of development and to identify, in general terms, the teaching/learning needs at each level” (Benner, 1984, p.20). As displayed in Figure 1, Benner’s model consists of the same five stages of progression found in the Dreyfus model (noted above). Each stage builds on the previous one, with respect to the ongoing acquisition of clinical skills, and, to the continuing integration and application of theory to practice.



*Figure 1: Benner’s (1984) Theory of Novice to Expert: stages of progression for new nurses in clinical nursing practice*

A discussion of each of the five stages in Benner's theory follows.

**Stage 1: Novice.** Beginning clinicians at this stage have little to no previous experience of the situations in which they are expected to perform. They begin this experience having been taught objective and theoretical principles, which are notably devoid of context and specificity. Benner noted that “the rule-governed behavior typical of the novice is extremely limited and inflexible” (Benner, 1984, p.21). She noted that novices are provided with rules to direct their performance, but that those rules can in fact hinder successful performance because they “cannot tell them the most relevant tasks to perform in an actual situation” (p.21). The novice's ability to use discretionary judgement is particularly limited. Of particular note is Benner's conclusion that the ‘novice’ label does not apply only to students, because any nurse entering an unfamiliar clinical setting may experience a ‘novice’ level of performance. Indeed, this principle could be extended to any health practitioner entering an unfamiliar clinical setting, with which she or he has no prior experience. To take this one step further, we are all novices at (least) one time or another.

**Stage 2: Advanced beginner.** At this stage, practitioners can demonstrate “marginally acceptable performance’ (Benner, 1984, p.22) in certain aspects of their responsibilities. This enhanced performance arises from the lived clinical experiences in which the novice has engaged. The advanced beginner now is able to apply learnings from clinical experiences, and, from interactions with patients and colleagues. As well, the nurse at this stage can begin to both understand and apply the previously taught principles to real situations, blended with growing personal judgement. Benner

emphasized that for individuals in this stage, mentorship support is important in helping advanced beginners to identify clinical patterns and set priorities.

**Stage 3: Competent.** Individuals in this stage have typically worked in the same setting for two to three years. “The nurse begins to see his or her actions in terms of long-range goals or plans of which he or she is consciously aware” (Benner, 1984, p.26). Essentially, nurses would at this stage have learned much from past experiences, and begin to view their actions in terms of long-range plans. These plans now encompass “a perspective...based on conscious, abstract, analytic contemplation of the problem” (Benner, 1984, p.26).

**Stage 4: Proficient.** The proficient clinician is able to view situations holistically, and in their entirety (rather than in their ‘aspects’). Decision making is greatly improved, and performance is guided by ‘maxims’. “The perspective (in relation to a clinical situation) is not thought out but presents itself based upon experience and recent events” (Benner, 1984, p.27). Benner observed that proficient nurses were confident about what to expect in given situations likely to present in their practice settings, and knew how plans would need to be modified to respond to those events. The nurses’ ability to recognize ‘whole’ situations (particularly when the ‘usual’ or ‘normal’ situation is absent) was noted in Benner’s research to be ‘less laboured’. Of note in her research was also the revelation that “the proficient performer considers fewer options and hones in on an accurate region of the problem” (Benner, 1984, p.29). Benner asserted that proficient performers respond best to inductive learning that uses experiences and exemplars for perspective.

**Stage 5: Expert.** Expert performers no longer rely “on an analytic principle (rule, guideline or maxim) to connect (their) understanding of the situation to an appropriate action” (Benner, 1984, p.31). They possess an intuitive grasp of the situations presenting to them, and their performance is fluid, flexible and highly proficient. Decision-making is faster and more confident (and accurate). Importantly, Benner noted that capturing the descriptions of expert performance of any expert (whether a nurse, or, as revealed in the Dreyfus model, whether a chess master or an airline pilot) is difficult “because the expert operates from a deep understanding of the total situation “(p.32), which they (themselves) often struggle to explain.

Benner’s novice-to-expert theory is worth understanding because of its significance in understanding how knowledge is acquired. It offers insights into the interplay between theoretical and experiential (practical) learning, and into the conscious (and subconscious) changes in practitioners when theory and practice become seamlessly interwoven. This theory suggests that anyone placed in a new and unfamiliar situation (whatever their background) becomes to some extent a novice, and evolves through stages of learning before becoming competent in their new role. It could be applied to health disciplines other than nursing (or even to other than health care disciplines in general). Further, it may have particular utility when considering the induction and ongoing educational and professional supports that organizations provide to new employees (whether new to the organizations and/or new to particular roles). It is also potentially a valuable framework when designing mentorship programs and competency models.

David C. Berliner (2004) augmented Benner's research by investigating the strategies used by teachers as they progress from the novice stage through to becoming experts, and particularly, by documenting the accomplishments of expert teachers. Similarly to Benner, he identified that "expertise is specific to a domain and to particular contexts in domains, and is developed over hundreds and thousands of hours" (p.201). He asserted that "experience alone will not make a teacher an expert, but it is likely that almost every expert pedagogue has had extensive classroom experience" (p.201).

From his investigations, Berliner concluded that novices are deliberate in their actions, while advanced beginners are insightful, competent performers are rational, proficient performers are intuitive, and expert performers are rational (meaning they "have both an intuitive grasp of the situation, and, seem to sense in nonanalytic and nondeliberative ways the appropriate response to be made" (p.207). Berliner's description of the behaviours of expert teachers aligns with Bolman and Gallos's (2011) discussion of pattern recognition by expert academic leaders: "to make sense of diverse forms and sources of information, higher education administrators do what doctors do ... they frame each situation by matching it with a familiar pattern. It's simple pattern recognition, honed by training and experience" (p.22)

As well, Berliner (2004) emphasized the important role of coaching and mentoring in the development of expert teachers, especially in an individual's early years in a teaching role. "Failure to provide these (coaching and mentoring) opportunities could restrict what and how much can be learned in the beginning years of learning to teach" (p.202).



## **Methodological approach**

Given that the research topic arose from a current problem of practice, Yin's (2014) model of using an exploratory qualitative case study to answer the 'how' and/or 'what' questions associated with a real-world challenge, seemed most appropriate for this study. "As a research method, the case study is used in many situations, to contribute to our knowledge of individual, group, organizational, social, political, and related phenomena" (Yin, 2014, p.4). Further, Yin (2014) stated that "the distinctive need for case study research arises out of the desire to understand complex social phenomena" (p.4).

Yin's argument in support of using exploratory qualitative case studies in research such as was being contemplated by this researcher, was found to be shared by others (Flyvbjerg (2006), Cohen, Manion & Morrison (2007), Creswell (2014), Merriam (1998), Mears (2009), and Gay, Mills & Airasian (2012)). All of these researchers recognized the limitations of qualitative studies in terms of generalizing their findings, but asserted that valuable information and practical knowledge can emerge from in-depth studies of particular phenomena. Whilst being context and situation-specific, exploratory qualitative case studies also illuminate living, dynamic situations by assigning value to the meanings offered by a study's participants (Merriam, 1998). This approach typically reports how individuals have interpreted their world, and accepts those interpretations as reality. Researchers using this investigative approach are themselves central players in the process, because they in turn interpret the interpretations of their research participants.

Sale, Lohfeld, and Brazil (2002) discussed the qualitative paradigm as being based on interpretivism. Ferguson (1993) viewed interpretivism as a process whereby

individuals explain and shed light on their lived experiences, and subsequently construct what they believe to be facts. The meaning given to something perceived and expressed by research participants in a qualitative case study is in fact their actuality. This researcher also felt that Maxwell's (2013) position that the research problem is an integral element in a study's conceptual framework was helpful guidance. As noted earlier, the researcher's review of the above-noted literature confirmed that an exploratory qualitative case study, using an Interpretivist stance, would be the most suitable manner in which to address her two research questions. The decision to use individual, semi-structured interviews with this study's participants arose from learning about its general merits from (example) Mears (2009), and, Creswell (2014), and from noting its use in some of the relevant studies found during the literature review (Hurst (2010), Anderson (2009), Boyd (2009), and, Logan, Gallimore & Jordan (2015)). In particular, semi-structured interviews provided an opportunity to ask the same core suite of questions to each participant, on a one-to-one basis, with the option of asking individual follow-up questions to participants depending upon the nature of their respective answers to earlier questions.

## **Chapter 3**

### **Methodology**

#### **Introduction, background and context**

Access to high quality, expert, and compassionate health care is a universal expectation in Western countries, a fundamental human right, and an important quality of life indicator. Canadians value their publicly-funded, universal and accessible health care system. Ontario is a leader with respect to its academic health science centres, medical research and regulatory framework that controls the entry to practice, licensing and monitoring of health professionals. In Ontario, as in the rest of Canada, the education of allied health professionals (as distinct from physicians) is the responsibility of community colleges, polytechnic institutions and universities. With the closure of hospital-based training programs from the 1970's onward, the education of most allied health professionals such as respiratory therapists, medical radiation technologists, pharmacy technicians, and occupational therapists (to name a few) migrated to community colleges.

Responsibility for the training of students in allied health programs, and for preparing them to write licensing examinations in the regulated disciplines, was therefore transferred to provincial ministries of education, while professional regulatory and licensing bodies for each allied health discipline, and accrediting agencies mandated to assess and adjudicate on the quality of education in those programs, maintained their oversight and influence. Collectively, these bodies determine the mandatory competencies for entry to practice, educational programs' curriculum content, student clinical experiences, licensing and registration requirements and lifelong learning

expectations of practitioners. The preparation of successive generations of health care providers is thus a highly controlled process comprised of a tightly interwoven matrix of educators, practitioners, policymakers, and diverse stakeholders who have a mandated accountability for contributing to the provision of high quality, safe and appropriate care to the public.

Faculty teaching courses deemed core to the particular college program and discipline must maintain registration and a license to practice with their respective professional body. Annual reporting requirements for licensure include detailing the teaching and/or clinical work they have undertaken related to their employment, what professional association activities they have engaged in such as serving on provincial or national committees, and participation in advocacy activities. These expectations are in addition to their educational employers' expectations for ongoing professional development in the field of education. Each must hold the credential particular to the allied health discipline, although the need for additional postsecondary academic credentials required to teach in a school of health sciences in a community college varies (example BSc, B.Ed. or M.Ed).

Overwhelmingly, before an individual obtains a full-time teaching role in a community college allied health program, she or he will have successfully acquired extensive employment experience as a practitioner in that discipline in a clinical (generally hospital) setting. They are customarily considered experts in their field, and will have been respected in their discipline prior to transitioning into an educational setting. Their personal and group identity is a strongly embedded sense of being a member of a human service, caring profession, with ethical responsibilities to patients

and society. Weidman (2001) and Swenson (1991) refer to the historical practice of faculty and practicing professionals serving a gatekeeping function into the professions, which remains an aspect of the culture of the health professions. These individuals assume a new identity of educator but do not discard their first identity of health professional. Their responsibilities and accountabilities as health professionals continue in parallel with their responsibilities and accountabilities as educators. They are simultaneously teachers and practitioners, and thus these two identities are, in effect, twinned throughout much of their careers.

### **The study's purpose and research questions**

The key purpose of this investigation was to contribute to the existing body of research that has examined the experiences of allied health faculty who transitioned from clinical practitioner roles into full-time educator roles. Overwhelmingly, the existing research has focused on allied health *nursing* faculty, and so the focus of this investigation was on *non-nursing* allied health faculty. As well, given that little of the currently available published research on this topic had been undertaken in a Canadian post-secondary educational setting, and none in a Canadian community college, this study could make a unique contribution by being situated in an Ontario community college.

An additional purpose was to contribute to the current body of knowledge about non-nursing allied health faculty's attitudes towards students in their programs with disabilities and/or requiring accommodations. This second focus was included because previous similar research (which, as noted, has been primarily on new nursing faculty) reported that incomplete and/or lengthy transitions from clinical practice into academia

were associated with faculty retaining their primary identity as a member of a health discipline, and not fully adopting identities as educators. The retention by these faculty of their primary health care identity (in place of identifying primarily as educators) has been noted in the existing research to affect their attitudes and approaches to students with disabilities and/or requiring accommodations. Challenges in reconciling professional duty of care obligations to the public with education system expectations to be 'student focused' have been shown to present in their attitudes towards students with disabilities requiring accommodations wishing to become health professionals.

It was hoped that this exploration would aid in developing understandings and strategies that could facilitate improved experiences for individuals transitioning from clinician to educator, and thus expedite their adoption of a personal identity as an educator. An expedited and more fulsome adoption of an 'educator' identity could as a consequence enhance their capacity and self-confidence in managing students with disabilities and/or accommodations. This research aimed to address what appeared to be a gap in the literature on this subject, pertaining to non-nursing allied health faculty in general, and in North America in particular. Through a qualitative, exploratory case study, two teams of full-time faculty, holding two different health professional designations and teaching in two different programs were interviewed.

As noted earlier, the two research questions were:

1. How did Respiratory Therapy and Medical Radiation Technology Faculty who transitioned from clinical practice into academia experience the transition?
2. What were the attitudes of Respiratory Therapy and Medical Radiation Technology Faculty towards students with disabilities requiring accommodations?

## Framework

The initial framework for this study was drawn from the preliminary review of the literature and published reports of similar investigations. As noted in Chapter 2, the most common research approach to previous investigations on these research themes has been to use exploratory, qualitative case studies. This study was therefore positioned within what was currently known on the topic, and how this knowledge was obtained. Also as discussed in chapter 2, this investigator chose to use Benner's (1984) theory of 'novice-to-expert' as the study's conceptual framework. The journey of allied health professionals transitioning into educator roles contrasts somewhat from Benner's model because allied health faculty become novice educators after having been expert practitioners (in the clinical setting). However, Benner's 'novice-to-expert' theory provided an excellent conceptual structure around which to consider the transitional evolution of allied health practitioners into allied health educators, from the perspective of knowledge and skills acquisition, *and*, identity realignment.

This researcher adopted (as had many of the previous researchers investigating similar topics) an Interpretivist paradigm to explore the research questions. The Interpretivist approach was appropriate because it *guides and frames* how phenomena and personal narratives can be studied, rather than imposing or testing specific theories in the process. It is concerned with discovering how individuals make sense and meaning, which aligned with this researcher's goal of understanding and interpreting the world of her study participants as revealed through their eyes.

Bakker (2010) states that because "the goal of case study research is to grasp the totality of a situation or process...case study research is associated with an emphasis on

the importance of interpretation of human meaning” (p.486). “Interpretive inquirers...emphasize the idea that research is a moral and practical activity that shares much in common with other forms of inquiry such as those practiced by novelists, journalists, and ordinary people in their day-to-day lives” (Smith, 2008, p.459). Smith (2008) states also that “the focus is on *the interpretation of the interpretations* people give to their own actions and activities” (p.461). Merriam (1998) writes, with reference to interpretive research, that “understanding the meaning of (a) process or experience constitutes the knowledge to be gained from an inductive, hypothesis or theory-generating (rather than a deductive or testing) mode of inquiry” (p.4). Sale et al (2002) assert that “the qualitative paradigm is based on interpretivism” (p. 45). Further, interpretivism has been characterized as the belief that facts “are the social constructions of humans who apprehend the world through interpretive activity” (Ferguson, 1993, p.36).

The research questions arose from a perceived problem of practice, that is, within a current situation and observed behaviours of individuals in a common setting, with goals of better understanding those behaviours, of contributing to existing related research and literature, and of offering recommendations to ameliorate the practice problem. Maxwell’s (2013) assertion that the research problem is a part of one’s conceptual framework “because it identifies something that is going on in the world...that is itself problematic” (p.40) was adopted, as was his statement that a research problem “functions to justify your study, to show people why your research is important; this problem is presumably something that is not fully understood, or that we don’t adequately know how to deal with” (Maxwell, 2013, p.40).



As well, the research questions for this study arose from personal experiential knowledge of this investigator, and from existing research literature which validated the pervasiveness of the practice problem, and provided justification for the study. An exploratory qualitative case study was highly appropriate for use, since the objective was to engage the participants in an exploration of their personal experiences and reflections. The case study approach suited this investigation's focus on what was an analysis of a contemporary and 'bounded' phenomenon, for the purpose of explaining it. The use of an exploratory qualitative case study in this instance also had strong merit because this research method is most useful in answering 'how' and/or 'what' questions (Yin, 2014, Creswell, 2014, Merriam, 1998), particularly as they relate to narrative data and natural phenomena. Yin (2014) stated that "the case study (method) is preferred when examining contemporary events, but when the relevant behaviors cannot be manipulated" (p.12). Further, (Yin, 2014), case study investigations rely on multiple sources of evidence (requiring data to converge in a *triangulated* manner), and are enhanced when theoretical propositions guide data collection and analysis. Importantly, the perceptions of case study participants are accepted as their reality, and the findings of case studies are dependent on the investigator's own interpretations.

Case studies support in-depth investigations into real world situations, and can accommodate the interpretivist perspective that acknowledges that multiple realities have multiple meanings. "Interpretive case studies ...contain rich, thick description (about a problem)...with the intent of analyzing, interpreting, or theorizing about the phenomenon" (Merriam, p.38). Thanh and Thanh (2015) noted that "in the interpretive paradigm, the crucial purposes of researchers are to get 'insight' and 'in-depth'

information” (p.26). Of particular importance to this researcher (because of the origins of her study in a real-world problem of practice), was the possibility (or more accurately, the hope) that “insights gleaned from case studies can directly influence policy, practice, and future research” (Merriam, 1998, p.18). As an educational leader, this researcher felt strongly that this study should have, as one its outcomes, knowledge that could be applied to the benefit of her educational work setting. Support for the suitability of a case study approach to this study is also noted by Merriam (1998), in that “because of its strengths, case study is a particularly appealing design for applied fields of study such as education” (p.41).

Although often criticized as lacking rigour and validity, and being too subjective, a qualitative, interpretivist approach can legitimately, comprehensively and thoroughly examine and offer explanations on a particular phenomenon (Creswell, 2014, Gay et al, 2012, Merriam, 1998, Yin, 2014). In defending case study as a method, Flyvbjerg (2006) asserts that, when done well, qualitative case study research typically develops context-dependent knowledge which is critical to competency development, mastery and expertise, and that the extent to which a case study can be generalized depends upon the case selected. Merriam (1998) adds that “in qualitative research, a single case...is selected precisely because the researcher wishes to understand the particular in depth, not to find out what is generally true of the many” (p.208).

Despite concerns about small sample sizes in qualitative studies, and criticisms about an inability to generalize findings, it is argued that this is case and situation dependent. In-depth case studies of a particular phenomenon can be illuminating and immensely valuable to specific settings and contexts, and produce practical knowledge to

inform and improve current, lived situations. Adopting an interpretivist approach within qualitative exploratory case studies means assigning value to interpreting the meaning made by participants to the events and circumstances in their worlds. The meaning given to understanding and representing the individual and collective narratives provided by this study's participants is the essence of the work.

### **Methodological design**

As noted in chapter one, this exploratory case study was a single case design with a single unit of analysis, consisting of two subunits (two groups of faculty participants, drawn from two program teams, distinguished by their health discipline). It explored the personal experiences and reflections of two groups of (non-nursing) allied health faculty in a School of Health Sciences in an Ontario community college, who had transitioned from full-time positions in clinical practice in health care settings to full-time teaching roles. The study's approach at the outset was not to purposefully compare the two faculty groups but to use the two groups as examples of non-nursing allied health faculty disciplines. However, it was intended that any notable differences in responses between them (if apparent) would be reported. One group was the full-time faculty in a Respiratory Therapy Program, and the second was the full-time faculty in a Medical Radiation Technology Program, in the same School of Health Sciences at the same Ontario community college. The groups selected were not intended to be random samples, but were specifically identified because of their relationship to the two research questions (that is, they were non-nursing allied health faculty, holding full-time teaching positions), and because the purpose of the interviews was to obtain depth – not breadth – of narratives. Only full-time faculty were included for participation because these

individuals (as distinct from less than full-time faculty) had definitively and fully made a complete employment and career transition from a clinical practice to educator role.

The maximum number of potential participants was ten (five from each program). As noted earlier in this chapter, a limitation and frequent criticism of qualitative case studies relates to their small sample sizes, however, as Merriam (1998) states, “sample selection in qualitative research is usually (but not always) nonrandom, purposeful, and small” (p.8). Further, “purposeful sampling is based on the assumption that the investigator wants to discover, understand, and gain insight, and therefore must select a sample from which the most can be learned” (Merriam, 1998, p.61). The sample size permitted in-depth interviewing of each participant within the expected timeframe for the study.

These two programs were selected from other non-nursing allied health programs in the School of Health Sciences because of their similarities. They are both three year advanced diploma programs (as determined by the Ontario Ministry of Advanced Education and Skills Development), and both are accredited programs (meaning both have been assessed by external ‘accrediting’ bodies as meeting or exceeding standards required to prepare students for entry into specialized professions). In addition, all ‘core’ courses (that is, courses central to the theory and practice of the particular health discipline) are taught fully by faculty holding licensure as regulated health professionals in the particular discipline in each program. Students in both programs have similar periods of placement expectations in clinical settings as part of their programs, and are prepared upon graduation to write professional licensing examinations. Within the School, these two programs have the first and second highest annual student intake, and

the highest number of students overall. Although the two programs, and the faculty teaching in them, share many similarities, the use of the two groups offered opportunities for comparison and analysis of similarities and differences in their interview responses. These particular respiratory therapy and medical radiation technology programs, within this particular school and college, were selected for study because this is the workplace of the researcher, and the author's understanding of the issues studies and situational dynamics were central to the investigation.

Following approvals from the Research Ethics Boards of both the University of Western Ontario and the community college where the two program were situated, a research assistant (RA) with experience in research interviewing was contracted to manage and conduct the interviews. The college REB required that because of the researcher's role as direct supervisor to the hoped-for participants, it was preferred that someone other than her recruit the participants, process the consents to participate and conduct the interviews so that there was participant anonymity. Because the RA did not have a healthcare or community college background, the researcher oriented her to the research topic and to the setting (that is, allied health programs, school, college, and student accommodations), and the terminology of regulated health professions and health associations. This was important, as, "to make the most of an interview, it is necessary to be informed enough about the topic and the setting so that questions can be well framed and appropriately posed" (Mears, 2009, p.81). Although the interview questionnaire was developed by the researcher, because of its semi-structured design (which allowed for follow-up questions by the RA) this researcher wanted the RA to be an 'informed'

interviewer, able to ask follow-up questions and/or seek clarification to responses, with a reasonable degree of understanding and confidence about the topics being discussed.

### **Data collection and analysis**

A Letter of Information (appendix i) and Consent Form (appendix ii) was emailed by the researcher to each member of the full-time faculty in the Respiratory Therapy and Medical Radiation Technology programs, using their work emails. Follow up communications to confirm participation, respond to questions, arrange the interviews and obtain consents were done by the research assistant (RA). Individual, one-to-one semi-structured interviews were conducted by the research assistant, using a common set of questions (appendix iii) but which allowed follow up questions by the interviewer, and open-ended, additional commentary by the participants. The researcher believed a semi-structured interview to be the most appropriate tool for engaging the participants because interviews “enable participants to discuss their interpretations of the world in which they live, and to express how they regard situations from their own point of view. (the) interview is not simply concerned with collecting data about life: it is part of life itself, its human embeddedness is inescapable” (Cohen, 2007, p.349). Merriam (1998) recommends the use of interviews “when we cannot observe behavior, feelings, or how people interpret the world around them. It is also necessary when we are interested in past events that are impossible to replicate” (p.72). In addition, “for the most part...interviewing in qualitative investigations is...open-ended and less structured” (Merriam, p.74). Mears (2009) also recommends the use of interview tools that are semi-structured and open-ended particularly when interviewing for education and social science purposes.

All interviews were conducted in a secure and private location (to ensure confidentiality), and arranged at the date, time and location preferred by the participants. All participants consented to the audiotaping of their interviews, and all nine answered every question. Interviews began on 15 August 2016 and concluded 29 September 2016 (appendix iv). Nine out of ten potential participants (four out of five from the Medical Radiation Program, and five out of five from the Respiratory Therapy program) consented to participate. The duration of the interviews ranged from 50 minutes to 1 hour and 45 minutes, with a typical length of 70 minutes. All participants responded to each interview question, and all offered additional, non-directed personal comments at the conclusion of their interview.

Between the sending of the LOI and consent email and the start of the interviews, all nine participants communicated directly with the researcher (seven in person) to hand deliver their signed consents, irrespective of the direction in the LOI that to maintain their privacy and anonymity of participation they would do this with the RA. Each also opened a conversation about their appreciation of, and keenness to, participate in the study and be interviewed. After the interviews began, the RA reported to the researcher that although she reminded each participant at the beginning of her/his interview that their identity and individual responses would be kept anonymous from the researcher, each replied that that was not of concern to them. During the interviews (all of which were audiotaped) the participants frequently identified themselves in the first person as well as referred to conversations with the researcher. The RA expressed she was struck by what she perceived as a sense of a shared purpose among the participants with the researcher, in exploring the study topic. Six of the nine participants emailed or came to

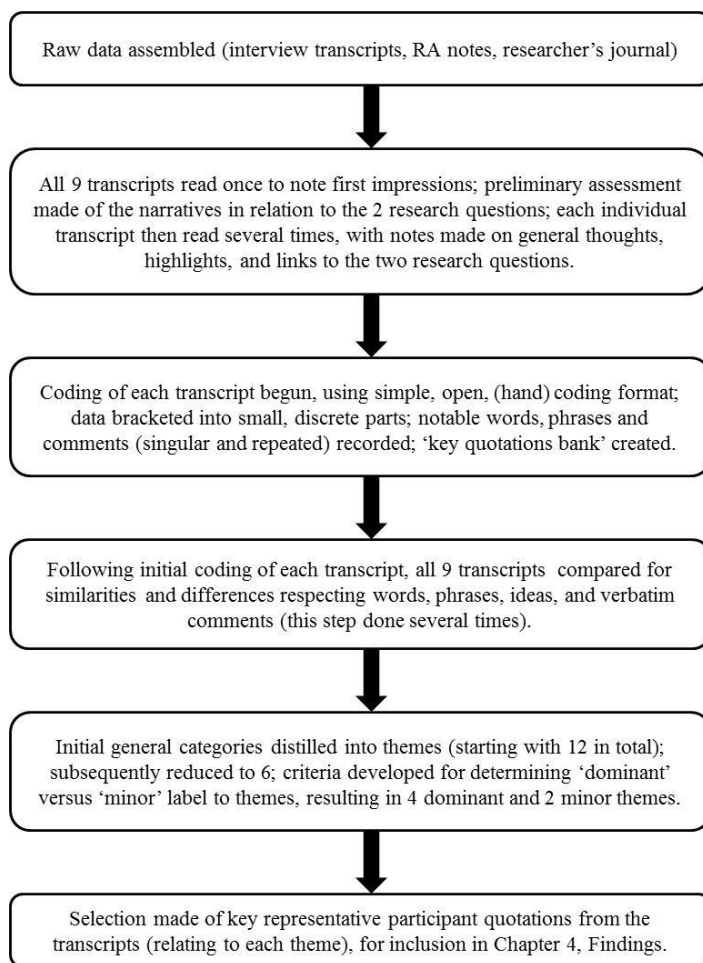
see the researcher immediately after her/his interview, to tell her how much they enjoyed it, and to complement her on the choice of RA. The remaining two participants approached the researcher to discuss their interviews within two weeks of them. Because of these responses and behaviours shown by all nine participants, the researcher transcribed the audiotapes and conducted the member checking meetings herself. Member checking meetings occurred between 04 October 2016 and 21 October 2016 (appendix v). All nine participants participated in individual, member-checking meetings.

As depicted in Figure 2, all nine transcripts were initially read quickly to note first impressions. Each narrative was reviewed in relation to the two research questions. Each transcript was then read several times before coding was attempted, and coding was done for only one narrative at a time. A simple, open coding format was used whereby the data were gradually broken into smaller, discrete parts from which categories and themes were created. Each time a transcript was read, comments relevant to the study questions were highlighted, and a 'key quotations bank' was created. Ideas, phrases (singular and repeated), and comments made with particular emotion by a participant, or which the author found moving or impactful, were noted. When this process was completed for each transcript, all nine transcripts were compared for similarities and differences respecting patterns of words, phrases and verbatim responses. This was done many times, in order to distill the information into categories.

The initial roughly labelled categories were subsequently distinguished as dominant and minor themes. The researcher most closely followed the guidance of Mears (2009), Merriam (1998), and Creswell (2014) on how best to interpret and manage



narrative data. As will be seen in Chapter 4 (Findings) considerable verbatim participant narratives are included because the narrative data was indeed rich, and also because, in the words of Mears (2009), “a clarity emerges from the narrative since it *recreates* the experience instead of *telling about it*” (p.126). Although the process was fully subjective, it was systematic, and included a collection of internal checks and balances. This investigator is confident that the themes she identified as emerging from the findings do (in Merriam’s (1998) words), reflect the purpose of the research, are mutually exclusive, and are sensitive to what is in the data.



*Figure 2: Process used for analysis and validation of interview data*

At each member checking meeting, the researcher informed each participant that her (that is, the researcher's) job "as a researcher is to ensure that his or her voice is accurately heard" (Mears, 2009, p.133), and that his or her assistance was needed to do that. The researcher's identification of words, key quotations, expressions and meaning were presented to the participants for validation, as were the themes perceived by the researcher. Each participant was given the opportunity to confirm (or correct, if needed) that the information collected from them, and the researcher's interpretation of that information, was accurate and faithful to their responses. Clarifications were made where necessary. Each participant was given the opportunity to reflect generally on the interview questions and on their responses. Member checking meetings focused only on that participant and not on any comparisons, patterns or differences from any other participant's narrative.

Triangulation of data was undertaken as an integral and expected (searching or investigative) element of data analysis. In qualitative research, triangulation is a process of using multiple data sources (or, depending on the research, possibly multiple methods and/or data collection techniques) to confirm the emerging findings (Merriam, 1998). It is used "to build a coherent justification for themes (and) if themes are established based on converging several sources of data or perspectives from participants, then this process can be claimed as adding to the validity of the study" (Creswell, p.201). Triangulation serves to cross-check the potentially wide variety of information sources qualitative case-study researchers may use in their investigations.

For this investigation, triangulation of data was undertaken using three distinct data sources: the research findings (the participants' interview narratives); the published

results of research related or similar to the topic of this research study (from the review of the relevant literature); and, documents and communications from government and other sources (provincial, Canadian and British health professions' regulatory bodies; provincial and Canadian professional practice associations; Ontario Human Rights Commissions directives and publications for Ontario post-secondary institutions; policies related to the admission and management of students with disabilities and/or requiring accommodations of the Ontario community college employing the study participants; and, Ontario Ministry of Advanced Education and Skills Development directives and policies). The assessment of how the information contained in all three areas connected with, reinforced or otherwise influenced each other (with special attention to how the findings were corroborated by the other two data sources) 'rounded out the picture' of what this investigation studied. This activity cross checked, verified and validated this researcher's conclusions by assessing linkages, relationships and patterns among the three data sources, The researcher amalgamated what she had observed and understood prior to the study with what she read and learned from the literature and other documents, with what she heard and learned from the interviews.

### **Validity, reliability, and ethics**

Several processes enhance the internal validity of qualitative investigations, that is, "the extent to which research findings are congruent with reality" (Merriam, 1998, p. 218). Measures considered standard to strengthening the validity of qualitative case study research, such as systematic coding, member-checking, investigator self-reflection, and triangulation of data, were used in this study. "Rigor in qualitative research derives from the researcher's presence ...the triangulation of data, the interpretation of

perceptions, and rich, thick description” (Merriam, 1998, p.151). Member checking (which was completed with all nine participants in this study) is widely considered to be a highly valuable strategy for enhancing the validity and reliability of qualitative research (Creswell (2014), Gay et al (2012), Merriam (1998), and Yin (2009)). Simple and straightforward internal validity actions that were taken included ensuring that the interview questionnaire was identical for each participant, the use of the same (and only) research assistant for each participant interview, and the completion of the member-checking meetings by the same person (the researcher). There was only one researcher interpreting the findings and all other data.

The researcher was aware that “in many respects, research from within (one’s own) setting becomes more challenging, for it requires overcoming your personal lens in order to understand from the other’s point of view. The practice of reflexivity can provide insights...through which a researcher recognizes, examines and understands how his or her own social background and assumptions can intervene in the research process, by reflecting on differences as well as similarities to the individuals whose experience is being researched” (Mears, 2009, p. 83). It was essential to this research to ensure that any and all data from the findings that was counter to the researcher’s initial expectations and/or to the findings of related research, be noted.

Yin (2014) cautions against the danger of case study interviews being used to confirm a researcher’s perspective, and as such, vigilance in regard to a researcher’s personal biases is essential when conducting qualitative research. The researcher’s self-reflections and journaling throughout the planning and completion of the study was a disciplined way to bracket or maintain a check on biases that could have inserted

themselves. Not only because of the researcher's previous identity as a health care professional but also because of her employment relationship with the participants, process repetition (redoing and rechecking each stage between 'breaks' in time) of coding and data analysis, identification and construction of themes, member checking and data triangulation was done. The researcher paused many times to reread and reflect on the participants' narratives, to ensure that as much as was possible (given the personal and subjective nature of the task), the conclusions she drew and the themes she developed arose wholly from the data, untainted by her own biases or projections. Because "deciding what is important...is up to the investigator...opportunities exist for excluding data contradictory to the investigator's views" (Merriam, 1998, p.216). The member checking process was a singularly important mechanism to ensure against this happening, and ultimately strengthened the trustworthiness of the data and the study's conclusions.

Participants were portrayed in the study and thesis so as not to identify them, and were addressed, for example, as 'participant # 'x' and disciplinary credential 'y''. When distinguished in direct quotations in Chapter 4, participants were noted by a number and by the professional designation of MRT or RRT. Data collection and data management adhered to the research ethics requirements of both the University of Western Ontario and the employing college of the participants. The security, confidentiality, storage and retention of all study materials including signed consent forms, audio-recordings, transcripts and emails conformed to the protocols of both REBs (University of Western Ontario and the participants' employing college).

## Chapter 4

### Findings

#### Participant Data

As noted earlier, nine of the ten potential participants invited to participate in the study agreed to do so. Four were full-time faculty in the Medical Radiation Technology Program, with each currently licensed to practice in Ontario as medical radiation technologists (MRT), and five were full-time faculty in the Respiratory Therapy Program, with each currently licensed to practice in Ontario as registered respiratory therapists (RRT). As shown in Tables 1 and 2, the length of time the MRT faculty participants had been registered in their discipline ranged from 25 to 33 years, with a median of 29 years. The length of time the RRT faculty participants had been registered in their discipline ranged from 10 to 39 years, with a median of 17 years. The length of time the MRT faculty participants had been employed full-time in their teaching positions ranged from three to sixteen years, with a median of 11.5 years. The length of time the RRT faculty participants had been employed full-time in their teaching positions ranged from 1 to 28 years, with a median of eleven years.

Table 1: *Individual MRT and RRT participant data*

<b>Participant # and discipline</b>	<b>Years registered in discipline</b>	<b>Years in part-time teaching and/or clinical supervision</b>	<b>Years in full-time faculty role</b>
#1 MRT	35	25	10
#2 RRT	17	5	11
#3 RRT	33	4	27
#4 MRT	33	10	13
#5 RRT	39	20	15
#6 RRT	13	11	1
#7 MRT	25	7	16
#8 MRT	25	22	3
#9 RRT	10	4	3

Table 2: *Aggregate participant data by discipline*

Professional designation	Number of participants	Median of years registered in discipline	Median of years in full-time faculty role	Number of participants with prior teaching and/or clinical supervision	Median of years in part-time teaching and/or clinical supervision
Medical radiation technologist	4	29	11.5	4 (100%)	9
Respiratory therapist	5	17	11	5 (100%)	5

All nine participants had either taught courses in their discipline in a community college and/or formally supervised students training in their discipline in a clinical (hospital) setting prior to assuming full-time teaching roles with their current community college employer. The length of time the MRT participants had been part-time professors and/or clinical supervisors prior to becoming full-time professors ranged from one to fifteen years, with a median of nine years. The length of time the RRT participants had been part-time professors and/or clinical supervisors prior to becoming full-time professors ranged from four to eleven years, with a median of five years. One MRT participant and three RRT participants continue to work in their discipline on a part-time or seasonal basis in local hospitals.

At the time of the study, all nine participants were actively engaged with their professional associations and/or their regulatory bodies on an ongoing basis, in activities such as certification examinations, accreditation teams, professional oversight committees, educational program standards, and codes of ethics reviews. Seven participants stated that the extent of their involvement in their professional associations

and/or regulatory bodies was unchanged from when they were employed full-time as clinicians to the present. One participant (RRT) stated he is more involved in professional and regulatory affairs since his appointment as a full-time professor, and one participant (MRT) stated he is somewhat less involved in professional and voluntary regulatory affairs since his appointment as a full-time professor. This individual cited his reduced involvement being due to his recent (two years) transition to full-time teaching, and his focus on adapting to his new role. At the time of the fieldwork, all nine participants fulfilled the requirements of their respective licensing bodies and of their employing college, to maintain certification (that is, to be legally registered in Ontario as an MRT or RRT) on an annual basis by participating in professional development and other activities sponsored or recognized by their professional associations.

Analysis of the findings from the nine interviews resulted in the identification of four dominant and two minor themes, based on the presence and prevalence of similar words, phrases, and ideas expressed by the participants. Dominant themes were issues, concerns, or recommendations expressed and given a focus by a minimum of seven participants, and minor themes were issues, concerns, or recommendations articulated by five to six participants, or referenced by several participants but described by them to be of lesser interest or concern.

### **Dominant themes**

1. Faculty who participated in this study retained their primary identity as a medical radiation technologist (MRT) or registered respiratory therapist (RRT) irrespective of their tenure in their full-time teaching roles, although this primary identity co-existed with, and while, their second (dual) identity as an educator evolved.



Responses to the interview question that explored their professional self-identification indicated a strongly felt allegiance to their original professional health care credential, that is, RRT or MRT, as compared to their identity as an educator. Eight faculty (five of five RRT faculty and three of four MRT faculty) stated that they both perceive themselves and refer to themselves solely as either an RRT or MRT, however, two RRT faculty and one MRT faculty stated that when asked, they generally immediately add that they also teach. One MRT faculty responded that she has for several years felt comfortable self-identifying as an educator, and then stated that this is in her professional field of MRT. Each participant discussed experiencing an evolution in how he/she perceives his or her professional/occupational self since becoming a full-time educator. However, although feeling comfortable in their primary occupation as educators, when they were asked how they respond to a question about who or what they are (at any time and not just during this interview), all but one faculty stated emphatically that they identify in terms of their RRT or MRT credential.

Our profession is our grassroots. That's where we come from. Am I an RT or an educator....(I'm) an RT first! All of our minds are programmed to be an RT first. If you asked all the faculty in our program what they are, they'd say they're RTs working as educators; respiratory therapists first, and we happen to be teaching respiratory therapy here at (college). All of our minds are still programmed to be an RT first. (Participant #3, RRT)

I wouldn't even know how to take off my respiratory hat to be just an educator or professor. How can you ask that of us? (Participant #5, RRT)

My profession in my mind has been my professional designation, and not identifying myself as an educator. But I feel like I'm evolving into a different form. The School is trying hard to make us better educators and it's kind of odd, when we don't have education credentials. (Participant #1, MRT)

“My biggest issue moving over (to full-time teaching) was to maintain my identity as a respiratory therapist.” (Participant #2, RRT)

After all these years I guess I see myself more as an educator than a tech but I am always a tech. I mentor as an educator but I can't disconnect myself as a practitioner. You have to meld the two. (Participant #4, MRT).

Every time I work at the hospital I feel like I'm home. (Participant #6, RRT)  
I still feel I am a working technologist as opposed to an educator. I wish I could work and teach so the students could see me work, because I could say I really do walk the talk. (Participant #8, MRT)

“Technically I'm a teacher, but when you asked me what I am, I introduced myself as a respiratory therapist,...and still do.” (Participant #9, RRT)

2. It is critically important to the allied health faculty that they remain current in their original professional discipline of MRT or RRT, which they described as being met by attending conferences, engaging in professional development activities, serving on professional association committees/task forces (example, preparation of registration examination questions), and keeping abreast with technological changes in equipment commonly used in their disciplines.

Maintenance of their currency as a health professional, as distinct from their skills as an educator, is viewed as essential to maintaining credibility with their students, fellow faculty, and colleagues in clinical practice. Eight faculty (five of five RRT faculty and three of four MRT faculty) expressed that to be a good educator in their professions it is very important that they remain knowledgeable about current clinical practices and emerging trends in patient care. Those eight faculty also noted that to accomplish this most expertly and comprehensively, this currency of knowledge and expertise is best attained by being actively engaged in their profession, either through personal clinical employment and/or being significantly involved in activities of their regulatory body or professional association. Examples given by them of the latter included participating in the development of professional codes of ethics, in revisions to program curricula, being

a member of accreditation teams, developing questions for licensure examinations, and in the planning of professional continuing education activities. This concept of professional currency was articulated as being of considerable importance with not just students and educational program colleagues but also with professional colleagues in the community, such as RRT/MRT practitioners, particularly those serving in roles of clinical supervisors to students on placements.

Clinical skills maintenance is essential for credibility with students. (you)...risk being less relevant to students if your skills aren't maintained. If we expect to prepare competent students we can't if we don't have teachers with competencies up to date. I think my colleagues in the field and my students respect me more because I keep current in the field. (Participant #1, MRT)

I can't be a credible teacher in this program if I'm not credible in the field. I'm even more credible with the students if I work... (because) I bring a different dynamic to the class. I see the reactions of the students. (Participant #6, RRT)

It's really important not to get stale; (you) have to stay current and stay ahead of technology, and keep on top of what's coming down the line. Just knowing how to teach is not enough. (Participant #7, MRT)

"Lots of people in the field think teaching is like at the end of your career instead of a career preference. That's hard, and if you're not current they sometimes think even less of you." (Participant #2, RRT)

"I was really bothered as time passed after I took this full-time teaching job. I was losing my clinical expertise. I wasn't current. That really bothered me. That was disturbing." (Participant #3, RRT).

3. The transition from clinical practice to academia was stressful and challenging for both the MRT and RRT faculty, and the single most important organizational

support mechanism during that time was mentoring from their program faculty peers.

The period of time during which the faculty ceased full-time clinical practice and assumed a full-time teaching position was described by all nine participants as highly stressful. This occurred irrespective of the extent of personal experience in part-time teaching and/or student clinical supervision roles prior to becoming full-time educators (which was 100%). It also occurred irrespective of whether they had previously been employed by the current employing college and had worked with the full-time teachers already in their respective programs. Their transition occasioned considerable anxiety, self-doubt, worries about personal competency, performance and 'fit', and was accompanied by a profound sense of loss. Their sense of loss related to leaving clinical practice, and was an amalgam of emotions surrounding exiting a setting where they were respected as experts, felt confident in their abilities, value and contributions, had colleagues with whom they held close relationships, and where they had directly impacted the health and wellbeing of the public. The extent of their anxiety and the duration of what each described as a stressful period varied in degree and duration among them, however, all nine stated they underestimated how difficult and lengthy the transition would be.

There was an awkward feeling. Shortly after I left (clinical practice) I realized what I was leaving behind. But I decided to be the best educator I could be, so I went back to school and got my B.Ed, and that helped me feel more comfortable. The B.Ed helped me understand that world better. There was an imposter period, where I went from being a clinician to an educator, and then there was a point in the middle when I didn't feel I was either, because I really wasn't a master of either. But now I feel comfortable where I am. No one brought it to my attention that you are going to feel that way; that you are going to go through this transition from being a clinician to an educator. No one talked about any of this stuff and I think it would have helped. It would have

been nice to know it's normal; that it was normal to feel this way. I was in that transition period for almost 10 years. It would really have helped if it had been discussed. Lots of faculty get stuck in that imposter period for a long time.  
(Participant #3, RRT)

“In the clinical world I felt I was on top of the world. It went from me being the go-to guy to being the guy who asks the questions. There were so many things I was unsure of.” (Participant #8, MRT)

Leaving clinical is a big decision....a really big decision. You have lots of emotions and you feel a loss.” (Participant #6, RRT)

I was super excited about transitioning to full-time teaching because I'd been bitten by the education bug from loving having students in clinic, but boy, I had a lot of trepidation for a long while. I had to tell myself not to look back.  
(Participant #1, MRT)

When I transitioned I felt over my head, scared. I didn't know if I belonged here.  
(Participant # 4, RRT)

All nine participants stated that their transition into full-time teaching was not only assisted by the support and mentoring (both formal and informal) received from their teaching colleagues, but that the support of colleagues was overwhelmingly the most important single factor in their adaptation to their new roles and in the reduction of their stress. Irrespective of whether the faculty in their program teams were known to them from having taught part-time with the college, or whether the full-time faculty were minimally known to them only by name, this collegial support was critically important. Elements of a shared disciplinary identity and camaraderie, and the implicit understanding by existing full-time faculty of what the new faculty were experiencing and feeling, was expressed as being instrumental to the success of their transition.

Further, although each participant had participated in the formal, college sponsored orientation and onboarding programs provided to all new full-time faculty, and despite the fact these programs had (over the twenty-seven year span between when the newest and longest serving participant was involved in them) undergone many iterations in content and structure, each participant asserted that the mentoring received from their coworkers was more important.

“100% was my coworkers – those were the supports that got me through.”

(Participant #2, RRT)

“Buddying you up with someone in your program was very helpful; the most helpful thing.” (Participant #1, MRT)

I felt over my head and scared in the orientation I attended. I had no idea what the terms meant, I mean – what was pedagogy? It felt like I didn’t belong here. But once I was in the labs and working with other faculty and students I felt 100% confident and supported. They helped me understand it was important to learn how to be an educator. (Participant #4, MRT).

“I was a good clinician but didn’t feel I was a good teacher. I was a subject matter expert but not experienced as a teacher. All the faculty were really helpful. They were the good supports.” (Participant #5, RRT).

If you come into education and you’ve never taught, that’s a big challenge. In the classroom I had to act as a teacher but in the lab or simulation ...I was being myself, an RT. My supports were definitely my coworkers – they were fantastic. (Participant #6, RRT).

I met some great people from other programs and colleges at orientation but most support came from the Coordinator of the MRT program. You just kind of relied on the people you worked with. I think there’s more help for new faculty now but your supports are really still your coworkers. (Participant #7, MRT).

The transition (to full-time teaching) was probably the most difficult thing I’ve ever had to do. In the clinical world I felt I was on top of the world...not here. But what was important in the onboarding – my team! They were outstanding!

They took so much stress off and guided me in my transition. (Participant #8, MRT).

“I received so much help from my Coordinator and the other faculty. That’s really a lot of how I survived.” (Participant #9, RRT).

4. The MRT and RRT faculty retained an acute obligation respecting their duty of care to the public and the provision of safe care by their students, while simultaneously fully embracing their obligations and responsibilities towards all of their students, including students with disabilities and/or requiring accommodations.

All nine participants conveyed they assign high importance to impressing on students the principle that as health care trainees and as future members of regulated health professions, their overarching obligation is and will be to individual patients and to their duty of care to the public. Comments relating to this issue were made as part of responses to several questions, including those related to their professional identity, their feelings during their transition to full-time teaching, and to their priorities and concerns respecting students in general and students requiring accommodations, in particular. References were made to the expectations regarding this by the RRT and MRT regulatory bodies and by the RRT and MRT professional associations, including in their codes of ethics. Three participants (all RRT faculty) referenced the implications of this on their personal license to practice.

We all stay as regulated RTs to teach here, and keep our license. We have to protect that; it plays a huge role on a day-to-day basis. (Participant #2, RRT)  
I’m the professional. I’m the respiratory therapist. I have to maintain my license. I’m obligated by my profession and I’m expected to toe that line. I sign a form every year with my membership renewal, that I will respect my profession and my obligations. (Participant #5, RRT)

“The role of the College of Respiratory Therapists is to protect the public and not necessarily protect the RTs. I have to respect that; that’s my primary obligation. “

(Participant #6, RRT)

The language used by the participants when discussing how they transmit the primacy of patient care and safety to their students incorporated perspectives from their prior roles as frontline practitioners.

I tell my students...the big picture is that you are taking care of someone, and their diagnosis hinges on the work that you do. I say any of you could be looking after any of each other’s loved ones in the future. (Participant #1, MRT)

I tell our students we deal with life and death situations – birth to death; in delivery rooms with babies born who can’t breathe, to the end of life, disconnecting life support. Our students know that we tell the clinical supervisors to never compromise patient safety and never put any patient in harm’s way. (Participant #3, RRT)

“It’s my duty to ensure all our students are safe for the public.” (Participant #6, RRT)

“We tell our students the patients are not there for you. You are there for the patients, always.” (Participant #7, MRT)

“The patient is always, always and first and foremost the centre of attention. We care for them and we keep them safe and hopefully help them get better. And we sure never do them any harm.” (Participant #8, MRT)

I hold myself at a certain standard, and because I am, and the students will be, members of a profession that takes care of the public, if I’m not treating what we do here with the same standard I held myself to in the hospital, are the students going to have lower standards? I’ll always see myself as the clinician at the bedside, and I want to impart that here. (Participant #9, RRT)



### **Minor themes**

1. A notable number of RRT faculty are concerned about the clinical performance of students with disabilities and/or requiring accommodations, and their ability to deliver safe patient care while students and once they become graduate practitioners.

Six (five RRT and one MRT) of the nine participants expressed a variety of concerns relating to students with accommodations in their programs. Without exception, each indicated strong support for the principles, practices and College policies promoting accessibility, inclusion and fairness towards applicants and students with disabilities and those requiring accommodations. There was unanimity respecting the importance of supporting these students to the best of their personal ability and to the capacity of their program teams. However, many concerns were noted that relate to these students being able to successfully complete the clinical/practical components of their programs, whether these students would be able to safely care for patients, and whether they (that is, these faculty) would as teachers be able to adequately prepare these students for clinical practice.

With references to their personal and professional standards of practice and to ethical and legal obligations to their professional regulatory bodies and to the public, participants expressed worries and doubts about how to identify and rectify where and when accommodated students are at risk to themselves or putting others at risk as either MRTs or RRTs. They (both MRTs and RRTs) worry somewhat about how to assess these students in a fair and compassionate way that respects their disabilities but that also guarantees to the same extent as non-accommodated students, their mastery of the

requisite didactic and practical knowledge. College counsellors and accessibility staff were described as being essential and welcome partners in the management of accommodated students, with 3 participants stating they wish there was more collaboration between faculty and counselling/accessibility staff, and more assistance to faculty. The same three participants also voiced a wish that academic advising staff and counselling/accessibility staff were more knowledgeable about health programs, and specifically, about the practice expectations of health program graduates.

“We have no choice but to accommodate...but the clinical environment is not that generous. The hospital is less forgiving, and so it should be!” (Participant #1, MRT)

So often with accommodations no one is telling them what this means in their future. We can accommodate for anxiety and stress at school but what about in clinic? They can't just leave the patient in the bed and come back later. Are we setting them up for failure? These students have to adapt to stress and pressure. (Participant #2, RRT)

It's when these individuals get to the clinic that they fail; when they really, really struggle. The same accommodations don't exist in the clinic. We support where we can, until it reaches the point where it is unsafe for patients. (Participant # 3, RRT)

When accommodated students graduate but can't pass the licensing exam and can't get work, people in the field ask us 'what are you doing'? It reflects heavily on us as a profession and as a School. It is discouraging in many ways. (Participant #5, RRT)

How do we accommodate (a student) who needs more time to think about what to do....standing in front of a patient who can't breathe? (Participant #6, RRT)

Where I see a problem is if accommodations don't set them up for reality. We are not the gatekeepers of the profession but I think we do have a responsibility to help them be successful in the profession. We want to see our students succeed but we don't want it to be a false sense of success. (Participant #9, RRT)

2. A notable number of MRT and RRT faculty are motivated to work in a clinical setting on a regular basis throughout the academic year.

Six (four RRT and two MRT) of the nine participants stated they wish the College would formally devise a way for faculty in their programs to be able to work in a clinical setting on a regular basis during the academic year. Three of them (all three being RRTs) regularly work in local hospitals on weekends and/or during vacation periods, and one had been regularly working part-time but had recently stopped. Opportunities for part-time work are in some instances becoming difficult to maintain because some hospitals are demanding more availability from part-time employees, and for some of these faculty, they have reduced or ended part-time clinical work because their overall work life balance became untenable. The other two participants who commented on this issue stated they were not personally interested in clinical work but feel it should be available to the full-time faculty who wish to do so. Reasons given by the six participants for supporting clinical work experience included: opportunities for heightened personal job satisfaction, enhancement of faculty 'currency' respecting trends in patient care and clinical practice, enhanced transfer of clinical knowledge to students (that is, from practice to didactic and vice versa), and opportunities to observe and assess student performance in clinical settings first-hand, rather than only via clinical supervisor assessments. Four of the six suggested that support by the College for the recognition of the importance for health faculty to maintain a clinical presence could be demonstrated in one of two ways: (i) permitting actual separate employment experiences during the academic year, or (ii) modifying faculty roles to permit them to assume clinical supervision duties in health care settings where students are doing their practicums.

I work a lot in the hospital I guess, and maybe I should redirect some of that into developing my educator knowledge but I have to keep sharp clinically. I have to be current, and it makes a big difference with the clinical people. I know they respect me more because I work as much as I do. (Participant #1, MRT)

“I love this job so much and would never think of going back to the clinic full-time but I love working part-time, too. I look forward to the summers when I can refresh my clinical skills.” (Participant #2, RRT)

It would be wonderful if there were opportunities to use academic time, instead of your summer vacation, to return to the field to stay current clinically. Even a week a year to either work yourself or be with the students in placement would be great. Maybe we could use the PD clause in our contract. We do a lot of other courses like all the mandatory online modules so why not this? (Participant #5, RRT)

“I work as many shifts in the hospital as I can. I can’t imagine not doing this. Sometimes I am tired and it’s hard doing that and full-time teaching but keeping up clinically is so important.” (Participant #6, RRT)

If it was an option, I would so love to still work some in (the clinic). That’s the one piece of taking the full-time teaching job that’s really, really hard for me. (Participant #8, MRT)

I wish very much I could still work in clinical practice. Don’t get me wrong – I love this job – but I miss the bedside and I worry the students are soon going to start thinking less of me. I just can’t fit shifts in now. I wish there was a way we could do some as part of our job here. (Participant #9, RRT)

### **Additional comments**

During the unstructured part of their interview, two participants commented that there is a need for educational leaders to study and discuss the topics covered during their interview. They indicated they have a story and perspective that needs to be told, so that members of their profession who teach are better understood. The research assistant who conducted the interviews reported that without exception, each participant effused

enthusiasm and eagerness to be interviewed, and was open, engaging and expansive in their responses. In so sharing, there is a prospect that there might be interest in participating in further research, or at the very least, in continued dialogue on the issues discussed in this study.

As will be discussed in chapter 5, the participants' rich and expansive narratives provided substantial and pertinent information, which enabled an examination of their perceptions in relation to the study's two research questions, and to relevant literature.

## **Chapter 5**

### **Discussion**

#### **Overview**

This study had two purposes, reflected in its two research questions. The first purpose was to investigate the experiences of medical radiation technology and respiratory therapy faculty in an Ontario community college who transitioned from roles in clinical practice settings into academia. Within the framework of Benner's (1984) 'novice-to-expert' theory, and using an Interpretivist approach, and individual, semi-structured interviews, this exploratory qualitative case study examined how the participants (a purposive sampling from two allied health programs' faculty) had adjusted to their new positions as full-time educators. This study queried how the participants identified themselves professionally in their current teaching positions (that is, primarily as health professionals, or as educators). This researcher wanted to discover if within this group of non-nursing allied health faculty there would be evidence of the retention of their original professional health identity instead of the adoption of an identity as educators, as has been reported by many similar research studies conducted with nursing and other allied health faculty disciplines.

The second purpose of this study was to explore within the same participant group what impact the retention of their primary professional identity as a health professional had on their attitudes towards students in their programs (MRT and RRT) with disabilities and/or requiring accommodations. The researcher hoped to contribute to the apparent gap in the available research on non-nursing allied health faculty in terms of transitional experiences, and most particularly, in relation to their attitudes towards

students with disabilities, resulting from dual (health professional and educator) identity conflicts.

This chapter examines the themes that emerged from the findings, and the researcher's interpretation of the participants' personal narratives in relation to the research questions. The chapter summarizes the findings, and examines them in relation to the relevant literature. Importantly, the meaning and significance of the findings is also addressed. The potential value of the study's findings is discussed in terms of its utility for post-secondary college leaders responsible for allied health programs. Specifically, considerations regarding possible implications for modifying allied health faculty induction strategies, enhancing onboarding support in their educator roles, and, focusing assistance for them in managing students in allied health programs with disabilities and/or accommodations, are addressed.

### **Summary of the findings**

The questions used in the participant interviews were designed to solicit information that would be directly relevant to responding to the two research questions. The analysis of the transcripts and identification of the six themes (four dominant and two minor) supports the conclusion that the questions and interviewing approach were highly appropriate to the study's purpose, (and suited the participants and the topics addressed with them). Each participant shared a great deal of information in her/his interview, which resulted in considerable pertinent information being obtained. The acquisition of narratives with such richness and depth of personal experience and reflections offers validation for having used an exploratory qualitative case study design and, in particular, semi-structured interviews.

As noted earlier, the study's two research questions were:

1. How did Respiratory Therapy and Medical Radiation Technology Faculty who transitioned from clinical practice into academia at one Ontario college experience the transition?
2. What were the attitudes of Respiratory Therapy and Medical Radiation Technology Faculty towards students with disabilities requiring accommodations?

The findings revealed that all nine of the participants perceived their transition experiences to have been considerably more stressful than they had anticipated. Their induction into academia was accompanied by a pervasive sense of loss of confidence, confusion about their role and status, feelings of no longer being an expert in their field, and occasional remorse of having left the clinical setting and direct patient care. The transitional experiences of the participants in this study were highly reflective of Benner's (1984) description of the novice stage in her model. All nine participants in this study revealed that upon entering the academic setting (as a full-time faculty member) they had for some considerable period of time felt unprepared, 'out of place', and 'like a novice'. Through their detailed narratives, these nine participants also revealed that the process of adjusting to their new role in academia (and importantly, to feeling confident as educators), took time, and resulted from continued, repeated practice and experience. Their individual passages from novice educator to expert (or close to expert) educator required ongoing, repeating opportunities to engage in 'educator' activities (example, designing and delivering courses, teaching didactic/theoretical curricula, assessing student performance, managing student academic accommodations). Several of these participants stated specifically that their confidence, competence, and performance



improved steadily over time, year after academic year, with each year of teaching experience behind them. This correlates with Benner's (1984) 'novice to expert' model that asserts that each stage in the acquisition of skills and knowledge builds upon what was learned in the previous stage.

All participants emphatically expressed that the key organizational support to them throughout their initial induction and ongoing transition was the mentoring they received (both formal and informal) from their programs' faculty colleagues. Each stressed that they continued to identify professionally primarily as a member of their health discipline (MRT or RRT) rather than as an educator, but that their educator identity has evolved to the point where they could express now that they are simultaneously health professionals and educators.

The findings also revealed that the participants' attitudes towards students with disabilities and/or requiring accommodations are influenced by the primacy of their identification as MRTs or RRTs, and from being members of regulated health professions with a duty of care to the public. The capacity of students with disabilities and/or accommodations to deliver safe patient care (both as students and as graduates) is something these participants stated they frequently reflect on. In addition, they expressed they frequently worry about the performance of these students when they are in their clinical practicums. Participants indicated that they at times feel that their obligations as health professionals to protect the public conflict with their obligations as educators respecting student accommodations. However, it is notable that all of the RRT participants highlighted this as a concern but only one MRT participant did.

The provision of focused supports to allied health faculty that would assist them in managing their dual (health and education) identities could improve their induction experiences, hasten their adoption of their identity as educators, and, as a consequence, perhaps enhance their comfort with (and management of) students with disabilities and/or accommodations in their programs. Strategies towards these goals could serve to respond to the growing expectations of health care regulatory bodies of their members respecting the provisions of safe, high quality care to the public, and as well, could assist allied health faculty to more comfortably and with confidence respond to changing human rights requirements for the inclusion of individuals with disabilities in post-secondary education.

### **Transitions and identities**

**Participants' transition experiences.** A key purpose of the study's first research question was to explore the transitional experiences of allied health faculty who left clinical practice roles to assume full-time teaching positions as faculty in an allied health program. All nine participants made the decision to make a career change to be a full-time educator with feelings of excitement, and with confidence they were making a good decision for themselves personally and professionally. All participants reflected that they were drawn to full-time teaching after having had rewarding experiences while serving as student supervisors in clinical settings and/or after having taught in part-time capacities in the programs they subsequently joined in a full-time capacity. The participants' decision to transition, and their entry into the transition process, was nonetheless accompanied by some anxiety but with self-assurance and confidence in their ability to be successful in

their new roles. Participants were motivated and positive about the decision they had made to undertake a career change.

Once having made the passage into their new career, however, the induction into full-time academia was notable for them by its stress and unexpected challenges. What had been assumed would be a rather smooth and enjoyable transition instead felt like a traumatic upheaval. It is noteworthy that even participants who had held part-time teaching and/or clinical supervision positions with the college for a considerable period of time (eleven to fifteen years) prior to assuming full-time positions, and who had well-established relationships with program colleagues and administrative staff, reported this. Commonly recurring statements by participants in both (MRT and RRT) groups related to their surprise that they had not expected to feel this way, having anticipated that the self-assurance and sense of 'fit' with being an educator that they had felt whilst holding part-time teaching positions, would have continued. As several also noted, there was a sense of 'shock' when the finality of having severed their prior clinical practitioner roles was acknowledged.

Participants' unanimous views of having underestimated how difficult and lengthy their transition would be, had two aspects in common: they experienced a profound sense of loss of having left clinical practice, and, the single most important support mechanism for them during the transition was mentoring from their faculty peers. With respect to the first aspect (a sense of loss from leaving clinical practice), in their narratives, the participants' statements about feeling unexpectedly awkward in their new roles, of doubting their value and competencies, and of experiencing an acute sense of loss, were expressed in association with references to how self-assured, valued and

competent they had felt in their prior clinical roles. Particular phrases in common among them related to having been previously respected as experts in their field, and of having been engaged in an occupation where they felt validated on a daily basis that they were directly helping people and improving the health and well-being of the public.

Immersed in their transition into academia as full-time faculty, they felt instead like novices, and lacked (in relation to that point) an equally strong sense of being worthy contributors in their new milieu. The fulfilment and gratification of playing a direct role in ameliorating suffering and enhancing someone's health as a member of a respected professional discipline was eliminated following their entry into full-time teaching, while the satisfaction of having mastered the expected new competencies of teaching skills and educational pedagogy, had not as yet begun. As part-time faculty in the MRT and RRT programs, the participants had usually taught practical skills courses in simulated clinical laboratory settings, where their 'hands on', clinical skills were in the forefront of their instructional activities. As full-time faculty, they were immediately assigned to teach, as well, theoretical courses in conventional classroom settings, which was for many of them a new and unfamiliar experience.

During their interviews, four participants recalled a similar occasion early in their transition when they attended an orientation session led by the college's Organizational Development and Learning department, offered to new faculty to advise them of the supports offered by that group. These four participants each recalled feeling embarrassed and anxious throughout the session, as the presenters used educational terms, theories and 'jargon' (the participants' words) with which they were completely unfamiliar (Bloom's taxonomy was mentioned as an example). Although all four of these participants held the

requisite (and terminal) credentials in their health discipline at that time, none had had formal studies in education. They recalled feeling inadequate in that moment. These expressions by the participants of feeling like novices in their new roles, of having felt a sense of loss, and of underestimating the length of time they thought their transitions would take, reflect to a markedly similar degree the findings of the researchers (example, Anderson, 2009; Cangelosi et al, 2009; Hurst, 2010; Logan et al, 2015; McArthur-Rouse, 2008; and Smith & Boyd, 2012) referenced in the Chapter 2.

As noted, this finding from this study is in keeping with what other researchers (Anderson, 2009; Boyd, 2010; Cangelosi et al, 2009; Duffy, 2013; Hurst, 2010; Logan, Gallimore & Jordan, 2015; Smith & Boyd, 2012; and Murray, Stanley & Wright, 2014) have found, for nursing and allied health professionals, in college and university settings, in several countries. Participants in Hurst's (2010) study expressed that "the transition from clinician to academic (was) a definite career change, typified by periods of uncertainty and anxiety, particularly regarding what is expected of them. Themes of plausibility and credibility and fears of being exposed as an inadequate teacher were strong at the start of participants' transition" (p.242). Murray et al's (2014) meta-synthesis of seven qualitative studies that explored the transition of nursing and allied health faculty from clinical practice into academia, revealed that common to the findings from all seven were themes that "the transition was confusing and challenging; (participants) were unsure of their identity and role; the transition was a stressful and daunting experience but which improved with time; and, clinical experts require support for cognitive, psychological and sociological aspects of the transition to academic"

(p.392). Dumphily (2011) stated in relation to American nurses, “cultural dissonance is a reality for nurses transitioning to academia” (p.18).

Duffy (2013) highlighted one nursing faculty’s reflections on her identity: “I don’t see myself as an academic, because my idea of an academic is somebody who is very driven by academic writing, by thinking their way around work and systems” (p.623). Anderson’s (2009) study of nurse practitioners and clinical nurse specialists who assumed educator roles in degree nursing programs revealed her participants felt a “loss of the expert role” (p.4) and dominant sensations of “feeling overwhelmed” (p.5). Cangelosi, Crocker and Sorrell (2009) reviewed the narratives of forty-five nurses who assumed roles as clinical nurse educators, and learned that their participants voiced a common theme of feeling uncomfortable and unsettled in their new roles, and were “quick to acknowledge that they may be expert clinical nurses, but they are novice nurse educators” (p.3). As one participant in the Cangelosi et al (2009) study stated, “if I could only use one word to describe my move from a role as a clinician to a nurse educator, it would have to be fear...I don’t believe I had any idea of what a full-time educator’s role was” (p.2). The findings from this researcher’s exploratory study support the conclusions made by those researchers that when allied health care practitioners leave clinical roles for full-time academic positions they commonly experience lengthy periods of stress, loss of confidence, and loss of their prior identity.

With respect to the role mentoring played in their onboarding experience, all participants emphatically expressed that the key organizational support to them throughout their initial induction and ongoing transition was the mentoring they received (both formal and informal) from their programs’ faculty colleagues. Formal mentoring in

the college system involves the identification of a faculty member in the new faculty member's program as the mentor to the new faculty. A weekly time allotment is assigned to both the mentor and the new faculty, on their standard workload assignments, for a period of one academic year (two terms/semesters). Informal mentoring was described by the participants as the spontaneous, ongoing and 'as-needed' guidance and assistance provided by faculty teaching with them in their programs. All participants stated that both the formal and informal mentoring supports had been critical to their transition.

Perspectives on the formal college orientation each received varied, ranging from statements that the entire experience had no value, to identifying that some aspects of it were helpful, to opinions that it was very valuable. Although the formal college faculty orientation program had undergone many iterations from when the longer tenured faculty had taken it, to when the newer faculty had participated, the particular orientation course design appeared not to be a factor in the responses. All nine participants stated that the networking opportunities provided through the college's orientation sessions to meet other faculty working at the same college (irrespective of discipline or program) was what they had most appreciated and benefitted from.

The importance the participants attributed to how support and mentoring (both formal and informal) from faculty colleagues contributed to their ultimate adjustment to their educator roles also especially supports the research done by others. As found in this research and in the research conducted by others (Boyd, 2010; Cangelosi, Crocker & Sorrell, 2009; Crist, 1999; Duphily, 2011; Hurst, 2010; Murray, Stanley & Wright, 2014; and Smith & Boyd, 2012), allied health faculty appear to benefit greatly from their shared membership with others teaching in their health discipline. In his study of newly

appointed lecturers in nursing and education, Boyd (2010) noted “they generally place high value on mentoring as a useful form of support” (p.160). In their meta-synthesis of nursing and allied health practitioners who transitioned into academia, Murray et al (2014) reported that “collegial contact and support is required to learn tacit knowledge” (p.394).

This mentoring support appears to have two dimensions in that it is not only practical (for example, how to prepare a lecture or a student assessment) but is also uniquely psychologically and emotionally helpful because faculty colleagues usually understand what new faculty are experiencing, and can demonstrate that a successful transition is possible. The essential role played by mentoring in the acquisition of skills and knowledge by novices is noted by Benner (1984) as being particularly important in what she identified as ‘stage 2 - ‘advanced beginner’. This study’s participants did not generally state the exact number of years the mentoring they received was most helpful to them, however, their typical description of it was that it was most important to them ‘early’ in their transition.

Personal reassurance from program faculty colleagues that the transition experience can be successfully managed appears to be an essential element of the transition experiences of allied health faculty are to be positive and effective. “Informal learning and peer support were the most valued mechanisms of support” (Hurst, 2010, p.240). Dumphily’s (2011) study into the impact of culture on the retention of nursing faculty illustrated “the significance for novice educators to maintain ...long term contact with a seasoned mentor” (p.18). That “mentoring (is) essential for nurses who are in the process of learning to teach” (Cangelosi et al, p.4), is reinforced by Crist (1999), who



stated (in regard to occupational therapy clinicians who become educators) “that positive transitions require mentoring or co-teaching with an experienced educator” (p.15).

McArthur-Rouse’s (2008) qualitative study on new nursing academics uncovered that their transition into academia was problematic, and identified peer mentorship as an important support.

The nine participants in this study reported that during their transition, they frequently looked back on their time as clinicians and reflected on, by comparison, how much less confident, ill-suited, and uncomfortable they were feeling (at that time) as educators. Each of them expressed that they felt they ultimately successfully navigated the transition process, and currently felt confident in their academic roles. However, a pervasive reflection among all nine participants was that they questioned why and if the experience for allied health faculty had to be that difficult. They articulated a strong personal sense of duty to make the transition experiences of new faculty much easier than theirs had been. This study’s participants stressed repeatedly that support, understanding, and mentoring from their faculty colleagues was singularly impactful and essential to their transition. Each also suggested that educational leaders should ensure this is incorporated into induction planning for new faculty in the future.

The prevalence of these issues in the participants’ narratives, and the importance assigned to them by the participants, warranted that the findings that (i) the transition from clinical practice to academia was stressful and challenging for these MRT and RRT faculty, and, (ii) that the single most important organizational support throughout their transition was peer mentoring, be noted a dominant theme of this study.

**Participants' identities, and their credibility as health professionals.** “The challenge for the clinical practice disciplines...has always been the identity transition from practitioner to academic or intellectual” (Logan, Gallimore & Jordan, p.7). The analysis of the participants' reflections about their career transition from clinician to educator revealed that their self-identification as health professionals figured prominently in their narratives. The appointment process each participant experienced for their full-time positions reinforced to them that their clinical expertise, demonstrated knowledge and skills as a practitioner, and values and attitudes in their health discipline, were key to being hired. The courses they had been assigned to teach while working for the college in a part-time capacity were most generally skills/laboratory based, which, as noted earlier, drew heavily on their clinical (as opposed to educational) acumen. Their perception was that they had been hired to be educators (on a full-time basis in the programs) because they were considered leaders in their health discipline, and, because they had demonstrated commitment and passion for their discipline and for students, while part-time faculty. They assumed that having academic credentials as educators (for example, possessing an additional credential in education, which the majority of them did not) was of lesser relevance in their appointments.

Smith and Boyd (2012) concluded after studying the transition to academia by (UK) nursing, midwifery and allied health lecturers that “they appear to hold on to their identity as practitioners and as supporters of new practitioners. They do not strongly focus on building new identities as higher education teachers. It is the clinical practice and procedural knowledge elements of the professional field that...have a priority status in the minds and practices of these new lecturers” (p.70). Hurst's (2010) qualitative

study of eight physiotherapists who assumed academic positions in an English university revealed that for four of the eight, after four years of full-time teaching, “their overall professional identity remained firmly associated with that of a physiotherapist” (p.244). Logan et al (2015), in their exploration of UK and Australian nurse clinicians who transitioned into university teaching, stated “identity and values developed in practice can conflict with those of the academy as the centrality of patient care is subverted by a multiplicity of drivers” (p.7). The conclusions of Murray et al (2014) following completion of their meta-synthesis of seven studies that investigated the transition experiences of nursing and allied health clinicians into academia were that these faculty undergo an identity transformation, and that the identity transformation process takes a considerable period of time (up to several years).

Recognition and acceptance of education as a meta-profession (Arreola, Theall & Aleamoni, (2001)) by allied health clinicians transitioning to academia is important for their transition to be complete. Ultimately, these new faculty must demonstrate expertise in both their ‘base profession’ (Arreola et al, 2001) of health care *and* their new meta-profession of education. This is very much in keeping with Benner’s (1984) view that expertise is almost always a function of the setting or context within which it is practiced. Duphily (2011) commented in relation to nursing practitioners transitioning to academic roles in the United States that “Novice faculty felt competent in their clinical skills, but doubted their capability as an educator” (p.18). Further, “the lack of educational grounding for the faculty role results in novice educators questioning their teaching abilities” (p.18).

Each participant in this study acknowledged that not long after they assumed their full-time college positions, they realized that they were expected to demonstrate additional knowledge and skills associated with being educators, such as curriculum development, adoption of flexible teaching styles, and the redesign of student assessment tools. Although they accepted this expectation, their belief of what they should be to remain valuable to their programs and credible to their students, depended overwhelmingly on how they were perceived by others as health professionals. Hurst (2010) found in her research on new physiotherapy lecturers that “Participants used clinical examples to support their teaching ...striving to remain close to their professional roots” (p.243). Boyd (2010) reported his study’s participants described “the importance of having credibility with students because of their very recent practitioner experiences as a ‘nurse’ or as a ‘school teacher’” (p.159). Crist (1999) noted that for occupational therapists “a unique characteristic of the academic environment is that the faculty member must not only address faculty role responsibilities, but also maintain clinical competence in a specific instructional area to provide contemporary teaching content. Thus, the new faculty member needs a plan to retain clinical competence” (p.17). As well, Crist highlighted the uniqueness of the occupational therapy faculty she studied that differentiated them from other, non-health faculty: “maintaining dual credentials, clinical and academic, is a continuing challenge for (them). Not all educators on a campus have similar requirements, meaning that maintaining clinical competence ...may not be recognized by the academy” (p.17). For the participants in this researcher’s study, the reality that their employment in education required maintenance of a license to practice

and of membership in their professional associations, emphasized and reinforced their identity as health professionals, and their desire to maintain clinical currency.

In addition to the theme discussed regarding their transition experiences, two other dominant themes were distinguished: that it is critically important to them that they remain current in their original (health) discipline, and, that the retention of their primary identity as an MRT or RRT continues irrespective of their tenure as educators (although their identity as an educator evolves). To remain current in their discipline means for the participants that they need to remain knowledgeable and up to date about changes in clinical practice, technologies and professional issues. As stated in the maintenance of licensure and membership statements of their respective health associations (MRT and RRT), members are expected to demonstrate support for their profession in myriad ways such as serving on association committees or executive boards, and attending conferences and events sponsored by those bodies. Allied health faculty perceive attention to such professional engagements and learning as being essential to good teaching in their disciplines, and to maintaining credibility with students and with faculty and clinical colleagues. Smith and Boyd (2012) reported that “nurse lecturers, in particular, express a need to maintain credibility as clinical practitioners” (p.68).

Many of this study’s participants commented that when they plan professional development activities throughout the year, they consider first and foremost what will be offered by their regulatory bodies and professional health associations (such as annual conferences and special themed seminars), and what commitments they have to those same bodies by virtue of membership on committees and task forces. These same participants stated they do not typically consider professional development opportunities

strictly related to ‘education’ (example, courses on how to convert face-to-face classes to online formats, trends in the use of educational technologies, or, higher education general conferences). Although they feel both types of professional development are important, they prioritize those related to their health discipline because they perceive it as more relevant to their teaching focus, and because their maintenance of licensure depends on it. In a sense, for many of this study’s participants, their lifelong learning goals and activities are ‘anchored’ in their health discipline.

Identified as a minor theme (due to being given a focus by six faculty in total – four RRT and two MRT) was a desire to be able to work in a clinical setting on a regular basis throughout the year as an integrated part of their teaching assignments. Although able to do occasional clinical work on their own time during the school year and during their vacation periods, these six participants were keenly interested in exploring if in some way they could maintain a presence in a clinical setting on a regular basis. The reasons the participants gave for this related to personal pleasure they would have at being able to continue clinical practice, and to their belief that they would have more credibility with their students and colleagues if they did so. These statements were made by participants (in this study) who indicated they believe they *have* successfully transitioned into the role of an educator. It appears that, as with the findings from the research undertaken by others that was reviewed for this study, these participants have adopted and work within two identities – that of health professional and of educator.

### **Identities, duty of care, and students with disabilities**

**Participants’ health identity and their duty to care.** An integral component of the identity of an allied health professional (as with all health professionals) which is

emphasized in their education, regulation and licensing, and ongoing professional accountabilities is their duty of care to the public. Duty of care for health professionals relates to the standard of care expected from their members for persons in their care, with the standards being those defined by each profession. The College of Respiratory Therapists of Ontario states in its mandate that it is “dedicated to ensuring that respiratory care services provided to the public by its members are delivered in a safe and ethical manner”, and that “the ethical principles are to...do no harm” ([www.crto.on.ca](http://www.crto.on.ca)). The Code of Ethics of the Canadian Society of Respiratory Therapists states that “respiratory therapists shall (be) guided at all times by their concern for the health and well-being of the patient”, and “are committed to life-long learning...to keep their practice current” ([www.csrt.com](http://www.csrt.com)). The newly-drafted national competency framework for Canadian respiratory therapists issued by the National Alliance of Respiratory Therapy Regulatory Bodies (2016) states it is “firmly patient centered”, and defines duty to patients as “being guided at all times by...concern for the health and well-being of the patient” (NCF 2016, letter). The mission of the College of Medical Radiation Technologists of Ontario is to “serve and protect the public interest” ([www.cmrto.org](http://www.cmrto.org)). The Canadian Association of Medical Radiation Technologists states that its members shall adhere “to the ...tenets of ethical conduct (of the association, respecting) patient centered care and safety” ([www.camrt.ca](http://www.camrt.ca)).

A breach of duty of care (whether by action or inaction) constitutes negligence. Cangelosi et al (2009) highlighted one specific participant’s comment from their qualitative study: “the biggest difference you can make in a patient’s life is to provide ...safe practice” (p.2). The statements made by all nine participants in this study that this

is a critically important responsibility for not only themselves but which they impart to their students, is widely supported in the studies reviewed by this researcher. It would be difficult to overstate the universal importance and respect assigned to this principle by allied health practitioners. In addition, health care practitioners are obliged to inculcate the duty of care into succeeding generations of health care practitioners.

As noted earlier in the discussion of findings, references to the duty of care principle were made by the participants as part of their responses to questions about their identities, their transitions, about teaching students in general, and about managing students with disabilities (with or without accommodations) in particular. The participants in this study echoed the comments made by participants in related studies that although they were employed in education, their adherence to their profession's duty of care standards were not, and could not, be diminished. Smith and Boyd (2012), researching in an English university setting, noted that "In contrast with the traditional route to academic roles via doctoral study, the majority of lecturers in health professions (in the UK) take up their academic posts having developed considerable clinical expertise" (p.64). (Similar to Ontario's legislative and regulatory framework for allied health professionals, in the UK the corresponding agencies are the Nursing and Midwifery Council (MNC, 2008) and the Health and Care Professions Council (HPC, 2005). (Health and Care Professions Council, [www.hcpc-uk.org](http://www.hcpc-uk.org); Nursing and Midwifery Council, [www.nmc-uk.org](http://www.nmc-uk.org).) These agencies are authorized to define professional codes of ethics and standards of practice, and, determine educational and training requirements.)



This study's participants asserted that it was their responsibility to ensure that their students understand the importance of that principle, and adhere to it not just theoretically in the future after graduating and working in their discipline, but including when they are students in their clinical placements, caring for patients. The comments made by all nine participants in this study about this principle were clearly strongly felt and were expressed with considerable passion and emotion. This finding was therefore identified as a dominant theme.

**Participants' approach to students with disabilities and/or requiring accommodations.** As noted in the findings, five of the nine participants stated explicitly that they were concerned about whether students with disabilities and/or requiring accommodations would be able to deliver safe patient care while students and when working as graduate practitioners. Though notable, only five of the nine participants made such a point, and so it resulted in this response being deemed a minor theme emerging from the study. However, it is important to note that all five participants from the RRT program identified this as an area of concern, while only one of four MRT faculty did. Given that no previous research into the attitudes of allied health faculty towards students with disabilities and/or requiring accommodations (regarding their potential workplace competence) was found, no direct comparisons can be made, however, comparisons with research into the attitudes of nursing faculty towards students with disabilities may be instructive in a broad sense.

Watson's (1995) analysis of the findings from her survey of 247 American baccalaureate nursing programs prompted her to conclude that "nursing educators are facing critical issues regarding the obligations of nursing programs to accept and

accommodate qualified applicants with disabilities” (p.148). She perceived widespread support for inclusion of disabled students in those nursing programs, but saw these sentiments co-existing alongside confusion about how disabled students could be accommodated within the context of “what one needs to be able to do to become a nurse” (p.152). Magilvy and Mitchell’s (1995) analysis of their survey of eight-six American baccalaureate and associate degree nursing programs about their approaches and policies towards ‘students with special needs’ revealed that although generally, classroom and simulation-based needs of these students were accommodated, “barriers external to the school(s) precluded the students moving on to successful nursing practice” (p.35). External barriers were things such as the inability of these students to complete required competencies in clinical sites, or the lack of accommodations by some state nursing boards. Further, they concluded that because (American) nursing licensure requirements are vocational in content, education programs have traditionally tied their schools’ graduation requirements to professional licensing examinations.

Magilvy and Mitchell also noted that although a practicing nurse who acquires a disability has the potential to adjust her/his type of professional work, students with disabilities entering nursing programs cannot as part of their education adjust the requisite competencies because of the scope of knowledge and skills tested on licensing exams. Writing within the UK context, Tee and Cowen (2012) stated “organizations such as higher education institutions are required by law to proactively prepare for the needs of students with disability to ensure they have equal access to the full range of teaching and learning opportunities. These issues become more complex in professional

healthcare programmes involving significant proportions of learning within a practice environment located within another organization” (p.10).

Swenson, Havens and Champagne (1991) concluded from their survey of 69 American baccalaureate and associate degree nursing programs that nursing faculty relied “on program and course objectives...as the most essential consideration(s) for determining...admission and continuation in the program” for physically, mentally and substance-impaired students (p.2).

Sowers and Smith (2004) surveyed faculty in American baccalaureate and associate degree nursing programs to ascertain their attitudes and knowledge towards applicants and current students in their programs. As a result, Sowers and Smith concluded from the analysis of the narratives of the eight-eight respondents that “nursing faculty attitudes toward nursing students with disabilities serves as a barrier to these students” (p.4). Of note was the finding that the respondents were more positive about the ability of disabled nursing students to practice as nurses than to complete their nursing program (p.4). “The results of this study clearly indicate that nursing faculty continue to have a number of specific concerns about having disabled students with disabilities in their programs. (their) concern about disabled students providing unsafe patient care...is the basis for many faculty’s perceptions that people with disabilities should not be admitted into nursing programs” (p.4).

Carroll (2004) expressed that “safety is the overwhelming concern voiced regarding the inclusion of people with disabilities in nursing (and) many of the concerns about safety center around the technical part of nursing” (p.208). She added, though, that “attitudinal barriers by health care providers (towards disabled students) are really at the

heart of the problem” (p.210). As Tee and Cowen (2012) noted, “the cautionary attitudes held by many when asked to consider admitting a student with a disability (to a health program) reflect those held by society as a whole” (p.7). They also cautioned that it is important to be aware that “unlike the academic learning environment, the practice learning environment is less susceptible to the measures that exist for implementing special arrangements for (disabled) students. The greater uncertainty and unpredictability in practice create unique challenges for inducting, supporting, teaching and assessing nursing students (with disabilities)” (p.10).

Ashcroft, Chernomas, Davis, Dean, Seguire, Shapiro and Swiderski (2008), who are affiliated with the University of Manitoba’s Faculty of Nursing, examined their program’s approach to the management of their undergraduate nursing students with disabilities. Noting that “the central goal of nursing education programs is to prepare graduates who are able to provide safe, competent nursing care consistent with entry-level competencies” (p.1), they acknowledged the existence of barriers to full inclusion and support by some faculty relating to their fear that disabled students might compromise patient safety. With respect to student clinical practicum experiences, they recognized that “implementing reasonable accommodation in clinical practice may present particular challenges” (p.10). (In Manitoba as in Ontario, institutions can refuse particular students and/or end their clinical placement prematurely if they believe the student poses a risk to patient safety.)

The statements made by the five participants referenced in this study on this question are remarkably similar to the comments and opinions reported of nursing faculty. Those allied health faculty shared with nursing faculty concerns about disabled

students entering clinical sites with inappropriate expectations, given that clinical settings do not currently accommodate to the same extent (if at all) as do educational settings, for both classroom and simulation learning. Participants shared concerns about students with disabilities not being adequately tested and prepared to handle stressful and high pressure situations, which could in a worst case scenario put patients at risk of harm.

Without exception, the participants responding to this question expressed fervent personal support for the college's policies and expectations to improve and promote accessibility and inclusion of students with disabilities and/or requiring accommodations in post-secondary education. However, they acknowledged worries that students were, in effect, being unfairly misled about their likelihood of success when they reached the clinical practicum phases of their education. Having been clinical practitioners themselves and therefore familiar with the demands on students in clinical settings, this study's participants believed they held realistic perspectives on how their students would be assessed by their clinically based colleagues.

This, too, echoes the literature about nursing faculty. These allied health faculty appear to share with their nursing counterparts a wish not to be perceived as knowingly misleading students about the likelihood of whether they will be successful in their choice of career. Two respiratory therapy participants in this study stated they would never make assumptions about a student's *ability* to achieve, or underestimate what a student could accomplish, but said they often ask themselves and their program colleagues if they should be more 'honest' (their word) with applicants and students about what (in their professional opinion as RRTs) are the students' likelihood of not only completing their program but practicing as RRTs.

### **Similarities and differences in the narratives of the MRT participants in contrast to the RRT participants**

As shown in Table 3, the responses of the MRT and RRT faculty (in terms of the number of faculty in each program responding in a similar way using similar words and phrases, and, in terms of the faculty from each team corresponding to the dominant and minor themes) were remarkably similar except with respect to the issue of having concerns about students with disabilities and/or requiring accommodations. Concerns about the capacity of these students to provide safe patient care in clinical settings (both while students and upon graduation) were more pronounced among the RRT faculty (as noted earlier, all five RRT faculty expressed this to be concerning). When discussing their concerns, the RRT faculty referenced examples of situations in clinical settings where students would not (for example) be able to take longer to think, make a decision, avoid stress and time constraints, or receive additional supports, in order to respond appropriately in an acute, emergency situation. Each RRT participant stated he/she could provide examples of students with disabilities (with accommodations), who had successfully progressed in their program, but who had failed in their clinical placements. These failures in practicums had at times had serious consequences (example, occasions of ‘near miss’ of harm to patients, expulsion of students from hospitals by clinical staff and hospital managers, and patient complaints).

The single MRT faculty member responding on this matter made a general statement about hospitals and clinical settings being ‘less forgiving of errors’, and less accommodating, than educational settings. The remaining three MRT participants expressed that they felt that learning supports and customized assessments provided to

students with disabilities and/or accommodations while at the college (before they went to their clinical placements) more than adequately prepared the students for success, and safe practice, in the clinical sites. As well, all four MRT participants stated that the degree of supervision afforded to those students when in clinical sites, was adequate to mitigate any serious risk issues. Specifically, two MRT participants noted that their students are *always* directly supervised while in practicum. Two MRT participants discussed their experiences with students in their program who had disabilities requiring accommodations, who were highly successful in their clinical placements, and who graduated from the program, passed their licensing examinations, and are now working in the field.

Table 3 *MRT and RRT participants' responses in relation to dominant and minor themes*

<b>Themes</b>	<b>MRT</b>	<b>RRT</b>
Dominant #1: retention of primary health identity, irrespective of tenure in full-time teaching	3/4	5/5
Dominant #2: important to remain current in their original health discipline	3/4	5/5
Dominant #3: stressful, challenging transition experience, with peer mentoring as most important support	4/4	5/5
Dominant #4: retention of duty of care obligation, along with strong support for inclusion of students with disabilities	4/4	5/5
Minor #1: concern about clinical performance of students with disabilities' ability to provide safe care	1/4	5/5
Minor #2: desire to work in a clinical setting on a regular basis throughout the academic year	2/4	4/4

Although this researcher is appropriately cautious in making assumptions based on this small sample size and single indicator, her knowledge about the working conditions and practices of both professions suggests that RRT faculty might have a different perspective from the MRT faculty because, as practitioners, they work in critical, high risk areas such as intensive care units, emergency rooms, cardiac arrests

management, withdrawal of life support, and neonatal resuscitation units. As well, RRT students in clinical placement in their third year of their program assume considerable independence and responsibilities for direct patient care, even in highly acute settings. The more typically-based work setting of MRTs is within a diagnostic departmental setting, and they (graduate MRTs and MRT students) are not routinely responsible for patient crisis or emergency care and management. It is only a tentative hypothesis, but perhaps since the personal clinical experiences of MRT faculty, and some of their personal experiences with students with disabilities and/or requiring accommodations in their programs, differ from those of RRT faculty, their assessment of the suitability of students with disabilities and/or requiring accommodations is that there is less reason for concern in their profession. This perception by the MRT faculty also differs from that expressed by nursing faculty in the research reviewed, and again, this might be a reflection of the clinical experiences and potential work settings that nursing faculty have.

### **Importance and significance of the findings**

As previously noted, the findings of this exploratory study are drawn from the personal narratives of nine individuals, working together in two program teams within the same academic School, in the same postsecondary education setting. As is common with many exploratory qualitative case studies, where there is limited existing literature on the topic (Yin, 2009), this research study drew purposely from a small sample size so as to conduct a focused, in-depth investigation. Accepting that conclusions drawn from its analysis would be generalized (if at all) with great caution, this study followed an inductive reasoning approach, with an Interpretivist stance. This researcher understood



that she would be accepting as reality the participants' interpretation of their lived experiences (in this instance, their transition experiences, and their experiences with students with disabilities and/or requiring accommodations). Further, she was aware that the conclusions she drew from this study would emerge from *her* interpretations of the participants' narratives.

This investigation was intended to augment current understanding about the transitional experiences of non-nursing allied health faculty who left clinical practice to assume full-time positions as educators. It also intended to augment current understanding about the attitudes of non-nursing allied health faculty towards students with disabilities and/or requiring accommodations in their health programs. Through its selection of participants drawn from two non-nursing allied health faculty program teams, using semi-structured interviews that provided substantial rich narrative data, this researcher believes the findings can legitimately address the study's purpose. Further, the siting of this study in a Canadian community college setting offers a perspective on the research topic unique to what the literature review indicated has been researched to date.

This exploratory case study had as its goal to share with others what the researcher has learned about (and from) her participants. It hoped to illuminate their perceptions, and their interpretations, of what *were* their transitional experiences, and what *are* their current thoughts and approaches to managing students with disabilities and/or requiring accommodations. This researcher was interested in learning if and how her participants (being non-nursing allied health faculty, working in a community college in Ontario, Canada) differed in their responses to the two research questions from participants in similar studies, responding to similar questions. As was shown, the results

were that this study's participants' experiences and responses in some ways mirror similar experiences and reflections of individuals in similar settings elsewhere (example, Hurst, 2010; Smith & Boyd, 2012; and Carroll, 2004), and in other ways offer differences, and provide new insights.

The participants' responses in this study that were reflected in the four dominant themes (retention of primary health identity; desire to maintain currency in their health discipline; experience of their transitions as having been stressful, with peer mentoring being critically important; and, strong sense of obligation to their 'duty of care' co-existing with personal support for the inclusion of students with disabilities), did, to a large, extent mirror the findings revealed in the studies located in the literature review. These participants' descriptions of their transition experiences were markedly similar to what has been reported about the transition experiences of nursing faculty, and allied health faculty in disciplines other than MRT and RRT. Also similarly, the participants in this study identified peer mentoring as the single most important organizational support throughout their transitions. As well, the findings in previous studies that nursing and allied health faculty view it as very important that they remain current in their health disciplines was echoed in this study. Further, similar to previous studies where it was reported that nursing and allied health faculty tend to retain their primary professional identity alongside their emerging educator identity, this study's participants articulated comparable sentiments.

With respect to the dominant theme relating to 'duty of care', the narratives of the participants in this study revealed a strikingly similar perspective about this professional obligation to their counterparts in other investigations, which should not be surprising,

given the similar education, standards of performance, and licensing requirements for nursing and allied health disciplines across Western countries. Also markedly in keeping with what is reported in the literature from similar research, this study's participants (like nursing and other allied health faculty studied) articulated full and unmitigated support for the inclusion of individuals with disabilities in health programs, and in careers in health care. However, as in prior similar research, the participants in this study occasionally struggle with how to reconcile their duty of care to the public with their obligations to students. And, as with previously studied nursing and allied health faculty, when challenged to make a choice, the faculty in this study also refer to their health discipline's imperatives for guidance.

With regard to the minor theme respecting the desire by some participants in this study to be able to work in a clinical setting throughout the academic year (instead of on their own time, independent of their employing college), this topic received negligible mention in the studies found in the literature review. It should be noted, however, that models of student clinical supervision differ greatly among nursing and allied health programs, across disciplines, countries, and educational setting (university or community-based college). In numerous nursing and allied health programs, full-time faculty directly supervise students in clinical sites (instead of employing clinical site staff to do this, as is the case for the programs in which the participants in this study work). This researcher wonders if the interest expressed by her participants in being able to work on a regular basis in clinical settings stems from wanting to practice their personal clinical skills, or if it relates to wanting to spend time in a clinical milieu, of which they have fond personal

and professional associations. This distinction was unfortunately not explored during the interviews.

With respect to the minor theme related to faculty concerns about the clinical performance of students with disabilities and/or requiring accommodations, and their ability to deliver safe patient care, as noted, this was identified as a minor (not dominant) theme because only six of nine participants noted it as a concern. As discussed in Chapter 2, Literature review, this researcher discovered that similar research on this question had been conducted only with nursing faculty (that is, none could be found on allied health faculty). Research has revealed there exists considerable concern among nursing faculty about the ability of nursing students with disabilities and/or requiring accommodations to deliver safe care, however, concerns to a similar degree were not evident in this study overall, and conspicuously not with the MRT participants. However, of important note is that although all five of the RRT participants viewed this as a concern, there is no known other group of RRT participants with which to compare them.

Although the narratives in this exploratory case study are unique to these participants, the themes that emerged from their responses arguably form a pattern that intersects and resonates with the results reported in studies reviewed earlier as part of this research project. This study makes a meaningful contribution to the current literature on the topic by adding specifically to an understanding of the experiences of non-nursing allied health professionals transitioning to educator positions in Ontario. It is to be hoped that this study will contribute to knowledge of how the maintenance of dual identities (health professional and educator) influences the attitudes of non-nursing allied health

faculty towards students with disabilities and/or requiring accommodations in their programs. The case study findings may open a discussion of this topic in the Canadian setting, specifically in community colleges, where many allied health programs are situated. Mears (2009) writes that “You cannot draw conclusions about the whole of experience...but you can contribute a deeper understanding” (p.140). This researcher agrees with Mears that such research-based knowledge has value.

### **Reflections on Benner’s theory of ‘novice to expert’**

As discussed in chapter 2, Benner’s (1984) ‘novice to expert’ theory was based on her (Benner’s) investigations into how novice clinical nurses acquire the requisite skills and knowledge to reach an expert level of performance. Benner introduced the concept that nurses become expert in their discipline through a combination of prior formal education and instruction, and, through an abundance of clinical experiences. Her model of five stages in the evolution of a new nurse from novice to expert proposes that each stage builds on the learnings of the previous stage. Benner noted, as well, that these stages (and the sensation of feeling like a novice) are not unique to new nurses, or indeed to nurses at all, but could apply to anyone entering a new and unfamiliar work setting. Her model also proposes that a practitioner can acquire skills and knowledge (‘knowing how’) without having learned the theory (‘knowing why’). Of particular note is this theory’s assertion that through experience, individuals working in fields such as nursing and medicine develop a fulsome understanding of the integration of theory and practice, which leads to improved patient care competencies and decision making.

As with the nurses studied by Benner in her research, the nine participants in this study stated they also felt like novices when they entered their new roles as full-time

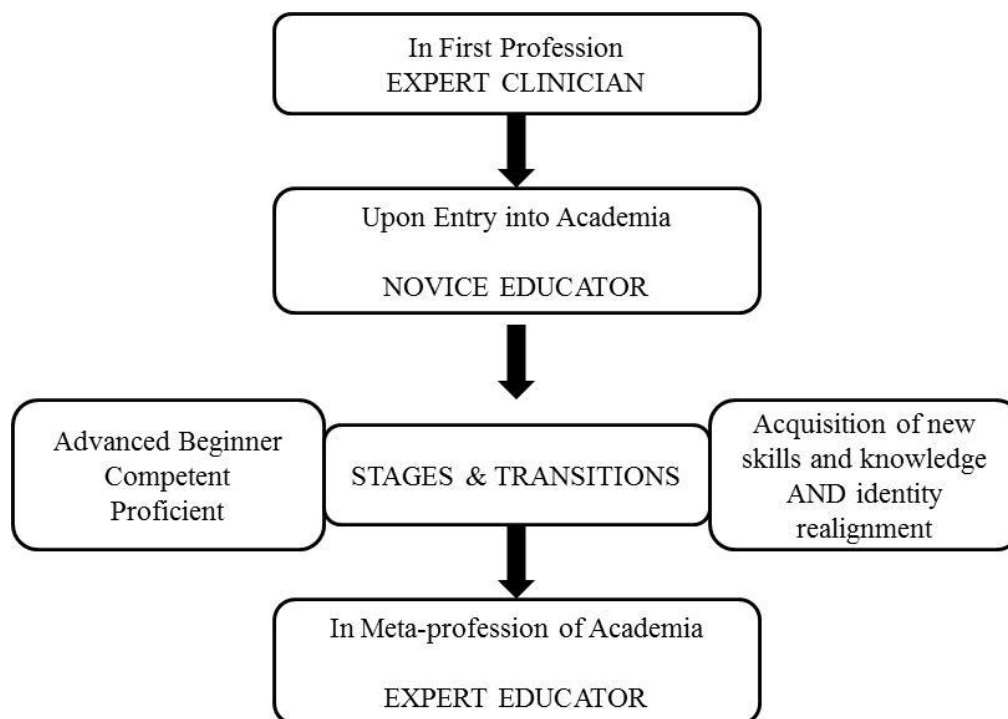
faculty. They similarly stated that they needed time, lived experiences in their new role (working as a full-time educator), and mentoring from colleagues who had undertaken the same journey before them, to become assimilated in academia, and to reach a stage where they felt competent. They stated their transition from novice to expert (or close to it) was gradual, progressive, and transpired over several years. These sentiments were made by all nine of these participants, irrespective of whether they had engaged in any formal instruction in education (example, completing a degree in education) after becoming full-time educators. It appears that their progression from novice to expert supports Benner's theory that practitioners can 'know how' without having to 'know that'.

However, the process of transition investigated in this study deviates from Benner's because (as shown in Figure 3) this study's participants had been experts in the clinical setting before becoming novices in the academic setting. Their individual journeys were not 'novice-to-expert', but were 'expert-to-novice-to-expert'. Their personal transitional journeys would be similar to those of any allied health practitioners transitioning from clinical care to academic positions in similar community college allied health programs. For these participants, and for similar new allied health faculty, for at least the second time in their professional careers, they entered a stage of being a novice, required to learn new skills and knowledge, adapt to a new culture, and acquire a new set of proficiencies.

Although the learning requirements of this study's participants (when they became educators) would have had aspects in common with neophyte educators with no prior professional identity, this researcher suggests that these (and possibly other) clinical

experts would benefit from unique, focused induction and support strategies when they become novices in academia. In contrast to when they entered clinical settings as novices, and had to learn (as graduate health professionals) how to integrate theory and practice, in their new profession of allied health educators they commonly must learn ‘the how’ in the absence of any previous formal preparation related to educational theory. In a sense, new allied health faculty often lack what Benner called the ‘knowing that’.

The rationale for designing unique induction and support strategies for new allied health faculty has more merit when the issue of these individuals having an established health identity is considered. The new skills and knowledge they must acquire as educators occurs in concert with their acculturation into a new setting, and adoption of an additional identity.



*Figure 3: Benner's (1984) Theory of Novice to Expert: Remodeled to Indicate Process for Clinicians Transitioning into Academia*

### **Implications arising from the findings**

Demands for quality improvements and enhanced compliance monitoring in the delivery of health care are evident across all Western countries, and therefore also in Ontario. Legislators, public advocacy groups and health regulatory bodies are intensifying their expectations on health care providers to improve care, services and patient experiences. Further, the growing complexity of health care in terms of technology, treatment modalities and the understanding of disease processes results in constantly changing curricula in health care programs. These influences are keenly felt by educational programs preparing health care professionals, both directly (through health program accreditation, and ministerial mandates), and indirectly (such as through industry/community input, and instructions to regulated health faculty).

In addition, expectations are increasing on post-secondary educational institutions in Ontario to enhance supports for students with disabilities and/or requiring accommodations, including comprehensive academic accommodations such as for instructional processes and assessments in simulation settings. As Western countries define new expectations for the inclusion of individuals with disabilities in all aspects of society, educational settings (and their community partners) must themselves adapt. Programs preparing students for careers in health care must, like all other programs, meet these expectations to the point of 'undue hardship'. While legislation and regulations are (rightly) expanding access to education for all members of society, health care regulatory bodies and health discipline professional associations are simultaneously increasing the accountabilities on health care practitioners to provide safe, expert care. These two key sets of expectations converge on allied health faculty who are members of regulated



health professions. They carry dual responsibilities of supporting students to be successful in their chosen field of study, while complying with obligations to their profession and to the public. The extent to which this is handled well or poorly impacts student success, faculty performance, and job satisfaction.

There exists a trio of compelling influencers (educational employer, regulatory/professional associations, and government/human rights bodies) that profoundly affect the practices, approaches, and priorities of allied health professionals who work as educators. Each group or sector exerts its influence and authority within the legislated and legal rights and obligations delegated to them in their respective jurisdictions. Both groups and sectors execute their mandates in the best interests of the public, and within ethical frameworks. Nevertheless, these differing imperatives, ethical frameworks and value sets, in effect, can compete in the educational setting when allied health faculty (in the delivery of their ‘front line’ service to their students) perceive that to honour one set of obligations would undermine another. This and other research findings (Watson, 1995; and, Sowers & Smith, 2004) suggest that allied health faculty do not dispute the importance or necessity of human rights directives being applied fully in their programs (quite the contrary). However, when one value or expectation is juxtaposed against another, to assist in their decision making they will typically refer or look to their professional discipline’s expectations for guidance.

Aside from assisting in the resolution of a problem of practice that appears not to be unique to this researcher’s work setting, perhaps the answer as to why this should concern a broader audience lies in the suggestion that each of us should recognize that as consumers of health care services, we have a stake in the knowledge, skills, values, and

overall performance of health care providers. By extension, we have a stake in the quality of their training and in the faculty we entrust to prepare them. As members of what most citizens hope is a just and caring society, many of us would not want to see individuals who could become excellent care providers but who have disabilities, hindered from entering the health professions.

It would be beneficial if there was greater understanding of the unique and significant sets of obligations borne by these faculty, and through educational leadership, and professional learning, assist them in finding the appropriate balance between their two identities. Duphily's (2011) recommendation that academic leaders should "respect and appreciate the values which initially attracted (them) to hire these individuals (allied health practitioners)" (p.19) is sensible. Murray et al (2014) recommended "that collegial and institutional support structures (should be) evaluated in light of the concerns and the *unique* needs of individuals coming to academia from clinical work' (p.394). Addressing these issues early in the onboarding of new allied health faculty may have merit. In the context of the two research questions posed in this study, suggestions for approaches that educational leaders of health programs (particularly in Ontario college settings) could take are offered.

With respect to the first research question, relating to the experiences of allied health faculty who transitioned from clinical practice to academia:

- Modify new faculty induction strategies to permit new allied health faculty to participate in sessions focused specifically on them, led conjointly by college orientation/organizational staff *and* by senior faculty in their (or other) allied

health programs, for the purpose of proactively initiating dialogue about what they might expect as they transition from clinician to educator;

- Include conversations in the above sessions about workplace culture, support structures, identity transformations, and the experiences of current allied health faculty;
- Consider permitting an extension of the formal mentoring partnership between new and senior allied faculty for a second academic year, where requested by new faculty;
- Prepare (possibly through organizational development and learning teams) individualized personal development support packages for new allied health faculty who will be teaching didactic/theory courses for the first time.

With respect to the second research question, relating to the attitudes of allied health faculty towards students with disabilities and/or requiring accommodations:

- Enhance the content in new allied health faculty orientation sessions related to legal and human rights obligations in educational settings, and on the expectations on faculty respecting student academic accommodations;
- Introduce in the initial orientation sessions for new allied health faculty an opportunity for senior faculty in their programs to discuss with them some student scenarios relating to disability related accommodations (example, case studies and best practices);
- Proactively initiate conversations about how their identity as a health professional influences their perspectives.

New allied health faculty may benefit from such focused and specific assistance in managing not just the practical logistics of adapting training scenarios and assessments to meet accommodation or universal design requirements, but from guidance on navigating the professional dilemmas they may encounter.

An important overall strategy that could be taken by educational leaders to buttress supports to new allied health faculty as expressed by Boyd (2010) is for “clear role models” to be provided, so that new faculty in nurse and teacher education have some guidance in reconstructing their identity as an academic within their professional field” (p.164). To this researcher, such clear role models should be drawn from the ranks of administrative leaders like Chairs, and from faculty, alike. Ultimately, the responsibility for ensuring that new allied health faculty are given the opportunities and supports they need to become the best educators they can be, lies with educational leaders.

## **Chapter 6**

### **Conclusions**

#### **Summary reflections on the study**

The origins of this study were in a perceived problem of practice in the workplace of this researcher. Over time, she had perceived growing tensions among numerous members of her allied health faculty that appeared to surface most notably surrounding discussions about student appeals and progression, and applicant entry requirements to their programs. Of particular note were faculty expressions of confusion, and occasionally discomfort, around how to appropriately ensure that students with academic accommodations were meeting all required vocational learning outcomes. At the same time, (in response to Ontario Human Rights Commission directives) the employing college of these faculty was expanding faculty obligations to students with disabilities and/or requiring accommodations.

This researcher observed that when her allied health faculty discussed entry criteria to their programs, student assessments and progression, and their approach to student appeals, their viewpoints were generally from the perspective of their (that is, the faculty's) status as health professionals, and not primarily from their status as educators. References to 'duty of care' to the public, and students' (and graduates') ability to provide safe patient care, figured prominently on those occasions. Conversations between these faculty and this researcher revealed that many of them were deeply concerned about how they could reconcile their legal obligations as members of regulated health professions to protect the public, with their obligations as educators to students. Specifically, they felt that as licensed health professionals, they must ensure that every

student they approve to enter clinical practicums is not a risk to patients, and, that every graduate of their programs meets all required competencies to be safe practitioners.

Many of these faculty struggled with how to integrate accommodation requirements in their programs without compromising program and professional standards.

It appeared to this researcher that her faculty members articulated a primacy of their health identity in relation to an identity as educators. Further, she felt that this tension between their two identities (health professional and educator) was at times irreconcilable. Although some of these faculty had been full-time professors for many years, and had not worked as health practitioners in clinical settings for a very long time, their transition from clinical practice into academia seemed not to have resulted in a reconfiguration of their primary identity from health clinician to health educator. As an educational leader and as the supervisor of these faculty, this researcher felt the situation was untenable, and therefore felt a responsibility to address it. Beyond this, she believed that a resolution of this issue would be to the benefit of not just her faculty, but also to the benefit of current and prospective students (particularly those with disabilities and/or requiring accommodations) in her allied health programs.

The opportunity to investigate this issue in a formal, structured manner through this doctoral research seemed especially opportune. It was hoped that through this investigation, much could be learned about whether the tensions felt by her allied health faculty were unique, or shared by allied health faculty in other settings. Further, it was hoped that the investigation might reveal strategies that could be applied to this researcher's work setting, to assist her faculty in resolving their identity tensions, and by

extension, improve their capacity to support students with disabilities and/or requiring accommodations.

As indicated earlier, this study had two goals, as reflected in its two research questions. The first research question aimed to explore how (non-nursing) allied health faculty teaching in an Ontario community college experienced their transition from clinical practice into academia. The second research question aimed to explore what were their attitudes towards students with disabilities and/or requiring accommodations in their programs. This researcher was intrigued to learn how such a faculty group would identify themselves (that is, as health professional or educator), and, to what extent their attitudes towards students with disabilities and/or requiring accommodations might be linked to their identity as health professionals.

The literature review undertaken by this researcher revealed that numerous studies had been conducted on the transition of nursing faculty from clinical practice into academia, but similar research on non-nursing allied health faculty was minimal. The research located on this topic of transition (for both nursing and non-nursing allied health faculty) also discussed these faculty's self-identification (health professional or educator) among each study's participants. Several studies had investigated the attitudes of nursing faculty towards students with disabilities and/or requiring accommodations, with references to the identification by these same nursing faculty as nurses rather than as educators. No research was found that focused on the attitudes of non-nursing allied health faculty towards students with disabilities and/or requiring accommodations was found.

Research reviewed for this study (for example, Anderson, 2009; Boyd, 2010; Duffy, 2013; Hurst, 2010; Logan, Gallimore & Jordan, 2015) revealed that allied health faculty (nursing and non-nursing) commonly experienced difficult transitions into academia, for which they felt unprepared. As also noted earlier in chapter 2 (Logan, Gallimore & Jordan, 2015; Smith & Boyd, 2012; Hurst, 2010; and, Murray, Stanley & Wright, 2014), allied health faculty, being members of regulated health professions, *must* maintain a license to practice in order to teach in their disciplinary field (this applies also in Ontario community college allied health programs). This mandated career-long affiliation with their professional health bodies ensures that allied health faculty continue to identify with, support, advocate for, and participate in, their health discipline.

Participants in the studies noted above reported that upon assuming full-time teaching positions in education settings, they experienced intense and prolonged feelings of inadequacy, loss of confidence, and cultural dissonance as educators. Irrespective of (successfully) having taught in part-time capacities prior to assuming full-time positions, the transition into full-time academic roles was fraught with feelings of loss (the departure from clinical care) and uncertainty. To compensate for feeling uncomfortable and like a novice in their new role (as distinguished from their prior confidence as expert clinicians), new allied health faculty tended to firmly hold on to the identity, practices, behaviours and values associated with their former roles as allied health practitioners.

The research from the literature review revealed that allied health faculty (nursing and non-nursing) tend to retain their primary identity of health professional for a considerable period of time after transitioning into academia. However, the reported research also showed that an 'educator' identity can evolve alongside the health



professional identity, and that most allied health faculty do find a way for their two (dual) identities to co-exist. Dedicated and focused induction strategies, and ongoing organizational support appear to be essential to assisting the evolution of this identity reconstruction for these faculty. Overwhelmingly, peer mentoring was noted as being the single most important organizational support strategy for these faculty in their transition.

The available research on attitudes of nursing faculty who transitioned from clinical practice into academia towards students with disabilities and/or requiring accommodations, showed they were fully supportive of the inclusion of those students in nursing programs. Participants in those studies affirmed they wanted to do their utmost to promote the success of those students, but felt there existed limits to what they could do to ensure those students' success in clinical placement (Watson, 1995; Magilvy & Mitchell, 1995; and, Sowers & Smith, 2004). Many of these same participants struggled with what they perceived as conflict between their health professions' accountabilities to the public (most critically, their duty of care to patients) and their accountabilities to their students. Those nursing faculty assessed their nursing students' ability to provide safe care, and suitability to practice, from the perspective of their health professional identity ahead of their educator identity.

Allied health faculty (nursing and non-nursing) teaching in programs preparing students for careers in regulated health professions are strongly influenced by a matrix of organizations. Provincial Ministry of Education directives are integrated in these programs with requirements from health program accrediting bodies, in addition to each health discipline's regulatory bodies. As generic post-secondary educators, allied health faculty are rightfully expected to adhere to legislative and human rights directives, and to

organizational policies, related to the full inclusion and support of students with disabilities and/or requiring accommodations. The literature suggests that allied health faculty wish to be able to respond to these disparate expectations in a manner that respects the duality of their identities, and which acknowledges their uniqueness among fellow, non-health faculty colleagues.

It was hoped that this researcher's study would add to the body of existing knowledge relating to the transition experiences of non-nursing allied health faculty who left clinical practice for academic posts. Further, it was hoped that an exploration of the attitudes of *non-nursing* allied health faculty towards students with disabilities and/or requiring accommodations would contribute specifically to this gap in the literature. Locating the study in a Canadian community college setting would provide a new comparator in the existing body of research. An additional aim of this study was to develop recommendations for college educational leaders on how to improve the induction of allied health faculty. Enhanced, supportive induction processes for allied health faculty might have the effect of expediting their adoption of their identity as educators, and by extension, better support their management of students with disabilities and/or requiring accommodations.

### **Study approach and findings**

Benner's (1984) 'novice to expert' theory was selected as the theoretical framework for this investigation. Her model of the acquisition of skills and knowledge by newly graduated nurses in a clinical setting, particularly as it relates to skills and knowledge acquisition linked with experience was deemed highly relevant for use here. Benner proposed that the progressive assimilation of context-specific skills and

knowledge occurs in stages (stage one being novice, and stage five being expert) over time. Further, she proposed that a clinician's perceptions and practices build on each other as she/he learns from each experience, and as she/he develops greater understanding of theory as it is applied in real world settings. A particularly noteworthy element of Benner's model is the assertion that learning how to do something ('knowing how') can be achieved without having explicitly learned the underlying theory ('knowing that').

As noted earlier, using an interpretivist approach, an exploratory qualitative case study was undertaken, using purposive sampling and individual, semi-structured interviews with nine participants (from a potential maximum of ten), drawn from the full-time faculty complement of the Medical Radiation Technology and Respiratory Therapy Programs in a School of Health Sciences in an Ontario community college. All participants (four medical radiation technologists and five respiratory therapists) were full-time faculty in their programs, held current licenses to practice in Ontario, and had worked in their programs in a part-time capacity before assuming full-time positions. All agreed to be audiotaped during their interviews. The interviews (conducted by a research assistant, which was a requirement of the college Research Ethics Board) provided rich personal narrative data. Each participant responded expansively to each question, and member-checking meetings were held with each participant. Triangulation of data was undertaken using: the participants' transcribed interview narratives; the literature review; documentation from and about the regulatory bodies and professional associations of the program faculty participants (medical radiation technology and respiratory therapy), and, as well, applicable legislation, human rights directives and relevant policies of the

participants' employing college. This study is thus able to offer analytic generalisability (as compared with statistical generalisability).

Simple, open coding of the transcribed interviews was conducted to highlight words, phrases and issues raised by the participants. The data from the nine narratives were subsequently organized into six themes: four considered dominant (given a focus by a minimum of seven participants) and two considered minor (given a focus by five to six participants).

#### **Dominant themes.**

1. Faculty who participated in this study retained their primary identity as a medical radiation technologist (MRT) or registered respiratory therapist (RRT) irrespective of their tenure in their full-time teaching roles, although this primary identity co-existed with, and while, their second (dual) identity as an educator evolved.
2. It is critically important to the allied health faculty that they remain current in their original professional discipline of MRT or RRT, which they described as being met by attending conferences, engaging in professional development activities, serving on professional association committees/task forces (example, preparation of registration examination questions), and keeping abreast with technological changes in equipment commonly used in their disciplines.
3. The transition from clinical practice to academia was stressful and challenging for both the MRT and RRT faculty, and the single most important organizational support mechanism during that time was mentoring from their program faculty peers.
4. The MRT and RRT faculty retained an acute obligation respecting their duty of care to the public and the provision of safe care by their students, while simultaneously

fully embracing their obligations and responsibilities towards all of their students, including students with disabilities and/or requiring accommodations.

### **Minor themes**

1. A notable number of RRT faculty are concerned about the clinical performance of students with disabilities and/or requiring accommodations, and their ability to deliver safe patient care while students and once they become graduate practitioners.
2. A notable number of MRT and RRT faculty are motivated to work in a clinical setting on a regular basis throughout the academic year.

It is worthy of comment that for the four dominant themes, two were deemed highly important by nine out of nine participants (#'s 3 and 4), and two were deemed highly important by eight out of nine participants (#'s 1 and 2). Differences in the responses of the participants based on their specific discipline were not noted except in regard to minor theme #1. Although considered a minor theme because fewer than seven participants in total referenced it in their interview, all five respiratory therapy participants raised it as a concern, whereas only one of four medical radiation technology participants raised it.

### **The study's significance and contribution**

This exploratory qualitative case study revealed that for the allied health faculty participating in this study, their individual transitions from clinical roles into academia in Ontario shared many aspects in common with the experiences of allied health faculty (nursing and non-nursing) reported in the literature (example, Hurst, 2010). Reflections by these participants of feeling unsure, lacking confidence, confused, of being a novice, and of having profound feelings of loss of purpose, value and credibility, were notably

similar to the reflections found by similar faculty in those other studies. The adjectives and phrases used by these participants when describing how they felt as novices when they entered academia were notably in keeping with Benner's (1984) description of the novice stage in her model.

Their concern that it is critically important for them to remain current in their health discipline is, as well, in keeping with results of similar studies (example, Logan, Gallimore & Jordan, 2015; Smith & Boyd, 2012). As with participants in similar studies, these participants view maintaining disciplinary currency as being essential to maintaining credibility with students, fellow program faculty, and community professional colleagues. The participants in this Ontario-based study, however, indicated that to remain current need not mean personally engaging in direct clinical work. They suggested currency expectations (as required by their professional associations) could include participation with their professional association, and/or other educational development activities. Only six participants (four of which were RRT's) indicated a desire to be able to work clinically throughout the academic year, however, four of the five RRT participants stated that (as of the date of their interview) they do occasionally work in clinical settings on their own time (weekends and during college vacation periods).

This study's participants' retention of their health identity as their primary identity, and their overwhelming sense of obligation to their professional duty of care, support the findings of research reported by (for example) Smith and Boyd (2012), and, Murray, Stanley and Wright (2014). However, the sense that the educator identity had evolved over time (up to several years) to become more 'equal' with the health

professional identity, was noted by these participants, as was found to be the case in other studies (Hurst, 2010; and, Duffy, 2013). Also voiced by this study's participants were reflections that the establishment of their educator identity had eventually occurred because of the support and influence of colleagues, and from growing self-confidence arising from the passage of time in their educator roles. For them, the evolution of their educator identity did not result from participation in the intentional, formalized induction strategies in which they had participated. However, they indicated that they likely would have 'felt more like educators' much sooner, had they received more focused supports that recognized their 'newness' in the educator role.

The identification by this study's participants that mentors were the most important organizational support mechanism for them mirrored the findings in related studies (example, Cangelosi, Crocker & Sorrell, 2009; and, Duphily, 2011). These findings support Benner's (1984) 'novice to expert' theory in relation to two particular aspects of the model: the importance of peer mentoring in the acquisition of requisite skills and knowledge, and, the critical significance that ongoing experience plays in the ability of a novice to progress through to expert levels of performance. Each of this study's participants emphasized that being an educator simply got easier year over year, as they grew more familiar with the expectations, routines and scope of their positions.

All of the nine participants who discussed their professional duty of care as a critically important issue added that they expend significant time and effort imparting this principle to their students (as they stated it was imparted to them by their instructors). In addition, they noted that as members of their professional (health) associations, and as faculty, they are expected to promote and support the participation of their students in the

associated student MRT and RRT associations, and through that, introduce their students to the associations' values and codes of ethics. Activities such as these serve to further reinforce to allied health faculty that they are members of regulated health disciplines, and as such, are expected to model *that* (health professional) identity in the education setting with their students.

It is notable that the finding relating to participants' concerns about the clinical performance of students with disabilities and/or requiring accommodations, and their ability to deliver safe patient care, was a minor theme. This was identified as a minor theme because of the total number of participants highlighting it (six), however, it was a very critical issue for all five respiratory therapy participants. This researcher posits that the differing patient care roles, professional scope of practice, and standard responsibilities assumed by these different disciplines may explain why the responses of the two participant groups varied.

The findings from this study do align with the findings from much of the previously conducted relevant research into allied health faculty transitions. This study augments what is known about the transition process, retention of a health identity, importance of mentoring, and respect for the duty of care, among non-nursing allied health faculty, by offering insights gleaned from two disciplinary groups of faculty not previously studied (MRT and RRT). It also augments what is currently understood about these phenomena from having situated the study in an Ontario community college, which has not been a location for prior studies. This study offers a new insight into the attitudes of non-nursing allied health faculty towards students with disabilities by noting that although this was not a dominant concern for all participants, when assessed on the basis



of health discipline, a marked difference of perspective between the two participant groups (MRT and RRT) existed.

This researcher believes that the findings from this study, which focused on non-nursing allied health faculty, support aspects of Benner's 'novice to expert' theory, and also possibly augment it. Specifically, novices (whether new nurses, or as in this study, new allied health educators) can experience a common set of feelings when entering an unfamiliar work setting. These novices learn from their experiences, start to integrate theory and knowledge with their daily practice, and progress through stages of learning and skill acquisition to the point where they can perceive themselves as experts (or proficient and near expert) in their new domain. Given that most of the participants in this investigation had not completed any formal course of study in education but still considered themselves to have mastered their educational role, this supports Benner's theory that skills and knowledge (the 'knowing how') can be acquired without having been taught the associated theory (the 'knowing what').

The findings of this investigation also suggest that with respect to allied health faculty transitioning into academia, Benner's model might be revised to reflect the dynamics of 'expert to novice to expert'. This would reflect the uniqueness of the allied health practitioner's pre-existing proficiencies (which were key to the individual being recruited to teach in an allied health program), but also acknowledge the person's status of novice in her or his new employment setting and role.

### **Implications for future research**

Given the paucity of research into the experiences of non-nursing allied health faculty who have transitioned from clinical practice into academia (in Canada and

Ontario in particular), additional investigations would be helpful for colleges that have such faculty and programs. Research on this amalgam of faculty working in Canadian community colleges would most obviously complement this study, as would a focus on either of these same disciplines (MRT and RRT).

The difference in response between the participants of the two faculty groups in relation to their attitudes towards students with disabilities and/or requiring accommodations does, in some ways, raise more questions than it answers. The RRT participants voiced concerns about the ability of students with disabilities to provide safe patient care that were very much in keeping with sentiments expressed by nursing participants in studies asking a similar question. However, as was shown, this issue was not demonstrated to be of similar concern to the MRT participants. This may or may not be significant, given this single study and small sample size. However, *if* the differing responses relate to the differing type of practice each discipline engages in, then one might expect to see this response pattern replicated with MRT and RRT participants in other studies, at different post-secondary settings. Understanding how concerns about (and resistance to) the inclusion of students with disabilities originates in faculty could aid the development of strategies to resolve it.

Research into the similarities and differences between the two groups of faculty studied here, and their counterparts in other post-secondary settings, might illuminate the factors that affect transitional experiences for non-nursing allied health faculty (for better or for worse). For example, studying the efficacy of varying approaches in employer onboarding for new allied health faculty, and the nature of ongoing support (such as

formal/informal peer mentoring, or from employers' organizational development units), could have value for college leaders.

Understanding if the transitional experiences and assumptions of an educator identity held by allied health faculty differs among different disciplines, among faculty of different tenures in academia, or with length of time in clinical practice prior to teaching, may have value because of the specificity of insights potentially illuminated. Such information – grounded in contemporary and sound evidence – would potentially enable a human resources department (and faculty supervisors) to better calibrate their support for newly-hired allied health faculty of any discipline. The goal should not be to minimize the significance or value of the health identity in allied health faculty, but to support its co-existence with an equally important educator identity. Both identities are absolutely essential to their role.

To devise broadly applicable strategies to improve the onboarding of health professionals into academic careers, and to enhance their subsequent identification as educators, more research is needed. This exploratory qualitative case study has paved the way for additional studies that could incorporate survey, narrative and explanatory case studies. Similarly, more research into challenges allied health faculty experience when managing students with disabilities in their programs, would be potentially very valuable, so that colleges can tailor learning supports for faculty that enhance the inclusion of these students in health programs, and subsequently enable these students to best learn.

Research on how transition challenges and dual identities in non-nursing allied health faculty influence how effective they become as educators with respect to embracing (for example) a personal research mandate, becoming more expert on

pedagogy or an avid publisher, is also minimal. Research into the impact of allied health faculty dual identity on their attitudes towards students with disabilities seems almost non-existent, and it would be timely for more studies to be undertaken. Responding to a research question such as how attitudes and teaching approaches differ among different disciplinary programs or educational settings, and if so, why, might elicit excellent insights. If another study demonstrated an absence of concern among a particular group of allied health faculty in relation to teaching students with disabilities, what might be the factors contributing to that increased level of comfort and confidence? Given what is known about this issue among nursing faculty, and given the importance of all educators successfully embracing the principles of inclusion, there is a great deal of room for new knowledge to be added to this topic.

### **Implications for practice and leadership**

This study began as a reflection on a problem of practice, and as both an educational leader and an early-stage researcher, an obligation is felt to apply the results of this study to this practice problem in hopes of lessening it (even if initially only on a local, college-based level). The excitement and passion which new faculty bring with them as they leave their familiar clinical milieus and enter ‘the world of education’ is to be celebrated and strengthened. Given that insights into the types of challenges they have faced and the dilemmas they struggle with have become known, educational stakeholders can deliberate on strategies to augment what the participants themselves stated is of help, and hopefully modify what is not. As a minimum, the leaders of allied health faculty should acknowledge and champion the breadth and depth of the expertise as health professionals that these faculty bring to their programs and college. At the same time,

educational leaders should be proactive in marshalling the supports these faculty will need to become expert educators.

Dialogue on how to strengthen peer mentoring clearly could be a priority, as could discussions with college organizational development and learning leaders about how to create a focus for allied health faculty within their standard faculty orientation sessions. Raising the profile of the dual identity issue could be proactively addressed with new faculty by their supervisor and senior colleagues early in the onboarding process. In collaboration with staff in college counselling and accessibility services, focused conversations on how to anticipate student accommodation requirements could be held proactively before issues arise. Because of its typically underlying values and ethics base, educational leadership can contribute meaningfully to making the transitions and identity adjustments expected of allied health faculty more seamless and comprehensive, and through this, support them in better supporting students with disabilities needing accommodations.

More generally, postsecondary educational leaders responsible for allied health faculty would benefit from reflecting on the important role they can play in assisting novice educators to develop a sense of pride about being an educator. Given what is known about the concerns allied health faculty have about losing credibility and status when they leave clinical practice to teach, should we not purposely assist them to develop a strong sense of pride and respect for their new profession? The speed and completeness with which they embrace their new roles as educators may in no small measure be impacted by the educational leaders they encounter. Leadership is all about relationships (Bennis, 2009; Kouzes & Posner, 2012; Preskill & Brookfield, 2009). The degree to

which educational leaders reach out to these faculty with openness, a willingness to listen and understand, an eagerness to help, and a determination to inspire trust, cannot but aid their transition and integration of their new identity, and with it, their new responsibilities.

Specifically for educational leaders, it would seem wise to:

- Acknowledge where faculty are struggling in their role as educators, particularly as it relates to their management of students with disabilities and/or requiring accommodations. Make the climate and organizational culture ‘safe’ for faculty to express their confusion or frustration when they feel challenged in making student accommodations work in their courses and programs. Do not assume or conclude faculty are unsupportive of the principles of inclusion and accommodation, when they express reservations (that may pertain to public safety) about some, particular, accommodation requests.
- Incorporate into conversations with faculty and organizational development providers the research and guidance available about how to: improve the induction of allied health professionals into academia; assist allied health faculty in developing their identity as educators; and critically, ensure allied health faculty fully understand and learn to expertly manage, student accommodation requirements).
- Demonstrate empathy, understanding, and openness to dialogue with all stakeholders in making this work, (including faculty, students and the clinician/practitioner community).

### **Limitations of the study**

As is not unusual with qualitative case studies, the small sample size (nine participants) of this investigation means that statistical generalizations cannot be made from this study. Given that the findings were drawn from the personal narratives of these participants, they are unique to these participants, and reflect their (and only their) experiences, perspectives and realities. Although the participants held two different health credentials, both faculty groups were employed in the same academic school, in the same community college, which underscores using caution if attempting to draw conclusions beyond these specific participants.

Nonetheless, although unique to these participants, their narratives are noteworthy in the extent to which they are markedly similar to the experiences reported by similar participants (nursing and non-nursing allied health faculty) in other studies (Hurst, 2010; Crist, 1999; Boyd, 2010; Smith and Boyd, 2012; Carroll, 2004; and, Magilvy and Mitchell, 1995). This study's focus on the transition experiences of *non-nursing* allied health faculty, and the exploration of their attitudes towards students with disabilities arising from their identity as health professionals rather than as educators, offers what appears to be a unique contribution to relevant research.

The study conformed to the protocols of the research ethics boards of both the University of Western Ontario and the employing college of the participants.

Appropriate measures were used to enhance internal validity.

### **Final thoughts**

The education and preparation of health care practitioners requires the teaching and instructional expertise of qualified, expert, and committed professional health

faculty. The individuals recruited into academia from clinical practice are drawn from the ranks of experienced and leading practitioners, whose interest and passion in developing the next generation of health practitioners propels them to leave their familiar direct patient care settings to become teachers. Their transition from clinical settings into academia does not eradicate their personal, professional, ethical and legal obligations to patients and the public. They do not cease to identify as health professionals, even as they adopt new identities as educators.

However, embracing as they do a new set of ‘clients’ (that is, students), to whom they owe a new and equally important duty of care, they sometimes struggle to reconcile obligations to students with disabilities within the context and perspective of their knowledge and insights into professional clinical practice. If they perceive accommodation requirements solely from the perspective of health professionals (rather than from the perspective of educators) they are at risk of failing to meet the overarching human rights obligations to which they are held.

Educational leaders, as learning leaders, have an obligation to demonstrate foresight, innovation, and inspiration, in relating to these faculty in a manner which supports the optimal, balanced coexistence of their dual health and educator identities.



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## Appendices

### Appendix A

#### LETTER OF INFORMATION

**Investigator: Christine Griffith**  
(email address) (telephone number)

**Research Assistant: Jenny Kassen**  
(email address)

**Principal Investigator: Dr. Pam Bishop**  
(email address)  
(office address)  
University of Western Ontario

(date)

(name of invited participant)  
School of Health Sciences  
(name of) College

Dear (participant):

**Re: Invitation to participate in a research study**

I am researching the experiences of respiratory therapy and medical radiation technology faculty as they transitioned from clinical practitioner roles into full-time roles as educators. I will also be studying how the professional identities and responsibilities of these faculty as members of regulated health professions influence their management of students with disabilities, requiring accommodations. I am being assisted in this study by a research assistant, Jenny Kassen.

I am seeking your participation because of your position as a full-time faculty member in the (Respiratory Therapy/Medical Radiation Technology) program at (your employing) College. If you agree to participate, your involvement will consist of an interview with Jenny Kassen, of about one hour. Your interview will be conducted at a time and place of your convenience, and, with your permission, will be audiotaped. The audiotaping of your interview is voluntary, and you may decline this. There is no compensation for your participation in this research.

Your interview will be kept confidential. Your name will not be noted in the research or thesis documents, wherein you will be identified only by a number. All information collected will be digitally stored, encrypted, and maintained in a secure manner. The complete transcript of your interview will be provided to you for your review and

approval prior to use of it by me in my study. As well, I will provide you with a summary of my findings, and will invite you to meet with me to review and comment on them.

All data, both paper and electronic, will be securely stored for up to five years, and no identifiable data will be retained beyond that period. Only the Principal Investigator and I will have access to the data. After the five year retention period, all identifiable data will be destroyed via confidential document shredding and destruction.

Your participation in this study is entirely voluntary. Your role, employment position, work and status within your program and within (your employing) College will absolutely not at any time or in any way be affected by your participation, responses or non-participation in this study. You do not waive any legal rights by participating in this study.

If you have any questions, please feel free to contact me at (telephone number) or by email (email address). If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics (telephone number), email: (email address), or, the Principal Investigator for my study, Dr. Pam Bishop, at (telephone number): email: (email address).

Jenny will email you shortly to ascertain your interest in participating, and to arrange your interview. A consent form for your review is attached to this letter, which you will sign with her at the time of your interview. By signing this consent form, you will have agreed to participate, however, you may change your mind or withdraw at any time.

Thank you in advance for your consideration of my request.

Sincerely,

Christine Griffith  
Ed.D candidate in Educational Leadership  
Faculty of Education  
University of Western Ontario

**Appendix B****CONSENT FORM**

**Project Title:** Experiences of Respiratory Therapy and Medical Radiation Technology Faculty Who Transitioned from Clinical Practice into Academia: How did they experience this transition; what were their attitudes towards students with disabilities, requiring accommodations?

**Study Investigator:** Christine Griffith

**Principal Investigator:** Dr. P. Bishop

**Research Assistant:** Jenny Kassen

I have read the letter of information inviting my participation in this study, have had the nature of the study explained to me, have had my questions answered to my satisfaction, and agree to participate.

I consent to the audiotaping of my interview: agree \_\_\_\_\_ disagree \_\_\_\_\_

**Participant's Name:** \_\_\_\_\_

**Participant's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Person Obtaining Informed Consent:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Appendix C

### PARTICIPANT INTERVIEW QUESTIONS

**Participant Identification Number:** \_\_\_\_\_

**Date:** \_\_\_\_\_

1. What is your professional designation (RRT or MRT)?
2. How long have you been an RRT/MRT?
3. How long were you a practicing RRT/MRT before assuming a FULL-TIME teaching position (either at your college or at another educational institution)?
4. Did you teach part-time or supervise students in a clinical setting before assuming a full-time teaching role? If 'yes' to either, for how long?
5. How long have you been a full-time professor at (your) College?
6. Aside from your role in your RRT/MRT program, do you engage in activities related to your professional association or regulatory bodies, such as committees, executive roles, accreditation surveying etc? Please elaborate.
7. What influenced you to leave clinical practice to become a full-time educator? Can you discuss what were your personal and professional goals and aspirations?
8. Reflecting on your transition from clinical practice to education, can you describe your feelings as you left clinical practice to join the educational community and become a professor?
9. Did you participate in formal and/or informal College orientation activities when you began your full-time teaching role, such as the College Educator Development Program, or one-on-mentoring with another faculty member, and if so, how beneficial were they in adapting to your new position?
10. Reflecting again on your transition from clinical practice into academia, what activities and supports were helpful to you during that initial onboarding period, and also since you have been a full-time professor? Have there been particular challenges, and can you think of supports you did not receive that might have assisted you in making an easier transition?
11. How comfortable and confident do you feel now in your role as an educator?
12. As a professor, have you had experience in managing the didactic, simulation and/or clinical activities of disabled students and students requiring accommodations? Please give an example of the settings, the circumstances and your responsibilities.
13. How comfortable are you in managing student accommodations in classroom, simulation and clinical placement settings? Can you reflect on particular challenges or concerns you have encountered, and how you managed them?

14. How could you be assisted to better manage student accommodations and meet the needs of disabled students within your program; are there specific understandings, policies, practices or supports you would suggest?
15. From the perspective of being both an educator and a member of a regulated health profession, are there unique aspects of preparing disabled students and those requiring accommodations, for careers in health care?
16. Regardless of the type of student, does your identity as a health professional impact on your role and accountabilities as an educator? How?
17. Is there anything you would like to add to any of the answers you gave to the questions, or anything you would like to comment on that has not been asked?

Thank you!

**Appendix D**  
**INTERVIEW SCHEDULE**

Case #1 – 15 August 2016 @ 2:00p.m.

Case #2 – 13 September 2016 @ 1:00p.m.

Case #3 – 15 September 2016 @ 9:00a.m.

Case #4 – 15 September 2016 @ 1:00p.m.

Case #5 – 15 September 2016 @ 2:45p.m.

Case #6 – 23 September 2016 @ 11:00a.m.

Case #7 – 23 September 2016 @ 2:00p.m.

Case #8 – 27 September 2016 @ 10:15a.m.

Case #9 – 29 September 2016 @ 2:00p.m.

**Appendix E****MEMBER CHECKING SCHEDULE**

Case #1 – 04 October 2016 @ 1:15p.m.

Case #2 – 06 October 2016 @ 2:00p.m.

Case #3 – 06 October 2016 @ 3:00p.m.

Case #4 – 04 October 2016 @ 10:00a.m.

Case #5 – 24 October 2016 @ 2:00p.m.

Case #6 – 21 October 2016 @ 10:30a.m.

Case #7 – 26 October 2016 @ 1:00p.m.

Case #8 – 04 October 2016 @ 3:30p.m.

Case #9 – 21 October 2016 @ 2:00p.m.

## Appendix F

### CURRICULUM VITAE

## Christine Griffith

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#### CREDENTIALS

**Doctorate in Educational Leadership (candidate)**

University of Western Ontario  
Planned convocation Spring 2018

**Masters in Health Administration**

University of Ottawa

**Bachelor of Science**

Dalhousie University

**Diploma in Nursing**

Saint John School of Nursing

#### PROFESSIONAL SUMMARY

I am an educational leader, passionately committed to providing the highest quality of service and support to students, staff and stakeholders. I role model my belief that leaders are accountable for unlocking the potential of their organizations with vision, courage, integrity and social purpose, and for facilitating openness, fairness and collaboration in the fulfillment of organizational mission, vision and goals.

I am a systems thinker, communicator and problem solver, with excellent critical thinking and reframing skills. My ability to forge organizational relationships and partnerships, and to apply successful leadership strategies, has been demonstrated across sectors, settings and challenges.

#### EMPLOYMENT HISTORY

**Fanshawe College:**

**Acting Dean, Faculty of Arts, Media and Design, January-July 2014**

At the request of the College, I assumed interim responsibility for the leadership of four schools, including degree, diploma and foundation programs:

- Language and Liberal Studies
- ESL and English Language Institute
- Contemporary Media
- Design



**Chair, School of Health Sciences, 2012-present**

Responsible for a portfolio of eleven allied health programs, including foundation, diploma and advanced diploma offerings, two continuing education provincial programs

Pan-College roles:

- Co-Chair, Joint Health and Safety Committee
- Research Advisory Committee
- Ombuds Advisory Committee
- Master Facilities Plan Steering Committee
- College Council
- Co-Chair, Academic Services Management Team
- Co-Chair, College Accommodations Working Group
- Wellness Centre Advisory Committee

**District Executive Director, 2010-2012**

- Victorian Order of Nurses, Middlesex-Elgin and Region

**Program Coordinator, Community Mental Health Programs, 2007-2010**

- Mission Services of London

**Vice President, Mental Health and Addictions, 2001-2003**

- North Bay General Hospital, North Bay, Ontario

**Chief Executive Officer, 1999-2001**

- Loch Lomond Villa Long Term Care, Inc., Saint John, New Brunswick

**Administrator (Interim), 1996-1997**

- Atlantic School of Theology, Halifax, Nova Scotia

**Coordinator, Health Facilities Planning, 1987-1990**

- Nova Scotia Ministry of Health, Halifax, Nova Scotia

**Administrator, 1982-1984**

- London Regional Cancer Centre, London, Ontario

**TEACHING AND RESEARCH EXPERIENCE**

Course Facilitator, Bachelor of Commerce Program, Nipissing University

- Organizational Behaviour
- Management of Human Resources
- Macroeconomics

Education Consultant, Canadian Healthcare Association, Distance Education Programs

- Health Services Management
- Modern Management

Guest Lecturer, Faculty of Business, University of New Brunswick, Saint John, NB

Research Assistant

- Masters in Health Administration Program, University of Ottawa

Administrative Resident

- Health and Social Policy Directorate, Health and Welfare Canada, Ottawa, ON

**CONTINUING EDUCATION**

Doctorate in Educational Leadership (ongoing), Faculty of Education, University of Western Ontario

Occupational Health and Safety Certification, Workplace Safety and Insurance Board of Ontario

Crisis Prevention Intervention Training, Crisis Prevention Institute

Certification, Level I, Ontario Wildlife Rehabilitation and Education Network

Certification, Canadian College of Health Leaders

**VOLUNTEER COMMUNITY SERVICE**

**Current:**

Merrymount Children's Centre, London, ON

- Vice-chair, Board of Directors

**Past:**

St. Joseph's Health Care, London, ON

- Human Resources Committee of the Board of Directors

London InterCommunity Health Centre, London, ON

- Chair, Board of Directors
- Chair, Facilities Planning Committee

City of London Housing Advisory Committee, London, ON

- Community Member at Large

Wellspring London Foundation, London, ON

- Board of Directors

Mission Services of London, London, ON

- Board of Directors; Vice Chair, Program and Strategic Operations Committee

Algonquin Child and Family Services, North Bay, ON

- Board of Directors

Rotary Club of Saint John, Saint John, NB

- Board of Directors

Saint John Boys and Girls Club, Saint John, NB

- Board of Directors; Chair, Human Resources Committee

Saint John Board of Trade, Saint John, NB

- Mentor Advisory Committee

MindCare New Brunswick Foundation, NB

- Board of Directors

Alzheimer's Association of Nova Scotia, NS

- Board of Directors

Harbour City Nonprofit Homes, Halifax, NS

- Chair, Board of Directors

YWCA of Halifax Social Housing Task Force, Halifax, NS