THE LIVED EXPERIENCE OF OCCUPATIONAL THERAPISTS WHO SUPERVISE STUDENTS WITH DISABILITIES

by

Jen Davis

Submitted in partial fulfilment of the requirements

for the degree of Master of Science

at

Dalhousie University

Halifax, Nova Scotia

February 2020

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

Occupational therapy in Canada has affirmed that people with disabilities have the right to equitable participation in occupational therapy education. Yet students with disabilities have difficulties as they progress through the programs, especially during fieldwork. This qualitative study explored the lived experience of occupational therapists who have supervised occupational therapy students with disabilities in a fieldwork setting. Using Qualitative Interpretive Description, seven therapists were interviewed about their supervisory experiences. Four themes emerged: variability of administration, perceptions of disability, the complexities of disclosure, and tensions between being an educator and being an OT. Preceptors had divergent experiences of student assignments. Preceptors were deeply committed to educating students, yet distrusted accommodations, fueling perceptions of students with disabilities as safety risks. Clearer attention to environment and occupation in fieldwork sites could lower the distrust. Educational programs could work with preceptors for clarity on learning objectives and standards, while implementing accommodations.

LIST OF ABBREVIATIONS USED

CAOT	Canadian Association of Occupational Therapists
ACOTUP	Association of Canadian Occupational Therapy University Programs
WHO	World Health Organization
CINAHL	Cumulative Index to Nursing and Allied Health Literature
EMBASE	Excerpta Medica dataBASE
ERIC	Education Resources Information Centre
BCEOHRN	British Columbia Environmental and Occupational Health Research Network
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
OT	Occupational Therapy/Occupational Therapist
PEO	Person-Environment-Occupation Model

ACKNOWLEDGEMENTS

A graduate program and a thesis are never solo projects, and so many people helped me to arrive at this point.

My first thanks goes to my original advisor Dr. Joan Versnel, who advised and mentored me for several years as the idea for this project emerged. I am equally thankful to Dr. Brenda Beagan, who stepped in as my advisor and has been unfailingly encouraging, whose advice and recommendations made this thesis so much more than I had anticipated.

I am also very thankful for the thoughtful feedback and support from Dr. Tal Jarus, from the University of British Columbia, who has generously given of her time to be on my thesis committee and provide her expertise.

My position as a Student Access Advisor at Dalhousie University's Student Accessibility Centre provided the inspiration for this thesis and I am indebted to the financial support I received through the tuition waiver from Dalhousie University and the support of my director. I also owe thanks to my co-workers who provided support, proofreading and words of encouragement.

Finally, I owe an enormous thanks to my wife and biggest supporter Kate MacInnes, who offered encouragement, support and cups of tea and without whom I would not and could not have completed this work.

Chapter 1 Introduction

Recently, the Canadian Association of Occupational Therapists (CAOT) along with the Association of Canadian Occupational Therapy University Programs (ACOTUP) published a joint position statement on inclusive occupational therapy education that affirms in the first sentence that people with disabilities have the right to "equitable participation in all aspects of their education" (CAOT, 2018, p. 1). With this document, two of the key professional leadership organizations in the country are declaring that students with disabilities have the right to enter occupational therapy programs with the goal of becoming practicing occupational therapists. Although there are certainly people with disabilities who have graduated from occupational therapy programs in the past and who are currently practicing, this is the first time that the CAOT has stated unequivocally that people with disabilities have a right to enter occupational therapy education programs and that educational institutions must create accessible and inclusive programs. Accessible means students with disabilities are able to be accepted into and progress through the programs without additional barriers, and inclusive means they are fully included in programs, with their contributions valued and disability being viewed as one form of diversity. In fact, the CAOT goes so far to say that this joint position statement is "a sign of solidarity and support for occupational therapy students and potential colleagues who have disabilities" (CAOT, 2018, p. 3). The CAOT is making clear their commitment to accessible and inclusive education, and by extension, a profession that is accessible and

inclusive for people with disabilities. Although the CAOT has likely been supportive of students with disabilities in the past and prior to this position statement being published, this statement is an unparalleled indicator of professional commitment to inclusivity.

Although there have likely been students with disabilities in the health professions for many years, it has been primarily in the last ten to fifteen years that this phenomenon has been examined by researchers, with ramifications explored for the professions, the students with disabilities and health professions faculty. In the last ten years, there have been increasing numbers of published studies seeking in particular to understand the experiences of students with disabilities as they complete their professional education (James, Brown & Mackenzie, 2006; Evans, 2014, Hargreaves, Dearnely, Walker & Walker, 2014; Jung et al., 2014, for example). What that literature reveals is that although students with disabilities may be entering health professions programs at universities in ever greater numbers, their progress through those programs is often not without difficulties (e.g., Easterbrook, Bulk, Ghanouni, Lee, Opini, Roberts & Jarus, 2015). Although each health program has a different curriculum, there are similarities to the challenges experienced by students and the trepidation expressed by educational programs.

The idea for this thesis emerged from my own clinical practice working at a university with students with disabilities. As an Access Advisor at Dalhousie

University's Student Accessibility Centre, I work with students with disabilities creating accommodation plans to help them overcome environmental and institutional barriers allowing for full participation in student life. The focus of my client base is students in the health professions (physiotherapy, nursing, pharmacy, dentistry and occupational therapy, among others). During my years of practice with this population, I have encountered some consistent challenges. My recommendations for accommodations have progressed with little difficulty when they are for a classroom or exam setting, but my recommendations are frequently met with resistance when they are for fieldwork or clinical settings. I have heard students expressing concern they will face discrimination in clinical settings because of their disabilities and I have heard clinical supervisors express concern regarding students with disabilities in health professions and their perceived ability to cope with the work required, or to perform competently and safely. Further exploration of these issues through academic courses led me to wonder why there does not seem to be a larger number of occupational therapists with disabilities working today and to question how welcoming the profession is to people with disabilities. My search of the literature suggests that the answer is 'not as welcoming as it could be'. This encouraged me to explore this issue further and to interview occupational therapists about their experiences supervising students with disabilities. As such, this thesis seeks to answer the question: what are the experiences of occupational therapists who have supervised occupational therapy students with disabilities in a fieldwork setting?

Disability in the health professions

The World Health Organization (WHO) estimates that approximately 15.6% of the world's population has a disability (WHO, 2011) and in Canada, there is an increasing number of students with disabilities entering into university programs (Cooper et al., 2012, Harrison & Wolforth, 2012). Though statistics on people with disabilities in the health professions are hard to come by, my own experience working in the field and a burgeoning literature suggests an increase in the number of students with disabilities entering university health professions programs. Yet programs appear to struggle making their programs accessible and inclusive. Students and practitioners with disabilities experience barriers, irrespective of profession. These barriers include negative attitudes from others (Ashcroft & Lutfiyya, 2013; Bevan, 2014; Brown, James & Mackenzie, 2006; Bulk, Easterbrook, Groening, Murphy, Lee, Ghanouni, Gagnon & Jarus, 2017; Chacala, McCormack, Collins, & Beagan, 2014; Evans, 2014; Walker, Dearnley, Hargreaves & Walker, 2013); having to do extra work of some type to prove themselves competent (Bevan, 2014; Chacala, McCormack, Collins, & Beagan, 2014; Easterbrook et al., 2015; Guitard, Duguay, Thériault, Sirois & Lajoie, 2010; Langørgen, Kermit & Magnus, 2018); as well as feeling unsupported in the workplace (Hargreaves, Dearnley, Walker & Walker, 2014; Jung et al., 2014).

Despite the seemingly good fit between students with disabilities and health care professions, students encounter difficulties in every field, and in multiple forms: negative attitudes from professors/academic programs, lack of support from

programs, lack of understanding about how to provide accommodations, lack of flexibility in the program, lack of appreciation for the strengths/positive attributes that students with disabilities bring to the professions, and belief that accommodations are not possible in fieldwork settings (Awang & Taylor, 2005; Bulk, et al., 2017; Brown, James & Mackenzie, 2006; Easterbrook et al., 2015; Tee et al., 2010). These challenges are seen across professions including medicine, nursing and allied health professions such as occupational therapy.

A growing body of literature on the experiences of university students with disabilities suggests that accessing needed accommodations is an ongoing challenge, experienced as burdensome, complicated, and frustrating (Cunnah, 2015; Easterbrook et al., 2015; Guitard, Duguay, Thériault, Siriois & Lajoie, 2008; Waterfield & Whalen, 2017). The process is generally regarded as an individual responsibility, with advice to individual students to speak up, overcome shame, disclose, follow proper processes, and advocate for themselves (Easterbrook et al, 2015; Gabel & Moskovic, 2014), regardless of common identity struggles concerning competence and disability identity (Easterbrook et al., 2015; Ennals, Fossey & Howie, 2015). Accommodation processes for university students are often highly bureaucratic, with students expected to prove disability through (often costly) documentation in a lengthy process experienced as a “complex system of paperwork, meetings, and organization” (Mullins & Preyde, 2013, p. 153). Some students refer to this as “battling the system” (Goode, 2007, p. 44). Student disclosure of disability is highly selective, relying on a complex weighing

of risks and benefits, and (particularly for those with mental health issues) students often opt for non-disclosure (Cunnah, 2014; Ennals, Fossey & Howie, 2015; Venville, Street & Fossey, 2014). While disclosure may make accommodations possible, accommodations are highly stigmatized, widely perceived as 'special advantages' (Bulk et al., 2017; Cunnah, 2015; Easterbrook et al., 2015; Mullins & Preyde, 2013). Students are forced to choose between invisibility – therefore not getting the support they need and undermining performance – and negative 'extravisibility' focused on a stigmatized identity that continues to undermine perceptions of competence (Goode, 2007, p. 42).

Within the health professions, there are intense debates about 'fitness to practice', with the belief that people with disabilities as health care professionals will be a safety risk to clients due to their disability (Ashcroft & Lutfiyya, 2013; Carroll, 2004; Clouder et al., 2016, Delisa, 2006; Duffin, 2001; Easterbrook et al., 2015; Evans, 2014; Hargreaves, Dearnely, Walker & Walker, 2014, Guitard, Duguay, Thériault, Siriois & Lajoie, 2008; Jung et al., 2014; McKee, Smith, Barnett, Pearson, 2013; Mercer, Dieppe, Chambers, MacDonald, 2003; Neal-Boylan, Guillett, 2008; Neal-Boylan, 2013; Oulette, 2013; Stanley, Ridley, Harris & Manthorpe, 2011, Stier, Barker & Campbell-Rempel, 2015; Watkinson, 2002). Health professionals report reluctance to work with or hire disabled colleagues (Bevan, 2014; Kontosh, Fletcher, Frain & Winland-Brown, 2007; Langørgen, Kermit & Magnus, 2018) who are hampered by stereotypes and assumptions of incompetence (Joyce, McMillan, Hazleton, 2009; Velde, Chapin, Wittman, 2005).

Those with invisible or episodic conditions constantly navigate disclosure, an ongoing, energy-consuming process (Bevan, 2014; Easterbrook et al., 2015; Moll, Eakin, Franche & Strike, 2013).

Within the health professions, there are indications that people with disabilities face systemic barriers to career progress, a narrowing of career options and trajectories, and pressure to leave or remain in positions based on availability of accommodations (Bevan, 2014; Chacala et al., 2012; Hargreaves, Dearnley, Walker & Walker, 2014; Neal-Boylan, Hopkins, Skeete, Hartmann, Iezonni & Nunez-Smith, 2012). They may not seek accommodations because the process is too stressful or for fear of being seen as incompetent; they may be unable to get accommodations in fieldwork as many believe that accommodations are not possible in this environment (Awang & Taylor, 2005; Bulk et al., 2017, Brown, James & Mackenzie, 2006; Easterbrook et al., 2015; Tee et al., 2010); and they may simply avoid disclosing (Bevan, 2014, Chacala et al., 2012; Matt, 2008; Stanley et al, 2011; Davidson, Rushton, Dotzenrod, Godack, Baker, Nolan, 2016). Finally, when students disclose disability and seek accommodations, they often report being treated as clients by their supervisors rather than as students/future colleagues (Ashcroft and Lutfiyya, 2013; Langørgen, Kermit & Magnus, 2018; Tee & Cowan, 2012).

Occupational therapy appears to be a good fit for students with disabilities as a chosen profession, given the profession's commitment to enabling full

participation in meaningful occupations (CAOT, 2018; Townsend & Polatajko, 2007). However, even within occupational therapy, students with disabilities encounter similar challenges as in other health care professions. These challenges appear to occur most frequently in relation to a fieldwork or clinical setting (Awang & Taylor, 2005). Guitard, Duguay, Thériault, Sirois & Lajoie (2010) describe students with physical disabilities in occupational therapy, as well as physiotherapy and speech language pathology having difficulties in fieldwork settings, including a service dog being denied access to a clinical site. Given the importance of a service dog for a person with a disability, the inability to bring a service dog to a clinical site would be a fundamental challenge for a student. As has been found in other research, the authors found students had their abilities questioned by clinical supervisors. Experiences of disability accommodation in occupational therapy field placements will be the focus of Chapter 2, but this preliminary exploration suggests disability accommodation is not straightforward in occupational therapy education, particularly in fieldwork.

Model of disability

When writing about disability, it is important to situate oneself within a theoretical framework. For many years, the medical model dominated all discourse regarding people with disabilities and their rights and needs. This model positions the person's impairment as the central focus of the person, reducing disability to an individual tragedy to be treated by medicine (Goodley, 2017). According to Hammell (2006), it is then incumbent on the person with a disability to "adapt

themselves to a society designed to meet the needs of the dominant population" (p. 58). In this model, society has no responsibility or requirement to change in order to help people with disabilities (Hammell, 2006). Disability is equated with individual inability.

In contrast to the medical model is the social model of disability. It is described as a model that understands "disability [as] something that is wrong with society" (Oliver, 1996a, as cited in Hammell, 2006, p. 61) rather than there being something wrong with the individual. This model describes disability as all things that restrict people with disabilities, whether this refers to an inaccessible building, individual discrimination or institutional discrimination, to name a few (Oliver, 1996, as cited in Hammell, 2006). It is important to note that even though the social model defines circumstances outside of a person as the disabling elements, this model does not deny that impairments cause real challenges for people (Hammell, 2006). The social model, according to Hammell (2006), makes clear that the difficulties that people with disabilities face are "compounded by oppressive social circumstances" (p. 65). Differing abilities are understood to be part of the human condition; what disables the individual is attitudes, rigidity, inflexibility and other social conditions.

Another model to consider is the affirmative model of disability by McCormack and Collins (2012) as set forth by Swain and French (2000). This model views disability and impairments as "non-tragic" and "grounded in benefits of being

impaired and disabled" (McCormack & Collins, 2012, p. 157). This model, McCormack and Collins (2012) argue, is important for occupational therapy to embrace, as they contend that the profession is focused on the medical model and practice tends to focus on individual impairment and remediating functional deficits. The model of affirmative disability orientation considers disability as a positive identity, as a form of diversity and an identity to be celebrated (McCormack and Collins 2012). The authors state that occupational therapists must consider affirmative disability orientation as a fundamental aspect of occupational therapy practice with people with disabilities and doing so may contribute to a truly authentic client-centred practice (McCormack & Collins, 2012). This theoretical approach should be applied not only to working with people with disabilities as clients, but also occupational therapists and occupational therapy students with disabilities.

This thesis will approach the topic of student with disabilities within occupational therapy informed by the social model of disability as well as the affirmative model of disability, where disability is a form of diversity and the environment and other factors outside of a person are often disabling.

Ableism and disablism

A fundamental concept in any discussion about disability is the concept of ableism. Ableism is,

> a pervasive system of discrimination and exclusion that oppresses people who have mental, emotional and physical disabilities [which

> combines] to create an environment that is often hostile to those whose abilities fall out of the scope of what is currently defined as socially acceptable" (Rauscher and McClintock, 1996, as cited in Kattari, 2015, p. 376).

In other words, ableism favours able-bodied people, to the detriment of people with disabilities. It is not an active prejudice or discrimination so much as a normative sense of what is 'normal' and right, which centres on the non-disabled body and mind. It is primarily about unexamined assumptions and expectations.

The literature also describes the term 'disablism', which although similar, varies somewhat from ableism. Deal (2007) defines disablism as discrimination, oppression or abuse that result from "the belief that disabled people are inferior to others" (Miller et al, 2004, as cited in Deal, 2007, p. 95). However, as Deal (2007) argues much discrimination is subtle and as such, he uses the term "aversive disablism" to describe subtle discrimination that is seen commonly, noting that someone who is an "aversive disablist is not anti-disabled, but rather pro-non-disabled" (p. 97). Throughout this thesis, I will use the term disablism to describe overt forms of discrimination against people with disabilities, and the term "aversive disablism" to refer to discrimination that is much more subtle and appears to stem from being pro-non-disabled, as described by Deal (2007). It has been argued that occupational therapy inevitably draws on and perpetuates a form of aversive disablism, in that a goal is often to enable clients to perform 'normally' (Hammell, 2006). Kielhofner (2005) states that an inherent and foundational professional belief of occupational therapy is that impairment is a negative occurrence and working to reduce or eliminate it through rehabilitation is

always a positive action. He states that occupational therapists and other rehabilitation professionals “unwittingly collude with social oppression” (p. 492) in our work with clients with disabilities.

When writing about disability, it is important to note that the word itself is infused with significance which must be unpacked and defined. The authors of the literature cited in this thesis use various terminology regarding disability. Some use ‘persons with disabilities’ while others use ‘disabled persons.’ For consistency, I have chosen to use one approach throughout this thesis. The most common terminology in occupational therapy practice, and the one that I use in my own practice, is person-first language. This choice however, is fraught with conflict as even the language itself is encoded with a definition of disability. If we understand disability as a social construct where differences in function are part of the range of human variation, and disabling people is viewed as a form of social oppression (Chacala, McCormack, Collins, and Beagan 2012; Goodley, 2017; Hammell, 2006), person-first language can position disability as something that a person has or does not have, ignoring the social and physical barriers that actually disable the person, as well as the larger political meaning of disability (Chacala, McCormack, Collins and Beagan, 2012).

According to Goodley (2017), person-first language was created by people who were challenging ableism: “social biases against people whose bodies function differently to those bodies considered to be normal, and beliefs and practices

resulting from and interacting with these biases to serve discrimination." (p. 13). It was intended to highlight the person, moving away from defining disability as their primary identity. It seems then like a natural fit that this is the terminology adopted by occupational therapy as a rejection of the medical model, which tends to reduce a person to their illness or disability (Goodley, 2017). Occupational therapy has positioned itself to be a profession that rejects the medical model in favour of a holistic view where the client is viewed as a whole person, a person first and foremost, and not merely an injury or illness (Townsend & Polatajko, 2007).

Similarly, person-first language has been widely endorsed in many other health professions. In psychology, Dunn and Andrews (2015) contrast it with "identity-first" language which they note arose from disability rights communities. Identity-first language (e.g., disabled person) reframes disability as valued and a point of pride, akin to Black Pride and Gay Pride movements, or more recently the MAD Pride movement focused on mental illness. Disabled people are conceptualized as a social 'minority group' with distinct sociopolitical experiences. Yet Dunn and Andrews (2015) also note that language use is very complex as in all social movements, with no clearly endorsed preferences within or without disability communities. They suggest alternating person-first and identity-first language.

In my clinical practice I use person-first language, emphasizing the person as a whole and not just an impairment to be rehabilitated. It feels risky to use the word

“disabled” given that I do not identity as a person with a disability, as if I do not have the right to do so; I am not a member of the disability community, but an ally. Moreover, my primary audience for this research is occupational therapists and occupational therapy educators, an audience where the use of identity-first language is experienced as jarring if not offensive. As such, I have decided to use person-first language despite awareness that this can introduce as many complications as it resolves, not the least of which is an acknowledgement that using person-first language is contradictory to the social and affirmative models of disability.

Approach

As noted above, I am not (currently) a person with a disability and despite my best efforts to challenge my own thinking and engage in critical reflexivity while conducting this research, I will undoubtedly still be making assumptions or drawing conclusions based on my privileged status as a person without a disability. As an occupational therapist with over thirteen years of clinical experience, more than seven of which involved working in a post-secondary institution with students with disabilities providing academic accommodations in various settings, including clinical/fieldwork settings, my views of academic accommodations and of students with disabilities in health professions is informed to a great extent by occupational therapy theory. In particular, the professional commitment to client-centred practice (Townsend and Polatajko, 2007), full participation in life for everyone and the belief that meaningful

occupation is essential for health and wellbeing (Wilcock, 2015). It is this theoretical background that has led me to be more curious about accommodations in a fieldwork setting. My occupational therapy background tells me that there is almost always a possibility of making reasonable accommodations in a fieldwork setting to enable people with disabilities to be successful. Not every request for accommodations is reasonable and not every fieldwork setting is a good fit for every student with a disability. The fact that I have encountered hesitancy and trepidation by some health care professionals has increased my interest regarding why this does not always happen and to discover more about why this occurs through research. At the same time, I heed the warnings by Hammell (2006 and Kielhofner (2005) that ableism, or even aversive disablism, are built into the professional norms, beliefs, goals and assumptions of the occupational therapy profession. Though I strive to challenge those in my research, I acknowledge that they inevitably affect my perceptions and interpretations.

This is a study of occupational therapy, a profession to which I belong. Throughout the thesis, I will use the language of ‘occupational therapists… we’ to acknowledge that I am part of the professional context which I am subjecting to critical analysis.

This thesis is comprised of separate chapters that explore the experience of occupational therapists who have supervised students with disabilities in a

fieldwork setting. This introductory chapter examines the theoretical approach I employ in this study, including important definitions that form the foundation of the conceptual work. The next chapter, Chapter 2, is a scoping review of the current literature seeking to explore the question: “what is the experience of occupational therapists who have supervised students with disabilities in a clinical setting?” This literature review is written somewhat differently than is found in most Masters theses; it is intended to be a standalone manuscript, in the form of a scoping review, to submitted for publication independently of the rest of the thesis.

The third chapter details the methodological approach for this qualitative study, a blend of interpretive description (Thorne, Kirkham & MacDonald-Emes, 1997) and qualitative descriptive (Sandelowski, 2000). It was guided by the research question ‘What are the experiences of occupational therapists who have supervised occupational therapy students with disabilities in a fieldwork setting?’ Qualitative in-depth interviews were employed to generate narratives from seven therapists who had acted as preceptors for students with disabilities. The fourth chapter of this thesis comprises the results of the study with a discussion of the findings and the implications of these findings for students with disabilities, educators and preceptors in occupational therapy. Finally, the conclusion of this thesis identifies implications for practice as well as implications for education programs that emerge from the findings and analyses.

Chapter 2 Literature Review

Occupational therapy is a profession that works with clients to enable full participation in all aspects of life (Townsend & Polatajko, 2007). This often means that we work with people with disabilities, either acquired at birth or at a later date. Although there is a vast amount of research about occupational therapists working with people with disabilities in many areas of life, there is very little in the research about the experience of working alongside people with disabilities as colleagues or future colleagues. However, students with disabilities continue to enter occupational therapy programs, and there are likely already many practicing occupational therapists who have a disability; and yet, their voices are almost absent from any research about people with disabilities working in the health care system. The research that does exist in this area shows how students and professionals with disabilities face great difficulty in health care fields, including occupational therapy. This difficulty generally becomes more pronounced during fieldwork (Awang & Taylor, 2005; Bevan, 2014; Bulk et al., 2017; Brown, James & Mackenzie, 2006; Easterbrook et al., 2015; Hargreaves, Dearnley, Walker & Walker, 2014; Jung, Baptiste, Dhillon, Kravchenko, Stewart & Vanderkaay, 2014; Tee et al., 2010) and carries on into practice (Bevan, 2014; Chacala, McCormack, Collins & Beagan, 2014). What is unclear from the research is why these students have such challenges when they are educated and supervised by occupational therapists, professionals who have supposedly embraced the importance of full participation in all areas of life for people with disabilities. In order to understand the source of these difficulties, this

scoping review seeks to understand the experiences of occupational therapists who supervise occupational therapy students with disabilities in fieldwork settings.

Methods

This review follows the scoping review framework set out by Arksey and O'Malley (2005). This review process was selected as it is widely cited as a method for completing scoping reviews within health care research. Levac, Colquhoun, and O'Brien's method (2010) was considered, but ultimately rejected, as they have added an additional step to Arksey and O'Malley's paradigm: namely to consult with people in the field regarding the results of the review. That step was beyond the bounds of a literature review for a Masters thesis study and considered not possible at this stage.

Journal articles were included in the study if they were written in English or French, if they were published on or after 2008 and if they focused on experiences of students with disabilities or faculty and/or clinical supervisors' experiences working with students with disabilities. Studies were eliminated if they focused on policy changes without addressing the lived experiences of the occupational therapy students or professionals. No studies were identified in any language other than English. 2008 was chosen as the cut-off date in order to have the most up to date research as well as because of the continuous technological advances that often enable students with disabilities to participate

more fully in academic life that was previously much more difficult. It has also been the perception among many university employees that within the past ten years more students with disabilities are entering professional education programs than they have previously – perhaps as a result of the technological advances making accommodations more accessible.

The following databases were searched: CINAHL, PubMed, EMBASE, ERIC, Scopus, Web of Science and OTSeeker. Grey literature was searched using Google, Google Scholar, Open Grey and BCEOHRN. The primary search terms that were used were: students with disabilities or disabled students; higher education; occupational therapy; occupational therapist; health professionals or nurses or physicians; occupational therapy education; ableism or disability discrimination; microaggressions (a form of discrimination); professional programs; fieldwork education; social inclusion and social exclusion. In addition to the search strategies listed above, reference lists of relevant articles were also searched by hand for additional studies that may not have been found through the database searches.

Figure 1: Flowchart of study retrieval and selection process (adapted from PRISMA, Moher et al., 2009)

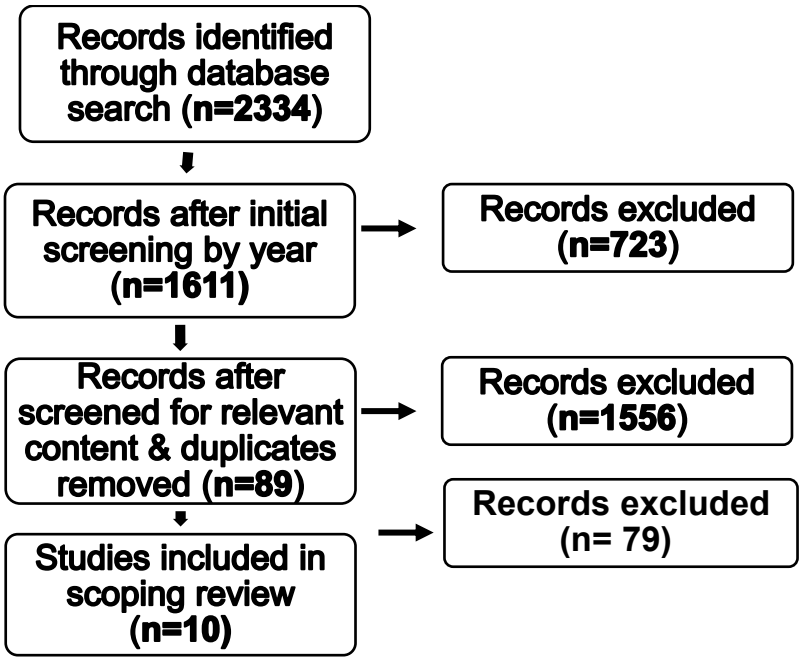

Figure one represents the method used for retrieving and evaluating the literature. Initially, a large number of articles were found (2334) however, an initial screening eliminated 723 articles, as they were published prior to the 2008 cut-off. A further screening excluded 1522 articles, as these studies focused on occupational therapists working with student with disabilities in a therapeutic setting, rather than supervising occupational therapy students with disabilities or were duplicates, leaving 89 articles. The remaining 79 articles were screened further to include occupational therapists supervising students with disabilities in a clinical setting, rather than articles that focused on solely academic settings or

only focused on theory or policies, leaving ten articles that met the full inclusion criteria.

To see if relevant articles were missed by this process, after the initial search and retrieval, a much broader search was conducted using fewer search terms: occupational therapy/therapist and students with disabilities. This broader search resulted in a significant increase in the number of initial results, but few were selected for the scoping review after applying inclusion and exclusion criteria.

Study Selection

Ten studies were selected for the scoping review that fulfilled all the search parameters. All the studies were published in English, with most studies using semi-structured or open interviews with a small group of participants. A few studies used a mixed methods approach, consisting of semi-structured interviews as well as a survey completed with a much larger sample. All the studies were conducted in Canada, the United Kingdom or the Republic of Ireland. The articles were primarily published in disability-focused journals, such as *Disability & Society* or education-focused journals; one article was published in a journal focused on organizational culture, and one was published in the *International Journal of Rehabilitation Research*. Only one article was published in an occupational therapy journal, namely the *Scandinavian Journal of Occupational Therapy*. A more detailed description of the studies is listed below in Table 1, following Arksey and O'Malley's (2005) approach to scoping reviews. In terms of

limitations, relevant studies may have been missed, despite extensive searching, and there is also the possibility of bias in applying inclusion and exclusion criteria, though choices were discussed with a second researcher.

Once the articles were selected, a thematic analysis was conducted on the results. This was undertaken by moving back and forth between the articles, using constant comparison analysis, and watching for similarities and contradictions between articles. All sources were analysed systematically, to ensure first impressions of the data were not assumed to be true. Too-easy interpretations of the data were challenged by looking for negative cases, where a pattern in the data does not appear.

Table 1: Studies Included

Author / Year of publication / study location	Study populations	Aims of the study	Methodology	Important Results
Bevan, J., 2013, UK	5 occupational therapists who have a disability	Provide the experiences and reality of occupational therapists with disabilities working in the health care system	Individual, unstructured, ethnographic interviews	All participants experienced barriers, with attitudinal barriers being the most common. They all faced having to prove themselves capable to others and were treated more like clients by clinical supervisors in the past.

Author / Year of publication / study location	Study populations	Aims of the study	Methodology	Important Results
Bulk, L., Easterbrook, A., Roberts, E., Groening, M., Murphy, S., Lee, M., Gagnon, J., & Jarus, T., 2017, Canada	12 health professions students (medicine, nursing, occupational therapy, physiotherapy, social work or teacher education) and 1 practicing health care practitioner.	Explore the inclusion of people (practitioners and students) with disabilities in health care professions and education programs	Semi-structured interviews and focus groups	All participants experienced marginalization as a barrier to full participation in health care professions. This marginalization takes three forms: dominant disabling discourses, discriminatory design in programs and institutions, and oppressive interactions.

Author / Year of publication / study location	Study populations	Aims of the study	Methodology	Important Results
Chacala, A., McCormack, C., Collins, C. & Beagan, B. 2014, Unreported location	2 occupational therapists with a disability	An exploratory study informed by disability studies and critical theory, to investigate the work experiences of occupational therapists who self-identified as disabled.	Semi-structured interviews	Several themes emerged, including that the participants faced barriers from attitudes and lack of awareness from their co-workers. They describe having to prove themselves to be competent to new clients, new colleagues and new managers. The authors call out the ableism that the participants are forced to confront through their constant education of others and call for further study on the experiences of occupational therapists with disabilities.
Clouder, L. Adefila, A., Jackson, C., Opine, J. & Odedra, S. 2016, UK	25 participants, including students with disabilities, and practice educators, from various health care professions, including occupational therapy	Investigate the perspectives of various stakeholders and students with disabilities on what helps, enables and improves chances of students with disabilities becoming health care professionals. Second stage of research compares findings of study with current discourse in health care in light of new guidelines.	Focus groups and telephone interviews (interview type was not defined)	Builds on previous research showing that tension continues to exist between stigma of disability (especially around disclosure) and a commitment to inclusivity. Authors highlight that many professionals have a fear that students with mental health issues are increasingly entering the health professions. The authors recommend further study of this finding.

Author / Year of publication / study location	Study populations	Aims of the study	Methodology	Important Results
Easterbrook, A., Bulk, L., Ghanouni, P., Lee, M., Opini, B., Roberts, E., Parhar, G., & Jarus, T. 2015, Canada	12 students with disabilities in Health and Human Services education programs, including occupational therapy, medicine, nursing, physical therapy, social work and teacher education.	Exploring the barriers that students with disabilities in health and human services face. The authors focus specifically on the need to prove themselves capable, as a student and a future professional.	Semi-structured interviews	Students with disabilities must show that they are capable of performing their roles through impression management, involving label negotiating (accepting, renegotiating or rejecting the label of disabled), selective disclosure, and advocacy. The authors conclude that this additional work by students, in addition to stigmatization and marginalization, creates many barriers to access and inclusion.
Guitard, P., Duguay, E., Thériault, F-A., Sirois, N. J., & Lajoie, M. 2010, Canada	23 surveys completed by university rehabilitation science programs followed by semi-structured interviews with 3 people with disabilities (1 professional & 2 students).	The aim of the study is twofold: to determine if Canadian rehabilitation science programs are able to admit students with physical disabilities and to explore the experiences of students (former or current) with physical disabilities at one Canadian university.	Mixed-methods: a survey was completed by 23 university programs. Semi-structured interviews completed with 3 individuals with disabilities.	The programs represented in the study (occupational therapy, physiotherapy & speech language /audiology) are well equipped to admit and support students with physical disabilities. Students developed compensatory strategies to be successful. They also experienced difficulties, including a service dog not being permitted at a clinical site and as well as professors, classmates and clinical supervisors questioning their abilities.

Author / Year of publication / study location	Study populations	Aims of the study	Methodology	Important Results
Hargreaves, J., Dearnley, C., Walker, S., & Walker, L. 2014, UK	9 students and 6 registered practitioners, all with disabilities (discipline not defined). As well as a survey with 96 health care practitioners (including nurses, doctors, allied health professionals), 20% of whom self-identified as being disabled.	Explore the experiences and presumptions about health practitioners with disabilities and to make recommendations for future practitioners.	Mixed methods: semi-structured interviews were conducted with 15 students and health care practitioners. 96 health care practitioners answered an online survey.	Results show that 68% of respondents reported not knowing enough about disability, 54% reported they did not always know enough about communication needs of students with disabilities and 56% didn't always know enough about reasonable accommodations. Many respondents also worried about fitness to practice for students with disabilities. Students and practitioners felt unsupported by the workplace and yet, they identified advantages that occurred due to their disability.
Jung, B., Baptiste, S., Dhillon, S., Kravchenko, T., Stewart, D., & Vanderkaay, S. 2014, Canada	14 occupational therapy students who self-identify as having a disability enrolled at a Canadian university	Explore the lived experiences of occupational therapy students with disabilities in Canadian universities.	14 open ended interviews conducted using a phenomenological approach.	The students described the mixed feelings surrounding disclosure. Many didn't disclose due to fear of being penalized and many thought it was risky to do so in future employment and may result in discrimination.

Author / Year of publication / study location	Study populations	Aims of the study	Methodology	Important Results
Nolan, C., Gleeson, C., Treanor, D. & Madigan, S., 2014, UK & Republic of Ireland	68 practice educators & 63 students with disabilities in various health professions, including occupational therapy, physiotherapy, medicine, nursing, speech-language pathology, dentistry, human nutrition, and radiation therapy	Identify concerns and issues of practice educators in providing support to student with disabilities in clinical placements.	Quantitative study using two separate surveys – one for practice educators and one for students with disabilities.	The practice educators identified different issues from the students, namely the difficulty knowing what accommodations are relevant for students with mental health challenges, the concern about students with disabilities being able to achieve the required standards of practice and how to provide them with the extra time they assumed that students with disabilities would need to be successful within the confines of a busy practice. Students with disabilities reported few opportunities to disclose their learning needs prior to beginning placement, with only 30% disclosing their disability to practice educators, often due to discomfort and possibly fear of stigma.

Author / Year of publication / study location	Study populations	Aims of the study	Methodology	Important Results
Walker, S., Dearnley, C., Hargreaves, J., & Walker, E., 2013, UK	Using the same data from Hargreaves, Dearnley, Walker, & Walker. 9 students and 6 registered practitioners, all with disabilities (type not defined). As well as a survey with 96 health care practitioners (including nurses, doctors, allied health professionals), 20% of whom self-identified as being disabled.	To explore the tensions between higher education and placement providers in health care as it relates to working with students with disabilities.	Mixed methods: semi-structured interviews with students and practitioners with disabilities and a survey completed by health care practitioners, most of whom did not have a disability.	Students with disabilities continue to face barriers in clinical placements, in particular negative attitudes and the perception that students with disabilities are a safety risk to clients. The authors put forward a model for education that challenges these notions that may reduce the actual or perceived risk of these students.

Analysis

The studies demonstrate vastly different perceptions between students with disabilities and the therapists who supervise them. Universally, the students and practitioners with disabilities all experience barriers, irrespective of their profession. These barriers are in the form of negative attitudes from others (Bevan, 2014; Bulk, Easterbrook, Groening, Murphy, Lee, Ghanouni, Gagnon & Jarus, 2017; Chacala, McCormack, Collins, & Beagan, 2014; Walker, Dearnley, Hargreaves & Walker, 2013); having to do extra work of some type to prove themselves competent (Bevan, 2014; Chacala, McCormack, Collins, & Beagan,

2014; Easterbrook, Bulk, Ghanouni, Lee, Opini, Roberts & Jarus, 2015; Guitard, Duguay, Thériault, Sirois & Lajoie, 2010); as well as feeling unsupported in the workplace (Hargreaves, Dearnley, Walker & Walker, 2014; Jung et al., 2014).

Many studies focused specifically on accommodations in the fieldwork setting. There is an unexplored assumption in the literature that not only are accommodations inherently more difficult in a fieldwork setting, but that some accommodations are not even possible in fieldwork (Hargreaves & Walker, 2013). This assumption is never explored further or nor is it challenged, it is merely taken for granted that fieldwork is a unique environment and the requirement to accommodate students with disabilities is not absolute in this setting.

Most studies also demonstrated that everyone is concerned about disclosure, but the students and practitioners with disabilities had different concerns than the practitioners without disabilities. Those with disabilities worried that disclosure would lead to discrimination and many disclosed selectively (Clouder, Adefila, Jackson, Opie & Odedra, 2016; Easterbrook et al., 2015; Hargreaves, Dearnley, Walker & Walker, 2014; Jung et al., 2014; Nolan, Gleeson, Treanor & Madigan, 2015). Practitioners and fieldwork supervisors were more concerned about students who did not disclose prior to the beginning of the fieldwork (Nolan, Gleeson, Treanor & Madigan, 2015) and many were especially concerned about what constitutes reasonable accommodations for students with mental health

disabilities (Hargreaves, Dearnley, Walker & Walker, 2014; Nolan, Gleeson, Treanor & Madigan, 2015).

Finally, the practitioners without disabilities and the fieldwork supervisors expressed concern about safety and fitness to practice for students with disabilities (Clouder, Adefila, Jackson, Opie & Odedra, 2016; Hargreaves, Dearnley, Walker & Walker, 2014; Nolan, Gleeson, Treanor & Madigan, 2015; Walker, Dearnley, Hargreaves & Walker, 2013). In all of these studies, there is an automatic concern that people with disabilities will be a safety risk to clients by virtue of having a disability. Clouder et al. (2016) states this succinctly: “Risk, fitness to practice and competence are brought together to contrive to introduce an element of doubt to defy even the keenest aspirations of admissions tutors or of potential students” (p. 13). Walker, Dearnley, Hargreaves and Walker (2013) report similar beliefs by health care practitioners but also state that it is not clear if this belief is based on actual risk or simply a perception. The authors go on to state that 80% of the participants (n=96) they surveyed believed that people with disabilities needed to be looked after. Perhaps this belief creates a situation whereby it is impossible to consider that people who need care or assistance can also be people who care for others and as a result, people with disabilities must inevitably be a safety risk to others.

These studies articulate that little has progressed for students with disabilities in occupational therapy in the past ten years. Each study similarly demonstrates

that the environment has not improved for students with disabilities: students feel unsupported, discriminated against and concerns remain around disclosure, client safety and appropriate accommodations in general. In her Casson Memorial Lecture of 2007, Dr. Clare Taylor challenged occupational therapists in the United Kingdom to consider why we struggle with having colleagues with disabilities, when as professionals, we do not seem to have the same negative views about our clients. We expect employers to support and provide accommodations to our clients with disabilities, but we do not have the same commitment for our students. Taylor (2007) also provides a counter argument to the frequently discussed concern of students with disabilities being a safety risk to clients: any student is a potential safety risk due to their lack of knowledge and experience.

Stier, Barker and Campbell-Rempel (2015) describe the findings of a survey conducted by the Association of Canadian Occupational Therapy University Programs (ACOTUP) about students with disabilities in the fourteen occupational therapy programs in Canada. Each university reported working with students with disabilities and providing them with a variety of accommodations, including during fieldwork. The authors report similar concerns across universities: fieldwork has a unique set of challenges, namely facilities and preceptors not being able to provide some accommodations due to a perception of “quality and risk issues related to client care” (Stier, Barker & Campbell-Rempel, 2015, p. 18). The authors conclude by stating that occupational therapists are perfectly

situated to lead the country in providing guidance to develop strategies to ensure the establishment of accommodations for students with disabilities and to "facilitate the equitable inclusion of all students" (p.18). However, questions remain concerning occupational therapist preceptors who do not provide accommodations and may view students with disabilities as risky, given their expertise in the creation of reasonable accommodations to "facilitate the equitable inclusion".

In the studies reviewed here, particular concerns emerge concerning mental health issues. Two studies (Clouder, Adefila, Jackson, Opie & Odedra, 2016; Nolan, Gleeson, Treanor & Madigan, 2015) describe practitioners and fieldwork supervisors as especially concerned about working with students with mental health issues. Clouder and colleagues (2016) report that many health care practitioners fear an increase in the number of students with mental health disabilities entering into the health professions. They call for further research, stating this issue must be addressed, but do not examine why study participants were worried specifically about these students. It is a surprising finding, given that many health professionals work with people with mental health concerns regularly. It is not clear whether the issue centers on how to provide accommodations for students with mental health concerns or whether having a mental illness is seen as incompatible with being a health care professional.

Discussion

The findings of this scoping review reflect the findings from similar analyses in other health professions, such as nursing. Disclosure continues to be a source of significant tension: students with disabilities are worried about facing discrimination and stigma if they disclose (therefore they often do not disclose and consequently they do not receive the support and accommodations they need) and fieldwork supervisors and professionals believe that it is essential that students disclose to the educational programs and are often frustrated when students do not disclose (Ashcroft & Lutfiyya, 2013; Hill & Roger, 2016; Rankin, Nayda, Cocks, & Smith, 2010). There is also concern about students with mental health disabilities entering into health professions, particularly regarding insight into their own needs and abilities, and potential for triggering (Ashcroft & Lutfiyya, 2013; Rankin, Nayda, Cocks, & Smith, 2010). Ironically, students are most concerned that they will face discrimination and these studies reveal that their concerns are valid. Rankin, Nayda, Cocks, and Smith (2010) state with no irony that the best scenario for students with disabilities is for them to understand how disclosure has a positive impact on success in their education program. Yet, it is clear from existing evidence that some health care professionals and educators hold biased views regarding mental health in particular.

The near-universal theme from all of this literature is the ever-present belief that students with disabilities are a safety risk to clients. This belief is mentioned in some way in every study (Ashcroft & Lutfiyya, 2013; Carroll, 2004; Delisa, 2006;

Easterbrook et al., 2015; Evans, 2014; Guitard, Duguay, Thériault, Sirois & Lajoie, 2008; Hargreaves, Dearnely, Walker & Walker, 2014; Jung et al., 2014; Mckee, Smith, Barnett, Pearson, 2013; Mercer, Dieppe, Chambers, MacDonald, 2003; Neal-Boylan, 2013; Oulette, 2013; Rankin, Nayda, Cocks, & Smith, 2010; Stanley, Ridley, Harris, Manthorpe, 2011; Stier, Barker & Campbell-Rempel, 2015). However, what is missing from these and all other studies is actual evidence to support this belief. The fact that this research has never been conducted allows a belief that may well be erroneous to perpetuate and supports the on-going ableist discourse to continue. Better understanding the experiences of students with disabilities and the occupational therapists who supervise them in clinical placements might help to shed more light on this long held belief.

Phelan (2011) calls for occupational therapy as a profession to engage in critical reflexivity regarding disability in relation to our clients. Examining the literature, it is clear that we need to go one step further and engage in this type of reflexivity about disability regarding our students and our coworkers. This type of reflexivity could be beneficial in other professions; Ashcroft and Lutfiyya (2013) report that nurse educators' perspectives about students with disabilities impacted whether a student with a disability was seen a safety risk. Hill and Roger (2016) report that students with disabilities in health care placements have more negative experiences than students in more socially-oriented programs, like social work and teacher training, suggesting some distinct perceptions or ideologies in the health professions.

What causes such beliefs? Phelan (2011) suggests that occupational therapy continues to be informed by a dominant biomedical discourse, causing us as professionals to continue to embrace the medical model of disability. Are other health professions also engaged in the same type of reductive thinking? The research suggests the affirmative. What is never examined in these studies is why the issue of safety seems to go hand in hand with any discussion about students with disabilities in occupational therapy. However, it is essential to challenge this dominant way of thinking, as averse disablism can lurk under the guise of client safety and risk management. By focusing on safety issues, students with disabilities are viewed as more of a risk than any other student, despite the lack of evidence to support this belief.

Implications for educational programs

Clearly there is much work to be done in higher education to challenge ableism and instill positive and realistic views of students with disabilities, not just as clients but as coworkers and equals. This is an essential step in creating a welcoming environment for students. In turn, this may create a new generation of practitioners who fully embrace the competency of students and professionals with disabilities. To accomplish this goal, universities need to tackle the discrimination that students with disabilities face, providing a better environment for all students (Tee & Cowen, 2012).

Although occupational therapy is a profession that eschews the medical model in its guiding theoretical models and approaches (Townsend & Polatajko, 2007), practitioners continue to engage with students and colleagues with disabilities as if they are in need of remediation. This means that therapists and students with disabilities may continue to be viewed as clients and not as occupational therapists (Bevan, 2014; Chacala et al., 2014; Guitard et al., 2010). It has been said that rehabilitation professions like occupational therapy "unwittingly collude with social oppression" (Kielhofner, 2005, p. 492) regarding people with disabilities. Although Kielhofner (2005) was referring to the relationship between client and occupational therapist, it is possible to see parallels between the client-therapist relationship and supervising occupational therapists and students with disabilities. Occupational therapists are possibly viewing students with disabilities using the same pro-non-disability lens described by Deal (2007) and applying the same rehabilitation principles that impairment is negative thus reducing or eliminating it is positive (Linton, 1998; Nagi, 1991; Scotch,2001; Zola, 1972, as cited in Kielhofner, 2005, p. 488). One of Kielhofner's (2005) recommendations for addressing this bias is to have more people with disabilities become occupational therapists.

Ashcroft and Lutfiyya (2013) and Jung et al. (2014) highlight the fact that university disability service providers did not organize accommodations for clinical settings. Both studies describe the difficulties this causes, with clinicians creating accommodations independently, without clear policies (Ashcroft &

Lutfiyya, 2013) and with disability service providers not knowing how to provide accommodations in clinical settings (Jung et al., 2014). Guitard and colleagues (2010) describe difficulties when university staff (professors or disability service providers) do not understand the fieldwork environment. Having disability service providers who are knowledgeable about clinical education, and strong policies in place would be a great help to students and faculty alike. As Stier, Barker and Campbell-Rempel (2015) point out, occupational therapists are perfectly situated to provide guidance to enable students with disabilities to have proper accommodations in any setting.

Many participants report their disability provides them with advantages when working with clients (Bevan, 2014; Chacala et al., 2014, Easterbrook et al., 2015), yet this possible advantage is explored by far fewer studies than are concerns about fitness to practice. If health professions are truly committed to embracing people with disabilities becoming health care practitioners, disability must be viewed as more than something to be accommodated or fixed, something evoking caution. As Hargreaves, Dearnley, Walker and Walker (2014) state: “Disabled people who aspire to be health professionals must ‘prove’ themselves in practice, facing a culture ambivalent about disabled staff and dilemmas about disclosure” (p. 311). This culture of ambivalence needs to be directly challenged within occupational therapy.

Implications for practice

The implications for practice are likely profound. It is not possible to know if qualified students have turned away from occupational therapy due to negative perceptions of their competence. However, the current review of the literature demonstrates that we are a profession that is at odds, at times, with our guiding principles. It also signals a need for further education of occupational therapists for us as a profession to truly embrace students and colleagues with disabilities.

This scoping review shows that there is a particular prejudice against people with mental health conditions, as several studies reported an uncertainty about how to support these students (Clouder, Adefila, Jackson, Opie & Odedra, 2016; Nolan, Gleeson, Treanor & Madigan, 2015) with other studies showing outright prejudice and concern about having an increasing number of students with these types of disabilities (Clouder, Adefila, Jackson, Opie & Odedra, 2016). These statements should alarm occupational therapists, as mental health has been a traditional practice area for decades. What is it about mental health in particular, that seems to cause such uncertainty and concern? Clouder, Adelfila, Jackson, Opie and Odedra (2016) speak of the “discourse of ambivalence” (p. 18) when referring to the “fear” (p. 18) of having students with mental health disabilities entering health professions. This is a concerning perspective and one that certainly seems to describe aversive disablism. Yet the word fear implies more than mere concern or worry. It implies that students are considered inherently unsuited for a health profession due to mental health diagnoses. It also suggests that as a profession

we are far away from the core principles outlined in Enabling Occupation II, namely that “justice concerns are for meaningful choice and social inclusion, so that all people may participate as fully as possible in society” (Townsend & Polatajko, 2007, p. 4). Clearly as a profession, we need to look more closely at our attitudes towards people with mental health challenges and challenge ourselves to unearth ableism.

Implications for future research

Most of the studies on this topic recommend further study, as most have small sample sizes. Given that most extant research is focused on nursing, there is a paucity of comprehensive research in the field of occupational therapy. The purpose of this scoping review is to examine the experiences of fieldwork supervisors and yet, many studies focus on almost exclusively on the experiences of students. Further research is needed to understand the experiences of occupational therapists who supervise students with disabilities, and how they view these students and their place in occupational therapy, plus navigate supervision in the context of disability and a professional commitment to occupational justice.

This future research should also focus on occupational therapists’ beliefs about people with disabilities, given what this scoping review has revealed. Is it possible that occupational therapists continue to hold negative opinions of disability? Taylor (2007) discusses the “hierarchy of disabilities” (p. 280) that

occupational therapists hold about who is an appropriate person to be a therapist, based on type of disability. Learning disabilities are at the top of the hierarchy, considered the most compatible with a career in occupational therapy, with various types of mental health disabilities at the bottom (Taylor, 2007). Taylor cites research that is more than fifteen years old and yet this scoping review suggests that some health care professionals continue to view students with mental health conditions entering these professions with concern.

Many studies recommend further professional development of therapists who are preceptors and this seems a good place to begin. The recent national position statement declaring unequivocal support for students with disabilities within occupational therapy commits the profession to inclusive education. Every university has an office of accessibility and they must work closer with occupational therapy programs to ensure proper accommodations for students with disabilities, especially in light of the fact that several studies show accessibility services were not involved in providing an accommodation plan for fieldwork. Just as important is the view of occupational therapists regarding people with disabilities as health care professionals. This scoping review shows that although students with disabilities are in occupation therapy programs (among other health care programs), many health care professionals remain ambivalent if not unwelcoming. Clear direction must come from university programs as well as licensing bodies and professional associations to help to dispel the aversive disablism that infuses our profession.

Conclusion

The results of this scoping review demonstrate how much work remains for students and professionals with disabilities to enter into and thrive in occupational therapy. Studies demonstrate that people with disabilities who enter and successfully complete health care programs, including occupational therapy, are still considered a safety risk, face discrimination and ableism, and are treated like clients, rather than peers. Few studies offer strategies beyond increased awareness and training for faculty and clinical instructors, and few question why professionals like occupational therapists should need further training. It is not enough to publish studies on this issue and continue to refer to discrimination as 'negative views.' In a profession that embraces and values diversity, and proclaims expertise regarding disability, the pervasive discrimination and injustice directed at students and professionals with disabilities illustrates how challenging it is to destabilize the deep-seated ideologies of ableism. We need to employ a critically reflexive stance within the profession, interrogating why and how preceptors and educators may struggle to engage with people with disabilities as colleagues and students.

Chapter 3 Methods

As was described in the previous section, little research has been conducted regarding disability within occupational therapy, and most of that research focuses on students rather than on therapists or educators. Those studies that do focus on health professionals tend to include occupational therapists as one of several health professions, rather than as an exclusive focus of the research. Given that occupational therapy students with disabilities seem to experience the same difficulties and discrimination as other students (Bulk et al., 2015; Clouder, Adefila, Jackson, Opie & Odedra, 2016; Easterbrook et al., 2015; Nolan, Gleeson, Treanor & Madigan, 2015; Walker, Dearnley, Hargreaves & Walker, 2013), it is important to understand how occupational therapists, who are skilled in enablement and are committed to full participation in all aspects of life for people with disabilities, seem to struggle when it comes to supervising students with disabilities. As such, for this thesis a qualitative research study was completed that focused on the perspectives of occupational therapists and their experiences supervising occupational therapy students with disabilities in clinical settings.

This research study was conducted using qualitative methods for a number of reasons. This topic is underexplored in the literature and it is important to have a greater understanding of occupational therapists' beliefs about this subject, given the number of students with disabilities in the health professions. This subject matter is also sensitive, making qualitative methods the best way to understand

therapists' perspectives on these issues (DePoy & Gitlin, 2016). Although a survey would have garnered a greater number of participants, constructing response options without much previous in-depth information would have been challenging. The survey format would also have been likely to over-simplify respondent's perspectives. By asking in-depth questions about participants' experiences, this study was able to uncover their complex feelings, as well as sometimes-contradictory detail about their experiences regarding students with disabilities. This method enabled a depth of understanding about the subject and this depth of results would not have been possible using quantitative methods.

The specific qualitative approach used in this study was informed by Sally Thorne's (2000, 2010) Interpretive Description and Margarete Sandelowski's (2000, 2010) Qualitative Description. The work of Thorne (2000, 2010) is especially informative in this study, as Interpretive Description is frequently used in health professions research as a way to address and solve "real-world problems" (Teodoro et al., 2018, p. 3). This approach is rooted in phenomenology and ethnography, however, it uses these elements as a way to provide solutions to practical issues in a clinical setting, such as occupational therapy, rather than being strictly about creating theory from the data, as is common in more traditional social sciences research (Teodoro et al., 2018). Similarly, Sandelowski's (2000, 2010) qualitative description is considered to be an excellent qualitative research method for studies in health care, as it provides a mechanism for acquiring "rich descriptive content from the subjects'

perspective” (Colorafi & Evans, 2016, p. 24). Both methods share a pragmatic approach to qualitative research in the health care field as well as flexibility to support any type of sampling technique in data collection (Colorafi & Evans, 2016). Both aim to stay close to the data (Sandelowski, 2000) focusing on lower inference interpretations than methodologies such as phenomenology and grounded theory. The fact that both approaches invite the use of any theoretical framework to inform analyses makes them well suited to an exploratory study such as this, guided by a critical lens regarding ableism and aversive disablism.

In order to explore these difficulties further, this study interviewed practicing occupational therapists who have been a clinical preceptor to master’s level occupational therapy students who have academic accommodations as a result of a disability. Semi-structured interviews were conducted with seven occupational therapists who have been preceptors to students with disabilities in the past five years.

Recruitment

The study population was occupational therapists who worked in Canada and who have acted as clinical preceptors within the past five years to Master’s level occupational therapy students who had academic accommodations as a result of disability. There are 14 occupational therapy programs in Canada, all at the Master's level for entry-to-practice. Assuming each teaches 35 students per year, and each student has four fieldwork placements over a two-year program, there

would be just under 2000 student field placements per year across the country. (These estimates would be low for some programs, as some universities have close to one hundred students per class while other universities have fewer than fifty). It should be noted that all 2000 fieldwork placements would not be with 2000 different preceptors, as some preceptors might take several students each year.

A range of student supervisory experiences was sought, particularly regarding students with different types of accommodations in different types of clinical settings. The goal was to interview five to eight participants to allow for theoretical saturation on key themes, given the homogeneity of the sample and specificity of the research question. Seven participants were interviewed in the end. Their work experience varied from fewer than five years to more than thirty. All participants had supervised at least one student with a disability in the past five years, with some participants having had multiple relevant experiences in the past few years. In addition, there was variability regarding the types of accommodations used by students as well as variability regarding the clinical settings, from in-patient to out-patient and community settings, as well as practice in pediatrics, neurorehabilitation and tertiary care.

An invitation to participate was sent (Appendix A) to all fieldwork coordinators at every Canadian university that offers fieldwork placements in the Master's level entry occupational therapy program where the language of instruction is English.

It should be noted that due to the researcher's current position at Dalhousie University as a Student Access Advisor working with health professions students with disabilities, including occupational therapy, the invitation to participate was not sent to the fieldwork coordinator at Dalhousie University's School of Occupational Therapy. It was highly likely that the researcher knew the identity of the students with disabilities from Dalhousie, thus making confidentiality much more difficult as well as placing the lead researcher in a position of conflict of interest. In total, the invitation was sent to eight Canadian occupational therapy programs.

The invitation requested that fieldwork coordinators send the invitation to participate (Appendix B) to occupational therapists who were known to have acted as a preceptor to occupational therapy students in the past five years and who were known to have supervised students who have had academic accommodations as a result of disability. It was assumed this information would have been known to the fieldwork coordinator as the accommodation plan would likely have been organized by the fieldwork coordinator prior to the beginning of a placement. The process described above resulted in two occupational therapists volunteering to be interviewed.

Several weeks later a second email was sent to the fieldwork coordinators to remind them to send out the invitation to participate (Appendix B), if they had not already done so. No further occupational therapists contacted the lead

researcher to volunteer for the study. As a result, an ethics amendment was submitted to gain permission to add a second recruitment strategy. The second strategy was approved by ethics and a new recruitment invitation was created (Appendix C). This invitation was posted on social media (Facebook and Twitter) and e-newsletters of four provincial professional occupational therapy societies. As a result of this second recruitment strategy, five more occupational therapists contacted the lead researcher and volunteered for the study.

Those who were interested in the study contacted the researcher by email with any questions, and returned the consent form by email if they wanted to participate. All of the occupational therapists who contacted the lead researcher about the study went on to participate in the study. Though the hope was to recruit preceptors who had worked with different kinds of accommodations, volunteers were accepted on a ‘first-come’ basis to speed recruitment. Thus, no screening was conducted apart from confirming at initial contact that they had indeed been preceptor to one or more students who had accommodations in the past five years.

Data Collection and Analysis

The occupational therapist participants were interviewed over the phone using a qualitative, semi-structured interview to explore their lived experiences, irrespective of their current or previous clinical practice settings or years of work experience. The semi-structured interview guide that was used is attached

(Appendix D). Interviews lasted about approximately one hour, with the longest one lasting approximately seventy minutes and the shortest interview lasting forty-five minutes. The use of a telephone had the potential to hinder forthcoming responses from the participants but it was my perception that the participants shared their thoughts freely. The lead researcher used silence as well as probing questions as a way to encourage the participants to share openly their thoughts and experiences.

Data was collected via audio recording during telephone interviews using a digital recorder. Audio recordings were uploaded onto a password protected computer. The audio recordings will be kept until completion of the study at which point they will be destroyed. All data from each interview was labeled and associated only with the assigned code and not any identifying information such as name or demographic information. The list linking names and ID numbers was kept separate from the data. Interviews were transcribed verbatim by a transcriptionist who had signed a confidentiality agreement. After a transcript was completed, the recording was listened to again to ‘clean’ the transcript, correcting any errors and removing or modifying any identifiable information. Any reference to individuals by name, or names of workplaces and institutions was de-identified, as was any identifying characteristics of the preceptors and students.

Data about each participant was recorded in table format where each participant was provided with a code. The participants were given codes versus

pseudonyms, as codes seemed the simplest way to protect their identity. Only the researcher had access to the table with the list of codes. Any reference to the participants either in the final document or to the other members of the research team was limited to their codes. Following completion of the study, this information will be destroyed. The data, which will include written interview transcripts, the coded data and the list of participants will be kept for five years, after which time it will be destroyed.

After reading each transcript multiple times, then reading back and forth between transcripts, in an iterative comparison, each transcript was coded. With each interview, additional codes were added and earlier transcripts were recoded. Some *a priori* codes were employed at the beginning of the coding process. These codes arose from previous knowledge of the literature and from the lead researcher's work experience. Many other codes and patterns emerged from the data during the coding process. Although some codes were created *a priori*, the evidence was examined systematically to confirm or refute preconceptions formed from the literature. Thirty-five codes were created by the lead researcher during the coding process.

After all transcripts were coded, codes were categorized into broader, overarching themes. The code list was shared with the research team (thesis advisor and thesis committee member) and some of the codes were adjusted according to feedback. Two coded interviews were shared with the research

team for feedback about the coding process. The sharing of the interviews helped to enhance rigor, as there was agreement between all of the members of the research team about the coding.

In keeping with social sciences methods, interpretation of the results was interwoven in the analysis section, rather than leaving the interpretation to the discussion section.

Member checking is a process whereby understandings and assumptions by the researcher is checked by the participants (DePoy & Gitlin, 2016) and is an important part of the research process. As such, all participants were provided with a summary of the preliminary analysis of all of the data, allowing them to confirm whether the analysis and conclusions drawn were accurate. Only one participant provided feedback on the summary. Some of the feedback was integrated into the final analysis.

Finally, an audit trail was completed to ensure trustworthiness of this study. The audit trail included all interview transcripts, all codes and themes generated through data analysis, notes regarding the decision making surrounding the assigning of codes and themes, and emerging interpretations in the analysis, personal notes and reflections during the data collection process. The audit trail was encapsulated in a reflexive journal that was kept for the duration of the study.

Risks and benefits to participants

The potential risks to participants from this study included the following: the risk of being identified, the risk of participants experiencing discomfort from sharing their experiences and feeling judged for their supervisory practices as a clinical preceptor, and the risk of employment/registration consequences if the supervisory practices they reported having used or using were perceived as harmful or unethical.

The risk of participants being identified was mitigated by having each participant assigned a code and using the code on all transcribed data that was analysed and viewed by members of the research team. No names or other identifying information was used when reporting data or when using direct quotes, including geographic location and type of practice. All demographic information was stored in a secure location (encrypted on a password protected computer) that was accessible to the lead researcher.

Participants were asked to sign the consent forms (Appendix F) and their names were only known to the lead researcher. These paper forms were scanned onto the lead researcher's personal computer. Once they were scanned, the paper forms were destroyed. Prior to being scanned, the paper forms were kept locked in the lead researcher's desk. The electronic consent forms were destroyed once the data was analysed and member checking was complete.

The risk of discomfort during the interviews was mitigated as much as possible by ensuring neutral language was used throughout, including as part of the semi-structured interview guide. Additionally, the interviewer asked clarifying questions to reduce assumptions being made during the interview.

Participants were reminded of their right to answer only the questions they wished to answer and that they had the right to end the interview at any time. This reminder in conjunction with non-judgmental language helped to create rapport between the researcher and the participants, which in turn enabled participants to share their experiences openly.

As an occupational therapist, the researcher had a duty to report if another therapist disclosed practices that had potential to harm patients/clients, or in any breach of the profession's codes of ethics (https://www.caot.ca/site/pt/codeofethics) or standards of practice. Given that the interviews were about work with students, this was highly unlikely to arise, but participants were warned about it in the consent document, and advised that the researcher had a duty to report obvious violations, but would have spoken with the participants about it first. There was no requirement to report any participant regarding a breach of the code of ethics.

There was no direct benefit to the participants. The indirect benefit was to discover further information about the experiences of occupational therapists who supervise students with disabilities in a clinical education setting. This information has contributed to having a greater understanding of some of the challenges that occupational therapists experienced when they have been a clinical preceptor to students with disabilities.

Summary

Semi-structured phone interviews were conducted with seven occupational therapists who had supervised a student with a disability in a clinical setting in the past five years. The interviews were transcribed and coded and following this, the codes were sorted into themes for a more in-depth analysis. Chapter 4 will describe the results of this analysis.

Chapter 4 Results

As noted in the previous chapter, seven occupational therapists participated in the study, sharing their experiences of having supervised at least one student with a disability in a fieldwork setting. Six of the seven participants were women. They lived in various cities across the country. Their level of experience as occupational therapists varied from fewer than five years to more than thirty. A few participants had supervised more than one student with a disability in the past few years. The students' disabilities varied from physical to mental health to learning challenges and many disabilities were unknown to the participants.

Four themes emerged from the data: **Do we walk the talk about disability?; Accommodations in clinical placements – It's a balancing act; Disclosure;** and **Blurring the lines** (see Figure 2). Although each theme is presented below as if it were distinct, many themes are connected to each other, with repetitions and intersections. For purposes of the analysis, themes will be discussed independently.

Figure 2: Themes and subthemes identified

1. **Do we walk the talk about disability?**
    i. Ways we do and do not embody core values
    ii. Paternalism regarding students with disabilities
    iii. Viewing students with disabilities as less capable and treating them too cautiously
2. **Accommodations in clinical placements - It's a balancing act**
    i. Lack of clarity about accommodations

ii. Balancing act of navigating process
iii. Lack of trust

3. **Disclosure**
    i. Wanting to know more about diagnosis
    ii. Frustration with lack of knowledge
    iii. Trustworthiness: their own and about the accommodations

4. **Blurring the lines**
    i. Creating safe learning experience
    ii. Feel the need to be perfect
    iii. Role confusion between teaching and treating

Do we walk the talk about disability?

This first theme examines the participants beliefs about disability and whether we, as occupational therapists, are truly embodying the spirit of accessibility and inclusivity in fieldwork education. The conflicting beliefs revealed by many participants can be separated into three different, although intertwined, ways: the ways that we do and do not embody our core values; a paternalism regarding students with disabilities; and as a result, the subtle way this implies that participants are viewing students as being less capable in fieldwork and as a result, participants treating students with disabilities too cautiously. This last belief can be seen as part of the paternalism although it is worth exploring this aspect of paternalism separately.

The participants of this study all seemed to feel very committed to their role as occupational therapists and preceptors and all held similar beliefs about

disability. Most often, the beliefs they expressed were aligned with core values of the profession. This was clearly articulated by one participant:

> *You know, if you're taking a student because it's going to make your caseload easier or it's going to mean you don't have to try then you probably shouldn't take a student. But if you're taking a student because, you know, you like the challenge or you see the value or you want to give back to the profession then do that because those people [students with disabilities] are your colleagues and they make great professionals, and they have a sense of empathy that's different. And, you know, it could be you down the road. It just means you didn't go through school with a disability but you might continue to work with a disability in the future. (Participant 6)*

This participant identifies a potential advantage that students with disabilities bring to the profession, a different kind of empathy for clients. This quote also illustrates an understanding that any therapist may face having a disability in their future. All of the participants expressed similar beliefs, highlighting in particular, the advantages that a student with a disability brings to occupational therapy.

At other times, the beliefs expressed by participants seemed to conflict with these same core beliefs of occupation therapy, namely that clients are more than just their illness or disability. In describing experiences with students, particularly regarding difficulties that arose, disability was seen as the reason for every student difficulty and performance issue. Every student with a disability who had difficulty in placement was understood to be struggling due to disability. It is possible that disability played a part in the student's difficulties but there may also have been other issues, such as academic ability or skill. An assumption seemed to be made by some preceptors that disability was the only possible explanation.

> *That's where I'm assuming it was a mental health accommodation. The student often was presenting as very anxious. […] High level of anxiety. [The student] had a lot of difficulty just feeling relaxed and comfortable, and just doing casual conversation with the clients to help build rapport.* (Participant 5)

Here the participant has drawn a direct connection between placement difficulties and (an assumed) mental health diagnosis. Yet, the student's struggles may have had nothing to do with mental health. It is possible that the student was simply overly nervous, unskilled, extremely shy, unprepared, or generally a poor student. Many of the same participants reported never having had a student struggle in a fieldwork placement until they worked with a student with a disability who struggled, *"and [this was] the first student [I've] ever failed"* (Participant 5). Perhaps this explains why participants assumed that disability was responsible for the difficulties. However, this suggests some preceptors may be reducing the person to their disability, a reductionism inherent in the medical model, and usually challenged by occupational therapy.

The participants in this study were located across the country, working in a variety of settings, including pediatrics, adult neurology and community outreach, among others. They were committed to educating students and providing positive and supportive learning environments, where it is okay to make mistakes and learn. Additionally, participants spoke of supporting students as they progress through academically rigorous occupational therapy programs. One participant

identified a tension between what occupational therapy professes as a profession and what we seem to expect from students.

> *It's an intense couple of years. It's a profession that is largely caregiving, you know. And we preach balance and we say we're not focused solely on enabling independence, and we're valuing interdependence, and we're valuing different ways of defining purposeful engagement. But then we're saying but [individually] work hard, study hard, do well on placements. And I'm not sure we're supporting students as well as we could be. (Participant 3)*

This participant seems to be suggesting that core principles of the profession sometimes clash with the rigors of a professional program, or minimally are not always borne out in the ways therapists and educators engage with students.

While it was never stated directly that students with disabilities are not as capable as students with disabilities, a bias was revealed in a variety of ways, most frequently as a certain paternalism towards students with disabilities. It was expressed as a concern that mental health issues are things that could invalidate the student's ability to provide therapy. For example, one preceptor stated:

> *I just am really concerned when that becomes something that you [a student with a mental health issue] can't help control when you are dealing with somebody like a trauma patient who is struggling with mental health because of the devastation of their injuries. Like, it can't cross so that it's hard for you to be their therapist. (Participant 2)*

It is essential to be present and supportive of one's clients; here, the participant appears to assume that having a mental health challenge will get in the way of providing good care to clients.

Of course, disability may be linked to struggles in placements, though not always in direct ways. When students with disabilities experience negative perceptions, assumptions or intolerance on a placement, they may be even more likely to struggle in a subsequent placement or perhaps be less likely to ask for assistance or accommodation. One participant described such a situation where a student with a physical disability was required during a previous placement to provide therapy to clients in a way that was very physically challenging, considering the student's disability. The student had a difficult time having their need for accommodation recognized. This undermined the student's confidence and performance in a subsequent placement with the participant.

> *She had kind of a hard time in terms of really not knowing how far she could push saying like physically this is really difficult for me. Or was there some validity, and she didn't know and she wasn't comfortable trying to figure out like or am I just not learning this well enough? Like am I not doing good enough as a student? So that part of things undermined her confidence. So by the time she ended up with me, she could put on a good front, you know, and kind of cover. And I was fine with whatever, you know, we were going to see. But yeah, I definitely wasn't surprised when I found out she was in treatment for mental health-related things. (Participant 3)*

We see how a negative experience where a student's disability was not accommodated, and in fact seemed to be ignored in a detrimental fashion, possibly created a disabling situation wherein the student had further difficulties in subsequent fieldwork.

Even the process of arranging placement matches sometimes seemed to position students with disabilities as 'a problem.' Some participants spoke about

being asked specifically if they could accommodate a student with a disability in a fieldwork placement. Some participants viewed the question posed by fieldwork coordinators “Can you accommodate this student?” as deeply biased.

> *Originally when the university had contacted me, they said […] ‘Would you be willing to take a student with a disability?’ Which like I think then having spoken to the Masters student, like setting it up with that sort of tone almost makes it sound like it’s like something negative, like it’s going to be a lot more work, or that like you’re going to have to do a ton of accommodations or adjustments, or whatever the case may be. They’re sort of selling it as like you’re doing us a huge favour by taking this student because they have a disability. And so my feedback to the university was basically like I don’t think you should be asking people vague questions like that. I think they should be extremely objective questions. […] I just don’t know [that] you should be able to say no to the student. You should be able to say no to like very objective [requests] like ‘they need this and they need this and they need this’. Well, you know, they have to drive to all the visits. If they don’t drive, it’s not an opportunity. (Participant 7)*

This quote indicates a way to move away from positioning a student with a disability as inherently a problem, a burden for preceptors, and positioning accommodations as a choice, to focus on specific occupational or environmental demands. This avoids some potential biases concerning providing accommodations in a fieldwork setting.

The paternalism discussed earlier was also seen when participants cast some types of fieldwork as ‘too difficult’ for students with disabilities. Almost all of the participants described their workplaces as challenging, difficult, hard or advanced practice. However, all of the participants worked in in-patient or out-patient hospital-type settings, with adults or children, and many worked in some form of neurology. Neurology and pediatrics are considered foundational learning in

entry-to-practice occupational therapy education and although many of these placements are busy or are the only one of their kind in the city or province, the placement environments themselves seem to be standard occupational therapy practice. So, while some areas may have more variety in terms of clients, it is not immediately clear why participants tended to see their work environments as advanced practice or practice requiring additional skills.

Furthermore, the participants who emphasized the complexity of their workplaces also had supervised students with disabilities who struggled in those placements. There appeared to be a link between the belief that the placement is 'advanced practice' and concern about taking students with disabilities. One participant stated that had she known that the student had particular difficulties and the types of accommodations needed, she would have refused to accept the student to such an advanced practice setting: *"I would have said no"* (Participant 2). In a more subtle way, several of the participants suggested they could only take students who do not require any extra assistance or support, students capable of working with few mistakes or hesitancy. This seemed to be understood as precluding students with disabilities. Does a student with a disability naturally fall into the realm of less capable or needing more help? As educators, preceptors strive to help students as they are learning. Does not learning often involve making mistakes, for all learners? The implicit argument that students with disabilities are best suited (perhaps only suited?) to simple (non-advanced)

practice settings appears to contradict other assertions by participants that, as preceptors, they provide a safe space for students to learn.

The desire to see students with disabilities succeed can lead any party in the field placement process to paternalism, which – though well-intended – undermines students and may limit their opportunities. One participant described a student advocating for the opportunity to take on a placement the university recommended against.

> *The university had recommended for her not to do an out-of-province placement. […] [The student] had expressed interest in going to another province, and was sort of told like, well, what if they won't make accommodations or what if it's really difficult for you? And I think having had such a successful placement sort of lead to her advocating. Like, 'No, I'm doing this.' […] Yeah, I think people, like clinicians telling you like, 'Well, do whatever you want. Like you don't have to have someone tell you that you can't,' I think it might have just been nice for her to have that too. […] I'm sure they've very well intentioned but it's also kind of like they shouldn't be telling people what they can't do.* (Participant 7)

This participant articulates a concern around treating students with disabilities too cautiously, to the detriment of the student. While accommodations may be needed, learning standards and learning opportunities need not be curtailed.

There is a sense through the stories of most participants that special care is needed when placing a student with a known disability in a fieldwork setting. Clearly, according to some participants, 'advanced practice' is not really the place for students with disabilities, nor are out-of-province placements. This paternalistic approach to students with disabilities also underlay instances when

students were placed in settings assumed to be too challenging, as a way to teach those students ‘a lesson’ about their limitations, possibly about taking a risk that may end poorly. This was described as a way to encourage students to limit their expectations, focusing on less physically demanding placements or even future job opportunities. One participant expressly stated a belief that a student had been placed with her, in an overly challenging setting, to learn their limitations.

> *It made me feel like we’d been both set up to fail. Like I don't think that was fair to the student to place her into a placement that was known to be challenging. You know, because she came excited to come […] to do this placement. And you know, I think she left on good terms with the co-supervisor and myself. And I hope it was a positive…I hope she learned lots and it was… Although it wasn’t a truly successful placement, I hope she felt like she learned something and it was positive that way. But I felt bad for her. I felt bad for us. […] Because having students is a lot of work. You know, you always end up with a student placement and your to-do list is like grown and… You know, it is a hit to your time. And it felt like our time hadn’t been respected because we were investing even more time in trying to do this. (Participant 5)*

This participant was convinced it was a deliberate strategy to place this student in a setting where they would inevitably fail, to show them the limits of their abilities.

This is a troubling situation, as a fundamental theory of occupational therapy is that not only are people with disabilities are the experts in their own lives but they also have the right to take risks (Law, Baptiste & Mills, 1995). At times the interviews suggest, once again, a paternalistic attitude towards people with disabilities, that others know their limitations better and that having a disability

means being constantly in need of protection, hence the ‘special care’ associated with placing a student with disabilities. This connects to the perception mentioned earlier that providing accommodations in a clinical setting is something done out of kindness and generosity towards a student rather than because it is the law, as well as the right thing to do.

Accommodations in clinical placements – It’s a balancing act

The topic that seemed easiest for participants to talk about freely concerns accommodations in a clinical setting. This theme comprises the sub-themes of the lack of clarity experienced by participants about the accommodation process including who determines the accommodations, who is notified of the accommodations, when are they notified and how. This theme also describes the balancing act that participants engage in to navigate the confusing process of accommodations while balancing their support of students with disabilities. This leads into the final sub-theme of the lack of trust by the participants in the university accommodation system that places students in the clinical setting. Being a preceptor is a role that has many administrative requirements that vary somewhat from one province to the next.

Each province and university seem to have their own processes for assigning a student to a particular occupational therapist and these processes are further complicated when assigning a student with a disability to a therapist. Some

participants spoke of having no notification at all that the student they supervised had any accommodation needs, while other participants were told of the student's disability and asked if the student could be accommodated in that workplace. Some participants were informed of specific accommodations required by the student, while many others received no formal plan or notification. Overall, the process of supervising a student with a disability varied greatly from participant to participant, with some having fairly negative experiences while others had great experiences with the process. Some participants also described the experience as being a good learning experience, both for the participant and the student, even if the student struggled to achieve the learning outcomes of the fieldwork placement.

According to these preceptors, whether a student struggled or had a great experience did not seem to depend on the accommodations that were in place. Many participants spoke at length about how the accommodations that were recommended for the student did not always work within the environment of the fieldwork placement, because they seemed inappropriate for the environment, they did not seem to be aligned with the student's disability, they would not work with the client population, or the student had learning issues that were not linked to the disability being accommodated. Other participants found the opposite and spoke of how the accommodations worked perfectly for the placement and were easy to integrate into the work day. There does not appear to be a pattern to explain why some accommodations worked well in certain sites. Where

participants struggled with the accommodations requested, there seemed to be an underlying lack of trust about the accommodation process. This will be discussed in more detail later, however, this lack of trust appears to be connected to a lack of knowledge about the disability and lack of input into the creation of accommodation plans. There was a clear perception among many participants that fieldwork coordinators do not understand specific fieldwork settings and there was frustration with having to implement accommodation plans that did not fit with the fieldwork environment or having to work with students that participants deemed to be unprepared or inappropriate for the site.

Some participants described how helpful the university was, including the fieldwork coordinator, while others described them as not very helpful at all. They also described who else around the preceptor had been helpful to them during the time they supervised a student with a disability, especially when things were not going well. The most helpful people tended to be the preceptor's co-workers or teammates as well as other co-workers.

In working with students with disabilities, preceptors often described what appears to have been a complete lack of input from accessibility services at the university in the creation of accommodation plans and on-going support of students at the fieldwork sites. In no case did accessibility services have any meaningful connection with the fieldwork site, with the exception of ensuring documents were accessible, which is clearly something that the fieldwork site

can do. This may be an important gap, as this is the on-campus department that works directly with students with disabilities and might be a valuable liaison between the student, the fieldwork coordinator at the university and the fieldwork preceptor. There was a sense from participants that accessibility services do not provide accommodations for clinical settings, either because they do not know how to, or what they recommend is simply at odds with the clinical environment. This then created a level of distrust among participants, as they saw themselves as being better able than university staff to create accommodations appropriate to their particular clinical environment.

> *So it was prescribed in the sense where she would say, "No, I can't do this physical task, I can't do that physical task." And yet she has certain performances that to me would seem to translate to that task. So for example, she had difficulty handwriting. And yet she had moments where her fine motor skills were perfectly within function.* (Participant 1)

This participant seems to express distrust about the accommodations, as the student's need for accommodation seems inconsistent with the student's behaviour and physical abilities.

According to participants, the process of being assigned a student with a disability requiring accommodations, varies greatly from program to program. Although each occupational therapy program is somewhat different, each program receives the same accreditation from the Canadian Association of Occupational Therapists (CAOT) and must meet the same national standards. One might expect a consistent process for the growing population of students

with disabilities. This is particularly curious as the CAOT (along with the Association of Canadian Occupational Therapy University Programs [ACOTUP]) has recently affirmed its commitment to accessible and inclusive education for students with disabilities in occupational therapy education programs (CAOT, 2018). It is therefore concerning that some universities may be approaching preceptors to supervise students with disabilities in a manner which leaves the decision whether or not to accommodate the student to the preceptor. As disability accommodation is a right and not a favour to be provided to the student, or a special request to be made of a preceptor, this notion of accommodation as optional may violate human rights. Additionally, in some locations there appears to be no process for the accommodations to be shared with the preceptor, as many describe not knowing about the student needing accommodations until the placement started. One participant described the student not having an official accommodation plan until nearly half way through the placement.

> *And as a result, because of the timing of the placement was already in progress, [the student] wasn't getting appointments fast enough. [The student] said, "Please bear with me. I know I have a telephone interview with the accommodations office for the following week." And so that was week 4. And then it became an official accommodation. And then we worked within the accommodation and we reset all the goals.*
> (Participant 2)

This leaves no time to modify the environment to meet the learning objectives and likely starts the placement in a negative way.

Another participant described being presented with the student's accommodation plan without having had the opportunity to contribute to its creation. Accessibility services at any university may know the occupational demands and environment of a classroom but preceptors seemed to wonder if they could know the occupational demands of a fieldwork site, especially without the input of preceptors.

> *Rather than just being dictated from the university, 'this is what the accommodation is.' You have no input as a supervisor. You get to deal with it. But yet it's my job as a supervisor to get the student through the placement. And I know best what the demands are of this clinical placement. And it could have been much more successful I think if before the student had even come, if we could have had a sit-down – This is what the accommodation needs are. Given your area of practice and what your placement is, how can we work this? Rather than coming…you know, suddenly finding yourself halfway through a placement, realizing there's significant needs, and that we only have a few weeks left. […] And no room it seems to negotiate this. (Participant 5).*

The suggestion here is that preceptors are more knowledgeable regarding the occupational demands of the site than the accessibility office or the fieldwork coordinator and therefore should be involved in the process of creating accommodations.

We might expect there to be specific mention of this growing population in the accreditation standards set out by CAOT, which could provide guidance to programs on how to implement accommodations processes. The standards mention only vaguely that "the program is safe and universally accessible and supports accommodations for special needs." (CAOT, 2017, p. 28). They go on to require that each program "critically reflects upon the process to determine

and implement appropriate accommodations for participants with varying levels of abilities." (CAOT, 2017, p. 28) This general statement makes no specific mention of what this implementation of accommodations might look like nor does it describe the process of assigning a student to a particular fieldwork site or preceptor (CAOT, 2017).

Not surprisingly, all participants had recommendations to improve the process, with some wishing to know more ahead of time, while others were fine with the level of knowledge they had received. Some wished to be notified prior to the beginning of the placement, while others thought it was okay to find out only on the first day. Most participants agreed that improved communication between the fieldwork coordinator, the preceptor, the placement site and the student would be helpful. Additionally, they had recommendations for other preceptors, such as to be prepared to have a student with a learning challenge, even if this has not been shared prior to the placement beginning.

One participant suggested not only assuming any placement student may present with disabilities, but also the need to be clear about standards even if that means failing a student.

> *You know, don't assume just because you haven't been told that there's an issue that there's not going to be one. I think you just sort of have to meet people where they're at and be able to adapt as you go. Look for help when you need it. I think though you still have to be diligent about your expectations. So if your expectations are by the end of this placement you need to be doing A, B, C and D, if they're not there it's okay to say to them 'You're not there. You just need another opportunity to*

> *practice this' or whatever. So it's okay to say, you know, 'You failed this one, let's find you another one and we'll practice it again'.* (Participant 4)

This participant suggests the importance of always expecting a learning challenge, but also having clear expectations of the learning objectives for students. This participant also hints that preceptors may need support in order to fail students. Another participant suggested students could self-select out of inappropriate placements if given more information.

> *I think having a clear understanding of what the placement is that people are signing up for. So with the university, students rate their placement choices from 1 to 10. So they kind of get a list of all the placement choices being offered this round, and they rank them. But the descriptions they get of the placements are super vague. Like it just says like community outpatient, complex. Like it doesn't tell you what you're going to be doing. And so if a student had a disability and was trying to pick a placement that was appropriate or that they thought they would excel at, it would be really hard to do that based on those descriptions. So I think the healthcare system could do a better job of describing those placements. And the school could make sure they have a real description of what the placement is before students sign up.* (Participant 6)

This system of having better placement description might help students with disabilities make more informed choices for placements, which could in turn improve the fit between students with disabilities and the occupational demands of a fieldwork site.

The participants all provided on-site accommodations to students with disabilities and adjusted the work to help support learning. Their general philosophy regarding working with students with disabilities was 'we are OTs, and we can make this work. They all spoke of breaking down learning into manageable parts

for students and doing whatever extra work was necessary to help students succeed. For example, one participant had a situation where extra time and effort was required to assist a student by grading the learning:

> *We stepped everything back. So we went back to, okay, what part of this is the part that you're missing? Let's practice that part, and then practice the next part, then put together the whole. And we kept working on it that way. (Participant 4)*

Most of the participants spoke about adjusting their teaching methods as they went along, modifying things to best suit the needs and abilities of a student.

At the same time, most participants struggled to accommodate students with disabilities in a variety of ways. Many of the participants discussed how the accommodations that were provided to the student prior to arriving at the placement were not adequate for the fieldwork setting, or in some cases were inappropriate. Some accommodations included extra time for performing assessments, missing placement time or omitting placement skills entirely; the latter two were judged as inappropriate and difficult to make work. Participants discussed at length how the accommodations came to be and what it was like to implement them in the clinical setting. All participants agreed that accommodations are important and although many thought it best that they are not aware of the reason for accommodations, they struggled not only with implementing accommodations but also with accepting the particular accommodations they were required to implement. One participant spoke of not

knowing whether or not a particular behaviour of a student was related to the reason for accommodations.

> *So there's an initial sort of preconception that there is something affecting her leading to her accommodations. I only know some of the consequences of those accommodations. She wouldn't disclose what caused it. So I didn't know [whether] anything that she presented that was outside the norm was also related to that or was not. And that was very confusing. Because there was more to what met the eye to begin with. And the university either knew and wouldn't be able to tell me. And you know, they guided me in terms of how to try to be as creative as possible. But in practice, these things are not as easy as you can say it verbally or on a piece of paper in terms of marking the competencies. (Participant 1)*

Knowing only the accommodations required and not the disability affecting the student left preceptors guessing as to whether gaps in performance were or were not related to disability – thus, whether they should devise more on-site accommodations, or assess inadequate mastery of competencies. This highlights the challenges when accommodations are determined in abstract, without knowledge of the field context of occupational demands, as well as the tensions between privacy rights of students and the benefits that might be enabled through more open disclosure.

Within the discussion of difficulties surrounding implementation of accommodations is the unspoken and perhaps unacknowledged lack of trust in the process of deciding what the accommodations are for a student. The participants all spoke of students who arrived at the placement with accommodations already decided, or decided quickly into the placement and none of the participants had any input into the process of determining

accommodations. Some would clearly like to have had input. One participant described a concern that the university accessibility services would recommend an accommodation plan that would cause barriers for the fieldwork site:

> *We wanted to pursue something that we felt would fit [the student] and the placement and the requirement for graduation. And we were a little bit maybe afraid that the accommodations office would say, 'No, you must let the student do 5 hours for this [documentation].' (Participant 2)*

The preceptor was certain the student's disability could be successfully accommodated, but was afraid the accommodation dictated by the university – without input – would make the fit between student and fieldwork site impracticable. Although the participant is referring to a lack of knowledge about the fieldwork site by the accessibility office, it also suggests a lack of faith that the accommodations will be appropriate. This participant worked in a fast-paced environment and spending hours on a task was considered incongruous with the fieldwork site. The participant's concern speaks to a worry that the accessibility office could require any kind of accommodation, no matter how incompatible with the clinical environment.

The difficulty appears on the surface to be about the process of implementing 'general' accommodations into day to day placements and caseloads. However, the concern, at least for some participants, goes beyond just incorporating accommodations into their practice. It seems to stem from the fact that preceptors have no input into the accommodations and no knowledge of the student's disability and therefore, there appears to be a lack of trust that the

accommodations are actually appropriate not just for the specific work place but also for the student. One participant spoke to the difficulty of integrating accommodations into a short placement when the accommodations lacked sufficient detail:

> *We had no other heads-up about other issues or anything. And you know, we're OTs, […] You know, we're hopefully pretty good at identifying where people need accommodations and need support. […] But you know, in a student placement, you only have so much time and […] the first couple of weeks are getting to know your student and what their needs are and what their learning objectives are. And then this is sort of coming to highlight. You don't have much time to figure out how you're going to support the student through a placement and make it successful for them. So a little bit more information would have been helpful. […]strategies just to help calm [the student] would have been, and help refocus would have been really helpful. Knowing how best to mentor [the student's] interpersonal skills. (Participant 5)*

This participant highlights some of the challenges when preceptors are not involved in accommodation planning and have little opportunity to negotiate the accommodation plan or to have specific accommodations that would address some of the student's barriers.

Although there is little information in the interviews about who at the universities created the accommodation plans for students, it is a reasonable assumption that fieldwork coordinators created them in conjunction with students. All fieldwork coordinators are occupational therapists and as such, it is curious that the participants have a level of wariness about the accommodations. This is especially curious as presumably the accommodation plans were created with the students who required them. It is one of the guiding philosophies of

occupational therapy that clients are the experts in their own lives (Law, Baptiste & Mills, 1995) and yet, participants often appear to question whether they can identify more appropriate accommodations for a student than the student can for themselves. On the other hand, each field setting presents unique, novel environmental and occupational demands students may not have previously encountered. Students many not know exactly what they will need. It should be noted that an occupational therapist working with a client to return to work after illness or injury would never create an accommodation plan for the client without having a thorough understanding of the workplace demands. Clearly the current process of identifying accommodations is lacking that crucial step.

Overall, it appears there is much room for improvement in the administrative processes of fieldwork assignment and disability accommodation. The difficulties that arise in this process reveal administrative challenges, a lack of clarity in the accommodation process as well as a lack of trust by the preceptors in the process of creating accommodation plan, mostly due to the lack of an objective method for accommodating students with disabilities based on an understanding of the environmental and occupational requirements of the placement site.

Disclosure

Participants shared their thoughts about disability disclosure as well as their complicated feelings about disclosure. This theme can be divided in several sub-

themes, namely the participants' experiences of wanting to know more about the student's diagnosis, their frustration with not knowing as much as they would like and issues of trustworthiness about themselves as preceptors and the accommodations provided to students.

It appears that a student choosing to disclose a disability has significantly more meaning than simply sharing medical information with a preceptor. As noted earlier, some preceptors spoke about wishing they knew more details about the diagnosis so that they could work more effectively with the student.

> *Without knowing the nature of her you know, the causation of her, of the accommodations, I didn't feel like I'm getting the full picture of how to accommodate her or how to even to in some sense empower her. Because there's a lot of things that I wouldn't be able to do that would have made, that would be skills that she will require as an OT. (Participant 1)*

This participant echoed what some other participants also described: they believed that they could do their jobs as educators better if they had more details about the student's disability, including the diagnosis, so that more appropriate accommodations could be arranged and provided. This suggests that some participants saw themselves as more knowledgeable about the student's disability than the students themselves.

A few participants hinted that they believed they were aware of the long term impact of disability in a way that the student might not be. Although clearly the participants know their work environment better than anyone else, they often

spoke of symptoms and symptom management when discussing disclosure rather than environmental adaptations or changes to the placement or to the occupational demands. This view shifts the focus of disability accommodations to the person level, rather than the person-environment-occupation fit. This approach seemed to contradict participants' stated beliefs about the place of disability within the profession and their genuine interest in helping students succeed.

The desire for students to disclose disability also appears to be connected to the lack of trust by preceptors regarding the process of placing students with disabilities in placement settings. This lack of trust was complicated when a few participants suggested they saw disclosure or lack of disclosure as a reflection of their own trustworthiness in the eyes of the students. For example, one participant viewed the lack of disclosure by a student as a sign that the student did not trust the preceptor, which appeared to cause friction in their relationship.

> *I try to practice as a preceptor with a sense of trust that you're able to tell me what…you know, the hardships that you're going through and how is it…how do we improve on those things. […] The more her abilities unravelled or her other aspects unravelled, it seemed like the trust isn't there. That I couldn't teach her without her being open and telling me what she needed help with.* (Participant 1)

Effective teaching was seen as demanding or requiring trust, symbolized by disclosure.

In the same vein, but in a contrasting experience, another participant viewed the disclosure of disability as a sign of both trust and student professionalism.

> *I mean it's none of my business as to why. And really she didn't have to tell me at all. But it was… It was helpful to know it, and it almost made our working relationship easier because there wasn't anything like that was hiding. Because I'm very upfront with my students, and I'm like this is kind of what I expect from you, this is what you can expect from me. If that's not working, like talk to me, let's change it. If I… You know, it's really hard for me to know if you don't tell me. And so I found that her telling me that fit really well with my style. And so when she came with [accommodations] […] it seemed really professional to me that she was like, 'This is some ways that I can help support myself. This is what I would appreciate from you.'* (Participant 6)

In both these instances, participants seem to not acknowledge that sharing deeply personal and private medical information with a preceptor may be difficult for a student. Rather they view it as something that should naturally be shared with a preceptor, ideally before they meet or on their very first day of fieldwork. Perhaps because the participants are occupational therapists who work every day with people with disabilities, they may forget that this information is deeply personal to students, who are not their clients. Participants appear at times to take it personally when students do not disclose to them. Additionally, there is no acknowledgement that students may not view the preceptors as appropriate confidants. In other words, there is an assumption that preceptors provide a safe space for students to disclose. However, what makes this space safe beyond the fact that the participants believe it to be so? Although all of the participants agreed that a student's disability is not the business of the preceptor, almost all of them felt frustrated with the lack of disclosure by students.

Blurring the lines

The final theme to emerge from the data speaks to the conflict that the participants feel about many aspects of being a preceptor, in particular to students with disabilities. They are deeply committed to providing a safe learning space for students and struggle with the idea of failing a student and yet some will report that the profession expects students and sometimes clinicians to be perfect. They view themselves as educators and value this role but interpret their teaching methods as clinical interactions at times with students with disabilities.

The participants in this study shared a deep commitment to student learning. Throughout the interviews, their commitment to providing positive and supportive learning environments was obvious. Participants spoke at length of the importance of providing a safe learning space for their students, where it is okay to make mistakes and learn. Additionally, participants spoke of supporting students as they progress through academically rigorous occupational therapy programs. One participant identified a tension between what occupational therapy professes as a profession and what we seem to expect from students.

> *It's an intense couple of years. It's a profession that is largely caregiving, you know. And we preach balance and we say we're not focused solely on enabling independence, and we're valuing interdependence, and we're valuing different ways of defining purposeful engagement. But then we're saying but [individually] work hard, study hard, do well on placements. And I'm not sure we're supporting students as well as we could be.*
> *(Participant 3)*

This participant seems to be suggesting that core values of the profession sometimes clash with the rigors of a professional program, or minimally are not always borne out in the ways therapists and educators engage with students.

Not all participants saw students struggling in fieldwork as necessarily problematic, seeing challenges as part of learning and part of a career in occupational therapy.

> *If we're creating clinicians that like oh my gosh, you can never fail and you can never have challenges and barriers and stuff, well, unfortunately like the climate of healthcare in most places is that like there are challenges and there are things that are going to be difficult. And like if we just sort of promote like oh, it should all go well and it should all be completely fine, and you should pass, and that sort of thing, yeah, you're not setting them up for the real career, I guess.* (Participant 7)

This participant saw the down side of having students who are only ever successful in fieldwork, and believed struggling in fieldwork could have advantages for students. This same participant put it even more succinctly, saying: "*Maybe you go somewhere, maybe it goes badly, maybe you don't pass, you know, worst case scenario. But is that really that bad? I don't know."* (Participant 7) This participant challenged the notion that students have to be perfect all of the time, suggesting failure is part of learning.

The notion of students – and therapists – needing to be perfect all of the time was also challenged by another participant, who acknowledged that personal experiences can hinder practice at one moment but enhance it at another.

> *I think that's a skill that we all have to learn as therapists. And so to me it's not like, oh, you have a mental illness and so you shouldn't be able to do this in therapy. You just learn a different set of skills. Or, oh, I have a hand injury and I'm doing hand therapy with a client, and it's still really traumatic for me. Maybe that's not the best placement at this time. […] So maybe you find a different placement. Where you can, you know, go through that process yourself in your own life and then you come back later and maybe you're a more empathetic therapist in that setting. […] You know, so when the student came to me and she had solutions, it was kind of like, okay, so she's in a place of like I'm moving forward, I'm managing as opposed to I'm in a place of needing treatment. […] You know, the same thing with an employee. I mean if you've currently got an injury and you're trying to do something for somebody else, and you're not in a place to be able to do that, then you're not going to be able to help them either. And so you know, maybe you take those clients off your caseload and give them to a colleague.* (Participant 6)

This participant describes how a person with a disability can thrive within the profession, as a student or a professional, without having to be perfect all the time. There is also acknowledgement here of conditions fluctuating over time, so that at one moment a placement may be unsuitable for a specific student, but could be well-suited at a different point in time.

The preceptors' role also seemed to come with a lot of responsibility and pressure for the occupation therapists. Some felt pressure not only to provide a good learning environment for students but also to ensure that students did well in the placement.

> *I think it's a struggle no matter… Like if you've got a student who isn't going to succeed, I think it's hard. And I think, you know, it would be nice for the fieldwork educator to say, "That's okay, you were perfect [as a preceptor]." But I don't know if you could hear it. Like I just think failing a student is a really hard thing for a preceptor to do. And it's just, I don't know what would make that easier.* (Participant 4).

Although some participants spoke of supports they have, including co-workers and fieldwork coordinators, it remained a trying situation when it became clear a student might not pass the placement. Participants spoke of all the extra hours they dedicated to help students learn and succeed. There was a sense from the data that some participants saw it almost as a personal failing if a student was not successful or was struggling.

> *I work in a fairly confined little space. And so a lot of clinicians observe what you're doing with your students, and observe what your students are doing. And so it was very apparent to my colleagues very quickly that this was not going to be easy. And often what would happen is one of my OT colleagues would say, 'I'm going to take this student for this particular assessment,' and I would say thank you because they were reading my, 'I need 5 minutes'. [laughs] And I'd say: 'So the thing that we're working on', and they would do that. And then they would come back and report what they saw a little bit. Which is reassuring in that it's not just you. You know, they would come back and say the exact same things that you just observed and go, 'So now what do we do?' And you know, we'd come up with strategies that way.* (Participant 4).

This participant described not only needing breaks from the work of teaching students who struggle, but also the value of having co-workers affirm their assessment of student performance. This sub-theme reveals how some participants have difficulty with students who are not perfect while others accept that not every student is perfect, whether they have a disability of not.

All of the participants identified themselves not just as occupational therapists and preceptors but also as educators. In fact, most of them described themselves as educators rather than clinicians who supervise students. It seems participants put immense pressure on themselves to be perfect educators and

occupational therapists. Several participants had similar stories to the one told by Participant 4 above, and expressed similar relief when co-workers saw the same difficulties with students with disabilities who were struggling. It is not clear why most participants felt so worried about failing a student with a disability. Is it because they have never had a student struggle with learning in their workplace and they are worried they will have to fail the student or is it something more? Do they feel that it is riskier to fail a student with a disability, that somehow they will be judged as discriminatory if they fail a student with a disability? This remained unclear in the data.

There is a theme running through the stories of most participants, that in the role of preceptor for a student with disabilities confusion arose regarding when they were acting as educators and when they were enacting a therapist/client stance. This tension runs through the descriptions of their teaching and evaluating methods, through the description of their work environments as well as their beliefs about students with disabilities in the profession. Most participants who had students who struggled with the learning environment spoke at length of the modifications they made to assist student learning. Many described these alterations as sliding into a therapist-client relationship.

> *I felt like I had to, you know… There wasn't a clean division between 'I'm your preceptor, you're a student occupational therapist who's going to be graduating and entering practice as my colleague in 2 months.' It felt like 'you're an OT student, I'm hoping that you're finishing well and entering this profession but I feel like you need some structure, some rehab about how you can manage some of those anxious symptoms, some of the thought processes on placement, like when you are being an OT.' (Participant 3)*

However, on closer examination, what may feel like a therapist-client relationship may simply be preceptors being good educators. By modifying the learning environment, scaffolding learning tasks and demands, they are helping students to learn by teaching them in a different way, responding to diverse student needs. This is what good teachers do. It is intriguing that participants tended to confuse the two roles. Is this occurring because as therapists, they are often modifying an environment or providing accommodations as part of their treatment of clients? Is this happening because many have little experience working with students with disabilities, so they do not have the language of pedagogy to describe their experiences? Or perhaps this is occurring because most preceptors do not receive formal educational training to be preceptors?

The role confusion described by participants colours their analysis of their experiences supervising students with disabilities and may fuel a negative bias. By positioning the educator-learner relationship as a therapist-client one, they pathologize students, positioning them as ‘needy’, yet also continue to support the notion that students have to be perfect during fieldwork. Learning difficulties become evidence of deficit. Students who are less than perfect become pathologized, whether disability was the reason for their fieldwork difficulties or not. This then raises or perpetuates concerns about people with disabilities being ‘unfit’ for certain work environments i.e., advanced practice, neuro rehabilitation and perhaps for the profession itself. It is unlikely that this belief is intended or overtly ableist. Rather, it may be an example of viewing anything outside of

perfection as problematic and outside of the norm. It is a version of averse disablism (Deal, 2007) when participants view their students with disabilities as needy and make a direct link to their disability, when in fact those students may simply need further teaching and not treatment.

Discussion

The results of this study align in many ways with the literature surrounding students with disabilities in health professions and particularly in fieldwork settings. There continues to be concern regarding student suitability in certain practice areas, with some areas of practice deemed less amenable or even incompatible with students with disabilities. There continues to be a heavy focus by occupational therapists on disclosure by students revealing a bias against students with disabilities as well as a focus on therapists believing that their actions towards their students with disabilities are more like those of a therapist with a client rather than an educator with a student.

The research reveals some new twists on themes evident in previous literature. There was much concern about the administrative aspects of assigning students with disabilities to clinical sites as well as the process that therapists should follow when problems arise. Finally, there continues to be some biased thinking surrounding students with disabilities entering a health profession like occupational therapy, although some therapists appeared to be challenging these assumptions in their own practice.

Administrative struggles

A frequent theme in the literature as well as this study is the incompatibility, according to some professionals, of accommodations within the fieldwork site and the challenges in having accommodations that seem inappropriate for the clinical setting. The literature describes how some university disability services do not provide accommodations for clinical settings (Ashcroft & Lutfiyya, 2013; Jung et al., 2014) as well as the difficulties that arise when disability services, among others, do not understand the clinical setting (Guitard, Duguay, Thériault, Sirois & Lajoie, 2010). There is also a focus in the literature regarding the belief that accommodations are not even possible in a clinical setting (Awang & Taylor, 2005; Brown, James & Mackenzie, 2006; Bulk et al., 2017; Easterbrook et al., 2015; Tee et al., 2010). This study substantiates those findings from the perspective of the clinicians who supervise the students in the clinical settings.

As in earlier studies, the current research shows the lack of connection between occupational therapy programs, preceptors (who are experts in their own workplace and their demands) and the university's accessibility/disability services (the experts on accommodations). The various parties seem to be working independently, without involving each other. More importantly, they appear to be making decisions, in particular the fieldwork coordinators and the disability services, without a proper understanding of the occupational demands of the fieldwork site. This runs contrary to a fundamental model of occupational therapy, the Person-Environment-Occupation (PEO) Model (Law, Cooper, Strong,

Stewart, Rigby & Letts, 1996). This model helps occupational therapists work with clients to identify and remove barriers “to improve occupational performance by creating a better person-environment ‘fit’” (Strong, Rigby, Stewart, Law, Letts & Cooper, 1999, p. 126). The PEO model can be used to reframe a situation of students with disabilities (person) in a fieldwork setting (environment) as a student occupational therapist (occupation). Using this model helps to shift the focus from viewing the difficulty as something that is wrong with the student to showing the difficulty is in fact a poor client-environment fit (Strong, Rigby, Stewart, Law, Letts & Cooper, 1999).

Many of the difficulties described by the research participants could be described as a poor person-environment-occupation fit, and the accommodations that were recommended for the student by the university did not improve this poor fit. Would the difficulties discussed by the participants have been so pronounced had there been a better person-occupation-environment fit? In order for this to occur, preceptors would need to be involved in the process of determining fieldwork accommodations. Stier, Barker and Campbell-Rempel (2015) have argued that occupational therapists are well versed in the interaction of the person, environment and occupation and can lead the field in Canada in developing strategies to ensure accommodations are implemented effectively in clinical sites. This obviously continues to be a challenge to implement and it is an area that could benefit from a national strategy on implementing accommodations for students in fieldwork.

It is ironic that while no occupational therapist would send a person with a disability back to work without knowing the occupational demands of the workplace, this seems to occur regularly with students with disabilities in fieldwork settings. Fieldwork coordinators and accessibility services are at times creating accommodation plans for students without knowing all of the occupational demands of the setting. This is especially true – according to several participants in the study – as some sites offer placements without yet having therapists or particular departments assigned. As such, accommodations are created based on very vague or general information only. This approach to providing accommodations runs completely counter to the way an occupational therapist would work with a client returning to work and may be the source of some difficulties for students with disabilities, and their supervising preceptors.

Disclosure, trust and safety

When discussing students with disabilities in the health professions, the discussion inevitably turns to the issue of students disclosing their disabilities. There are questions about when they should disclosure, to whom and why. Throughout the health professions literature, there is a consistent focus by clinical preceptors on the need for students to disclose their disability (Ashcroft & Lutfiyya, 2013; Hill & Roger, 2016; Rankin, Nayda, Cocks, & Smith, 2010). As Nolan, Gleeson, Treanor and Madigan (2015) found, many occupational therapists who are fieldwork preceptors are concerned about students who do not disclose prior to fieldwork and the current study reveals similar findings.

However, unlike previous studies, many of the participants in the current study acknowledge that disclosing a disability to a preceptor is a choice for the student alone to make and not something that is required. This is something that may differ over time, or by jurisdiction, as it is directly influenced by human rights protections and privacy law.

There was some indication that participants may experience disclosure as emotionally loaded, revealing as much about the person to whom the disclosure is made as it does about the person who is disclosing. Stanley, Ridley, Harris and Manthorpe (2011) describe how students see themselves as honest by disclosing, which personalises disclosure and makes it so much more than discussing barriers to learning and ways to reduce those barriers. It is interesting to note that if students disclose, this is seen as a sign of honesty, which automatically implies that students who choose not to disclose are seen as dishonest. Participants in the current study tended to describe the disclosure process as one centering on trust, whereby the student is judged to trust the preceptor by disclosing, and when disclosure does not occur participants may feel that there is a lack of trust by the student, implying a negative judgement about the preceptor as untrustworthy. There is some suggestion of progress when compared to other recent literature, as participants generally did agree that disclosure is not required by the students and students should be able to choose whether or not to disclose. However, participants did not seem to fully acknowledge that sharing very personal medical information with a near-

stranger, a person who holds a great deal of power in the relationship, would be very difficult and not an action to be undertaken lightly or to be disclosed casually.

Many of the participants spend a great deal of time trying to ensure that their clinical setting is a safe space for student learning and that they, as occupational therapists, are supportive and 'safe' for their students to confide in. Consequently, participants appear to feel that student's choice not to disclose disability is a personal statement about them as a supervisor and their own level of 'safeness' or trustworthiness to students. We also continue to see some participants express frustration at the lack of disclosure and the difficulties that occur with last minute or *ad hoc* accommodations, as is described elsewhere in the literature (Ashcroft & Lutfiyya, 2013; Bulk et al., 2017; Cunnah, 2015; Easterbrook et al., 2015; Hill & Roger, 2016; Mullings & Preyde, 2013; Rankin, Nayda, Cocks & Smith, 2010). However, disclosure of a disability and request for accommodations are two different things. Students can discuss the barriers that they face and the possible accommodations that may help without having to disclose their disability. Having a student disclose personal and private medical information does not necessarily tell a preceptor the student's barriers, nor does it identify the best accommodations. One of the participants described this situation by recalling a student who came to the placement not only explaining her functional limitations (not her disability) but also the solutions that worked for her. The ease of integrating the accommodations was not just due to the

student's sharing the accommodations that worked well for her but also because she indicated her barriers. Throughout the interview, that participant reflected on how she was able to keep this in mind and create solutions to possible issues before the student was even aware of them. Disclosure of the diagnosis then was irrelevant, as the focus was on the occupational demands and the barriers the student may face in meeting those demands.

Weaving through the findings of this research study is a theme of trust and distrust: Student trust in preceptors (or lack thereof), preceptor believing they are not trustworthy when the student does not disclose, preceptor and student trust that the accommodations requested are appropriate for the fieldwork site, as well as preceptor trust that the student selected for a particular fieldwork setting has been deemed suitable for that environment. Trust is an important factor in the professional life of an occupational therapist, including the need to be trustworthy for the client and the public, and to have a trusting relationship between the therapist and client (Townsend & Polatajko, 2007). The participants in this study spoke about trust in many ways and the issue of trust intertwines its way through many discussions. This is especially clear when discussing accommodation plans in the clinical setting and who decides what is appropriate for the setting.

Participants revealed a lack of trust in the system as it occurs in their province. Although each province/university has their own system, they all appear similar in their lack of consultation with fieldwork preceptors. Preceptors generally

distrusted the accommodation plan created for students with disabilities as well as the decision to place students with certain learning needs in their fieldwork sites. This lack of trust is similarly reflected in the literature, often in the discussion about fitness to practice and client safety. Concerns about patient/client safety and fitness to practice for students with disabilities is a common finding in the occupational therapy literature (Clouder, Adefila, Jackson, Opie & Odedra, 2016; Hargreaves, Dearnley, Walker & Walker, 2014; Guitard, Duguay, Thériault, Siriois & Lajoie, 2008; Jung et al., 2014; Nolan, Gleeson, Treanor & Madigan, 2015; Stier, Barker & Campbell-Rempel, 2015; and Walker, Dearnley, Hargreaves & Walker, 2013). It is also described in the wider literature of the health professions (Ashcroft & Lutfiyya, 2013; Carroll, 2004; Delisa, 2006; Duffin, 2001; Easterbrook et al., 2015; Evans, 2014; McKee, Smith, Barnett, Pearson, 2013; Mercer, Dieppe, Chambers, MacDonald, 2003; Neal-Boylan, Guillett, 2008; Neal-Boylan, 2013; Oulette, 2013; and Stanley, Ridley, Harris & Manthorpe, 2011; Watkinson, 2002).

This concern about fitness or safety is similarly reflected in this study, although the concern is not generally framed using words such as trust. However, lack of trust is often at the root of discussions about client safety and student accommodations. This lack of trust seems to stem from the fact that the preceptors are not involved in planning the accommodations and they are unaware of the reasons for the accommodations (i.e., diagnoses). As one participant stated: *“You have no input as a supervisor. You get to deal with it. But*

yet it's my job as a supervisor to get the student through the placement." As clinicians, it appears that they lack trust that the accommodations granted are appropriate for the student, the environment and the client population. Given students work directly with the clients/patients in that clinical setting, how do preceptors know that the accommodations will ensure safe practice, and thus that clients/patients will be protected? Clouder et al. (2016) state: "Risk, fitness to practice and competence are brought together to contrive to introduce an element of doubt to defy even the keenest aspirations of admissions tutors or of potential students." (p. 13) when referring to students with disabilities entering health care programs. In other words, students with disabilities constantly have to contend with concerns that they pose safety risks to clients, and an aura of distrust hangs over them. This is exacerbated when preceptors do not know the functional limitations or the diagnosis, have no role in accommodations planning, yet bear responsibility for client safety. Interestingly enough, in a recent study focusing on the voice of the clients, they expressed a preference for having a clinician with disabilities (Jarus et al., 2019), negating the claim that students with disabilities pose risks to clients.

Challenging the bias

This study reveals that perceptions about disability which are pervasive in Western societies, may also be evident within occupational therapy. As Phelan (2011) has argued, therapists may unwittingly adopt and enact dominant societal 'metanarratives' about disability that equate it with helplessness, dependency,

incompetence, and inadequacy. In this study, such perceptions take many forms, including seeing students with disabilities as unsuited for advanced fieldwork settings, and viewing them as needing protection in a way that differs from students without disabilities. However, this study also reveals occupational therapists who challenge this line of thinking, promoting the idea that students with disabilities can take risks with their learning just the same as their peers without disabilities. As well, some participants acknowledged the added expertise that students with disabilities bring to the profession, that of their lived experience of living with a disability.

The literature reveals that students with disabilities must battle the assumption that they are not capable of the work (Joyce, McMillan, Hazleton, 2009; Velde, Chapin, Wittman, 2005). The current study supports this line of thinking, as several participants stated that their practice is inherently ill-suited for students with disabilities because it is ‘advanced practice’, specifically if those disabilities are (or are presumed to be) cognitive/learning disabilities, or mental health challenges.

This study also shows occupational therapists who are pushing back against the assumptions and biased thinking that often accompany students with disabilities. These clinicians are challenging the practice – which appears to be common among fieldwork coordinators – of asking whether a preceptor can accommodate a student with a disability. They are insisting that the question should be: can you

provide this type of accommodation, given the occupational demands of your workplace? This move shifts the focus from the person, to the fit with environment and specific occupational demands.

The student/client confusion

A theme that emerges from this study and has been reported elsewhere in the literature is the issue of occupational therapists treating and/or viewing students with disabilities more like clients than students. We see this within occupational therapy where therapists with disabilities report being treated like clients by supervisors (Bevan, 2014) and within the wider health professions research where students with disabilities are treated like clients or patients by their preceptors (Ashcroft & Lutfiyya, 2012; Brown, James & Mackenzie, 2006; Hirneth & Mackenzie, 2004; Langørgen, Kermit, & Magnus, 2018; Tee & Cowan, 2012). In the current study, some participants interpreted their actions towards students with disabilities as being more therapeutic than pedagogical, as if the students were their clients. This occurred most often when students were struggling and the result was participants altering how they were teaching in order to facilitate student learning. As discussed previously, participants often assisted students by grading and scaffolding the learning, so students could perfect one aspect of a skill, before moving on to the next element. Although altering the teaching method is not a therapeutic intervention, participants interpreted this action as treating students like clients, perhaps because grading and scaffolding are standard enabling methods in occupational therapy practice.

Much of the literature describes this phenomenon occurring but does not describe why it occurs. Both Brown, James and Mackenzie (2006) and Hirneth and Mackenzie (2004) describe occupational therapists treating their students with disabilities like clients, without describing what transpires in this dynamic. Given that this phenomenon occurs in many health care professions, it seems as though health care professionals may have the mistaken impression that accommodating someone with a disability (whether a student or co-worker) is the same as providing treatment to a client or patient. This is problematic in many ways. It suggests that occupational therapists (and other health professionals) struggle to differentiate between effective, flexible teaching methods and clinical treatment. It implies that the tendency to pathologize disability remains just under the surface, causing anything short of full independence, without any accommodation or assistance – seen as lesser, or deviant (Phelan, 2011). It also suggests more education regarding pedagogy might help preceptors to see their accommodations, grading and scaffolding as simply good pedagogy, rather than as therapeutic practice. This is turn may help them see students with disabilities as learners, rather than akin to clients.

Conclusion

This study reflects some of what has been evident in previous literature regarding students with disabilities in occupational therapy in fieldwork settings. We see clinicians who view their role as clinical preceptor and educator as an integral

element of their professional image. We see occupational therapists who are committed to diversity and who want students with disabilities to be successful in the profession. These therapists also struggle with the administration of the fieldwork process, as this process does not take into consideration the elements necessary to facilitate learning, namely the occupational demands and the person-environment-occupation fit. As such, the fieldwork site is frequently deemed to be too advanced for students with certain (or assumed) needs and abilities, and occupational therapists struggle to help their students to learn without feeling that they are providing treatment for a client. What is heartening is that we also see occupational therapists accepting and welcoming students with disabilities into their fieldwork sites, and see some challenging of dominant narratives equating accommodations with client safety risks.

This study also reveals a gap in the administration of assigning students to fieldwork placements, particularly regarding gaining adequate detail about the setting and the occupational demands, elements that all occupational therapists know are essential for an optimal person-environment-occupation fit. This gap is a promising area for future research. There is also a hint in the results that therapist-preceptors may take it as an indictment of their personal trustworthiness when a student chooses not to disclose a disability or diagnosis, availing of their privacy rights. This finding also suggests a potential area for intervention.

Chapter 5 Conclusion

This thesis research provides a small but important addition to the literature surrounding students with disabilities entering into occupational therapy. The results reflect the experiences of a small group of occupational therapists who have served as preceptors in Canada. The analysis shows a group dedicated to educating occupational therapy students and committed to including students with disabilities in the profession. Yet it also highlights important struggles.

Strengths and limitations

This was a small study with a very small sample of seven preceptors. The study findings reflect the thoughts and experiences of a group of occupational therapists at a particular moment in time. They worked in diverse practice settings, in different provinces and health care jurisdictions across the country. While this is a strength of the study, it is also a limitation, in that it is impossible to ascertain from the data how specific contexts shaped experiences.

Given the small sample size, it is not possible to generalize the findings to the profession at large, despite the fact that some of the findings reflect the current literature. Samples are not intended to be representative of the profession, rather they seek depth of experience. In some ways, the scope of a Masters thesis hinders that depth of experience. For example, it would have been ideal to engage in purposive sampling, recruiting participants for specific experiences which begin to emerge as relevant in the analyses. In the current study, there is a

hint that mental health issues prove particularly problematic for preceptors – it would have been worthwhile to recruit preceptors specifically to test this analysis, allowing comparisons between experiences with students with mental health and other disabilities. In this aspect of the analysis, it is safe to say the sample did not allow theoretical saturation. It is also a limitation of the study scope that only individual interviews were conducted. Speaking with each preceptor again a few days or a week later might have given them time to think more deeply about their responses, enriching the data. Finally, it is possible the study drew participants who had particular challenges working with students with disabilities; the stories of preceptors who have had no difficulties may be rendered invisible here through the volunteer bias that is part of qualitative study recruitment.

At the same time, a major strength of the study is the focus on preceptors and their experiences working with students with disabilities. The vast majority of existing literature consists of research with students with disabilities in the health professions, and first-person accounts of occupational therapists and other clinicians with disabilities reflecting on their experiences in practice. There are few previous studies highlighting the experiences of preceptors. As such this study unearthed some novel results.

Regardless of geographic location, the occupational therapists who participated in this study struggled with the processes for assigning students to clinical sites. These processes differ from university to university and yet they all appear to

have a siloed approach. The fieldwork coordinator, perhaps with the input of the university's disability/accessibility services, creates accommodation plans for students without a full understanding of the environmental or occupational demands of the fieldwork site, and mostly without the input of the actual preceptor. This unilateral system leaves fieldwork preceptors with a feeling of distrust about the accommodations and causes them to want more detail about the student's disability in order to assure themselves that the accommodations are appropriate for the fieldwork setting. This distrust, due to a lack of information and meaningful consultation, also fuels perceptions of students with disabilities as a safety risk or conversely, though related, as in need of protection. Participants in this study are committed to assisting students and they believe that students with disabilities belong in the profession of occupational therapy. Some of them may question whether students with disabilities belong in every workplace or if every disability is 'compatible' with many workplaces, however, they do not question the important perspectives and skills that these students bring to the profession in general.

Implications

There are number of implications for educational programs and for practice that arise from this study. Primarily, it will be **important for educational programs to improve their links with fieldwork settings**. All of the participants had negative comments regarding the process of having a student assigned to them, even if the placement was a success. Students arrive at a fieldwork site with

accommodations already arranged without anyone from the fieldwork site having been consulted. The environmental and occupational demands of the site have not been taken into consideration and preceptors often have no knowledge of the accommodations until students arrive. When the fieldwork preceptor is contacted in advance, the process may veer too far in the opposite direction, giving preceptors the ability to refuse to take a student with a disability because accommodations will be required, rather than assuming the placement will occur if the accommodations will work in that particular environment.

Many of the participants spoke of students being assigned to their department with the preceptor assigned only a few weeks before the placement begins. This does not allow time for communication and confirmation that the accommodations are appropriate for the fieldwork site. Similarly, accommodations are often being recommended without knowing the occupational demands of the fieldwork site. There should be **proper job site assessments for each fieldwork site** so that students, fieldwork coordinators, and disability services can provide accommodation plans that take the actual occupational demands and environment into consideration. A job description that states ‘adult mental health, community’ does not provide the information required to make informed decisions by anyone involved. It only furthers the disconnect between the different stakeholders, whose shared goal is student learning.

CAOT (2018) has declared its commitment to inclusive academic programs and the inclusion of students with disabilities, including accessible and inclusive fieldwork placements (CAOT, 2017). However, there is little guidance regarding what this should look like, nor how to achieve such goals. It is imperative that university programs develop a more structured process for accommodations in fieldwork, one that generates adequate detail about setting and occupational demands, and a process to support both students and preceptors to optimize student performance and ability to demonstrate competencies. Given that Canadian universities all must adhere to the accreditation standards of CAOT, this **expectation could be explicitly embedded in accreditation standards**. Students with disabilities are a growing demographic in occupational therapy programs across the country and needs will continue to grow. Having a more routinized and effective process will likely foster better relationships between fieldwork preceptors and university programs and may reduce some of the distrust that seems to exist surrounding students with disabilities.

It is also clear from the results of this study that at least some preceptors struggle with a perception that they are responsible for student success, and experience particular distress when they may have to fail a student with a disability. It may be helpful for educators to work with (all) preceptors to better understand that responsibility for success rests with the student. Preceptors may need **coaching on how to be clear about learning objectives, without lowering standards, while implementing accommodations**. Taking responsibility for student

performance, reducing expectations, accepting students only into placements perceived as ‘easy’ – all of these undermine the capabilities of students with disabilities.

Moreover, from the results of this study it appears there is a role for educators to **work with preceptors around tenets of pedagogy**. Understandably, preceptors – who are first and foremost occupational therapists – experience confusion, blurring the boundaries between self-as-educator and self-as-therapist. When they work with a student with disabilities they may struggle to know what role they are enacting. Occupational therapist engagement with clients may include grading tasks, increasing or decreasing degrees of challenge to scaffold learning and performance success, finding the ‘just right challenge’. This first requires task analysis. They may also engage in adapting occupations or the performance of an occupation to meet goals that have been set. With clients, they may provide mechanisms for cognitive assistance, such as cueing, or reducing distractions. All of these are also components of effective pedagogy – for all students, not least for students with disabilities. Good educators also adjust and adapt both teaching and assessment, seek conditions for optimal learning and demonstration of learning, and grade tasks and assessments to scaffold learning while maintaining standards regarding learning objectives. It is possible that if preceptors knew more about pedagogy they might have less concern about accidentally sliding into therapist-mode. It would be a shame indeed if occupational therapy students are less likely than others to receive

accommodations from preceptors and educators, because of misguided resistance to establishing a therapist-client dynamic.

Finally, the results of this study suggest that at least some therapist-preceptors may experience student non-disclosure about disability as an indictment of their personal trustworthiness. The broad **issues of trust and distrust warrant exploration and discussion between educational programs and their affiliated fieldwork sites**. Students with disabilities, preceptors, fieldwork coordinators and accessibility service providers from the universities all need to move toward greater trust in the other players. Altering processes, as noted above, would go some way toward this. But fieldwork coordinators and others at the university level may also need to work with preceptors to better understand that students' availing themselves of privacy rights does not signal distrust of their preceptors (nor does it signal student dishonesty); they may benefit from coaching on how not to take it personally when a student chooses not to disclose private information.

Implications for future research

Given that this study is small, further research is required into the breadth of experience of fieldwork preceptors in Canada who have supervised students with disabilities. This continues to be an understudied subject within the profession of occupational therapy and in particular in Canada. Further research could focus on interviewing a larger number of preceptors from all provinces about their

experiences. Research using focus groups would enable preceptors to spark ideas off one another, generating very rich data. Now that exploratory qualitative data is available, a survey might build on the results of this study to examine a more representative sample, teasing out differences by type of site, experience levels of preceptors, types of student disabilities and so on. Further research should also focus on occupational therapist views on students with disabilities in the profession, as this study, not unlike the wider literature, continues to reveal some of the dominant perceptions about disability that link it to incompetence and dependence, thus ultimately to safety risk when working with clients. Given what appears in this study to be a particularly negative perception regarding mental health issues among students, this warrants specific attention in future research.

There have been calls to challenge the ableism, or aversive disablism (Deal, 2007), within occupational therapy for many years. As Hammell (2006) points out, health professionals are not immune to the societal ideologies and beliefs in which we are steeped. In the West this includes perceptions of people with disabilities as lesser, incapable, dependent and in need of help. Phelan (2011) argues that critically reflexive examination – turning a critical lens on practice in social context – is necessary to reveal how the professional values and commitments of occupational therapy may be undermined by simultaneous adherence to socially dominant perceptions of disability as problematic. Critical reflexivity, she insists, encourages not only questioning, but also opening new

conversations, challenging current practice, and enacting change (Phelan, 2011, p. 165). It is in this spirit of critical reflexivity that I invite all occupational therapy educators, preceptors, fieldwork coordinators and students to continue interrogating current practice to improve the experiences of both preceptors and students with disabilities. Supporting equitable participation in all academic endeavours brings occupational therapy closer to realizing an inclusive and stronger profession that draws from the strengths of all and aligns with a value of justice. (CAOT, 2018)

References

Ashcroft, T. J., & Lutfiyya, Z. M. (2013). Nursing educators' perspectives of students with disabilities: A grounded theory study. *Nurse Education Today, 33*(11), 1316-1321. doi:http://dx.doi.org.ezproxy.library.dal.ca/10.1016/j.nedt.2013.02.018

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology, 8:*(1), 19-32, DOI: 10.1080/1364557032000119616

Awang D, & Taylor, M.C. (2005). Professional practice placements and disabled students: How prepared are you? *International Journal of Therapy and Rehabilitation*, *12*(11), 478.

Bevan, J. (2014). Disabled occupational therapists - asset, liability... or 'watering down' the profession? *Disability and Society, 29*(4), 583-596. doi:10.1080/09687599.2013.831747

Botham, K. A., & Nicholson, J. (2014). Supporting the transition of disabled students from university to practice placement. *Disability & Society, 29*(3), 460-476. doi:10.1080/09687599.2013.823078

Brown, K., James, C., & Mackenzie, L. (2006). The practice placement education experience: An Australian pilot study exploring the perspectives of health professional students with a disability. *British Journal of Occupational Therapy***,** 69(1), 31-37.

Bulk, L.Y., Easterbrook, A., Roberts, E., Groening, M., Murphy, S., Lee, M., Ghanouni, P., Gagnon, J., & Jarus, Tal. (2017). 'We are not a anything alike': marginalization of health professionals with disabilities. *Disability & Society*, 1-20. doi:10.1080/09687599.2017.1308247

Canadian Association of Occupational Therapists. (2001). *Frequently Asked Questions by Occupational Therapists on Entry-Level Education of Occupational Therapists in Canada*. Retrieved from http://umanitoba.ca/rehabsciences/media/fwk_caot_faq.pdf

CAOT. (2017). *Academic Accreditation Standards and Self-Study Guide*. Retrieved from http://caot.in1touch.org/uploaded/web/Accreditation/CAOT%20Accreditation%20Self%20Study%20Guide%202017%20English.pdf

Canadian Association of Occupational Therapists. (2018). *Joint Position Statement on Inclusive Occupational Therapy Education for Persons with Disabilities* [Position statement]. Retrieved from https://www.caot.ca/site/pt/caot_posn_stmt?nav=sidebar

Carroll SM. 2004. Inclusion of people with physical disabilities in nursing education. *Journal of Nursing Education, 43*(5), 207-212.

Chacala, A., McCormack, C., Collins, B., & Beagan, B. L. (2014). 'My view that disability is okay sometimes clashes': Experiences of two disabled occupational therapists. *Scandinavian Journal of Occupational Therapy, 21*(2), 107-115. doi:10.3109/11038128.2013.861016

Clouder, L., Adefila, A., Jackson, C. Opie, J., & Odedra, S. (2016). The discourse of disability in higher education: Insights from a health and social care perspective. *International Journal of Educational Research, 79,* 10-20. Doi: 10.1016/j.ijer.2016.05.015

Cooper, J., Coyston, S. Crooks, D., Gabbert, M., Leclair, L., Secter, H., Shalaby, A., Whitmore, M. (2011). *Report of the ad hoc committee of senate executive to examine accommodation of students with disabilities and governance procedures related to academic requirements.* Retrieved from http://umanitoba.ca/student/saa/accessibility/media/Cooper_Commission_Report_Feb_2012.pdf

Colorafi, K.J. & Evans, B. (2016). Qualitative descriptive methods in health science research. *Health Environments Research & Design Journal*, *9*(4), 16–25. https://doi.org/10.1177/193786715614171

Cunnah, W. (2015). Disabled students: Identity, inclusion and work based placements. *Disability & Society, 30*(2), 213-226. DOI: 10.1080/09687599.2014.996282

Davidson PM, Rushton CH, Dotzenrod J, Godack CA, Baker D, Nolan MN. 2016. Just and realistic expectations for persons with disabilities practicing nursing. *AMA Journal of Ethics*, *18*(10): 1034-1040.

Deal, M. (2007). Aversive disablism: Subtle prejudice toward disabled people. *Disability & Society, 22*(1), 93-107. doi:10.1080/09687590601056667

Delisa J. 2006. Physicians with disabilities: Why aren't there more of them? *New Jersey Medical School Pulse 4*(1), 32-33.

DePoy, E., Gitlin, L. N. (2016). *Introduction to Research: Understanding and Applying Multiple Strategies.* (5th ed.) St. Louis, Missouri: Elsevier, 2016.

Dunn, D., & Andrews, E. (2015). Person first and Identity first language: Developing psychologists' cultural competence using disability language. *American Psycholoigst,*70(3), 255-265. doi: 10.1037/a0038636

Easterbrook, A., Bulk, L., Ghanouni, P., Lee, M., Opini, B., Roberts, E., Parhar, G. & Jarus, T. (2015). The legitimization process of students with disabilities in Health and Human Service educational programs in Canada. *Disability & Society*, *30*, 1505-1520.

Ennals, P., Fossey, E., & Howie, L. (2015) Postsecondary Study and Mental Ill-Health: A Meta-Synthesis of Qualitative Research Exploring Students' Lived Experiences. *Journal of Mental Health, 24*(2), 111-119. DOI: 10.3109/09638237.2015.1019052

Evans, W. (2014). “If they can't tell the difference between duphalac and digoxin you've got patient safety issues”. Nurse Lecturers’ constructions of students’ dyslexic identities in nurse education. *Nurse Education Today, 34*(6), e41-e46. doi:http://dx.doi.org.ezproxy.library.dal.ca/10.1016/j.nedt.2013.11.004

Gabel, S.L., & Miskovic, M. (2014) Discourse and the containment of disability in higher education: An institutional analysis. *Disability & Society, 29(7*), 1145-1158. DOI: 10.1080/09687599.2014.910109

Goode, J. (2007). 'Managing' disability: Early experiences of university students with disabilities. *Disability & Society, 22*(1), 35-48. DOI: 10.1080/09687590601056204

Goodley, D. (2017). *Disability studies : An interdisciplinary introduction* (2nd edition). Los Angeles: SAGE, 2017.

Grimes, S., Southgate, E., Scevak, J., & Buchanan, R. (2018). University student perspectives on institutional non-disclosure of disability and learning challenges: Reasons for staying invisible. *International Journal of Inclusive Education,* 1-17. doi:10.1080/13603116.2018.1442507

Guitard, P., Duguay, E., Thériault, F-A., Sirois, N.J., & Lajoie, M. (2010). Integration of students with physical impairments in Canadian university rehabilitation sciences programs. *International Journal of Rehabilitation Research, 33*(1), 81-83.

Hammell, K. W. (2006). *Perspectives on disability & rehabilitation: Contesting assumptions, challenging practice*. Edinburgh: Churchill Livingstone/Elsevier, 2006.

Hargreaves, J., Dearnley, C., Walker, S., & Walker, L. (2014). The preparation and practice of disabled health care practitioners: *Exploring the issues. Innovations in Education & Teaching International, 51*(3), 303-314. doi:10.1080/14703297.2013.778048

Harrison, A. G., & Wolforth, J. (2012). Findings from a pan-Canadian survey of disability services providers in postsecondary education. *International Journal of Disability, Community and Rehabilitation*, *11*(1). Retrieved from http://www.ijdcr.ca/VOL11_01/articles/harrison.shtml

Hill, S. & Roger, A. (2016). The experience of disabled and non-disabled students on professional practice placements in the United Kingdom. *Disability & Society, 31*(9), 1205-1225. DOI: 10.1080/09687599.2016.1236718

Human Resources and Skills Development Canada. (2010). Federal Disability Report: The Government of Canada's Annual Report on Disability Issues: Chapter 4 Employment. (HS61- 1/2010E-PDF). Gatineau, Quebec: Government of Canada Publication Services. doi:978-1 100-16832-6

Jarus, T., Bezanti, R., Trivett, S., Lee, M., Bulk, Y. Battalova, A., Mayer, Y. Murphy, S., Gerber, P & Drynan, D. (2019) Professionalism and disabled clinicians: the client's perspective. *Disability & Society, 2019,* 1-18. DOI: 10.1080/09687599.2019.1669436. Retrieved from: https://www.tandfonline.com/doi/full/10.1080/09687599.2019.1669436

Joyce, T., McMillan, M., & Hazleton, M. (2009). The workplace and nurses with a mental illness. *International Journal of Mental Health Nursing, 18*(6), 391-397.

Jung, B., Baptiste, S., Dhillon, S., Kravchenko, T., Stewart, D., & Vanderkaay, S. (2014). The Experience of student occupational therapists with disabilities in Canadian universities. *International Journal of Higher Education, 3*(1), 146-154. doi:0.5430/ijhe.v3n1p146

Kattari, S. K. (2015). Examining ableism in higher education through social dominance theory and social learning theory. *Innovative Higher Education, 40*(5), 375. doi:10.1007/ s10755-015-9320-0

Kontosh, L.G., Fletcher, I., Frain, M., & Winland-Brown, J. (2007). Work place issues surrounding healthcare professionals with disabilities in the current labor market. *Work 29*(4), 295-302.

Kielhofner, G. (2005). Rethinking disability and what to do about it: Disability studies and its implications for occupational therapy. *American Journal of Occupational Therapy, 59*(5), 487-496.

Law, M., Baptiste, S., & Mills, J. (1995). Client-centred practice: What does it mean and does it make a difference? *Canadian Journal of Occupational Therapy, 62*(5), 250-7.

Law, M., Cooper, B. A., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The person-environment-occupation model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy*, *63*, 9–23.

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: Advancing the methodology. *Implementation Science: IS, 5*(69), 1-9. doi:10.1186/1748-5908-5-69

Longørgen, E., Kermit, P. & Magnus, E. (2018). Gatekeeping in professional higher education in Norway; ambivalence among academic staff and placement supervisors towards students with disabilities. *International Journal of Inclusive Education,*1-15. DOI: 10.1080/13603116.2018.1476599

Matt, S.B. (2008). Nurses with disabilities: Self-reported experiences as hospital employees. *Qualitative Health Research,18*(11), 1524-1535.

McClelland, G. T., Horne, M., Dearnley, C., Raynsford, J., & Irving, D. (2015). Experiences and outcomes among undergraduate health professional higher education students with protected characteristics: disability, gender, and ethnicity. *Journal of Psychological Issues in Organizational Culture, 6*(1), 38–64. doi:10.1002/jpoc.21168

McCormack, C., & Collins, B. (2012). The affirmative model of disability: A means to include disability orientation in occupational therapy? *British Journal of Occupational Therapy, 75*(3), 156-158. doi:10.4276/030802212X13311219571909

McKee, M.M., Smith, S., Barnett, S., & Pearson, T.A. (2013). What are the benefits of training deaf and hard-of-hearing doctors? *Academic Medicine, 88*(2), 224-232.

Mercer, S., Dieppe, P., Chambers, R., & MacDonald, R. (2003). Equality for people with disabilities in medicine. *BMJ*, 327(7420), 882-883.

Meyer, J. T. (2014). Ensuring a diverse workforce: Fieldwork success for occupational therapy students with disabilities. *OT Practice, 19*(20), 18-19. Retrieved from http://ezproxy.library.dal.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=107805453&site=ehost-live

Moll, S., Eakin, J.M., Franche, R-L., & Strike, C. (2013). When health care workers experience mental ill health: Institutional practices of silence. *Qualitative Health Research*, *23*(2), 167-179.

Mullins, L. & Preyde, M. (2013) The lived experience of students with an invisible disability at a Canadian university. *Disability & Society, 28*(2), 147-160. DOI: 10.1080/09687599.2012.752127

Neal-Boylan, L., Guillett, S.E. (2008). Work experiences of RNs with physical disabilities. *Rehabilitation Nursing*, *33*(2), 67-72.

Neal-Boylan, L., Hopkins, A., Skeete, R., Hartmann, S., Iezonni, L.I., & Nunez-Smith, M. (2012). The impact of permanent sensory or physical disability on the career trajectories of healthcare professionals. *Academic Medicine*, *87*, 172-178.

Neal-Boylan, L. (2013). End the disability debate in nursing: Quality care is fact. *Insight Into Diversity.* www.insightintodiversity.com April/May 2013.

Nolan, C., Gleeson, C., Treanor, D., Madigan, S. (2015). Higher education students registered with disability services and practice educators: Issues and concerns for professional placements. *International Journal of Inclusive Education, 19*(5), 487-502. doi:10.1080/13603116.2014.943306

Oulette, A. (2013). Patients to peers: Barriers and opportunities for doctors with disabilities. *Nevada Law Journal, 13*, 645-667.

Phelan, S. K. (2011). Constructions of disability: A call for critical reflexivity in occupational therapy. *Canadian Journal of Occupational Therapy, 78*(3), 164-172. doi:10.2182/cjot.2011.78.3.4

Rankin, E.R., Nayda, R., Cocks, S., Smith, M. (2010). Students with disabilities and clinical placement: Understanding the perspective of healthcare organisations. *International Journal of Inclusive Education, 14*(5), 533-542. doi:10.1080/13603110902730176

Shpigelman, C-N., Zlotnick, C., & Brand, R. (2016). Attitudes toward nursing students with disabilities: Promoting social inclusion. *Journal of Nursing Education, 55*(8), 441-449. doi: 10.3928/01484834-20160715-04

Shrewsbury, D. (2015). Disability and participation in the professions: Examples from higher and medical education. *Disability and Society, 30*(1), 87-100. doi: 10.1080/09687599.2014.982785

Stanley, N., Ridley, J., Harris, J., Manthorpe, J. (2011). Disclosing disability in the context of professional regulation: A qualitative UK study. *Disability & Society*, *26*(1), 19-32.

Stier, J., Barker, D., Campbell-Rempel, M.A. (2015). Student accommodations in occupational therapy university programs: Requirements, present environment and trends. *Occupational Therapy Now, 17*(3), 16-18.

Strong, S., Rigby, P., Stewart, D., Law, M., Letts, L., & Cooper, B. (1999). Application of the Person-Environment-Occupation Model: A practical tool. Canadian Journal of Occupational Therapy, 6(3).

Taylor, M. C. (2007). The Casson Memorial Lecture 2007: Diversity amongst occupational therapists - rhetoric or reality?. *British Journal of Occupational Therapy, 70*(7), 276-283.

Tee, S., & Cowen, M. (2012). Supporting students with disabilities – promoting understanding amongst mentors in practice. *Nurse Education in Practice*, 12(1), 6-10. doi:http://dx.doi.org.ezproxy.library.dal.ca/10.1016/j.nepr.2011.03.020

Tee, S.R., Owens, K., Plowright, S., Ramnath, P., Rourke, S., James, C., & Bayliss, J. (2010). Being reasonable: Supporting disabled nursing students in practice. *Nurse Education in Practice, 10*(4), 216-221.

Teodoro, IPP., Rebouças, VCT., Thorne, SE., Souza, NKM., Brito, LSA., & Alencar, AMPG. (2018). Interpretive description: A viable methodological approach for nursing research. *Escola Anna Nerv*, *22*(3), 1–4. https://doi.org/10.1590/2117-9465-EAN-2017-0287

Thorne, S., Kikham, S.R., MacDonald-Emed, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health*, *20*, 169–177.

Townsend, E. A., & Polatajko, H. J. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation*. Ottawa: Canadian Association of Occupational Therapists, 2007.

Velde, B., Chapin, M., & Wittman, P. (2005). Working around 'It': The experience of occupational therapy students with disability. *Journal of Allied Health*, *34*(2): 83-89.

Venville, A., Street, A., & Fossey, E. (2014) Student perspectives on disclosure of mental illness in post-compulsory education: displacing doxa. *Disability & Society, 29*(5), 792-806, DOI: 10.1080/09687599.2013.844101

Walker, S., Dearnley, C., Hargreaves, J., & Walker, E. A. (2013). Risk, fitness to practice, and disabled health care students. *Journal of Psychological Issues in Organizational Culture, 3*(4), 46-59. doi:10.1002/jpoc.21081

Waterfield, B. & Whelan, E. (2017). Learning disabled students and access to accommodations: socioeconomic status, capital, and stigma. *Disability & Society, 32*(7), 986-1006. DOI: 10.1080/09687599.2017.1331838

Watkinson, S. (2002). Dyslexia is cause for concern in nursing. *Nursing Standard, 16(32)*, 30.

Wilcock, A. A. (2015). *An occupational perspective of health* (Third edition). Thorofare: SLACK Incorporated, 2015.

World Federation of Occupational Therapists. (2008b). *Position Statement–Inclusive Occupational Therapy Education WFOT*. Retrieved from: http://www.wfot.org/ResourceCentre.aspx

World Health Organization (2011). *World Report on Disability*. Retrieved from https://www.who.int/disabilities/world_report/2011/report.pdf

DALHOUSIE UNIVERSITY

Appendix A – Invitation to Participate

Study Title: The lived experience of occupational therapists who supervised students with disabilities.

Dear Fieldwork Coordinator,

Have you arranged fieldwork placements for entry-level occupational therapy students who have a disability? Have any of them had accommodations for disability? How did this work out – for you, for them, for clients? I'd love to talk with the preceptors about their reflections and experiences!

More occupational therapy students are being granted accommodations/adjustments in fieldwork settings, yet we do not know much about the experiences of supervising these students. Want to help increase our knowledge about this growing practice in occupational therapy?

My name is Jen Davis I am a graduate student at the School of Occupational Therapy at Dalhousie University. I am conducting a research study as part of the requirements of the Master's of Science (Post-Professional) in Occupational Therapy and I would like to invite preceptors to participate.

The purpose of this study is to understand more about the experiences and challenges of occupational therapists who have been a clinical preceptor to one or more occupational therapy students who have had academic accommodations due to a disability. In order to participate, the specific type of accommodations is not important, nor is it important to know the type of disability. I am interested in

interviewing preceptors who have supervised one or more students who had some type of accommodation/adjustment to the fieldwork setting due to disability in the past five years.

This is a qualitative style study where participants are asked to recall and reflect on being a preceptor to an occupational therapy student with accommodations due to a disability.

Will you send the attached invitation to participate to preceptors in your province you know have supervised one or more entry-level occupational therapy students who have had academic accommodations as a result of disability?

Participation in this study is completely voluntary and requires approximately 45-60 minutes of the preceptor's time in order to complete this telephone interview.

Please feel free to contact me with any questions or concerns.

Thank you for taking the time to read this letter.

Jen Davis, M.A., BSc, OT, OT Reg (NS)
Candidate, Master's of Science (Post-Professional) Occupational Therapy
Dalhousie University
502-3051 Isleville Street,
Halifax, NS
Tel: (902) 222-9697
Jen.davis@dal.ca

Supervisor of Research Project:

Dr. Joan Versnel, Ph.D., Associate Professor
School of Occupational Therapy
5869 University Avenue
Forrest Building, Room 327
Dalhousie University
Halifax, NS B3H 3J5
Tel: (902) 494-2601

Fax: (902) 494-1229
jversnel@dal.ca

DALHOUSIE UNIVERSITY

Appendix B – Invitation to Participate

Study Title: The lived experience of occupational therapists who supervised students with disabilities.

Dear Occupational Therapist,

Have you been a preceptor for entry-level occupational therapy students? Have any of them had accommodations for disability? How did this work out – for you, for them, for clients? I'd love to talk with you about your reflections and experiences!

More occupational therapy students are being granted accommodations/adjustments in fieldwork settings, yet we do not know much about the experiences of supervising these students. Want to help increase our knowledge about this growing practice in occupational therapy?

My name is Jen Davis I am a graduate student at the School of Occupational Therapy at Dalhousie University. I am conducting a research study as part of the requirements of the Master's of Science (Post-Professional) in Occupational Therapy and I would like to invite you to participate.

The purpose of this study is to understand more about the experiences and challenges of occupational therapists who have been a clinical preceptor to one or more occupational therapy students who have had academic accommodations due to a disability. In order to participate, the specific type of accommodations is not important, nor is it important to know the type of disability. I am interested in interviewing you if you have supervised one or more students who had some

type of accommodation/adjustment to the fieldwork setting due to disability in the past five years.

This is a qualitative style study where participants are asked to recall and reflect on being a preceptor to an occupational therapy student with accommodations due to a disability.

Participation in this study is completely voluntary and requires approximately 45-60 minutes of your time in order to complete this telephone interview. You will be contacted for the telephone interview, at a mutually agreed upon time, once you have returned the signed consent indicating that you are willing to participate. Once the interview is transcribed and preliminary analysis has been completed, a summary of the initial analysis will be emailed to you. You will be asked to confirm whether the conclusions drawn are accurate based on your interview and you can add additional information at that time.

Your confidentiality is of utmost importance. Although the telephone interview will be recorded for the purposes of accurate data collection, no identifying information such as your name or place of practice will be used in the analysis or reporting of the study. Your participation in the study will also be kept confidential. Identifying information will be asked in order for the administration of the follow-up contact. Once data has been collected, each will be coded to maintain confidentiality. The information obtained will only be used for the purposes of this study.

Please review the attached Consent Forms for detailed information regarding this study. In order to participate, please complete the signed consent form and return by email.

Please feel free to contact me with any questions or concerns.

Thank you for taking the time to read this letter.

Jen Davis, M.A., BSc, OT, OT Reg (NS)
Candidate, Master's of Science (Post-Professional) Occupational Therapy
Dalhousie University
502-3051 Isleville Street,
Halifax, NS
Tel: (902) 222-9697
Jen.davis@dal.ca

Supervisor of Research Project:

Dr. Joan Versnel, Ph.D., Associate Professor
School of Occupational Therapy
5869 University Avenue
Forrest Building, Room 327
Dalhousie University
Halifax, NS B3H 3J5
Tel: (902) 494-2601
Fax: (902) 494-1229
jversnel@dal.ca

DALHOUSIE UNIVERSITY

Appendix C – Invitation to Participate

Study Title: The lived experience of occupational therapists who supervised students with disabilities.

Dear Occupational Therapist,

Have you been a preceptor for entry-level occupational therapy students? Have any of them had accommodations for disability? How did this work out – for you, for them, for clients? I'd love to talk with you about your reflections and experiences!

More occupational therapy students are being granted accommodations/adjustments in fieldwork settings, yet we do not know much about the experiences of supervising these students. Want to help increase our knowledge about this growing practice in occupational therapy?

My name is Jen Davis I am a graduate student at the School of Occupational Therapy at Dalhousie University. I am conducting a research study as part of the requirements of the Master's of Science (Post-Professional) in Occupational Therapy and I would like to invite you to participate.

The purpose of this study is to understand more about the experiences and challenges of occupational therapists who have been a clinical preceptor to one or more occupational therapy students who have had academic accommodations due to a disability. To participate, the specific type of accommodations is not important, nor is it important to know the type of disability. I am interested in

interviewing you if you have supervised one or more students who had some type of accommodation/adjustment to the fieldwork setting due to disability in the past five years. It also is not important if the accommodations were arranged before the student started the placement or if they were arranged later on.

Participation in this study requires approximately 45-60 minutes of your time for a telephone interview. Please contact me if you are interested in participating in my study or if you have questions about the study. I would love to talk to you!

Jen Davis, M.A., BSc, OT, OT Reg (NS)
Candidate, Master's of Science (Post-Professional) Occupational Therapy
Dalhousie University
Halifax, NS
Tel: (902) 222-9697
Jen.davis@dal.ca

Supervisor of Research Project:
Dr. Joan Versnel, Ph.D., Associate Professor
School of Occupational Therapy
Tel: (902) 494-2601
jversnel@dal.ca

DALHOUSIE UNIVERSITY

Appendix D – Interview Guide

Part 1 – Demographic Questions

What is your area of practice in occupational therapy?

How long have been practicing as an occupational therapist?

Approximately how many students have you supervised in the course of your work? How many had a disability that you were aware of?

Why do you supervise occupational therapy students? (probe: required by your employer; giving back to the community? Other?)

Part 2 – In-depth questions

Please tell me about your experiences supervising occupational therapy students with disabilities, both positive and negative? (Probe: different types of disability?)

Did your student(s) disclose their disability prior to or during their placement? What was your reaction to their disclosure? (Probe: Why did you react/feel/ think that way?)

Thinking of one or more students, how has the process of accommodating disability tended to go? (Probe: what makes it easier or more difficult?)

During those placements do you seek help or guidance from your colleagues, or the Accessibility Office of the student's university? (Probe: Why/ Why not? Other sources of assistance?)

How have you changed your supervisory/teaching style when working with students with disabilities?

What concerns do you have, if any, about supervising occupational therapy students with mental health disabilities?

What concerns do you have, if any, about having occupational therapists with different types of disabilities? With mental health disabilities?

What advantages do you think a student with a disability brings to the fieldwork environment? The profession?

What recommendations do you have for other occupational therapists who work with students with disabilities?

What can the healthcare and educational systems do differently to help students with disabilities excel in fieldwork placements? (Probe: To support preceptors?)

Thank you for your participation!

DALHOUSIE UNIVERSITY

Appendix E – Confidentiality Agreement

This agreement is between:

Jen Davis, Dalhousie University
and [transcriptionist/research staff name and affiliation] for
The lived experience of occupational therapists who supervised students with disabilities.

Summary of job description/service provision:

The transcriptionist will transcribe verbatim the interview audio files provided by Jen Davis, Lead Researcher, “The lived experience of occupational therapists who supervised students with disabilities” into Microsoft Word files. The audio files will be transcribed within two weeks of receiving them from the Lead Researcher. When they files have been transcribed, the completed transcript will be sent to Jen Davis, Lead Researcher as a Word document by email.

I agree to:

1. keep all the research information shared with me confidential. I will not discuss or share the research information with anyone other than with Jen Davis, or others identified by Jen Davis.
2. keep all research information secure while it is in my possession.
3. return all research information to Jen Davis when I have completed the research tasks or upon request, whichever is earlier.
4. destroy all research information regarding this research project that is not returnable to the Jen Davis after consulting with the Jen Davis.

5. comply with the instructions of Jen Davis about requirements to physically and/or electronically secure records (including password protection, file/folder encryption, and/or use of secure electronic transfer of records through file sharing, use of virtual private networks, etc.).
6. not allow any personally identifiable information to which I have access to be accessible from outside Canada (unless specifically instructed otherwise in writing by Jen Davis).
7. other (specify):

Transcriptionist/Research staff:

_____ _____

_____

(Print Name) (Signature) (Date)

I agree to:

1. Provide detailed direction and instruction on my expectations for maintaining the confidentiality of research information so that [transcriptionist/research staff] can comply with the above terms.

2. Provide oversight and support to [transcriptionist/research staff] in ensuring confidentiality is maintained in accordance with the Tri Council Policy Statement Ethical Conduct for Research Involving Humans and consistent with the Dalhousie University Policy on the Ethical Conduct of Research Involving Humans.

Researcher(s):

_____ _____

_____

(Print Name) (Signature) (Date)

DALHOUSIE UNIVERSITY

Appendix F – Consent Form

Project title: The lived experience of occupational therapists who supervised students with disabilities.

Lead researcher: Jen Davis, Dalhousie University, 902-494-6824, jen.davis@dal.ca

Other researchers

Dr. Joan Versnel, Associate Professor, School of Occupational Therapy. Supervisor. jversnel@dal.ca

Dr. Brenda Beagan, Professor, School of Occupational Therapy, Committee member. Brenda.beagan@dal.ca

Dr. Tal Jarus, Professor, Department of Occupational Science and Occupational Therapy, University of British Columbia, Committee member. Tal.jarus@ubc.ca

Introduction

I invite you to take part in a research study being conducted by me, Jen Davis, a student at Dalhousie University as part of my Post-Professional Master's degree in Occupational Therapy. Choosing whether or not to take part in this research is entirely your choice. There will be no impact on your continued ability to provide fieldwork placements for occupational therapy students if you decide not to participate in the research. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience.

You should discuss any questions you have about this study with Jen Davis. Please ask as many questions as you like.

Purpose and Outline of the Research Study

The goal of the study is to learn more about the experiences of occupational therapists who have acted as fieldwork preceptors to occupational therapy students who have identified as having a disability. I would like to know what challenges you have had with supervising students as well as any other relevant information. I would like to interview between 5 and 8 occupational therapists who have supervised an occupational therapy student who had academic accommodations for disability within the past five years.

Who Can Take Part in the Research Study

You may participate in this study if you are a licensed occupational therapist who has supervised an occupational therapy student who has had accommodations for disability in a clinical fieldwork setting within the past five years.

What You Will Be Asked to Do

To participate in this study, you will be asked to complete an interview with the lead researcher regarding your experiences supervising occupational therapy students with disabilities. The interview will take place over the phone and the interview will be recorded. As part of the interview, you will be asked to respond to questions as well as answer questions about your past experience working with occupational therapy students who have had academic accommodations during fieldwork as a result of disability.

The interview will last between 45 and 60 minutes and will be set at a time that is convenient for you.

Following your interview, you will be provided by a summary of the preliminary analysis of your interview by email from the lead researcher. You will be asked to

confirm whether the conclusions drawn are accurate based on your interview and you can add additional information at that time.

Possible Benefits, Risks and Discomforts

Participating in the study will likely not benefit you directly however, we might learn more about the challenges that occupational therapists experience supervising students who have had academic accommodations as a result of disability. This information may also help to inform changes in the future for occupational therapists.

The risks associated with this study are the following: the risk of being identified, the risks of experiencing discomfort from sharing your experiences and the risk of employment/registration consequences if the supervisory practices you report having used or using are perceived as harmful or unethical.
However, you may refuse to answer any question that you are asked.

As an occupational therapist, the lead researcher has a duty to report if another therapist discloses practices that have potential to harm patients/clients, or in any breach the profession's codes of ethics (https://www.caot.ca/site/pt/codeofethics) or standards of practice. Given that the interviews are about work with students, this is highly unlikely to arise, however, the researcher will have a duty to report obvious violations**.**

Compensation / Reimbursement

There is no compensation for participating in this study. There will also be no cost to you to participate.

How your information will be protected:

Privacy: Every step will be taken to ensure your privacy as you participate in this study. The interviews will take place at a location/time chosen by you and will be conducted by phone.

Confidentiality: Your electronic data, including audio recordings and interview transcripts will be encrypted and password protected on a computer that only the lead researcher has access to. Any hard copy data will be stored in a locked filing cabinet, accessible only to the researcher. Your identity will be protected by the use of a pseudonym and any identifiable demographics (location, place of work) will be removed. The list of pseudonyms will be encrypted and kept on a separate computer from the rest of the data. Once the data have been analyzed and you have confirmed the information in your summary, the list of names and contact information will be destroyed.

All identifying information about you will removed, including your name, your place of work, your city and province and any other uniquely identifying information.

Data retention: The data will be retained by the lead researcher for a period of five years. After five years, all data will be destroyed, including consent forms.

If You Decide to Stop Participating

You are free to leave the study at any time. If you decide to stop participating at any point in the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. You can also decide for up to two months if you want us to remove your data. After that time, it will become impossible for us to remove it because it will already be analyzed and de-identified.

Questions

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Jen Davis (at 902 494-6824, jen.davis@dal.ca) or Dr. Joan Versnel (at 902 494-2501, jversnel@dal.ca) at any time with questions, comments, or concerns about the research study.

If you have any ethical concerns about your participation in this research, you may also contact Catherine Connors, Director, Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca

Signature Page

Project Title: The lived experience of occupational therapists who supervised students with disabilities.

Lead Researcher: Jen Davis, Dalhousie University, 902-494-6824

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in an interview that will occur at a location acceptable to me, and that the interview will be recorded. I understand direct quotes of things I say may be used without identifying me. I agree to take part in this study. My participation is voluntary and I understand that I am free to withdraw from the study at any time, until two (2) months after my interview is completed.

Name Signature

Date