“They put you on your toes”: Physical Therapists’ Perceived Benefits from and Barriers to Supervising Students in the Clinical Setting

Robyn Davies, Elizabeth Hanna, Cheryl Cott

ABSTRACT

Purpose: To identify the perceived benefits of and barriers to clinical supervision of physical therapy (PT) students.

Method: In this qualitative descriptive study, three focus groups and six key-informant interviews were conducted with clinical physical therapists or administrators working in acute care, orthopaedic rehabilitation, or complex continuing care. Data were coded and analyzed for common ideas using a constant comparison approach.

Results: Perceived barriers to supervising students tended to be extrinsic: time and space constraints, challenging or difficult students, and decreased autonomy or flexibility for the clinical physical therapists. Benefits tended to be intrinsic: teaching provided personal gratification by promoting reflective practice and exposing clinical educators to current knowledge. The culture of different health care institutions was an important factor in therapists’ perceptions of student supervision.

Conclusions: Despite different disciplines and models of supervision, there is considerable synchronicity in the issues reported by physical therapists and other disciplines. Embedding the value of clinical teaching in the institution, along with strong communication links among academic partners, institutions, and potential clinical faculty, may mitigate barriers and increase the commitment and satisfaction of teaching staff.

Key Words: clinical teaching, education, organizational culture, professional issues, role stress, students

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RÉSUMÉ

Objectif : Identifier les bénéfices perçus et les obstacles à la supervision clinique des étudiants en physiothérapie (PT).

Méthode : Pour cette étude qualitative descriptive, trois groupes de discussion ont été formés et six entrevues avec des intervenants principaux ont été organisées avec des physiothérapeutes qui pratiquent en clinique et des administrateurs en soins de courte durée, en réadaptation orthopédique ou en soins prolongés complexes. Les données ont été codées et analysées dans le but de regrouper les idées communes à l’aide d’une approche comparative constante.

Résultats : Les obstacles perçus pour la supervision des étudiants ont tendance à être intrinsèques : contraintes de temps et d’espace, étudiants difficiles ou qui éprouvent des difficultés, perte d’autonomie et de souplesse pour le physiothérapeute superviseur en clinique. Les avantages ont tendance à être intrinsèques : le fait d’enseigner est valorisant sur le plan personnel, car cela favorise la pratique réflexive et permet d’actualiser les connaissances des éducateurs cliniques. La culture des divers établissements de soins de santé constituait un facteur important dans la perception que les thérapeutes avaient de la supervision des étudiants.

Conclusions : Malgré la présence de diverses disciplines et de modèles variés de supervision, il existe de grandes similitudes entre les problèmes signalés par les physiothérapeutes et ceux propres aux autres disciplines. Intégrer la valeur de l’enseignement clinique à l’établissement, avec des liens de communication solides entre les partenaires universitaires, les établissements et les facultés cliniques potentielles pourrait aplanir les obstacles et accroître l’engagement et la satisfaction du personnel enseignant.

Mots clés : culture organisationnelle, éducation, enjeux professionnels, enseignement clinique, étudiants, stress lié au rôle

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INTRODUCTION

Clinical experiences are a crucial part of the curricula of physical therapists. The hands-on practice students receive in real-life settings depends greatly on the skill and commitment of the students' clinical educators (CEs). In its 2008 position statement, the Canadian Physiotherapy Association (CPA) recognized that there are challenges for CEs in their "ability to manage the responsibilities of student clinical instruction,"^{1(p.2)} including human resources, changing practice environments, and organizational support. CPA also noted that physical therapy (PT) programmes in Canada require more than 4,600 clinical placements per calendar year.¹ These numbers are expected to increase as programmes increase enrolment,¹ making appropriate placements and supervisors more challenging to find. There is therefore a need to understand the reasons CEs give for not wanting to supervise students, as well as the benefits they identify from offering supervision. While a number of studies have focused on the productivity of various student-supervision models and on the needs of students and academic or clinical institutions, they do not add to our understanding of CEs' perceptions of supervising students.²⁻⁴ Such understanding will help academic and health care institutions to effectively shape the methods they use to support existing supervisors, as well as helping to guide the development of programmes that will provide successful incentives and mentorship for those therapists who currently resist clinical supervision.

The literature examining perceived barriers to and benefits of clinical supervision in Canada is not extensive, and no studies thus far have dealt with physical therapists. A British Columbia study that examined the factors motivating family physician preceptors to supervise medical students found that personal satisfaction (e.g., enjoyment of teaching) was the most important reason for maintaining a role as a teacher.⁵ The practice situation, described in terms of space, patient population, and time, was the most important barrier to taking students.⁵

PT literature examining the barriers and opportunities outside the Canadian setting is also sparse, but at least one study was noted. In their 2000 qualitative study, Baldry Currens and Bithell⁶ examined the barriers to supervising PT students in a region of England and found that while students are perceived to enhance the clinician's practice through reflection and building confidence, they also create increased stress as a result of time constraints, a perceived decrease in productivity, and a sense that clinical supervision is not valued.⁶

Other non-Canadian studies have examined motivations for supervising students, primarily among physicians but also among nurse practitioners and dietitians. Motivations for taking students frequently involve intrinsic factors such as enjoyment of teaching.⁷⁻¹² The

influence of students in terms of keeping their preceptors current or even *on their toes* was also highly valued.^{8,10-16} Clinicians appear to attach importance to training the next generation⁸ or giving something back.^{7,10,11,17} These concepts are supported in the 1997 literature review conducted by Gerrity et al.,¹⁸ who reviewed 38 articles on physicians' job and career satisfaction and found that motivators for supervising students were primarily intrinsic (e.g., joy of teaching, increased confidence and learning). Additional motivators identified included involvement in the students' curriculum¹⁹ or being a part of the academic community, often through faculty appointments.^{8,9,13,15,20} Less frequently cited benefits associated with supervising students included recognition and access to continuing education,^{9,11,21} future recruitment,^{11,13} and the positive impact of students on patient care.^{15,21-23}

Most frequently cited perceived barriers to supervising students included time constraints or heavy workloads,^{7,12,14,24} constraints related to practice space,^{17,24,25} and the resulting increase in stress that students bring.^{15,17} These findings are supported by Gerrity et al.'s¹⁸ review, which also found that the barriers identified tended to be extrinsic (i.e., cost, space, and busy practices).

Some authors have also alluded to the impact of institutional culture on CEs' perceptions of the reported barriers and opportunities. We used Peterson and Spencer's definition of culture: "the deeply embedded patterns of organizational behavior and the shared values, assumptions, beliefs, or ideologies that members have about their organization or its work."^{26(p.181)} Examples of the influence of institutional culture can be seen in the work of Baldry Currens and Bithell,⁶ who observed that CEs wanted to be recognized and valued by both health care institutions and universities. Gibson et al.¹⁹ and Skeff et al.²⁰ also noted that lack of organizational recognition and support are suggested as reasons for not taking students. Finally, it has been noted that CEs want faculty support and involvement in shaping the curriculum.²⁰ These concepts suggest that clinicians desire a sense of belonging and of being valued.

While the literature reviewed above offers insight into motivators and barriers, it should be noted that the model of clinical education in these studies is different from that of Canadian PT students. The purpose of this study is to identify the perceived benefits of and barriers to physical therapists' supervising students during clinical placements, in order to help inform strategies aimed at increasing clinicians' participation in the supervision of students.

METHODS

A qualitative descriptive approach using focus groups and key-informant interviews was chosen in order to learn more about physical therapists' perceptions of the

barriers to and benefits of taking students. The qualitative descriptive approach was selected as most appropriate to the overall goal of the study, which was to learn more about physical therapists' perceptions of clinical supervision. Sandelowski has argued that the goal of qualitative description is to provide a "comprehensive summary of events in the everyday terms of those events."^{27(p.334)} Qualitative description stays close to the words and events that make up the raw data and does not require a conceptual framework for its interpretation.

Context

The study was conducted at two hospitals in a large urban centre in Ontario. The two principal investigators (PIs) are employed in education roles at these two hospitals. The larger of the two hospitals is a fully affiliated teaching hospital with two sites: Site 1A includes several clinical areas ranging from acute care to long-term care, while Site 1B specializes in orthopaedic rehabilitation. The second hospital, Site 2, is a mid-size complex chronic care and rehabilitation hospital that is a community affiliate of the university. Focus groups and key-informant interviews were conducted at each of these three sites.

Sampling and Recruitment

Convenience sampling was used to recruit the focus-group participants, who were self-selected on the basis of interest and availability. No restriction was placed on the number of student placements participants might have supervised. An initial invitation and information package were sent to the approximately 115 physical therapists employed at the three sites by a research assistant (RA), who subsequently provided further information about the study to those who were interested in participating ($n = 20$), determined participant availability, and arranged for further information sharing with the PIs as requested. Following the focus groups, six key-informant interviews were held: three with individual members of the original focus groups, two with administrators from each of the two hospitals, and one with a representative from the university. Analysis of the focus-group data provided direction for the selection of the key informants and guided the one-on-one interview questions. One participant from each of the focus groups was selected to allow deeper exploration of concepts that arose in the groups in order to achieve saturation of categories and to provide member checking. The administrators were chosen to provide perspectives on the organizational cultures in which the CEs worked.

Participants

There were six physical therapists in each of the focus groups at Sites 1A and 2, and eight in the focus group at

Figure 1a Demographic analysis of focus-group participants: Number of years working at site

Figure 1b Demographic analysis of focus-group participants: Total number of students supervised per physical therapist, by site

Figure 1c Demographic analysis of focus-group participants: Total number of years working as a physical therapist

Site 1B. Participants ranged in age from their late 20s to their late 50s, with a corresponding range of experience both as CEs and as therapists, but the majority were very experienced student supervisors: 11 of the 18 participants reported supervising more than 10 students in their career. Additional demographic information is provided in Figures 1a, 1b, and 1c.

Table 1 Focus-Group Questions

Q1	What has been your experience with having students?
Q2	Can you tell me about a time when you had a student that was a really positive experience?
Q3	Can you tell me when it didn't go quite so well? What would have helped? What didn't help?
Q4	Are there any other pros and cons not mentioned?
General probes to be used throughout / as required:	Can you expand on that thought? Can you give an example? How did it make you feel?

Data Collection

The focus groups were moderated by an experienced facilitator hired and oriented to the project by the PIs. Informal debriefing and feedback were provided to the facilitator following the first two focus groups. The RA attended each focus-group session to take field notes, and completed a speaker log to assist in the transcription process. The subsequent key-informant interviews were conducted by the two PIs, each interviewing at the hospital(s) where she was not an employee. Prior to the beginning of each focus group and interview, the purpose of the research was reviewed, and participants were offered another opportunity to ask questions. All participants signed the consent form in the protocol approved by the Research Ethics Boards at both hospitals. Demographic data were collected via a brief pen-and-paper survey. A semi-structured interview format was used for the focus groups (see Table 1). All focus groups and interview materials were audiotaped and then transcribed verbatim by a professional transcriptionist; any identifying information was removed from the transcripts. The PIs reviewed the focus-group tapes and transcripts for accuracy; to help ensure the anonymity of the participants, each PI reviewed the tape or tapes for the site(s) where she was not employed.

Data Analysis

Data analysis took place concurrently with data collection. Simultaneous collection and analysis, whereby each element shapes the other, is referred to as *sequential* or *interim* analysis²⁸ and encourages a rich exploration of the data. After each focus group, the PIs met to review and discuss the transcripts. As described earlier, initial analysis of the focus groups guided selection of the six key informants for the one-on-one interviews. During the early stages of coding, the two PIs worked independently, reading through each of the focus-group transcripts and using open coding methods to organize the material. They subsequently met to compare their individual codes for one of the focus groups, and

reached consensus on initial concept identification through discussion. These identified codes were then used to guide a review of the initial coding of the other two focus groups and the key-informant interviews. Coding for these was conducted independently by the two PIs, followed by further discussion and refinement of the codes. Refining of codes, along with the development of concepts and categories that addressed the study's research questions, continued throughout the analysis process. Identification of any new codes was always agreed upon by the two PIs. Once the coding scheme was completed, the two PIs met with the senior author to review and discuss the findings.

RESULTS

Three broad categories emerged from the data: perceived barriers to taking students, perceived opportunities to taking students, and the role of institutional culture. Each of these categories is described below.

Perceived Barriers to Taking Students

The overarching barrier was expressed as increased stress. The perceived causes of the stress that students provoked were related to external factors over which the physical therapists felt they had little control: time and space constraints, challenging or difficult students, and decreased autonomy or flexibility.

Adding any student to the health care team alters the status quo for the supervising therapist. This change and the added responsibility were often described in negative terms:

I find it tremendously draining ... you have that interaction with patients and then on top of that interacting with a student, I feel like I'm talking all the time and I don't like to talk all the time. (Site 1B, Respondent 4)

All focus-group participants agreed that supervising a student takes more time, but there was considerable variation in their perceptions of the impact this had.

Many felt that this additional time was an issue only during the beginning of the placement:

Now instead of just having your full patient load, you also have a student ... your workload will definitely increase in the first week or two. (Site 2, Respondent 5)

Others felt that time was an issue throughout the student experience. Some therapists conceded that by the conclusion of the placement a student, especially an excellent or senior student, may have assumed a substantial part of the therapist's caseload. But no matter whether students were perceived to save time at the end, cause increased workload at the beginning, or create more work all the way through, the students alter the status quo: they change the way workload is managed:

Instead of doing your paperwork you're educating or you're reviewing your student's paperwork, you're going over their problem solving, you're reviewing their assessments and what do they think and trying to pull stuff out of them. (Site 1B, Key Informant (Member Checking))

In the model of supervision that is most common in PT programmes in Canada, students spend much of their day with the CE. Even when they do not, as with a senior student, the CE will have to keep track of and balance two schedules: his or her own and the student's. This constant need to be aware of and responsible for the student can be perceived as causing a loss of autonomy for the therapist, which can be stifling:

So it's like you have a little partner shadow that you have to be thinking about all the time as opposed to just going and doing your work. (Site 1A, Respondent 6)

While it is certain that any student will bring change, they also bring with them the unknown. The CE has no direct knowledge of the student's strengths, weaknesses, or learning style. This can be an added source of stress that may depend on the supervisor's level of comfort as a therapist or on his or her past experiences with students:

I think that there is always fear; are you going to get a bad student or a good student? What are they going to be like? ... That's always one of the fears—it's just butterflies sometimes when you first get them. (Site 2, Respondent 3)

Even strong students can be threatening for some clinicians, particularly those with less experience. As one respondent said,

You worry about having a student that's going to come in and show you up and ask you questions you don't know the answers to. (Site 1B, Key Informant (Member Checking))

Fear that the unknown student will prove to be *difficult* was strongly voiced at all three sites. Students

were perceived to be challenging in two ways: they might be struggling students in danger of failure (producing added responsibility, extra time, and emotional stress), or they might have a difficult personality (e.g., be overly emotional, be overconfident, be immature, or have a poor work ethic):

I would give this particular person feedback, she would cry. So it was very stressful. I didn't take a student for a year after that because I said, oh God, I couldn't deal with that any more. (Site 2, Respondent 6)

The stress resulting from a heightened sense of responsibility is particularly acute when the student's failure is clear-cut:

You don't want to be the final say in someone's education or career. (Site 2, Respondent 3)

When a student is struggling, but not clearly failing, responsibility may be compounded by self-doubt. Perhaps the student's troubles are due to the CE's lack of skill as an educator. Perhaps the student is in fact doing an adequate job, and it is the CE's evaluation skills that are lacking. The support of a team (either inter-professional or unidisciplinary) was seen to mitigate the stress the struggling student might provoke:

One of the things, actually, that I enjoy about working on our team is that you're not the sole therapist on the floor, so you have other resources available ... (Site 1A, Respondent 3)

The team's ability to reduce the stress of a challenging student was something all three sites broadly agreed on; however, each site differed in the weighting of this factor. In this instance, as in others, there was general agreement across the three sites on the perceived barriers to taking students, but the extent to which these negative factors were felt differed from site to site. Differences between sites were related to the level of perceived workplace support for educational activities, which ultimately is part of the culture of the environment in which the clinician functions.

Perceived Benefits of Taking Students

Physical therapists generally saw the benefits of having students as intrinsic. The overarching concept of love of teaching was prominent, even as clinicians acknowledged the barriers that make it challenging. Secondary concepts—students' bringing current knowledge, stimulating reflection, bringing positive change to the patient dynamic, and reinforcing CEs' enjoyment of their role in preparing the next generation—all contributed to the love of teaching. These factors were again influenced by the perceived support for educational activities and the culture of the environment at the different sites. As one focus-group participant said,

It's part of the culture that when you work here there's an expectation that you're involved, whether it's taking students on-site versus working down at the university. (Site 1A, Key Informant (Member Checking))

At all sites, therapists agreed that they have busy clinical schedules, which afford them little time to stay up to date with the latest in research and current trends of the profession. Students were perceived as playing a valuable role in bringing this knowledge to the therapists. Thus students are valued as teachers *themselves*, and as facilitators of evidence-based practice, through their ability to quickly research an area of clinical interest:

Before I knew it, she'd gone and researched and done a lit search and came in the next day equipped with articles and evidence that really, I think, exceeded what the assessing orthopaedic surgeon was aware of, so I felt by having her, I was really given this kind of gift of getting a research assistant. (Site 1B, Respondent 2)

Students also bring current academic knowledge into the clinical setting and help to create a two-way learning interaction with their CEs; this was seen as a highly profitable experience that contributes to the growth of both participants:

I think you can also find out new information, lots of new ways of doing things. You know, sometimes we do things because it works, but they tell me about some new ideas that they're being taught. It kind of keeps you current. (Site 2, Respondent 6)

Students are part of the integration of fresh academic knowledge with clinical expertise. Beyond actual new information, the students provoke self-reflection on practice that participants saw as beneficial. Students' questioning voices cause CEs to look at their choices critically:

They say, well, you know, our teacher told us this. This is kind of the stuff that's out in the research, you know? So, yeah, it makes us self-reflect and thinking, why are we doing this stuff? Why are we doing it the way we're doing it? And you go and review the stuff. (Site 1B, Respondent 7)

The reflection that the students' presence promotes in their more experienced CEs arises from their excitement about the profession the students are about to join. This provides an appreciated stimulant to clinical practice that in some cases may have slipped into routine for some CEs:

The tremendous satisfaction you get and the knowledge that they bring with them, and enthusiasm that they can generate in you. You see your caseload a little bit differently and you say, "Oh, wow, this is kind of fun." (Site 1A, Respondent 4)

It is a learning experience because they put you on your toes. (Site 2, Respondent 2)

CEs found it rewarding to see two different aspects of students' progress: their journey toward becoming practising professionals and their growth as human beings:

I find that it's satisfying to see somebody who is initially not shy, but maybe a bit hesitant or tentative and their confidence isn't there. And then see how their confidence in that specific area improves and how they begin to get a lot more comfortable with clients. (Site 1A, Respondent 1)

Seeing my student actually in the workforce 4 years later, it was really cool ... I did have a hand in it, did I not? (Site 2, Respondent 3)

The idea of *giving back* was frequently mentioned. When asked why therapists take students, one participant suggested that it is to *do good* and to help the profession grow. The same interviewee told the story of a young therapist who made her first job choice partly on the basis of the opportunities for teaching it would provide her. She wanted to return the teaching *favour* that had been given her when she was a student.

Although students were consistently reported to take time by all participants, there was also consistent acknowledgement they also take time *for the patients*, and that this is seen as a bonus by patients and their families:

[They] will often spend more time just talking with the patients as well. I really see that it seems to me the patients really enjoy that interaction of having students around. (Site 1A, Respondent 3)

The student's attention and time change aspects of the clinician–patient relationship in a beneficial way. Patients are taken out of their institutional role and have a part in teaching as well:

Things open up that might not open up before because there's kind of a group discussion with the patient ... You learn more from the patient, the patient learns more from the teaching that goes on. (Site 1A, Respondent 4)

Again, adding the student to the clinical setting brings change, one that in this case is seen as empowering patients and potentially bringing fresh perspectives to the supervising clinician.

The Role of Institutional Culture

While many common barriers and benefits were articulated at all three sites, each focus group reflected a different organizational culture. These differences appeared to be connected to the perceived support (or lack of support) for providing clinical educational experiences to students. Figure 2 illustrates the ameliorating or negative effects the institutional culture can have on perceptions of benefits and barriers related to supervising students. When the culture is seen to be supportive of clinical teaching, the importance of the barriers

Figure 2 The culture of an institution may affect how barriers and benefits to clinical education are perceived.

appears to diminish, and the value of the benefits seems to increase. The reverse is true in settings where teaching is less central in the organizational culture.

One instance of this seemed to be how the teaching is viewed. Some organizations are less committed to teaching as part of the role description of physical therapists, placing more value on their clinical role. As one administrator said,

If you're saying is it [clinical teaching] a part of what they should be doing as a professional, yes ... but is it core to the work that they're hired to do at a hospital? Not necessarily, because the patient-care role is the role that they're hired for.

Other organizations see teaching as a central part of the role or identity of a physical therapist. The importance of teaching is something that needs to be expressed clearly to staff as early in the recruitment process. As another administrator said,

I think that when you recruit somebody, you should put it out there on the table that our expectation is that you will take a student.

The organization model of all three sites is that of programme management, whereby staff, including physical therapists, are hired and managed by a patient-care programme and not by a PT department. The absence of centralized organization-wide protocols around clinical education means that individual patient-care units may support it to varying degrees. Depending on their managers, therapists reported experiencing different levels of backing:

My issue was this is a teaching hospital; you're asking me to take students; now I'm going to get trained for it, and you should be just allowing me to go on the hospital's education time, not my own personal time. Depends who your manager is. Your manager will give you a hard time and you just kind of give up and go, you know what, I'm not even gonna ask this year. (Site 2, Respondent 5)

At times therapists perceived the lack of management support for teaching indirectly. For example, at one site CEs reported a significant lack of treatment and office space for themselves, and noted that the addition of a student taxes this limited space even further. Therapists are required to use public spaces (such as the cafeteria) for private activities (e.g., giving feedback to students). If the resources are not there for CEs to do their job properly, they may feel unsupported and undervalued.

To varying degrees, CEs at all sites questioned the extent to which their caseload was appropriate for a student; this questioning was more profound at one site than at the other two. The organizational culture (or assumptions and beliefs about appropriate clinical learning) influence CEs' decisions about whether or not to provide a clinical experience to a student. CEs at this site felt that it might be inappropriate to have a student in the environment of a quick-turnaround clinic, where other professionals may not be patient with students' need for a slower pace. Finally, CEs' own perceptions of their caseloads led to the conclusion that the placement might be inappropriate:

So most of the patients we have are 8 or 9 months (post injury), so they're in the chronic phase, so a lot of the things that would work in acute or sub-acute, they don't work. For the student that can become very frustrating. (Site 1B, Respondent 6)

It was difficult for CEs at this site to believe that the students might have a rewarding learning experience in the chronic-care setting, although the CEs reported that the environment was satisfying for them.

DISCUSSION

Despite differences in geography, discipline, and health care systems, the findings of this study are broadly in accordance with those of other clinical education research. Perceived benefits tended to be intrinsic, and while barriers were *experienced* as intrinsic (stress), they were often the *result* of extrinsic factors (lack of time, lack of space, challenging students). The overarching benefit of supervising students was the enjoyment the PTs receive from their love of teaching. This finding is supported by the work of Gerrity et al.¹⁸ and Usatine et al.¹² Satisfaction in giving back to the profession by supporting the growth of the next generation has been identified in four previous studies.^{5,7,13,17} Another intrinsic value documented in the literature and reflected in this study's findings was the stimulation students provide to their supervisors, either by injecting their current knowledge^{11,13} or by provoking reflection on practice.^{5,7,8,15,16} The perception that students' interactions improve patient satisfaction or care has also been noted in the literature.^{12,15,21–23} Recognition in the form of institutional and academic support, along with a sense of being connected to what is going on in the university, was

noted by all groups as an ameliorating factor; this finding confirms those of previous reports.^{9,14}

Likewise, the barriers identified in the focus groups and interviews generally matched those suggested in the literature. Several studies have noted that the additional stress students may bring can create a barrier,^{12,15,18} at times even to the point of professional burnout.¹⁷

The sources of stress tended to be extrinsic: environmental factors, such as insufficient space or heavy caseload that the CEs felt powerless to change. The extra time needed to teach is almost universally agreed to be a barrier.^{5,8,12,15,17,20,25}

While respondents at each site in the present study echoed similar issues, the relative weight accorded to each benefit or barrier varied in fairly consistent ways. The voices of the individual CEs in each focus group blended together to make up the "character" that expressed the culture of that site. As shown in Figure 2, when institutional support for clinical teaching was perceived to be strong, the effects of barriers diminished in importance, and when it was seen to be weaker, the benefits, though acknowledged, were less able to compensate for the potential negative impact of supervising students.

Starr et al.⁹ looked at what factors contribute to the formation of "teacher identity" in the context of family physicians. One of the important findings of their study was the integration of the teaching role with the professional role: "being a physician means being a teacher."^{9(p.824)} The authors postulated that physicians who see themselves as teachers "may be more likely to enjoy teaching, to teach more, and to be recognized by students and other faculty as good teachers."^{9(p.820)} If the culture of the institution is such that students are viewed as part of the job, then the additional stress they may bring with them is seen not as an insurmountable barrier but, instead, simply as part of the job. In our study, whereas physical therapists generally agreed that heavy caseloads are a possible deterrent to clinical education, it was the culture of the organization that seemed to influence the extent to which CEs saw their caseload—whether heavy or light—as *suitable* for student teaching. Some saw their caseloads as too complex for students, whereas others saw their caseloads as not interesting or challenging enough.

The impact of the extra time students are seen to take was a recurring issue. While some research has sought to quantify the time actually added to a CE's day by a student,^{4,29–31} varying methodologies and sometimes different health care systems make it difficult to arrive at firm conclusions. There is somewhat clearer evidence that productivity in a student/CE dyad may increase,^{32,33} potentially leading to better patient care; however, given the universality of the perception that students take time, this factor must be acknowledged in any comprehensive plan to support education in the clinical setting.

It may be that the change in the CE's workload division, from patient care to patient care plus student education, may contribute to the CE's feeling that *more time* is needed for student supervision, when in fact it is mainly a *different use* of time, one that requires the CE's daily adaptation to the needs of the student, and this may contribute to increased stress.

The idea of being *on your toes* has complex meanings. Someone on his or her toes is alert, in a set of metaphorical starting blocks, ready to go. While generally seen as positive, being on your toes is not a place of rest or peace, and perhaps some of the stress that CEs speak of arises from the double-edged aspect of being stimulated, and therefore challenged, day after day. Ultimately, in taking on the role of CE, physical therapists submit to a change in their clinical practice. This change may be interpreted as positive by some and as negative by others. In our study, the CEs' responses to change were clearly subject to the cultural influences of their institutions.

LIMITATIONS

Because of the limited response from potential participants, the present study was not able to examine the possible effects of clinician experience or student level on perceptions of benefits and barriers. Further, all participants worked in a large urban area and were affiliated with the same university, and therefore it was not possible to examine possible differences that might be due to university affiliation or the effects of the institutions' being in a large urban, as opposed to smaller urban or rural, centre. Research into both areas may provide valuable insights.

CONCLUSION

Fostering a culture of education is a complex, multi-tiered process that, if successful, can contribute to excellence in clinical education. Health care institutions need to value clinical education explicitly, embedding it on a high level in the institution's mission, vision, and values and on the ground level in job descriptions and performance reviews. Strong communication links between clinicians, academic partners, and health care institutions need to be forged and maintained. Recognition that clinical teaching, however rewarding, can also be stressful is essential. CEs need to know they will be supported, particularly when they are confronted with challenging students. This can be an explicit and formal process overseen by a staff member who acts as designated resource to the CE, but may also be valuably supplemented by informal support from the team in which the CE works. Resources (e.g., casual coverage to reduce caseload) may be committed to relieve the early-internship time stress of student orientation.

Rich ongoing communication between the institutions that provide clinical education and their academic partners, including the perspective of the student supervisors, is essential in adapting programmes and support that will foster a flourishing culture of education.

A culture of education is a challenging concept to examine, much less measure, but it may be worthwhile to evaluate the effects of implementing programmes designed to support clinical staff in their teaching roles to see whether such programmes alter attitudes toward student supervision, increase the number of placements overall, or affect student site evaluations. It is hoped that this study and the suggested future research will lead to better support for CEs and, in turn, to heightened excellence in clinical teaching.

KEY MESSAGES

What Is Already Known on This Topic

Much of the research examining health care professionals' identification of the barriers to and benefits of taking students has been from the perspective of medicine and nursing. There are fewer studies looking at this subject from the health discipline perspective, and no studies examining what Canadian physical therapists identify as barriers to and benefits of supervising students; however, there are many commonalities among the studies that do exist. Teaching is seen as providing personal gratification, as stimulating valuable reflection, and as exposing clinical educators to current knowledge. Barriers to clinical teaching include increased stress resulting from the additional time the student is seen to take. Challenging students, reduced space, and loss of autonomy are also seen as adding to stress.

What This Study Adds

The results of this qualitative descriptive study suggest that the benefits and barriers identified in other health care settings and other disciplines are similar to those identified by physical therapists in the Canadian setting. Institutional culture can play a large role in the relative weight that these benefits and barriers carry for CEs: when student education is seen as an integral part of the institutional culture, barriers may seem less significant.

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